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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: OHM9

Facility ID: 00238

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245183**
2.STATE VENDOR OR MEDICAID NO.
(L2) **531716900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTH RIDGE HEALTH AND REHAB**
(L4) **5430 BOONE AVENUE NORTH**
(L5) **NEW HOPE, MN** (L6) **55428**

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) **01/01/2014**

6. DATE OF SURVEY **06/05/2015** (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 **351** (L18)

13.Total Certified Beds **351** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	351			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christine Bodick-Nord, HFE NE II 09/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/03/2015 (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
05/01/1972
(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.
00270
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/06/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245183

September 3, 2015

Mr. Ryan Chies, Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, Minnesota 55428

Dear Mr. Chies:

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

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

Effective July 12, 2015 the above facility is certified for:

351 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 351 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 10, 2015

Mr Ryan Chies, Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, Minnesota 55428

RE: Project Number S5183024 and Complaint Numbers H5183106, H5183107

Dear Mr. Chies:

On June 25, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on June 5, 2015 that included an investigation of complaint numbers H5183106 and H5183107. This surveys found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 4, 2015, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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 and to investigation complaint H5183108. This survey found the most serious deficiencies in the facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D).

On July 20, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the abbreviated standard surveys, completed on June 3, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 12, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to an abbreviated standard survey, completed on June 3, 2015.

However, compliance with the health deficiencies issued pursuant to the June 4 & 5, 2015 abbreviated standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the abbreviated standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective September 4, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 4, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 4, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, North Ridge Health And Rehab is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 4, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

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

Jan.Suzuki@cms.hhs.gov

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

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312)886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov .

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day

period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245183	A. Building B. Wing	8/13/2015

Name of Facility	Street Address, City, State, Zip Code
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **07/12/2015**	ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **07/12/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **07/12/2015**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **07/12/2015**	ID Prefix **F0246** Reg. # **483.15(e)(1)** LSC	Correction Completed **07/12/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **07/12/2015**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/12/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/12/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **07/12/2015**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **07/12/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **07/12/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **07/12/2015**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/12/2015**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **07/12/2015**	ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **07/12/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/kfd	09/02/2015	27955	08/13/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245183	A. Building B. Wing	8/13/2015

Name of Facility	Street Address, City, State, Zip Code
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0431**	Correction Completed **07/12/2015**	ID Prefix **F0465**	Correction Completed **07/12/2015**	ID Prefix **F0467**	Correction Completed **07/12/2015**
Reg. # **483.60(b), (d), (e)**		Reg. # **483.70(h)**		Reg. # **483.70(h)(2)**	
LSC		LSC		LSC	

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 6/5/2015	_____	**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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245183	A. Building B. Wing **01 - MAIN BUILDING 01**	7/20/2015

Name of Facility	Street Address, City, State, Zip Code
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **07/12/2015**	ID Prefix	Correction Completed **07/12/2015**	ID Prefix	Correction Completed **07/12/2015**
Reg. # **NFPA 101** LSC K0018		Reg. # **NFPA 101** LSC K0038		Reg. # **NFPA 101** LSC K0043	
ID Prefix	Correction Completed **07/12/2015**	ID Prefix	Correction Completed **07/12/2015**	ID Prefix	Correction Completed
Reg. # **NFPA 101** LSC K0072		Reg. # **NFPA 101** LSC K0076		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GS/kfd	09/02/2015	28120	07/20/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/3/2015			

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00238	A. Building B. Wing	8/13/2015

Name of Facility	Street Address, City, State, Zip Code
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20530** Reg. # **MN Rule 4658.0300 Subp.** LSC	Correction Completed **07/12/2015**	ID Prefix **20540** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **07/12/2015**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **07/12/2015**
ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp.** LSC	Correction Completed **07/12/2015**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **07/12/2015**	ID Prefix **20840** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **07/12/2015**
ID Prefix **20905** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **07/12/2015**	ID Prefix **21025** Reg. # **MN Rule 4658.0615** LSC	Correction Completed **07/12/2015**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Su** LSC	Correction Completed **07/12/2015**
ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp.** LSC	Correction Completed **07/12/2015**	ID Prefix **21610** Reg. # **MN Rule 4658.1340 Subp.** LSC	Correction Completed **07/12/2015**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **07/12/2015**
ID Prefix **21980** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **07/12/2015**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Su** LSC	Correction Completed **07/12/2015**	ID Prefix **23240** Reg. # **MN Rule 4658.5405** LSC	Correction Completed **07/12/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/kfd	09/02/2015	27955	08/13/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 6/5/2015

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: OHM9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00238

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245183**
2.STATE VENDOR OR MEDICAID NO.
(L2) **531716900**

3. NAME AND ADDRESS OF FACILITY
(L3) **NORTH RIDGE HEALTH AND REHAB**
(L4) **5430 BOONE AVENUE NORTH**
(L5) **NEW HOPE, MN** (L6) **55428**

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) **01/01/2014**

6. DATE OF SURVEY **06/05/2015** (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 **351** (L18)

13.Total Certified Beds **351** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	351			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NE II 07/01/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 07/29/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1972
(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.
00270
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Revised Letter 7/2/2015

Electronically delivered
July 2, 2015

Mr. Ryan Chies, Administrator
North Ridge Health and Rehab
5430 Boone Avenue North
New Hope, Minnesota 55428

RE: Complaint Number H5183108. Project Number S5183024 and Complaint Numbers H5183106, H5183107

Dear Mr. Chies:

On June 4, 2015, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D).

In addition, on June 5, 2015 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 and to complete an investigation of complaint numbers H5183106 and H5183107 which were found to be substantiated at F323. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACTS

Questions regarding this letter and all documents submitted as a response to the abbreviated survey, i.e., the plan of correction should be directed to:

Michelle Ness, Investigation Unit Supervisor
Office of Health Facility Complaints, Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4217 Fax: (651) 281-9796
General Information: (651) 201-4201 or 1-800-369-7994

Questions regarding this letter and all documents submitted as a response to the standard survey, i.e., the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street NW, Suite A
Bemidji, Minnesota 56601
Telephone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey

and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 14, 2015, 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 July 14, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will

recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by September 4, 2015 (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 December 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING _____ B. WING _____	06/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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. Investigation of complaints H5183106 and H5183107 were also completed. The complaints were substantiated at F353.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess for the safe practice of self administration of nebulizer medication (a inhalation treatment of respiratory medication) for 1 of 1 resident (R270) observed self-administering a nebulizer treatment / medication (SAM).	F 176	Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider to the accuracy of facts alleged or conclusions set forth in the Statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law.	7/12/15

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

Electronically Signed | 07/01/2015

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

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F 176	Continued From page 1 Findings include: R270's Discharge Orders and Information dated and electronically signed by physician 5/4/15, directed albuterol- Ipratropium 2.5-0.5 milligrams / 3 milliliters (ml) solution vial (Duoneb) 3 ml inhale orally via nebulizer every four hours for COPD. The Order did not indicate R270 could self-administer this medication nor any others. R270's significant Minimum Data Set (MDS) dated 5/15/15, indicated R270's diagnoses included chronic obstructive pulmonary disease (COPD) and dementia. R270's care plan dated 5/22/15, indicated R270 had behavior problems related to yelling out, refusing medications/oxygen secondary to dementia with delusions and narcissistic personality disorder. The care plan directed staff to administer R270's medications as ordered, however did not address R270's self administration of medication ability. On 6/4/15, at 6:10 a.m. R270 was observed in his room, laying on his back on the edge of the bed with his legs stretched out to the floor, sleeping. R270's a nebulizer mask was resting loosely on his forward. The nebulizer machine was turned on and running with liquid medication noted in the nebulizer chamber. R270 was did not easily arouse to voice or noise. -At 6:13 a.m. licensed practical nurse (LPN)-E was observed to wheel a medication cart past R270's room and came to the nursing station. -At 6:20 a.m. LPN-E remained at the desk administering pain medication to R508. -At 6:23 a.m. when asked if R270 had a	F 176	F176 - Resident #270 has expired. All residents with nebulizers have been reviewed, assessed, care planed, and orders obtained where appropriate for self administration of nebulizers after nurse set up. Licensed staff have been re-educated regarding requirements regarding requirements for self administration of neb treatments. Don/Designee will audit 2 residents/unit/week for self administration of nebs. Audi results will be reviewed in QA&A.	

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F 176	Continued From page 2 self-administration order for the nebulizer medication, LPN-E indicated she would check. After LPN-E reviewed R270's electronic physician orders, she verified R270 did not have an order to self-administer medications. LPN-E confirmed R270 required a SAM order and an assessment completed to determine R270's ability to safely practice self administration of medication. -At 6:27 a.m. both the surveyor and LPN-E walked into R270's room and found the nebulizer still running. LPN-E remained in the room for the rest of the treatment. On 6/4/15, at 2:13 p.m. the direct of nursing (DON) stated this was poor practice and verified R270 required a self administration assessment and physician order prior to self administering medications. Administering Medication policy revised December 2009, directed "Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.	F 176		
F 221 SS=E	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 221	F221- Residents #74 & 566 have had	7/12/15

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F 221	Continued From page 3 review, the facility failed to identify the use of zipped backed, full body suits as a restraint and failed to follow the facility's restraint policy for 2 of 2 residents (R566, R74) observed wearing full body suits which limited access to one's body. The facility also failed to recognize the use of wheelchairs (w/c) brakes as restraint devices which prevented freedom of movement for 2 of 2 residents (R327, R138) observed with engaged w/c brakes which prevented freedom of movement. Findings include: R566's Diagnosis Report dated 1/22/15, identified R566's diagnoses as Alzheimer's disease, depression, cerebrovascular disease (stroke) with hemiplegia (weakness on one side), lack of coordination and generalized muscle weakness. R566's quarterly Minimum Data Set (MDS) dated 4/17/15, indicated R566 had severe cognitive impairment, required extensive assist with dressing and personal hygiene and had upper and lower extremity impairment on one side. In addition, R566's MDS assessment for restraint use indicated "none used" for bed rail, trunk, limb or other. On 6/3/15, at 12:18 p.m. registered nurse (RN)-E, unit manager, and nursing assistant (NA)-E entered R566's room and using a mechanical lift assisted R566 from his wheelchair to his bed. R566 was observed wearing a light blue topped one piece body suit which was zipped up the back and prevented R566 access to his body. On 6/3/15, at 7:06 p.m. R566 was observed seated in his wheelchair wearing the light blue	F 221	restraints reviewed and are appropriate. Orders, assessments, consents, and care plans have been obtained. Residents # 327 & R138 are not having their wheelchair brakes applied at the dining table. Current residents have been reviewed for potential restraints with no other residents identified. New residents will be review for restraint use in M-F stand up meeting. Any new equipment put in place will be assessed to determine if it is a restraint. 1. Nursing staff will be re-educated on the definition of a restraint and types of devices which may become restraints. 2. Licensed Nursing staff will be re-educated on the appropriate process in regards to the use of restraints, consent, assessment and documentation. 3. Nursing Assistant staff will be re-educated on the process's surrounding the use of restraints. DON/Designee will audit and review each resident with a restraint weekly x 4, bi weekly x 4, monthly x 3 for appropriate documentation, consent and follow up.	

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F 221	Continued From page 4	F 221		

topped one piece body suit which remained zipped up the back.

On 6/4/15, at 9:45 a.m. R566 was observed seated in his wheelchair by the aviary dressed in a cobalt blue, one piece body suit zipped up the back.

R566's Order Summary Report dated 2/10/15, revealed it was okay for R566 to be placed in a one piece outfit at all times to prevent disrobing.

R566's care plan dated 2/17/15, directed staff to place R566 in a one piece garment at all times, as available, due to disrobing and smearing of feces.

R566's treatment administration records from 4/1/15, thru 6/3/15, indicated R566 had been placed in a one piece garment at all times.

On 6/3/15, at 7:40 p.m. NA-G confirmed R566 wore a full body suit which zipped up the back.

On 6/4/15, at 10:44 a.m. RN-E verified R566 wore a one piece body suit which zipped up the back. RN-E stated the body suits were made to zip up the back in order to keep the resident from accessing part of their body. RN-E confirmed they had not identified the one piece body suits with the backed zipped enclosure as a physical restraint; however he understood they were a physical restraint as they had limited access to the resident's body.

On 6/4/15, at 11:53 a.m. RN-F stated she understood the one piece body suits with the backed zipped enclosure were restraints as they restricted access to the residents' body. RN-F

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F 221	Continued From page 5	F 221		

confirmed R566 had not had a pre-restraint assessment completed prior to implementation of the physical restraint. RN-F stated she was not knowledgeable of the content of the facility's restraint policy.

R74 utilized a full body suit which zipped up the back and prevented R74 access to body and the facility failed to recognize this as a restraint and follow their restraint policy and procedures related to the use.

R74's care plan dated 3/16/15, directed staff to put R74 in a one piece outfit at night and during the day as needed.

R74's Diagnosis Report dated 3/19/14, identified R74's diagnoses as cerebrovascular disease (stroke), dysphasia (difficulty in swallowing), hypertension (high blood pressure), muscle weakness and difficulty walking.

R74's significant change MDS dated 4/17/15, indicated R74 had severe cognitive impairment and required extensive assist with dressing, toileting and personal hygiene. In addition, R74's MDS assessment for restraint use indicated "none used" for bed rail, trunk, limb or other.

R74's Order Summary Report dated 8/6/14, revealed a physician order for a one piece suit to be worn at night and as needed throughout the day.

R74's treatment administration records from 4/1/15, thru 6/3/15, indicated R74 had been placed in a one piece suit every evening except for 4/24/15.

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F 221	Continued From page 6	F 221		

On 6/3/15, at 12:30 p.m. NA-E was observed to enter R74's room. R74 was observed wearing a one piece, dark blue, neck to ankle body suit which was zipped up the back and prevented R74 access to her body. NA-E was observed to remove R74's body suit, change her incontinent brief, provide perineal-care and apply a clean brief while following infection control practices. While reapplying R74's one piece suit, NA-E noticed the one piece suit's legs were soiled. NA-E attempted to find another one piece suit in R74's closet and stated R74's other one piece suit must be in the laundry. NA-E proceeded to dress R74 in sweat pants and sweatshirt and stated he would put another one piece suit on R74 later once it was washed.

On 6/3/15, at 12:30 p.m. NA-E verified R74 usually wore a one piece body suit with a backed zip enclosure every day because she picked at her incontinent brief and would tear it apart. NA-E also verified R566 wore a one piece body suit because he dug in his brief. NA-E verified R566 was currently wearing a one piece body suit which was zipped up the back.

On 6/4/15, at 10:50 a.m. RN-E and social worker (SW)-A both confirmed R74 wore a one piece, body suit with a backed zip enclosure. RN-E and SW-A both agreed they could see how this could be viewed as a restraint.

On 6/4/15, at 12:25 p.m. RN-F confirmed the one piece body suits with the backed zip enclosures were absolutely considered a restraint. RN-F confirmed R74's care plan had not addressed the one piece body suit as a physical restraint nor had a pre-restraint assessment been completed on R74 or an informed consent obtained from

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F 221	Continued From page 7 R74's legal representative with regards to restraint usage. On 6/4/15, at 2:03 p.m. RN-E and RN-F confirmed it was their expectation staff followed the facility's restraint policy. RN-F confirmed R74 and R566's medical records lacked documentation of informed consent for the use of a physical restraint and documentation of monitoring of these residents while in restraints. R327 was observed with engaged w/c brakes which limited movement and the facility failed to recognize the use as a restraint device and implement their restraint policy and procedures. R327's quarterly MDS dated 5/22/15, indicated R327's diagnoses included muscle weakness, difficulty walking, restless legs syndrome and bipolar and had moderately impaired cognition. R327's Fall Care Area Assessment (CAA) dated 3/5/15, indicated R327 was at risk for falls, had falls related to attempting self transferring and staff were directed to monitor for falls per protocol. R327's Communication CAA dated 3/5/15, indicated R327 was heard of hearing, was able to communicate effectively using a pocket talker and was able to let staff know when she could not hear them. R327's care plan dated 3/16/15, indicated R327 was at risk for falls, was unaware of safety needs and R327 utilized anti-roll back brakes on the w/c. On 6/3/14, at 8:24 a.m. R327 was observed in the dining room seated in a w/c next to the dining table. R327 was observed to repeatedly attempt pull self forward by gripping the table to wheel herself but the left w/c brake was noted to be	F 221		

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F 221	Continued From page 8 engaged. When R327 attempted to wheel self backwards, the w/c would not move as an anti-roll back device was engaged on the back of R327's w/c. R327 was observed to independently stand, step over the foot pedal and as she held the pocket talker in her hand, she independently ambulated, with a steady gait, approximately 30 feet when the dietary manager intervened and asked another staff member to get her w/c. -At 8:32 a.m. R327 was observed to ambulate down the unit hallway to the nursing station where NA-C intervened and asked R327 if she wanted to use the walker or w/c for mobility in which R327 responded she wanted to use her w/c. NA-C proceeded to ambulate with R327 back to her room at which point NA-C turned around and asked another staff member if they knew where R327's w/c was which was found near the medication cart near the nursing station. NA-C stated R327 needed to use the w/c because she was a fall risk. RN-B who heard this conversation, did not respond. Upon looking at the back of the w/c an anti-roll brake black bar was noted to be installed. At 8:45 a.m. R327 was observed seated in a w/c at the dining room table. The w/c brakes were observed engaged. -At 9:02 a.m. NA-B was observed to unlock R327's brakes, cleanse R327's hands and wheel R327 out of the dining room. -At 9:11 a.m. NA-B verified R327's w/c brakes were engaged and stated at times R327 would use the w/c to wheel herself around the facility and would also use the walker. When asked if R327 was able to independently release the w/c brakes, NA-B stated no, R327 would not be able to do so and added, engaging the w/c brakes would be considered a restraint and she did not know who engaged R327's w/c brakes.	F 221		

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F 221	Continued From page 9 On 6/4/15, at 10:43 a.m. RN-D stated staff encouraged the residents to lock their w/c brakes when self transferring or standing and would not expect the staff to lock the w/c brakes while in the dining room. RN-D further stated during meal times the residents' w/c brakes would be locked while eating, however when asked who was responsible to ensure the brakes were released when the resident' were done eating, RN-D was unable to answer but indicated when the staff took the residents back to their room they would then release the brakes. RN-D verified R327 had not had a restraint assessment completed. On 6/4/15, at 2:20 p.m. the director of nursing (DON) stated she was not so familiar with R327 and indicated if R327 was able to wheel herself independently she would have expected staff to not have the brakes engaged and was not sure if R327 could release the brakes herself. R138 was observed with engaged w/c brakes which limited movement and the facility failed to recognize the use as a restraint device and implement their restraint policy and procedures. R138's care plan for mobility initiated 3/7/15, indicated R138 was able to propel his wheelchair independently on the unit and directed staff to assist upon request and as needed. R138's annual MDS dated 5/15/15, indicated R138 had moderate cognitive impairment, no physical behaviors, required extensive assistance of one staff for locomotion with the wheelchair, was independent with eating and had no restraints.	F 221		

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R138's undated Face Sheet indicated R138 had diagnoses that included cerebrovascular disease (stroke) with hemiplegia (weakness or paralysis on one side of the body), difficulty walking, muscle weakness, convulsions, dementia and anxiety.

R138's Activity of Daily Living (ADL) CAA dated 5/15/15, indicated R138's primary mode of transportation was the wheelchair and R138 was able to independently propel himself and also with staff assistance.

R138's medical record indicated R138 had a history of falls with majority of falls having occurred during staff assisted transfers. The medical record lacked documentation of physical restraint use.

On 6/3/15, at 5:42 p.m. R138 was observed seated in a w/c at the dining room table independently eating the meal.
-At 5:48 p.m. upon completion of the meal, R138 was observed attempting to push his w/c back away from the table in order to leave the table. R138' w/c tipped slightly back, however did not move. R138 was observed to intermittently shift self in his w/c seat while attempting to push the w/c back. The left w/c brake was noted to be engaged therefore the w/c did not move.
-At 5:53 p.m. R138 reported to a few staff members in the dining room that he could not move. RN-H was observed to release the w/c brake and wheel R138 out of the dining room.

On 6/4/15, at 2:09 p.m. RN-H confirmed if a device limited or prevented movement it would be

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F 221	Continued From page 11 a restraint. RN-H stated she did not know why R138's w/c brake was engaged and was unaware of any type of restraint assessment or assessment for the w/c brakes to be locked that was to be completed. On 6/5/15, at 11:20 a.m. RN-H verified that locking w/c brakes at the dining table which prevented freedom of movement when the resident was unable to independently release, would be considered a restraint. The Use of Restraints policy, revision date 9/2012, indicated: · Defined a physical restraint as any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body which restricted normal access to one's body · Directed staff to compete a pre-restraint assessment prior to placing a resident in restraints · Directed staff to obtain informed consent for the use of restraints which included the risks and benefits of all options under consideration, including the use of restraints and alternatives · Care plans for residents in restraints would reflect interventions that addressed not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s) · A resident restrained would be monitored at least every thirty minutes and the staff would document these observations	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		7/12/15

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F 225	Continued From page 12 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 225	Residents 138,228 and 152 incidents	

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F 225	Continued From page 13 review, the facility failed to report timely to the State agency and /or investigate allegations of abuse, neglect, injuries of unknown origin and accidents with serious injury for 3 of 5 incidents involving 3 of 3 residents (R138, R228, R152) reviewed for abuse. Findings include: An incident report dated 5/7/15, at 7:40 p.m. indicated R138 fell during a one staff assisted transfer from the wheelchair to the toilet when R138 lost his balance and fell against the wall. The report indicated R138 bumped his left arm and the left side of his head. The report also indicated the director of nursing (DON) and the nursing supervisor were notified. The nursing note on the incident report dated 5/8/15, indicated R138's care plan was updated to indicated two staff assist was needed for transfers and ambulation. The predisposing physiological factors were identified as weakness/fainted. The report also indicated R138's responsible party was notified on 5/7/15, at 7:50 p.m., and the physician was notified on 5/8/15, at 2:04 p.m. The incident report lacked indication of State agency notification, as required. R138's undated Face Sheet and Diagnosis List printed 6/4/15, indicated R138's diagnoses included hemiplegia (paralysis on one side of the body) due to cerebrovascular disease (stroke), convulsions (seizures), difficulty in walking, muscle weakness, dementia without behavioral disturbance, depressive disorder and anxiety. A Fall Risk Evaluation dated 5/6/15, indicated R138 was at high risk for falls and had 1-2 falls in the 90 days prior. The fall risk evaluation	F 225	have been reported and investigated per P&P and regulations. Prior to MDH survey - facility re-educated RN who failed to follow proper reporting procedure in regards to resident 152. All resident incidents are being investigated and reported per regulation. All staff have been re-educated regarding reporting and investigating requirements. DON/Designee will audit 2 incidents/unit/week for reporting and investigating requirements. Audit will be reviewed at QA&A.	

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indicated R138 had no cognitive changes, ambulated with problems and a device, his gait was unsteady and he required physical assistance to stabilize.

R138's Progress note dated 5/8/15, indicated R138 complained of pain in ribs from the fall.

R138's Progress note dated 5/10/15 at 2:41 p.m., indicated R138 complained of pain in his chest on both sides.

R138's Progress note dated 5/10/15, at 10:30 p.m. indicated R138 complained of left side pain, pointing to the rib area. No bruising or swelling was noted.

An order by the nurse practitioner (NP) dated 5/11/15, directed an x-ray of the right and left ribs and chest x-ray for diagnosis of pain.

A radiology report dated 5/11/15, indicated R138 had acute rib fractures of the left third, fourth, and fifth ribs.

R138's Progress note dated 5/11/15, at 9:40 p.m. indicated a chest x-ray result included rib fractures of 3 ribs. The note indicated a call was placed to the assistant director of nursing (ADON) to report the injury (fracture) and the fall report was reviewed. The report also indicated R138 was spoken to and he reported the fractures occurred when he had fallen the previous week and reported his pain level as 10 on a scale of 1-10, which indicated almost unbearable pain.

R138's NP progress note dated 5/12/15, indicated R138 had falls with injury and noted R138 had left

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rib fractures. In addition, the NP noted R138 had a 10 pound weight loss and his blood pressures were too low and the blood pressure medication had just been decreased and labs had been ordered. The note also indicated the NP had ordered R138's blood pressures and heart rate checks twice daily for one week.

R138's annual Minimum Data Set (MDS) assessment dated 5/15/15, indicated R138 had moderate cognitive deficit, displayed no rejection of care and required extensive assistance of two staff for transfers and ambulation. The MDS also indicated R138 had balance problems and was unsteady with position changes. In addition, the MDS indicated R138 had almost constant pain rated at 10 out of 10, which indicated almost unbearable pain.

R138's Fall Care Area Assessment (CAA) dated 5/15/15, indicated R138 was potentially at risk for falls due to balance problems during position changes and receiving an antidepressant medication. The CAA indicated R138 required assistance with transfers and would ambulate short distances in his room with staff assist and the use of a walker, but the wheelchair was his primary mode of transportation.

R138's Progress note dated 5/29/15, at 7:45 a.m. indicated R138 reported, "someone busted up my neck." The note indicated when R138 was asked what was going on, he talked about how no one helped him the previous night, something was wrong with his neck and he wanted an x-ray. The progress note indicated R138 was told the charge nurse would be notified to schedule an x-ray and the doctor would be informed.

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R138's Progress note dated 5/29/15, at 8:54 a.m. indicated R138 complained of pain in the lower neck, running along upper shoulder blade region. R138 stated he felt pain when moved by NA that morning and said that he was moved in such a way as to cause pain in his neck. The progress indicated the nurse assessed the location of R138's pain.

R138's medical record lacked any documentation of the State agency notification related to the fall with resultant rib fractures. In addition, R138's medical record lacked any documentation related to R138's report of neck pain and rough movement.

R138's falls care plan initiated 6/12/14, and revised 2/9/15, indicated R138 was at risk for falls and directed staff to follow the facility's fall protocol, review the information on past falls and attempt to determine cause of falls, record possible root causes of the fall, and then to alter or remove any potential causes, if possible. The care plan further directed staff to educate the resident, family and staff regarding the causes.

R138's care plan for activities of daily living (ADLs), initiated 3/7/15, and revised 5/8/15, indicated R138 required the assistance of two staff for transfers, bed mobility and toilet use.

R138's care plan dated 4/24/15, indicated R138 had the potential for pain related to arthritis and was able to call for assistance when in pain, was able to reposition self, ask for medication, communicate how much pain he was experiencing and what increased or alleviated the pain.

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R138's care plan for mobility initiated 3/7/15, indicated R138 required the assistance of two staff for ambulation with a quad cane (a cane with 4 ends, hemi cane) with a goal for R138 to ambulate daily with the quad cane and assist of one staff.

R138's previous care plan printed 12/20/13, and updated as recently as 1/15/15, indicated R138 was to ambulate with restorative nursing up to 300 feet with the assistance of one staff using the quad cane on the right side. The care plan indicated R138 was at risk for falls, required extensive assistance of 1 to 2 staff for pivot transfers with the quad cane and assistance needed varied daily due to weakness, pain and confusion.

R138's care plan updated on 12/5/14, indicated R138 had a fall and the care card was updated.

R138's Resident Care Card (the care plan used by nursing assistants) printed 6/4/15, directed the use of two staff for transfers, two staff assist with the quad cane for ambulation and two staff assist for toilet use. The Resident Care Card printed 3/9/15, indicated R138 required two staff for transferring. A note by the registered nurse (RN)-H dated 12/16/14, indicated R138's resident care card dated 12/5/14, directed staff to transfer R138 with two staff assist and also indicated the care plan was not followed during R138's incident of 12/5/14, when R138 fell during a transfer with only one staff assist. RN-H stated this indicated R138's care card had been changed prior to 12/5/14, directing the use of two staff assist for transfer.

The undated nursing assistant (NA) group sheet

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provided by RN-H indicated the NAs were to refer to the Care Card for transfers and toilet use guidance. The group sheet did not indicate how R138 was to ambulate or if he could ambulate.

The facility Minnesota Department of Health Tracking Form for vulnerable adult (VA) reports made by the facility lacked documentation which indicated R138's incident of 5/7/15, rib fractures and the report of neck pain alleged to be caused by treatment by staff.

On 6/3/15, at 2:17 p.m. R138 stated some staff were rough in the morning because they were in a hurry. R138 also stated he was more sore in the morning and at times, felt staff were disrespectful and ignored his needs. R138 also stated he was not afraid of staff and did not feel the staff purposefully tried to hurt him. R138 confirmed he had had broken bones and bruises from falls.

On 6/4/15, at 2:09 p.m. RN-H stated since prior to 12/5/14, R138 had required the assist of two staff. RN-H stated the facility reported falls with major injuries, bruises of unknown cause, bruises in odd spots and altercations as well as allegations of abuse, neglect and mistreatment to the State agency. RN-H stated R138's rib fractures were probably related to the fall that had occurred that week during a transfer, however was unaware if the incident was reported to the State agency. RN-H verified the allegations related to the neck pain should have been reported to the State agency, immediately.

On 6/4/15, at 4:35 p.m. the director of nursing (DON) stated she would expect staff to follow the resident care cards when providing cares as the

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care card was the individual resident care plan for NA's to use. The DON stated staff called the DON with all falls and stated R138's fractured ribs were related to his fall on 5/7/15. The DON verified R138's care plan was not followed during the incident and the fall with a fracture should have been reported to the State agency, as required. In addition, the DON verified R138's allegation of neck pain and mistreatment by staff was not reported the next day because R138's pain had diminished. The DON stated the nurse was to protect the resident first, pull the alleged staff member from the floor and report the allegation to the State agency right away.

R228 sustained an unwitnessed right hip fracture and the facility failed to report and investigate the incident as required.

R228's annual MDS dated 2/6/15, indicated R228's diagnoses included, non-Alzheimer's dementia, arthritis and osteoporosis. The MDS indicated R228 had memory loss, impaired decision making skills, required limited assist with walking and transferring and used a walker and wheelchair for mobility.

R228's significant change MDS dated 5/22/15, indicated R228's diagnoses included non-Alzheimer's dementia, arthritis, osteoporosis and hip fracture.
The MDS indicated R228 had memory loss, impaired decision making skills, was totally dependent on two staff for transfers and was non-ambulatory. The MDS indicated R228 had impairment in range of motion on one side in lower extremity and used a wheelchair.

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R228's Nurse Progress note dated 2/14/15, at 7:39 a.m. indicated R228 was found on the floor, lying on right side between the bathroom door. The note indicated R228 was yelling out and screamed when right leg was touched. The note further revealed R228's right leg was shorter and rotated therefore a telephone call placed to physician and supervisor.
The 9:29 a.m. nurse progress note indicated x-ray showed hip fracture.

The 2/14/15, Fall report indicated R228 had a fall in her room, was confused, incontinent, had gait imbalance, impaired memory, was non-compliant, had weakness/fainted. The report indicated R228's predisposing situation factors were ambulating without assistance.
The report indicated R228 was alone and unattended, and call light was not in use at time of fall.

Review of the facilities Fall Log report on 6/4/15, indicated R228's fall/fractured hip was not on the report.

On 6/4/15, at 12:30 p.m. RN-D stated R228 would not be on the Fall log because an incident report was not completed because the facility was following R228's care plan at the time of the fall. RN-D added, it was not facility practice to report an incident such as R228's hip fracture because staff were following the resident's care plan.
RN-D also verified the facility did not complete an investigation related to R228's fall and fracture because staff were following the care plan.

On 6/5/15, at 3:00 p.m. the administer and DON were interviewed. The administrator stated it was not their policy to report an incident such as

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R228's fall and hip fracture because staff were following R228's care plan at the time of the fall.

R152 sustained a fractured rib of unknown origin and the facility failed to timely report the incident to the State agency, as required.

R152's undated Transfer/Discharge report indicated R152 had diagnoses of Alzheimer's Dementia, generalized pain, coronary arteriosclerosis and depression.

A facility Investigation Report dated 5/4/15, indicated on 5/3/15, R152 had complained of right sided pain, R152 denied falling, an X-Ray was ordered and revealed an acute right 7th fractured rib. The section of the report form titled, date administrator and medical director notification was blank. The Summary of Investigation section was also blank.

The Investigation Report-undated indicated R152's incident occurred/or was noted on 5/4/15, and location of incident was "unknown."

The VA report filed with the State agency was dated 5/5/15, therefore was not reported immediately, as required.

On 6/5/15, at 3:00 p.m. the administer and DON were interviewed. The administrator verified the VA report was not reported timely and stated the RN supervisor should reported the incident as required. The administrator stated the RN supervisor involved was given disciplinary action and education was provided.

The facility policy and procedure for Reporting Abuse to the State Agencies and Other

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F 225	Continued From page 22 Entities/Individuals revised 2006, directed if a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility will promptly notify the State agency. The facility policy and procedure for Recognizing Signs and Symptoms of Abuse/Neglect revised 2006, indicated neglect was defined as "failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness". The policy identified some signs of abuse or neglect including inadequate provision of care and caregiver indifference to resident's personal care and needs. The facility policy and procedure for Reporting Abuse to Facility Management revised 9/12, indicated it was the responsibility of the employees to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The policy and procedure directed employees must immediately report any suspected abuse or incidents of abuse to their direct supervisor, abuse coordinator and/or administrator. In addition the administrator or DON must be immediately notified of suspected abuse or incidents of abuse regardless of the time lapse since the incident occurred.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents	F 226		7/12/15

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F 226	Continued From page 23 and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed operationalize their abuse prohibition policy and procedures related to timely reporting to the State agency and / or investigate allegations of abuse, neglect, injuries of unknown origin and accidents with serious injury for 3 of 5 incidents reviewed which involved 3 of 3 residents (R138, R228, R152). Findings include: An incident report dated 5/7/15, at 7:40 p.m. indicated R138 fell during a one staff assisted transfer from the wheelchair to the toilet when R138 lost his balance and fell against the wall. The report indicated R138 bumped his left arm and the left side of his head. The report also indicated the director of nursing (DON) and the nursing supervisor were notified. The nursing note on the incident report dated 5/8/15, indicated R138's care plan was updated to indicated two staff assist was needed for transfers and ambulation. The predisposing physiological factors were identified as weakness/fainted. The report also indicated R138's responsible party was notified on 5/7/15, at 7:50 p.m., and the physician was notified on 5/8/15, at 2:04 p.m. The incident report lacked indication of State agency notification, as required. R138's undated Face Sheet and Diagnosis List printed 6/4/15, indicated R138's diagnoses included hemiplegia (paralysis on one side of the	F 226	The community has operationalized the P&P for reporting and investigating incidents and potential abuse. All incidents are being investigated and reported. All staff have been re-educated regarding reporting and investigating requirements. DON/Designee will audit 2 incidents/unit/week to ensure that staff have operationalized the policies and procedures for reporting and investigating. Audit results will be reviewed at QA&A.	

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body) due to cerebrovascular disease (stroke), convulsions (seizures), difficulty in walking, muscle weakness, dementia without behavioral disturbance, depressive disorder and anxiety.

A Fall Risk Evaluation dated 5/6/15, indicated R138 was at high risk for falls and had 1-2 falls in the 90 days prior. The fall risk evaluation indicated R138 had no cognitive changes, ambulated with problems and a device, his gait was unsteady and he required physical assistance to stabilize.

R138's Progress note dated 5/8/15, indicated R138 complained of pain in ribs from the fall.

R138's Progress note dated 5/10/15 at 2:41 p.m., indicated R138 complained of pain in his chest on both sides.

R138's Progress note dated 5/10/15, at 10:30 p.m. indicated R138 complained of left side pain, pointing to the rib area. No bruising or swelling was noted.

An order by the nurse practitioner (NP) dated 5/11/15, directed an x-ray of the right and left ribs and chest x-ray for diagnosis of pain.

A radiology report dated 5/11/15, indicated R138 had acute rib fractures of the left third, fourth, and fifth ribs.

R138's Progress note dated 5/11/15, at 9:40 p.m. indicated a chest x-ray result included rib fractures of 3 ribs. The note indicated a call was placed to the assistant director of nursing (ADON) to report the injury (fracture) and the fall report was reviewed. The report also indicated

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R138 was spoken to and he reported the fractures occurred when he had fallen the previous week and reported his pain level as 10 on a scale of 1-10, which indicated almost unbearable pain.

R138's NP progress note dated 5/12/15, indicated R138 had falls with injury and noted R138 had left rib fractures. In addition, the NP noted R138 had a 10 pound weight loss and his blood pressures were too low and the blood pressure medication had just been decreased and labs had been ordered. The note also indicated the NP had ordered R138's blood pressures and heart rate checks twice daily for one week.

R138's annual Minimum Data Set (MDS) assessment dated 5/15/15, indicated R138 had moderate cognitive deficit, displayed no rejection of care and required extensive assistance of two staff for transfers and ambulation. The MDS also indicated R138 had balance problems and was unsteady with position changes. In addition, the MDS indicated R138 had almost constant pain rated at 10 out of 10, which indicated almost unbearable pain.

R138's Fall Care Area Assessment (CAA) dated 5/15/15, indicated R138 was potentially at risk for falls due to balance problems during position changes and receiving an antidepressant medication. The CAA indicated R138 required assistance with transfers and would ambulate short distances in his room with staff assist and the use of a walker, but the wheelchair was his primary mode of transportation.

R138's Progress note dated 5/29/15, at 7:45 a.m. indicated R138 reported, "someone busted up my

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neck." The note indicated when R138 was asked what was going on, he talked about how no one helped him the previous night, something was wrong with his neck and he wanted an x-ray. The progress note indicated R138 was told the charge nurse would be notified to schedule an x-ray and the doctor would be informed.

R138's Progress note dated 5/29/15, at 8:54 a.m. indicated R138 complained of pain in the lower neck, running along upper shoulder blade region. R138 stated he felt pain when moved by NA this morning and said that he was moved in such a way as to cause pain in his neck. The progress indicated the nurse assessed the location of R138's pain.

R138's medical record lacked any documentation of the State agency notification related to the fall with resultant rib fractures. In addition, R138's medical record lacked any documentation related to R138's report of neck pain and rough movement.

R138's falls care plan initiated 6/12/14, and revised 2/9/15, indicated R138 was at risk for falls and directed staff to follow the facility's fall protocol, review the information on past falls and attempt to determine cause of falls, record possible root causes of the fall, and then to alter or remove any potential causes, if possible. The care plan further directed staff to educate the resident, family and staff regarding the causes.

R138's care plan for activities of daily living (ADLs), initiated 3/7/15, and revised 5/8/15, indicated R138 required the assistance of two staff for transfers, bed mobility and toilet use.

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R138's care plan dated 4/24/15, indicated R138 had the potential for pain related to arthritis and was able to call for assistance when in pain, was able to reposition self, ask for medication, communicate how much pain he was experiencing and what increased or alleviated the pain.

R138's care plan for mobility initiated 3/7/15, indicated R138 required the assistance of two staff for ambulation with a quad cane (a cane with 4 ends, hemi cane) with a goal for R138 to ambulate daily with the quad cane and assist of one staff.

R138's previous care plan printed 12/20/13, and updated as recently as 1/15/15, indicated R138 was to ambulate with restorative nursing up to 300 feet with the assistance of one staff using the quad cane on the right side. The care plan indicated R138 was at risk for falls, required extensive assistance of 1 to 2 staff for pivot transfers with the quad cane and assistance needed varied daily due to weakness, pain and confusion.

R138's care plan updated on 12/5/14, indicated R138 had a fall and the care card was updated.

R138's Resident Care Card (the care plan used by nursing assistants) printed 6/4/15, directed the use of two staff for transfers, two staff assist with the quad cane for ambulation and two staff assist for toilet use. The Resident Care Card printed 3/9/15, indicated R138 required two staff for transferring. A note by the registered nurse (RN)-H dated 12/16/14, indicated R138's resident care card dated 12/5/14, directed staff to transfer R138 with two staff assist and also indicated the

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care plan was not followed during R138's incident of 12/5/14, when R138 fell during a transfer with only one staff assist. RN-H stated this indicated R138's care card had been changed prior to 12/5/14, directing the use of two staff assist for transfer.

The undated nursing assistant (NA) group sheet provided by RN-H indicated the NAs were to refer to the Care Card for transfers and toilet use guidance. The group sheet did not indicate how R138 was to ambulate or if he could ambulate.

The facility Minnesota Department of Health Tracking Form for vulnerable adult (VA) reports made by the facility lacked documentation which indicated R138's incident of 5/7/15, rib fractures and the report of neck pain alleged to be caused by treatment by staff.

On 6/3/15, at 2:17 p.m. R138 stated some staff were rough in the morning because they were in a hurry. R138 also stated he was more sore in the morning and at times, felt staff were disrespectful and ignored his needs. R138 also stated he was not afraid of staff and did not feel the staff purposefully tried to hurt him. R138 confirmed he had had broken bones and bruises from falls.

On 6/4/15, at 2:09 p.m. registered nurse (RN)-H stated since prior to 12/5/14, R138 had required the assist of two staff. RN-H stated the facility reported falls with major injuries, bruises of unknown cause, bruises in odd spots and altercations as well as allegations of abuse, neglect and mistreatment to the State agency. RN-H stated R138's rib fractures were probably related to the fall that had occurred that week

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during a transfer, however was unaware if the incident was reported to the State agency. RN-H verified the allegations related to the neck pain should have been reported to the State agency, immediately.

On 6/4/15, at 4:35 p.m. the director of nursing (DON) stated she would expect staff to follow the resident care cards when providing cares as the care card was the individual resident care plan for NA's to use. The DON stated staff called the DON with all falls and stated R138's fractured ribs were related to his fall on 5/7/15. The DON verified R138's care plan was not followed during the incident and the fall with a fracture should have been reported to the State agency, as required. In addition, the DON verified R138's allegation of neck pain and mistreatment by staff was not reported the next day because R138's pain had diminished. The DON stated the nurse was to protect the resident first, pull the alleged staff member from the floor and report the allegation to the State agency right away.

R228 sustained an unwitnessed right hip fracture and the facility failed to report timely to the State agency and investigate the incident as required.

R228's annual MDS dated 2/6/15, indicated R228's diagnoses included, non-Alzheimer's dementia, arthritis and osteoporosis. The MDS indicated R228 had memory loss, impaired decision making skills, required limited assist with walking and transferring and used a walker and wheelchair for mobility.

R228's significant change MDS dated 5/22/15, indicated R228's diagnoses included

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non-Alzheimer's dementia, arthritis, osteoporosis and hip fracture.
The MDS indicated R228 had memory loss, impaired decision making skills, was totally dependent on two staff for transfers and was non-ambulatory. The MDS indicated R228 had impairment in range of motion on one side in lower extremity and used a wheelchair.

R228's Nurse Progress note dated 2/14/15, at 7:39 a.m. indicated R228 was found on the floor, lying on right side between the bathroom door. The note indicated R228 was yelling out and screamed when when right leg was touched. The note further revealed R228's right leg was shorter and rotated therefore a telephone call placed to physician and supervisor.
The 9:29 a.m. nurse progress note indicated x-ray showed hip fracture.

The 2/14/15, Fall report indicated R228 had a fall in her room, was confused, incontinent, had gait imbalance, impaired memory, was non-compliant, had weakness/fainted. The report indicated R228's predisposing situation factors were ambulating without assistance.
The report indicated R228 was alone and unattended, and call light was not in use at time of fall.

Review of the facilities Fall Log report on 6/4/15, indicated R228's fall/fractured hip was not on the report.

On 6/4/15, at 12:30 p.m. RN-D stated R228 would not be on the Fall log because an incident report was not completed because the facility was following R228's care plan at the time of the fall. RN-D added, it was not facility practice to report

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an incident such as R228's hip fracture because staff were following the resident's care plan. RN-D also verified the facility did not complete and investigation related to R228's fall and fracture because staff were following the care plan.

On 6/5/15, at 3:00 p.m. the administer and DON were interviewed. The administrator stated it was not their policy to report an incident such as R228's fall and hip fracture because staff were following R228's care plan at the time of the fall.

R152 sustained a fractured rib of unknown origin and the facility failed to report timely to the State agency, as required.

R152's undated Transfer / Discharge report indicated R152 had diagnoses of Alzheimer's Dementia, generalized pain, coronary arteriosclerosis and depression.

A facility Investigation Report dated 5/4/15, indicated on 5/3/15, R152 had complained of right sided pain, R152 denied falling, an X-Ray was ordered and revealed an acute right 7th fractured rib. The section of the report form titled, date administrator and medical director notification was blank. The Summary of Investigation section was also blank.

The Investigation Report-undated indicated R152's incident occurred / or was noted on 5/4/15, and location of incident was "unknown."

The VA report filed with the State agency was dated 5/5/15, therefore was not reported immediately, as required.

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On 6/5/15, at 3:00 p.m. the administer and DON were interviewed. The administrator verified the VA report was not reported timely and stated the RN supervisor should reported the incident as required. The administrator stated the RN supervisor involved was given disciplinary action and education was provided.

The facility policy and procedure for Reporting Abuse to the State Agencies and Other Entities/Individuals revised 2006, directed if a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility will promptly notify the State agency.

The facility policy and procedure for Recognizing Signs and Symptoms of Abuse/Neglect revised 2006, indicated neglect was defined as "failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. The policy identified some signs of abuse or neglect including inadequate provision of care and caregiver indifference to resident's personal care and needs.

The facility policy and procedure for Reporting Abuse to Facility Management revised 9/12, indicated it was the responsibility of the employees to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The policy and procedure directed employees must immediately report any suspected abuse or incidents of abuse to their direct supervisor, abuse coordinator and/or administrator. In addition the administrator or

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F 226	Continued From page 33 DON must be immediately notified of suspected abuse or incidents of abuse regardless of the time lapse since the incident occurred.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were accessible for 1 of 3 residents (R298) observed needing staff assistance and capable of using the call light, however the call light was out of her reach during 2 of 2 observations. Findings include: R298 was able to use her call light to summon staff assistance, however the facility failed to place the call light within R298's reach. R298's Fall Care Area Assessment (CAA) dated 12/15/14, indicated R298 was at risk for falls due to difficulty maintaining sitting balance, cognitive impairment and impaired balance during transitions. R298's quarterly Minimum Data Set (MDS) dated 3/6/15, indicated R298's diagnoses included	F 246	Resident #298 has her call light within reach. All resident have their call lights within reach. All call light cords have been checked to ensure a clip is available on the cord for secure placement. All staff have been re-educated regarding having call lights within reach. DON/Designee will audit 2 residents/unit/week to ensure appropriate call light placement. Results of audits will be reviewed at QA&A.	7/12/15

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muscle weakness, fatigue and malaise and dementia. The MDS also indicated R298 required extensive physical assist of one to two staff for all activities of daily living (ADLs), had moderately impaired cognition and used a wheelchair for mobility.

R298's care plan most recently revised 6/15, lacked indication of R298's call light use.

On 6/1/15, from 6:10 p.m. until 6:17 p.m. R298 was heard yelling "help help" from her room. Upon entering R298's room, R298 was observed lying on her back in bed with the head of the bed elevated at approximately 45 degrees. R298 asked the surveyor to lower the head of bed. When R298 was asked asked if she was able to use the call light, R298 stated "yes but I don't know where it is." The call light was observed lying on floor with the call light cord hanging on the grab bar facing downward not accessible to R298. The surveyor requested assistance from licensed practical nurse (LPN)-D who was at the nurses station. LPN-D assisted R298 and repositioned her call light within R298's reach.
-At 6:18 p.m. when asked if R298 was capable of using the call light to summon staff assistance, LPN-D stated "yes" and acknowledged it was supposed to be within R298's reach.

On 6/2/15, from 8:42 a.m. to 8:44 a.m. R298 heard calling out "help help" from her room. Upon entry to R298's room, R298 was observed seated in her wheelchair which was stationed parallel to the bed. The call light was observed lying almost in the middle of the bed next out of R298's reach. R298 stated the call light was too far away from her reach and asked the surveyor to put it on for her. The surveyor requested the assistance of

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F 246	Continued From page 35 registered nurse (RN)-C who came to the room and asked R298 what she needed, reached out for the call light and wrapped it around R298's right wheelchair armrest, activated it and stated she was going to find help for R298. RN-C acknowledged R298 was unable to reach the call light and stated it should have been within R298's reach. On 6/5/15, at 10:00 a.m. the director of nursing (DON) stated resident call lights were supposed to within the residents' reach at all times, for those able to use them. On 6/2/15, at 4:03 p.m. RN-D stated the facility did not have a policy or procedure related to call light use.	F 246		
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than	F 278		7/12/15

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F 278	Continued From page 36 $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the residents' dental status for 2 of 3 residents (R228, R163) reviewed for teeth/dental and accurately reflected the residents' restraint status for 2 of 2 residents (R74, R566) reviewed for restraints. Findings include: R228's significant change Minimum Data Set (MDS) dated 5/22/15, inaccurately indicated R228 had no dental issues. R228's significant change MDS dated 5/22/15, indicated R228's had "no" broken or loosely fit full or partial dentures and "no natural teeth or tooth fragments. R228's Oral Health Screening dated 4/21/15, indicated R228 had an exam which noted multiple root tips and optional recommendations for treatment such as: leave as is, take x-rays and extractions or fill #11 tooth and make new upper partial and reline lowers.	F 278	Residents 228, 163, 74, 566 have had modifications completed for an accurate MDS assessment. All residents' assessments are reviewed for accuracy prior to submission. MDS staff have been re-educated regarding accuracy of MDS data. Director of Reimbursement/Designee will audit 2 residents/unit/week MDS to ensure accurate coding. Results of audits will be reviewed at QA&A.	

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R228's care plan dated 5/2015, indicated she had her own teeth.
On 6/2/15, at 11:54 a.m. R228 was observed with her front teeth missing.

On 6/3/15, at 5:30 p.m. R228 stated her front teeth fell out and her power of attorney knew about it. She stated she did not know if she was going to get new teeth or not.

On 6/4/15, at 7:00 a.m. licensed practical nurse (LPN)-F verified staff knew R228 had missing teeth and stated R228 had lost three teeth around 2/15.

On 6/4/15, at 10:10 a.m. the above identified MDS's were reviewed with RN-E, the MDS coordinator. RN-E verified the MDS information and stated they both were incorrect as R228 did have broken, missing teeth.
R163's MDS dated 5/22/15, failed to accurately reflect R163's dental status.

R163's quarterly MDS dated 5/22/15, and significant change MDS dated 10/6/14, indicated R163 had "no broken or loosely fitting partial or full denture."

R163's care plan dated 5/28/15, indicated R163 "has her own teeth."

On 6/2/15, at 8:23 a.m. R163 was observed without the lower denture in place.

On 6/2/15, at 10:22 p.m. R163's family member, (FM)-A, stated R163's lower denture did not fit properly and had not fit for a couple of years.

On 6/5/15, at 10:18 p.m. R163 stated she did not

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wear her bottom dentures as they "wobbled" in her mouth and did not fit her.

On 6/5/15, at 1:53 p.m. nursing assistant (NA)-U stated R163 did not have bottom dentures.

On 6/5/15, at 2:06 p.m. registered nurse (RN)-D verified the care plan indicated R163 had her own teeth.

06/05/2015, at 3:19 p.m. RN-E verified the above identified MDS documentation and confirmed the MDS assessments were inaccurately coded.

According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, "Steps for Assessment" directed staff to:
-ask the resident, family, or significant other whether the resident had or recently had dentures or partials (If resident or family/significant other reported that the resident recently had dentures or partials, but they did not have them at the facility, ask for a reason).
-if the resident had dentures or partials, examine for loose fit.
The coding instructions directed a denture was coded as loose if the resident complained that it was loose, the denture visibly moved when the resident opened his or her mouth, or the denture moved when the resident tried to talk. The coding instructions further directed to check "no natural teeth or tooth fragment(s) (edentulous)" if the resident was edentulous or lacked all natural teeth or part of teeth.

R74's MDS dated 4/17/15, failed to accurately reflect the use of a physical restraint.

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F 278	Continued From page 39 R74's significant change MDS dated 4/17/15, indicated R74's assessment for restraint use indicated "none used" for bed rail, trunk, limb or other. On 6/3/15, at 12:30 p.m. R74 was observed dressed in a one piece, dark blue neck to ankle body suit which was zipped up the back and prevent R74 access to own body. R74's Order Summary Report dated 8/6/14, revealed a physician order for a one piece suit to be worn at night and as needed throughout the day. R74's care plan dated 3/16/15, directed staff to put R74 in a one piece outfit at night and during the day as needed. R74's treatment administration records from 4/1/15, thru 6/3/15, indicated R74 had been placed in a one piece suit every evening except for 4/24/15. On 6/3/15, at 12:30 p.m. NA-E verified R74 usually wore a one piece body suit with a backed zip enclosure every day because she picked at her brief and would tear it apart. On 6/4/15, at 10:50 a.m. RN-E and social worker (SW)-A confirmed R74 wore a one piece body suit with a backed zip enclosure. RN-E and SW-A agreed they saw how this could be viewed as a restraint. On 6/4/15, at 12:25 p.m. RN-F confirmed the one piece body suit with the backed zip enclosures were absolutely considered a restraint.	F 278		

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On 6/4/15, at 12:25 p.m. RN-E and RN-F verified R74's MDS was inaccurate for restraint use as R74 utilized a physical restraint (one piece body suit) and this had not been reflected on the restraint section of the MDS.

R566's MDS dated 4/17/15, failed to accurately reflect the use of a physical restraint.

R566's quarterly MDS dated 4/17/15, indicated R566's assessment for restraint use indicated "none used" for bed rail, trunk, limb or other.

On 6/3/15, at 12:18 p.m. RN-E, NA-E were observed to enter R566's room and transfer R566 from his wheelchair into bed using a mechanical lift. R566 was observed dressed in a light blue topped one piece body suit which was zipped up the back and prevented R566 access to his body.

On 6/3/15, at 7:06 p.m. R566 was observed seated in his wheelchair wearing the light blue topped one piece body suit which remained zipped up the back.

On 6/4/15, at 9:45 a.m. R566 was observed seated in his wheelchair by the aviary dressed in a one piece body suit zipped up the back.

R566's Order Summary Report dated 2/10/15, revealed it was okay for R566 to be placed in a one piece outfit at all times for disrobing.

R566's care plan dated 2/17/15, directed staff to place R566 in a one piece garment at all times as available due to disrobing and smearing of bowel movement.

R566's treatment administration records from

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4/1/15, thru 6/3/15, indicated R566 had been placed in a one piece garment at all times.

On 6/3/15, at 7:40 p.m. NA-G confirmed R566 wore a full body suit which zipped up the back.

On 6/4/15, at 10:44 a.m. RN-E verified R566 wore a one piece body suit which zipped up the back. RN-E confirmed they had not identified the one piece body suits with the backed zipped enclosure as a physical restraint; however he understood they were a physical restraint as they limited R566 access to his body.

On 6/4/15, at 11:53 a.m. RN-F stated she understood the one piece body suits with the backed zipped enclosure were restraints as they restricted access to the residents' body.

On 6/4/15, at 12:12 p.m. RN-E verified R566's MDS was inaccurate for restraints as R566 did utilize a physical restraint (one piece body suit) and this had not been reflected on the restraint section of the MDS.

According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, the "DEFINITIONS PHYSICAL RESTRAINT" was any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily, which restricts freedom of movement or normal access to one ' s body. In addition, the manual provided "Steps for Assessment" and directed staff to:

· Review the medical record, including physician orders, nurses notes, and NA notes to determine if physical restraints were used.

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F 278	Continued From page 42 · Considering the physical restraint definition, observe the resident to determine the effect the restraint has on the resident's normal function. · Evaluate if the resident can easily and voluntarily remove the device, material, or equipment. If the resident cannot easily and voluntarily remove the restraint, continue with the assessment to determine whether the device restricts freedom of movement or the resident's access to his own body.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 280	Resident 63 has had her care plan	7/12/15

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F 280	Continued From page 43 review, the facility failed to revise the care plan to include interventions regarding pressure ulcer and incontinence care for 1 of 3 residents (R63) identified with a pressure ulcer and incontinence for 1 of 2 residents (R63) reviewed. Findings include: R63's undated Diagnosis Report indicated R63 had diagnoses that included hemiplegia (total or partial paralysis of one side of the body) due to cerebrovascular disease, aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write), generalized muscle weakness, osteoarthrosis, dementia and peripheral vascular disease. R63's quarterly Minimum Data Set (MDS) dated 4/1/15, indicated R63 was rarely/never understood and had severely impaired cognitive skills for daily decision making. The MDS also indicated R63 required extensive assistance of two staff for bed mobility, transfer and toilet use. The MDS also indicated R63 was non-ambulatory and had functional limitations in range of motion of the upper and lower extremities with impairment on one side. The MDS further identified R63 as always incontinent of bowel and bladder and was at risk for the development of pressure ulcers. R63's Care Plan dated 4/10/15, lacked interventions regarding the frequency of incontinence care for bowel and bladder incontinence as well as interventions to minimize the risk of pressure ulcer development or worsening.	F 280	reviewed and revised to reflect her current B&B and skin status. All residents with skin impairment or B&B incontinence have been reviewed and updated to reflect their current status. Licensed staff have been re-educated regarding revision of care plans. DON/Designee will audit 2 residents/unit/week to ensure care plans accurately reflect B&B and skin status. Audits will be reviewed at QA&A.	

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F 280	Continued From page 44 The Skin Condition Report dated 6/1/15, identified R63 had a stage II (abrasion, blister or a shallow crater in the skin) pressure ulcer to her right buttock measuring 0.6 cm x 0.4 cm x 0 cm. On 6/3/15, R63 was observed to not have been offered or assisted with positioning from 7:05 a.m. until 10:05 a.m. and was not offered or assisted with incontinence care from 7:05 a.m. until 10:24 a.m. On 6/4/15, at 10:21 a.m. registered nurse (RN)-G verified the care plan lacked specific interventions regarding the prevention of pressure ulcers or incontinence care and stated it was the minimum expectation of the facility to turn and reposition residents as well as check and change for incontinence every 2 hours. The Care Plans-Comprehensive policy dated November 2012, identified the basis of the comprehensive care plan was a thorough assessment of the resident that was ongoing and indicated care plans were revised as information about the resident and the resident's condition changed. The policy indicated one of the purposes of the care plan was to reflect treatment goals, timetables, and objectives in measurable outcomes.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		7/12/15

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F 309	Continued From page 45 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure appropriate positioning was provided during meal time for 3 of 3 (R152, R19, R287) residents reviewed for positioning. Findings include: R152 was observed seated parallel to her evening meal during the evening meal observation on 6/3/15. R152's Diagnosis Report dated 7/25/14, identified R152's diagnoses as esophageal reflux, Alzheimer's disease and dementia. R152's quarterly Minimum Data Set (MDS) dated 3/6/15, indicated R152 had severe cognitive impairment, required extensive assist with transfers and required staff to assist with setting up her meal tray. The Activities of Daily Living Care Area Assessment (CAA) identified R152 as having difficulty maintaining a sitting balance and impaired balance during transitions. On 6/3/15, at 6:06 p.m. R152 was observed seated off to the right of the open dining area in a high wing backed chair parallel to a large wooden desk. R152's meal tray was observed to be placed on the desk. R152 was observed repeatedly twisting at her waist in order to reach her food on the tray. -At 6:08 p.m. R152 grabbed the bowl of squash off of the tray, held it over her lap and proceeded	F 309	Resident #152, table has been lowered. Table was adjusted to decrease the overall height that would be appropriate for use during meals. Resident #19 and 287 are being provided appropriate seating areas for mealtime. The desk was moved to adjacent area and will no longer be used for meal times. Current residents have the potential to be affected by this alleged deficiency. Residents are being provided appropriate seating areas for mealtime. Current nursing staff have been re-educated regarding appropriate seating and positioning at mealtime, including table height for mealtime. DON/Designee will audit each dining room at lunch daily x 5, weekly x 4, monthly x 3 to validate that each resident requiring additional seating needs will be accommodated.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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to take a few bites. R152 again had to twist at the waist in order to place the bowl back on the table / tray. R152 took a forkful of mashed potatoes and while holding a napkin under the fork brought it to her mouth. Each time R152 took items of food off of her tray she needed to twist at the waist and brought the eating utensil and morsel of food across her body and up to her mouth.
-At 6:15 p.m. R152 was observed to have turned her tray slightly so the corner of the tray was hung off of the desk.
-At 6:22 p.m. R152 was observed holding her ice cream cup over her lap with a napkin placed under the cup.

R152's care plan directed staff to assist R152 in setting up her meal tray.

R152's nutritional assessment dated 5/20/15, indicated R152 required assistance with setting up her meal tray. In addition, R152 had showed a gradual non-significant weight loss at 30, 90, 180 days and that further weight loss was not desired.

R152's meal intake form indicated she consumed 51-75% of her evening meal on 6/3/15.

R19 was observed seated at a table which was too high during the evening meal on 6/3/15.

R19's Diagnosis Report dated 5/15/15, identified R19's diagnoses as dementia, muscle weakness, depression and difficulty walking.

R19's admission MDS dated 5/15/15, indicated R19 had severe cognitive impairment, required extensive assist with transfers and required staff assist with setting up her meal tray.

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F 309	Continued From page 47 On 6/3/15, at 6:11 p.m. R19 was observed seated in the dining area at a high table. Her meal tray was positioned directly in front of her. The height of the table was approximately two inches away from R19's chin. When asked, R19 stated it was difficult for her to eat at this table as she thought her chair was "really low." From 6:11 p.m. until 6:45 p.m. R19 was observed to have to raise her right arm (the arm/hand she used to feed herself) up even with her shoulder in order to reach the food on her tray. R19's care plan directed staff to assist R19 in setting up her meal tray. R19's nutritional assessment dated 5/20/15, indicated R19 was 63 inches in height, and she required assistance with setting up her tray. R19's meal intake form indicated she consumed 0-25% of her evening meal on 6/3/15. R287 was observed seated parallel to her meal during the evening meal on 6/3/15. R287's Diagnosis Report dated 10/26/11, identified R287's diagnoses as dementia, dysphasia (difficulty in swallowing), esophageal reflux and muscle weakness. R287's quarterly MDS dated 5/15/15, indicated R287 had severe cognitive impairment, moderately impaired vision, was on a mechanically altered die, and required staff to assist with setting up her meal tray. The Activities of Daily Living CAA identified R287 as having difficulty maintaining a sitting balance and impaired balance during transitions.	F 309		

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F 309	Continued From page 48 On 6/3/15, at 6:26 p.m. R287 was seated off to the right of the open dining area in a high winged back chair parallel to a large wooden desk. R287 was seated across from R152. R287's meal tray was placed on the desk by therapeutic aide (TA)-L. R287 continued to be positioned facing towards the open dining area and parallel to her meal tray. R287 was observed during the meal time 6:26 p.m. until 6:45 p.m. as having to twist at her waist, bring the food across her body and up towards her mouth. At 6:31 p.m. registered nurse (RN)-E, R287 and slightly repositioned her chair towards the desk, however, R287 remained parallel to her meal tray. R287 was observed spilling Jello on her clothing protector as she was tried to bring the Jello across her body and to her mouth. R287's care plan directed staff to assist R287 in setting up her meal tray. R287's nutritional assessment dated 5/15/15, indicated R287 required assistance with setting up her meal tray. R287's meal intake form indicated she consumed 51-75% of her evening meal on 6/3/15. On 6/3/15, at 6:43 p.m. RN-E confirmed the table R19 was seated at was too high for her. In addition, the two residents (R152 and R287) seated at the wooden desk were positioned parallel and facing away from their meal trays. Policies on positioning, positioning during meals, and dining experience were not provided.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		7/12/15

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F 311	Continued From page 49 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to act upon a physician's order for a physical and occupational therapy evaluation and treatment for 1 of 3 residents (R228) reviewed for ambulation. Findings include: R228's annual Minimum Data Set (MDS) dated 2/6/15, indicated R228's diagnoses included, non-Alzheimer's dementia, arthritis and osteoporosis. The MDS indicated R228 had memory loss, impaired decision making skills, required limited assist with walking and transferring used a walker and wheelchair for mobility. R228's significant change MDS dated 5/22/15, indicated R228's diagnoses included non-Alzheimer's dementia, arthritis, osteoporosis and hip fracture. The MDS indicated R228 had memory loss, impaired decision making skills and was totally dependent on two staff for transfers and was non-ambulatory. The MDS indicated R228 had impairment in range of motion on one side in lower extremity and used a wheelchair. R228's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 5/29/2015, indicated R228 was at risk of functional decline due to	F 311	Resident #228 orders for therapy are current and is receiving therapy services per order. Current residents with therapy orders were reviewed to validate therapy is being provided per order. Licensed Nursing staff were re-educated on the process of therapy notification and therapy staff will review current case load against notification, daily M-F in standup meeting. DON/Designee will review current therapy caseload with the Therapy Staff, weekly, M-F, x 4 weeks, bi weekly M-F x 4 weeks and as a standing item ongoing in daily clinical stand up meeting. Phone orders and electronic orders will be reviewed daily M-F between nursing and therapy in clinical standup meeting.	

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complications of immobility such as contractures, incontinence and depression. The CAA indicated R228's physical limitations consisted of weakness, limited range of motion, poor coordination, poor balance, visual impairment and pain.

The 2/14/15, Fall Report indicated R228 had gait imbalance, impaired memory, non-compliant, weakness/fainted and had ambulated without assistance.

The medical record indicated R228 sustained a right hip fracture on 2/14/15.

R228's physician's order dated 5/18/15, physician's order indicated R228 was to receive physical therapy (PT)/occupational therapy (OT) services. On 5/19/15, an order was received to re x-ray the hip for healing. On 5/20/15, the PT/OT order was clarified with an "Ok" for full weight bearing. However, the order was never received in the PT/OT department.

R228's care plan revised 5/27/15, indicated R228 was weak and had a recent history of right hip fracture requiring assist of two staff for transfers and was non-ambulatory.

On 6/3/15, at 8:10 p.m. nursing assistant (NA)-T was observed to wheel R228 to the bathroom. NA-T and another NA were observed to transfer R228 onto the toilet. When R228 was done using the toilet, both NA's were observed to transfer R228 back into the wheelchair and wheeled her out of the bathroom.

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F 311	Continued From page 51 On 6/4/15, at 11:10 a.m. registered nurse (RN)-D verified R228 had a physician's order for PT to evaluate and treat R228, however, was unable to find any additional information in R228's medical record as to whether the order was fully process or not. On 6/4/15, at 11:30 a.m. physical therapist (PT)-O stated there was some miscommunication and PT had not evaluated R228 but would get right on it. On 6/5/15, at 8:45 a.m. PT-L, stated the 5/18/15, physician order to evaluate and treat R228 should have been completed the day it was written or the next day. On 6/5/15, at 9:25 a.m. PT-N stated he could recall writing down some questions for the physician regarding R228's weight bearing status for the physician (around 5/18/15) to answer and had not heard anything further until yesterday (6/4/15-during survey). PT-N stated he thought the order was lost in communication as they had not received the order in the therapy department. PT-N stated when there was an order written for therapy evaluation and treatment the orders were considered completed when it would show up on their schedule which was made out by the Assistant Rehabilitation Director/COTA. PT-N stated R228 was on the schedule for an evaluation today (6/5/15). On 6/5/15, at 9:33 a.m. the Assistant Rehabilitation Director/COTA stated she never got the 5/18/15, PT evaluate and treat order for R228. She stated nursing should have faxed the order to the therapy department and the order was never received. She stated she was aware	F 311		

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F 311	Continued From page 52 PT-N had left questions for R228's physician to answer during rounds and she had been looking in the computer system for the next couple days for a physician response, however by the next week she stated she had forgotten about R228's case. On 6/5/15, at 3:50 p.m. the administrator and DON were interviewed. The DON stated they would expect a PT evaluate and treat to be acted on that day or the next. The administrator stated it sounded like a "mix-up" had occurred.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide eating assistance for 1 of 1 resident (R247) observed who was not provided adequate assistance as directed or appropriate positioning in order to enhance independent eating during 1 of 2 dining observations. Findings include: R247's annual Minimum Data Set (MDS) dated 5/15/15, indicated R247 was rarely/never understood and had diagnoses that included	F 312	Resident # 247 is receiving timely assistance with eating. Current residents with assistance need for meals are potentially affected by the alleged deficiency. Residents identified through MDS as needing assistance with eating were reviewed. Current nursing staff (licensed and nursing assistants) have been re-educated regarding provision of appropriate assistance with dining at	7/12/15

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F 312	Continued From page 53 aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write), stroke, dementia, hemiplegia (total or partial paralysis of one side of the body), abnormal posture, muscle weakness and oropharyngeal dysphagia (a swallowing problem involving the mouth and throat). The MDS also indicated R247 required extensive assistance of one person for eating, had a functional limitation in range of motion to the upper and lower extremity on one side and received a mechanically altered diet. On 6/3/15, at 8:10 a.m. R247 was observed seated in the 1SW dining room in a tilt in space wheelchair. R247's wheelchair was positioned at the table with R247's knees even with the edge of the table top. The breakfast meal which consisted of four half slices of toast, cereal, orange juice and water was placed on a tray on the table in front of R247. R247 was observed to reach and grab one of the half slices of toast with his fingertips and feed himself. However, the cereal, beverages, and additional 3 half slices of toast on the tray were out of R247's reach. -At 8:13 a.m. nursing assistant (NA)-J was observed to approach the table, give R247's tablemate a cup of coffee, however did not offer or assist R247 who had just finished the half slice of toast. -At 8:16 a.m. R247 gestured and pointed to his beverage which was out of his reach. No staff were near R247 in order to assist him. -At 8:25 a.m. R247 remained at the table unable to eat the rest of his meal as the food remained out of his reach. R247 continued to attempt to reach the food without success. NA-J was seated at the next table assisting another resident. NA-K, NA-L, and NA-I were distributing	F 312	meals. Point of Care System and resident kardex care cards have been updated to add a specific task to identify those whom need additional assistance. Care plans reviewed and updated for those requiring additional assistance. DON/Designee will audit each dining room at breakfast, lunch, and dinner M-F x4 weeks, bi weekly x 4 weeks, weekly x4 weeks, monthly x 3 to validate the appropriate feeding assistance is being given at the times of meals.	

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the meals throughout the dining room, passing by R247. Staff did not offer assistance to R247 or move his food within his reach.
-At 8:27 a.m. NA-K joined NA-J at the table next to R247 and assisted another resident to eat. R247 looked their way, still unable to reach his food.
-At 8:34 a.m. NA-L was observed to walk up to R247's table, stab a half piece of toast on R247's plate, hand it to him and left R247's table to continue distributing meals. R247 ate the half slice of toast independently.
-At 8:37 a.m. NA-I sat at R247's table and attempted to assist his tablemate to eat who refused assistance so NA-I left the table. R247 had finished eating the half slice of toast, however NA-I did not offer R247 assistance to eat any additional items on his tray.
-At 8:38 a.m. NA-I returned to the table, brought a straw and stood next to R247 and held his glass to assist him to drink fluids. R247 turned his head and refused a sip of water.
-At 8:40 a.m. NA-I moved R247's wheelchair closer to the table, sat in a chair next to him and began to assist R247 to eat the remainder of his breakfast.

On 06/03/2015, at 10:46 a.m. NA-I stated R247 could feed himself once the food was in his hand. NA-I stated he could feed himself his toast and other finger foods but had difficulty with other food items and holding onto cups or glasses. NA-I confirmed R247 could not reach all of his tray and required assistance to eat.

On 06/04/2015, at 3:09 p.m. registered nurse (RN)-G confirmed R247 required assistance to eat. She stated she would have expected that once he was served his meal he would have

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F 312	Continued From page 55 been assisted to eat it. Policies regarding dining or dignified care were requested but none were provided.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning assistance in order to enhance wound healing for 1 of 3 residents (R63) reviewed with an active pressure ulcer. Findings include: R63's Diagnosis Report indicated R63 had diagnoses that included hemiplegia (total or partial paralysis of one side of the body) due to cerebrovascular disease, aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write), generalized muscle weakness, osteoarthrosis, dementia and peripheral vascular disease.	F 314	Resident 63 is being repositioned per plan of care. All residents requiring assistance with repositioning to prevent pressure ulcers are being provided with assistance to reposition per plan of care. All nursing staff have been re-educated regarding providing assistance with repositioning. DON/Designee will audit 2 residents/unit/week to ensure appropriate repositioning is occurring. Audit results will be reviewed at QA&A.	7/12/15

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R63's quarterly Minimum Data Set (MDS) dated 4/1/15, indicated R63 was rarely/never understood and had severely impaired cognitive skills for daily decision making. The MDS also indicated R63 required extensive assistance of two staff for bed mobility, transfer and toilet use. The MDS also indicated R63 was non-ambulatory and had functional limitations in range of motion of the upper and lower extremities with impairment on one side. The MDS further identified R63 as always incontinent of bowel and bladder and was at risk for the development of pressure ulcers.

R63's Pressure Ulcer Care Area Assessment (CAA) dated 10/10/14, indicated R63 was at risk for pressure ulcers due to weakness, hemiplegia, incontinence, assistance with activities of daily living (ADLs) and cognitive losses. The CAA indicated R63 was assisted to turn, reposition and off-load and had a pressure redistribution mattress and cushion in place.

R63's Care Plan dated 4/10/15, directed staff to encourage R63 to change position frequently and to encourage not sitting in one position for long periods of time due to a diagnosis of peripheral vascular disease. The Care Plan also identified R63 required extensive assist of two staff or use of a mechanical lift, EZ stand, as needed for transfers. The Care Plan further identified R63 refused to allow staff to assist with repositioning/offloading when staff offered and directed staff to attempt to reapproach and have different staff try to encourage R63 to offload / reposition.

The Skin Condition Report dated 6/1/15 identified R63 had a stage II pressure ulcer (partial

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thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) to her right buttock measuring 0.6 centimeters (cm) x 0.4 cm x 0 cm.

On 6/3/15, during continuous observation from 7:05 a.m. until 10:24 a.m. the following was observed:
At 7:05 a.m. R63 was observed seated erect in her wheelchair at a table in the 1SW dining room.
-At 7:56 a.m. breakfast was delivered and set up for R63.
-At 8:32 a.m. volunteer (V)-A approached R63 and asked if she would like to have her hair done. V-A then transported R63 directly from the dining room to the 2nd floor beauty shop.
-At 8:54 a.m. R63 was seated in her wheelchair having her hair done in the beauty shop .
-At 8:56 a.m. R63 remained seated in the wheelchair, in the beauty shop.
-At 10:04 a.m. R63 was assisted back to her room and was observed wheeling her wheelchair independently in her room.
-At 10:05 a.m. nursing assistant (NA)-I and NA-J entered R63's room and adjusted her posture as R63 was observed leaning in her wheelchair.
-At 10:06 a.m. NA-I confirmed they had just adjusted R63 so she wasn't leaning in her chair.
-At 10:11 a.m. R63 was assisted to the dining room for a musical activity.
-At 10:27 a.m. NA-J stated R63 preferred to sit up during the day and would often refuse repositioning. NA-J stated they were to check on R63 every 2 hours. NA-I stated R63 required two staff assistance for transfers. Throughout observation R63 was not offered or provided repositioning or off loading assistance from 7:05 a.m. until 10:05 a.m. for a total of three hours.

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F 314	Continued From page 58 The facility's "The Prevention of Pressure Ulcers Guidelines" dated May 2013, recommended general interventions and preventive measure for a person in a chair to include change position at least every hour. The Guidelines also recommended interventions and preventive measures for residents with a risk factor of chair-fast to include change position at least every 2 hours. A risk factor of bowel and bladder incontinence recommended interventions and preventive measures that included check resident for incontinence at least every 2 hours and clean skin when soiled. On 6/3/15 at 2:38 a.m. registered nurse (RN)-G confirmed R63 had an ongoing challenge with pressure ulcers. RN-G stated "they come and go." RN-G confirmed R63 currently had a stage II pressure ulcer to her right gluteal fold and stated R63 would allow offloading at night but refused most of the time during the day. RN-G confirmed R63 staff should have offered or attempted to reposition, offload R63 at least every 2 hours or more frequently.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		7/12/15

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F 315	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 of 2 residents (R63) reviewed for incontinence. Findings include: R63's Diagnosis Report indicated R63 had diagnoses that included hemiplegia (total or partial paralysis of one side of the body) due to cerebrovascular disease, aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write), generalized muscle weakness, osteoarthrosis, dementia and peripheral vascular disease. R63's quarterly Minimum Data Set (MDS) dated 4/1/15, indicated R63 was rarely/never understood and had severely impaired cognitive skills for daily decision making. The MDS also indicated R63 required extensive assistance of 2 staff for transfer and toilet use. The MDS also indicated R63 was non-ambulatory and had functional limitations in range of motion of the upper and lower extremities with impairment on one side. The MDS further identified R63 as always incontinent of bowel and bladder and was at risk for the development of pressure ulcers. R63's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/15/14, indicated R63 remained incontinent of bowel and bladder, did not verbalize the need to use the toilet, was aphasic and had some	F 315	Resident 63 is being provided toileting assistance per plan of care. All residents requiring assistance with toileting are receiving assistance per plan of care. Nursing staff have been re-educated regarding provision of toileting assistance per plan of care. DON/Designee will audit 2 residents/unit/week to ensure toileting assistance. Audit results will be reviewed at QA&A.	

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dementia. The CAA indicated staff assisted R63 to use the toilet and managed/changed incontinence pad per protocol.

R63's Bladder Incontinence Evaluation dated 12/31/14, identified R63 was totally dependent for ADLs and wore adult briefs at all times. The evaluation indicated the care plan had been updated.

R63's Care Plan dated 4/10/15, identified R63 was at risk for skin breakdown related to incontinence, weakness, immobility, aphasia, and hemiplegia and directed staff to complete skin treatments as ordered and to monitor for signs and symptoms of urinary tract infection.
The Care Plan also identified R63 required extensive assist of two staff for toilet use. The care plan lacked interventions regarding incontinence care for bladder incontinence.

The Skin Condition Report dated 6/1/15 identified R63 had a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) to her right buttock measuring 0.6 centimeters (cm) x 0.4 cm x 0 cm.

On 6/3/15, from 7:05 a.m. until 10:24 a.m. continuous observation revealed the following:
-At 7:05 a.m. R63 was seated in her wheelchair at a table in the 1SW dining room.
-At 7:56 a.m. breakfast was delivered and set up for R63.
-At 8:32 a.m. R63 had independently completed her meal. Volunteer (V)-A approached R63 and asked if she would like to have her hair done. V-A then transported R63 directly from the dining

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room to the 2nd floor beauty shop.
-At 8:54 a.m. R63 was observed having her hair done in the beauty shop.
-At 8:56 a.m. R63 remained in the beauty shop.
-At 10:04 a.m. R63 was assisted back to her room and was observed wheeling her wheelchair independently in her room.
-At 10:05 a.m. nursing assistant (NA)-I and NA-J entered R63's room and adjusted her posture as R63 was leaning in the wheelchair.
-At 10:06 a.m. NA-I confirmed they had just adjusted R63 so she wasn't leaning in her chair. NA-J confirmed they had not checked R63 for incontinence since they got her up that morning, but would be doing so later.
-At 10:11 a.m. R63 was assisted to the dining room for a musical activity.
-At 10:24 a.m. NA-I approached R63 during the activity and requested to check her for incontinence which R63 refused.
-At 10:27 a.m. NA-J stated R63 preferred to sit up during the day and would often refuse incontinence cares. NA-J stated they were to check on R63 every 2 hours. NA-I stated R63 required two staff assistance for transfers.

On 6/3/15 at 2:38 a.m. registered nurse (RN)-G confirmed R63 currently had a stage II pressure ulcer to her right gluteal fold and stated R63 should have been checked and changed for incontinence at least every two hours or more frequently and incontinence cares should have at least been offered/attempted every two hours.

On 6/4/15, at 10:21 a.m. RN-G verified 63's care plan lacked specific interventions regarding incontinence care and stated it was the minimum expectation of the facility to check, change and provide incontinence care to an incontinent

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F 315	Continued From page 62 resident every 2 hours. The Prevention of Pressure Ulcers Guidelines dated May 2013, indicated a risk factor of bowel and bladder incontinence recommended interventions and preventive measures that included check resident for incontinence at least every 2 hours and clean skin when soiled.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to thoroughly evaluate the root cause for falls, implement appropriate interventions and follow the individual care plan which resulted in actual harm for 1 of 3 residents (R138) reviewed for accidents and who had sustained fractures from falls. Findings include: R138's incident report dated 11/16/14, indicated R138 fell while being transferred from the toilet with the assistance of one staff member. A Fall Risk Evaluation dated 11/17/14, indicated R138 had 1-2 falls in the 90 days prior and had	F 323	Resident 138 has had root cause analysis regarding his falls completed. A post falls QAPI has been completed for resident #138. Current residents whom are at risk for falls have the potential to be affected by the alleged deficiency. Residents with falls are having falls investigated and root cause analysis completed in our daily incident meetings. Nursing Assistants have been re-educated on the process of licensed nursing notification in the event of a fall.	7/12/15

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F 323	Continued From page 63 no cognitive changes. The Fall Risk Evaluation indicated R138 ambulated with problems, used a device for ambulation, his gait was unsteady and was unable to stabilize without physical assistance of staff. R138's fall risk score was 18, indicating he was at high risk for falls. An incident report dated 12/5/14, indicated R138 fell while being transferred in the bathroom with assistance of one staff. R138 indicated he lost his balance when the nursing assistant (NA) held him from the left side. The incident report indicated R138 had a diagnosis of a stroke with left hemiplegia (paralysis of one side of the body). The subsequent nursing note dated 12/13/14, indicated R138 required the assistance of two staff for transfers and the NA did not follow R138's Care Card (the care plan used by NAs) which resulted in the fall. The note further indicated R138's Care Card was updated to reflect R138's diagnosis of left hemiplegia and how to approach him during transfers. A nurse practitioner (NP) progress note dated 12/18/14, indicated R138 had a fall on 12/5/14. There were no changes in orders. An incident report dated 1/15/15, indicated R138 fell while being transferred from the toilet to the wheelchair with the assistance of one staff. The note indicated R138's legs gave out and he sat down quickly in the wheelchair causing the wheelchair to tip backwards and R138 hit his head on the floor. The nursing note on the incident report dated 1/15/15, indicated R138 required the assistance of two staff for transfers and R138's care plan was not followed by the NA which resulted in the fall.	F 323	Licensed nurses have been re-educated to complete the process post fall, including the post fall QAPI, incident report, care plan update, and notifications. DON/Designee will review each fall to validate required post fall metrix are followed. Incident reports will be completed per community procedure. DON/Designee will review each residents falls weekly in Patient Risk meeting to validate the post fall process has been followed, including Post Fall QAPI (identification of cause). Administrator will review incident reports and post fall review ongoing.	

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A Fall Risk Evaluation dated 2/6/15 indicated R138 was at high risk for falls and had 1-2 falls in the previous 90 days. The fall risk assessment indicated R138 had no cognitive status changes but was confined to a chair, did not ambulate and was not able to attempt standing without physical help.

A nursing progress note dated 4/8/15, indicated R138 fell during a transfer to the shower chair. The note also indicated R138 fell back on the bed on his left arm. An incident report dated 4/8/15, indicated R138 reported arm pain and stated he landed on his arm.
-A progress note dated 4/9/15, indicated R138 had gone to an unrelated physician appointment and was sent to the emergency room for x-rays of his left arm due to complaints of pain and report of breaking his arm.
-A progress note dated 4/9/15, indicated the facility was informed R138 had a fractured humerus (upper arm). An incident report with further information was not provided for the fall.

A physician's consultation note dated 4/9/15, indicated R138 had returned to the physician's office for a follow up visit that was unrelated to the fall on 4/8/15. R138 reported he had a fall the previous day and experienced pain and snapping in his left upper extremity. He was referred to the emergency room for an x-ray which identified R138 had a fracture of the left humerus.

A NP note dated 4/10/15, indicated R138 had returned from the hospital with a fractured left humerus related to a fall on 4/8/15. The NP note indicated R138 was having pain related to the fracture. Orders for pain medication were reviewed.

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A Fall Risk Evaluation dated 5/6/15, indicated R138 was at high risk for falls and had 1-2 falls in the 90 days prior. The Fall Risk Evaluation indicated R138 had no cognitive changes, ambulated with problems and a device, his gait was unsteady and he required staff physical assistance to stabilize.

An incident report dated 5/7/15, indicated R138 fell during a transfer with one assist from the wheelchair to the toilet when R138 lost his balance and fell against the wall. R138 bumped his left arm and the left side of his head. The director of nursing (DON) and the nursing supervisor were notified. The nursing note on the incident report dated 5/8/15, indicated R138's care plan was updated to direct two staff assist for transfers and ambulation. The predisposing physiological factors indicated on the report were identified as weakness/fainted.
-A progress note dated 5/8/15, indicated R138 complained of pain in ribs from fall.
-A progress note dated 5/10/15, at 2:41 p.m., indicated R138 complained of pain in his chest on both sides.
-A progress note dated 5/10/15, at 10:30 p.m. indicated R138 complained of left side pain, pointing to the rib area. No bruising or swelling was noted.
-A progress note dated 5/11/15, indicated a chest x-ray identified R138 had three rib fractures. R138 reported the fractures occurred when he fell the previous week in the bathroom. He reported his pain level as 10 on a scale of 1-10.

A radiology report dated 5/11/15, indicated R138 had acute rib fractures of the left third, fourth, and fifth ribs.

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A NP progress note dated 5/12/15, indicated R138 had falls with injury and noted R138 had left rib fractures.

The incident reports and documentation lacked a thorough post fall assessment and root cause analysis to determine causal factors of each fall nor was a trend in falls identified, interventions initiated and implemented in order to minimize / prevent further falls and injury.

R138's undated Face Sheet and Diagnosis list printed 6/4/15, indicated R138's diagnoses included hemiplegia (paralysis on one side of the body) due to cerebrovascular disease (stroke), convulsions (seizures), difficulty in walking, muscle weakness, dementia, depressive disorder and anxiety.

R138's annual Minimum Data Set (MDS) assessment dated 5/15/15, indicated R138 had a moderate cognitive deficit, displayed no rejection of care and required extensive assistance of two staff for transfers and ambulation. The MDS also indicated R138 had balance problems and was unsteady with position changes.

R138's Falls Care Area Assessment (CAA) dated 5/15/15, indicated R138 was potentially at risk for falls due to balance problems during position changes and receiving an antidepressant medication. The CAA indicated R138 required assistance with transfers and would ambulate short distance in his room with staff assist and the use of a walker, but the wheelchair was his primary mode of transportation.

R138's care plan for falls initiated 6/12/14, and

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last revised 2/9/15, indicated R138 was at risk for falls. The care plan directed staff to follow the facility fall protocol, review the information on past falls and attempt to determine cause of falls, record possible root causes of the falls and then to alter or remove any potential causes if possible. Staff were to educate the resident, family and staff regarding the causes.

R138's care plan for activities of daily living (ADLs) initiated 3/7/15, and revised 5/8/15, indicated R138 required the assistance of two staff for transfers, bed mobility and toilet use.

R138's care plan for mobility initiated 3/7/15, indicated R138 required the assistance of two staff for ambulation with the quad cane (a cane with 4 ends, hemi-cane).

R138's Resident Care Card (the care plan used by nursing assistants) printed 6/4/15, directed two staff for transfer, two staff assist with the quad cane for ambulation and two assist for toilet use. The previous Resident Care Card printed 3/9/15, indicated R138 required two staff assist with transferring. A note by the registered nurse (RN)-H dated 12/16/14, indicated the Resident Care Card dated 12/5/14, directed staff to transfer R138 with two assist, and that the care plan was not followed during incident of 12/5/14, when resident fell during a transfer with one staff assist.

The undated nursing assistant (NA) group sheet provided by RN-H indicated NAs were to refer to the Care Card for transfers and toilet use directives. The group sheet did not indicate how R138 was to ambulate or if he could ambulate.

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On 6/3/15, at 2:09 p.m. R138 was observed lying bed and had put on his call light to request assistance to get up. Trained medication assistant (TMA)-C and RN-I were observed to sit then stand R138 up. R138 was observed to be unsteady and require the extensive assist of two staff, a gait belt and the hemi walker while he walked a few steps and turned to sit in the wheelchair.

During an interview on 6/3/15, at 2:17 p.m. R138 stated he did not try to get up by himself. R138 stated he had a fall onto the bed during a transfer and has had broken bones. R138 stated the staff had not always used two staff to transfer him into the bathroom. R138 was noted to have bruising on his arms and on his back. R138 stated they were from his falls and from trying to get his balance and also laying on it. R138 further stated he had pain from his falls and that the pain pills had not helped much. At this time, R138's Care Card with a print date of 5/27/15, was observed posted in his closet which indicated R138 was to be transferred with two staff assistance.

During an observation on 6/4/15, at 7:25 a.m. NA-Q and NA-R were observed to assist R138 up from bed. R138 had asked to walk to the bathroom. NA-Q told R138 that he could not walk, "Remember, you can't walk." NA-Q informed him they were going to use the wheelchair. The NAs were observed to assist R138 to stand, walk a few steps, turn and sit in the wheelchair. R138 was observed unsteady on his feet and required the balancing support of the two staff as R138 was unable to steady himself. Once in the bathroom, R138 was observed to require two staff assistance to transfer onto the toilet. R138 stated sometimes they used two staff

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to transfer him and sometimes not. Both NA's were observed to stand R138 up, cue him to hold onto the grab bar as they dressed him then transferred R138 back into the wheelchair. Both NAs stated R138 was doing good while standing and holding on to the handrail. Both NAs said R138 could not usually stand that long.

During an interview on 6/04/15, at 2:09 p.m. RN-H verified R138 currently transferred with the assistance of two staff. RN-H verified R138 had previously transferred with the assistance of 1-2 staff but had an incident/fall and was changed to the assist of two staff. In addition, RN-H stated the staff had interdisciplinary team (IDT) meetings to discuss resident falls, injuries and to determine the root causes. RN-H stated R138 has had different causes but staff only documented pertinent findings and not everything that had been ruled out. RN-H identified the only root cause for the incident when R138 fell from his wheelchair in the hallway when he caught his foot under the chair. In addition, RN-H stated if R138 fell on 4/8/15, there should have been an incident report with analysis completed for that fall. RN-H stated the rib fractures were probably from the incident that week when R138 had fallen while being transferred or the incident prior to that one. RN-H stated that after the incident in November, she changed R138's Care Card to indicated R138 was to be transferred with the assist of two staff but someone else was completing R138's care plan and would have gotten the care plan information from the MDS. RN-H stated she changed R138's Care Card with a pen by writing the change on the Care Card and did not change it in the computer. RN-H verified R138 should have been transferred with the assist of two staff ever since the incident in

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November and was 100% sure the group sheets reflected that. RN-H verified R138's care plan should have indicated R138 was required transfer with the assist of two staff and that she had provided education and communication to staff on 12/16/14, regarding R138's fall on 12/5/14, because R138's Care Card was not followed for transfers on 12/5/14, which resulted in the fall. RN-H further stated when there was a change in care it was to be written in the staff communication book so that the NAs could see and read that there was a change/ update in a residents' care needs. RN-H verified it was her expectation R138's Care Card was followed by staff. RN-H again verified the residents' Care Cards were the care plans the NAs referred to for care directives.

During an interview on 6/4/15, at 2:25 p.m. NA-V stated R138 required two staff assistance for transfers.

During an interview on 6/4/15, at 2:30 p.m. NA-W stated R138 required two staff assist for ambulation and transfers. NA-W stated R138 was sometimes weaker and did not transfer as well when he was agitated.

During an interview on 6/4/15, at 2:40 p.m. NA-X stated R138 transferred with the assist of one before he broke his arm, but now required two staff assist. NA-X stated R138 was weaker on the left side and stronger on the right and needed two staff to assist with transfers due to the weakness.

During an interview on 6/4/15, at 4:35 p.m. the director of nursing (DON) verified the resident Care Cards were the care plan directives for the

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NAs and stated it was her expectation the staff followed the Care Cards as written. The DON stated staff could always increase the amount of assistance they provided but could not decrease the amount of assistance provided to the residents as directed on the Care Cards. The DON further stated that since December 2014, the nurse who assisted a resident up after a fall was to call the DON, and that was with every fall. The DON stated staff had an IDT meeting to determine the root cause of falls and to also request a therapy screen following the fall. The DON stated R138's rib fractures on 5/11/15, were related to a fall on 5/7/15.

During an observation and interview on 6/5/15, at 10:40 a.m. NA-Q stated R138 had walked to the bathroom and to his bed that morning. R138 stated it was the first day he had recently walked and stated it was good to walk. NA-R and NA-Q came to assist R138 up from his bed to go to lunch. NA-R put the ankle/foot orthotic brace on R138's left leg and was going to put on his regular tennis shoes. R138 reminded him that he needed his black shoes on with the brace. R138 sat up in bed with the extensive assistance of two staff. A gait belt was put on and his hemi-walker was given to him. He stood up from his bed with the extensive assistance of two staff, staff allowed R138 time to get steadied and R138 slowly and deliberately walked out of his room and down the hall with NA-R and NA-Q holding the gait belt on each side of him.

During an interview on 6/5/15, at 9:04 a.m. the certified occupational therapy assistant (COTA)-I stated therapy received the 24 hour facility report and would screen residents who had fallen in addition to any routine quarterly screens. COTA-I

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F 323	Continued From page 72 stated therapy screened R138 on 5/8/15, following a fall and had changed R138's transfer status to 1-2 staff during toileting because R138 had slipped during toilet transfers with an NA and he had previously been transferred with one assist. When COTA-I was informed R138's Care Card had indicated two staff to assist with transfers since the end of November, she said, "Oh, Ok." During an interview on 6/05/15, at 2:55 p.m. the DON stated she was not aware R138's Care Card had been changed to indicate two staff assist with transfers and thought R138's care plan had been followed. The DON verified the floor interdisciplinary team meetings were to be held to also review falls and root causes and then the daily clinical full team met daily and also reviewed the facility's 24 hour report board which included facility falls. The facility policy and procedure for Falls-Clinical Guidelines revised 2/14, indicated a Fall Risk Evaluation would be completed upon admission and quarterly and the interdisciplinary team would attempt to identify individuals with a history of falls and risk factors for subsequent falling. The policy and procedure further indicated if a fall should occur, the staff would complete the Falls Investigative Worksheet as well as an Incident Report. The care plan was to be updated at that time with a review of current interventions and communicated to staff. A request for therapy screen was to be made as appropriate.	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to	F 353		7/12/15

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F 353	Continued From page 73 provide nursing and related services to 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. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient qualified nursing staff was available to meet the needs of residents observed / interviewed (R71, R285, R290, R627, R365, R376, R177) as well as family members and staff who voiced concerns regarding lack of staff to assure resident needs were met timely. This had the potential to affect all 351 residents that resided in 5 of 5 units at the facility. Findings include: Complaints of inadequate staffing were received from residents, family members and staff.	F 353	Resident 71, 285, 290, 627, 365, 376, 177 needs are being met with sufficient staff. Prior to MDH survey facility had addressed in QA&A industry wide nursing shortages. Facility had developed an action plan to strategically address staff recruitment and retention. Current residents have the potential to be affected by this alleged deficiency. Staff patterns have been reviewed for the community with adjustments made where appropriate. Resident needs are being	

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F 353	Continued From page 74 Residents voiced concerns that staff either do not answer the call lights or turn off the call lights and do not meet or respond to their needs. On 6/1/15, at 5:50 p.m. R71's call light was observed on. -At 5:53 p.m. registered nurse (RN)-D was overheard after being in R71's room tell an nursing assistant (NA) in the hallway that R71 needed help. -At 5:54 p.m. again R71 put her call light on. Observed a staff who was passing the room trays enter the room, turn the call light off and immediately came out. -At 5:55 p.m. R71 put her call light on again. Observed licensed practical nurse (LPN)-F go past the room wheeling another resident. -At 5:55 p.m. NA-P walked pasted the room. At the same time NA-A was observed passing room trays down the same hallway and walked past the light and another staff again went past the light. -At 5:58 p.m. LPN-F and NA-A both walked past the room call light never went to room to answer it. -At 5:59 p.m. another staff again approached R71 stated she was going to see if someone was available to help her. -At 6:00 p.m. another staff was observed go to R71's room shut the door then call light was off again, then came out. -At 6:05 p.m. R71's call light was on again and LPN-F was observed in the hallway setting up medications as she stood by the medication cart. -At 6:06 p.m. LPN-F and NA-A both were observed to walk past R71's call light and never offered to assist her. -At 6:07 p.m. another staff came to R71 and stated somebody was going to assist her. R71 at this time was observed to be distressed and	F 353	met by sufficient staff. Staffing personnel and nursing supervisors have been re-educated regarding planning and assigning for sufficient staffing. Nursing staff have been educated regarding changes in staffing patterns. Daily monitoring of staffing ratios will be performed by staffing. Any staffing needs will be filled as appropriate.	

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angry and yelled "I want somebody to put me to bed."
-At 6:09 p.m. NA-L was observed standing at the end of the hallway by the nursing station. At the same NA-P again went past R71's room and never offered to help. R71's call light was still on and the signal was audible when standing in the hallway.
-At 6:10 NA-L was observed go to R71's room, shut the call light off then came out of the room and went and stood at the nursing station. NA-L was observed carrying a towel and gown and went into R71's room and shut the door.
-At 6:45 p.m. when approached R71 stated this was even better and sometimes she would be begging at staff to use the toilet or be put to bed. R71 indicated the staff were slow, rude and at times did things that would benefit them not the residents. When asked how long it would take for assistance to come when she had put her call light on, R71 stated 45 minutes to over an hour and this had gotten worse since the new company took over and thought the staff were short and overworked.

On 6/1/15, at 7:20 p.m. activity aide (AA)-A stated the nursing floors were always busy as there usually was not enough staff members to assist with resident cares. She stated the facility frequently did not have enough staff members.

On 6/1/15, at 7:20 p.m. LPN-B stated the Bridgewater memory care area was always busy in the evening. She stated the residents frequently displayed behaviors in the evening and they were busy. She stated the facility did not have enough staff members to assist the

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F 353	Continued From page 76 residents. On 6/2/15, at 10:06 a.m. R285 stated she had been at the facility for several different admissions. R285 also stated it took staff forever to answer call lights and she had waited for one and a half hours the previous night for her leg to be wrapped. R285 further stated staff would not answer call lights if it was not their hall they were assigned to work. R285 stated weekends were the worse for answering call lights. As R285 was still talking to surveyor RN-G entered the room and R285 stated "oh crap, I'm in trouble now." R285 stated she thought she was going to be "treated like crap now" and confirmed she was concerned of retaliation. On 6/2/15, at 10:20 a.m. family member (FM)-A stated she frequently visited the facility and the staff members do not always respond to resident requests timely. She stated when she visited her family member, she may put the light on for the staff to assist her family member to the bathroom, but the staff were slow and she usually ended up taking her family member to the bathroom herself. She stated the facility did not seem to have enough staff to care for the residents. On 6/3/15, at 9:35 a.m. RN-A who was working on the second floor of the west building stated when she had arrived at the facility for the morning shift, she had been informed the second floor west building would be working with three nurses instead of five. She stated normally the second floor was staffed with one nurse on each of the four medication carts and a charge nurse during the day. RN-A stated in order to cover all of the areas, a trained medication aide (TMA) had	F 353		

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been assigned to pass medications on an assigned wing. She stated the charge nurse would then be required to complete the medications the TMA was unable to complete such as injections and complete any treatments for the wing. She stated when the charge nurse was completing other assignments, the charge duties were not completed as effectively as she wished. She indicated this problem occurred frequently and the staff were not made aware of their assignments until they arrived at the facility for the day.

On 6/3/15, at 10:00 when asked if she was able to do her work load TMA-B stated since the new company took over a lot of the original people quit and they were hiring, however the people just don't stay. TMA-B stated they worked a lot and at times we work a lot of doubles and they will be calling you to work all the time. TMA-B stated at times they were floated around the units which also included the nurses and when you go to a unit you are not familiar with the resident care was very hard to do as you don't know the routine and if someone was passing medications it took a long time to do so in a different unit because you have to be careful to not get medication errors and have to keep checking and checking. I will tell you the truth and if you asked the other staff they will tell you the same. "I feel like sometimes resident care is sacrificed because of the short staff problem."

On 6/3/15, at 10:10 a.m. R290's call light was observed on. R290's room was located right across from the nursing station and the call light sound was audible and even louder when standing at the station.

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-At 10:14 a.m. RN-J was observed seated at the nursing station as NA-B and another NA were observed standing at the nursing station.
-At 10:16 a.m. NA-B walked past R290's room with call light still going off. NA-B then returned to the nursing desk and all three staff were observed and heard talking to each other about their hours of work as the call light was still going.
-At 10:17 a.m. RN-J stood up from the desk and was observed go into R290's room, immediacy exit the room and stated to NA-B R290 wanted to get out of bed.
-At 10:18 a.m. NA-B and another NA went to R290's room with a transfer lift to assist R290.

On 6/3/15, at 11:32 a.m. RN-B stated the facility could use more help and thought the only thing that really bothered her was the split groups as she felt the residents were neglected "I want residents to have a nurse assigned to them and so is a nursing assistant. It just bugs me with the split shift."

On 6/3/15, from 12:00 p.m. until 12:09 p.m. R627's call light was observed to be on. NA-B was observed to walk past the call light and walk towards the dining room area. A family member in the room was observed peeking outside the hallway then went back in the room at 12:06 p.m.
-At 12:08 p.m. to 12:09 p.m. the call light remained on. NA-B and another NA-T were both observed to stand outside of room 240 and overheard talking about the double hours they were working and what they had done on recent days off.
-At 12:09 p.m. NA-T went to R627's room, a family member remained in the room and was overheard informing NA-T R627 needed to use the toilet. NA-T responded "let me find someone

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for you" then came out of the room and straight to room 240 and came out with another NA who then went to R627's room to assist R627 to the toilet at 12:12 p.m.

R627's admission Minimum Data Set (MDS) assessment dated 4/30/15, indicated R627 had memory impairment, required extensive physical assistance of two staff with toilet use and used the wheelchair for mobility.

On 6/3/15, at 1:05 p.m. RN-B stated the facility frequently did not have enough licensed nurses to cover all of the areas of the building. She stated she was informed when she came to work as to what area of the building she would be working and the facility was short staffed on an regular basis ("almost every day.")

On 6/3/15, at 1:22 p.m. R120's daughter stated her father was not getting straight catheterized (cath) in a timely manner therefore he would start leaking and get sore and right now R120 was sore in the groin, more so on the left. She stated R120 had a neurogenic bladder, had been straight catheterizing himself for eight years and now a physician order was obtained by the facility which clarified staff could straight cath R120 when R120 felt the need to be. She further stated, it took 45-50 minutes after he asked staff to be straight cathed before staff would return and straight cath him. R120's daughter stated she / he would put the call light on and the staff would come in, turn the call light off and tell him they would be back. R120's daughter stated last night, (6/2/15) R120 did not get cathed until after the change of shift and R120's urine output was 700 cubic centimeters (cc) and was normally 300-400 cc's. R120's nurse progress note dated 6/2/15,

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verified R120's urine output was 700 cc's. when cathed.

R120's admission MDS dated 4/25/15, indicated R130 had moderately impaired cognition, required extensive assistance with toileting, transferring and required intermittent catheterization.

On 6/3/15, at 2:38 p.m. a staff member who wished to remain anonymous stated both the licensed nurses and the nursing assistants worked short staffed on a daily basis. He/she stated the nursing assistants attempted to divide the unstaffed work load as best they could but stated this caused the staff members to work harder and they may not get patient cares completed timely.

On 6/4/15, at 6:05 a.m. NA-D stated the work was very heavy and we have to split group one and sometimes we have 13 residents and we don't even take our breaks because we are short staffed. They fire people here like all the time and can't keep people they even hire. They would fire good staff for very little things and sometimes we are not able to do all the work like repositioning all the residents on time. We try to do the best and they know it's bad.

On 6/4/15, at 7:38 a.m. from the hallway, R365's call light was observed on. At the time TMA-E was observed in the hallway, two doors down standing by the medication cart setting up medications.
-At 7:41 a.m. a NA was observed to walk past R365's room.
-At 7:44 a.m. the NA was observed to enter R365's room, turn the call light off, inform R365

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F 353	Continued From page 81 "today is your shower" then left the room. -At 7:47 a.m. R365 was observed lying in bed and stated about 10-15 minutes ago he had put his call light on and someone had been in his room, shut the call light off and told him they were coming back to assist me to get up for breakfast. R365 stated he put his call light back on and one of the staff who had been to his room he did not even understand and that staff member left the room without R365 receiving assistance. R365 went on to state "I hope this light is going to the nursing station and the nurse sees someone is screwing up, this is what they do, I am always waiting for a long time for help and nobody comes or they would turn the light off, leave and not come back again. R365 stated he was now going to be late for breakfast. R365 appeared sad, upset and closed his eyes. -At 7:58 a.m. NA was observed to enter R365's room to assist which was more than 20 minutes since he had initially asked for assistance. R365's quarterly MDS dated 5/9/15, indicated resident had moderately impaired cognition and required extensive assistance with toileting, transferring, bed mobility, dressing and personal hygiene and used the wheelchair for mobility. On 6/4/15, at 8:05 a.m. R376's call light was observed on. -At 8:08 a.m. a NA was observed enter the room and informed R376 she would find their NA and left the room. NA turned the call light off. -At 8:22 a.m. still nobody came back to the room to assist R376. On 6/4/15, at 10:21 a.m. when the surveyor requested the facility call light logs the administrator and director of nurses (DON)	F 353		

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indicated the facility did not have a system that logged call light use and response times. The surveyor requested the facility call light audits but none were provided.

On 6/4/15, at 12:00 p.m. The DON and the staffing coordinator (SC) were both interviewed. The SC stated the facility staffing pattern was determined by resident census. When asked about the split group shifts on 2 West and other units, as posted on the white boards in the units, the DON stated the nurse managers determined how the groups were to be split and they looked at the groups individually as well as the resident care needs. The DON stated she would check with the nurse managers regarding the split shifts to determine if this was related to the staffing concerns. When SC was asked who did staffing when she was not at the facility, the SC stated there were two other girls who worked evenings and shared the job, however, recently one had left. When asked who handled the sick calls, the SC stated the staffing office did and would notify the department and supervisor who would manage the calls and re-arrange staff if need be. When asked what happened when the census was low and if the facility staffed down, the DON nodded and stated "yes." The SC added, at times when the census was low a NA would be floated to another unit where they were needed. Both the DON and the SC indicated the facility did not use supplemental agency staffing (pool nursing). When asked if there were any employee injuries in the last 3 months, the DON indicated she was going to find out and would provide information. When asked what the facility turnover rate was, the DON stated it was 43% as of 6/3/15. When asked the number of open positions, the SC stated she would provide that information. When

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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asked if the turnover rate had been reported to quality assurance (QA) at the last meeting, the DON confirmed staffing was discussed. When asked if staff had brought to her attention concerns about the workloads, the DON stated staff had not indicated being able to finish their work but had complained about the staffing so we pulled them in to help problem solve. The DON further stated the facility was reinforcing their multiple call-in's policy and were educating staff on facility core values and some of the staff who had problems with staffing were those that had been working at the facility when the facility was a non-profit and would reflect the previous staffing levels which has changed since Mission Health for profit management had taken over. Even though the facility had indicated the insufficient staffing was being addressed, the facility continued to have complaints from residents and family members reporting poor resident care which included grooming, positioning and call lights not being answered timely among others which were being reported to the surveyors during the standard survey days.

On 6/5/15, at 9:45 a.m. R376 stated sometimes the staff would come turn the call light off, leave come back half hour later. R367 stated "I used to work in a place like this as a nurse and I have learned to wait on them they do come eventually. I have told them if am in bed I want to get up and if I fall asleep it's okay for them to wake me up as I like to get out of bed early."

R376's quarterly MDS dated 4/10/15, indicated R327 had intact cognition, had no rejection of cares and required extensive assistance of one to two staff with activities of daily living.

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F 353	Continued From page 84 On 6/5/15, at 10:25 a.m. via a telephone interview, R190's FM-D stated every time she came the facility there were call lights on. FM-D stated one of two specific incidents she recalled was last fall when R190's call light had taken over 45 minutes to get answered. FM-D stated she had arrived at the facility at approximately 5:30 p.m. and at that time R190 indicated her call light had been on for about 10 minutes. FM-D stated she waited until 6:20 p.m. at which time she went to the nurses desk to look for help and had come across a NA by the nurse's station. FM-D stated when she told the NA R190 had been waiting for her call light to be answered, the NA responded by saying "they know we can't help during dinner." The NA further stated they could not assist residents' during dinner as they were too busy feeding people. FM-D stated during meal time, the aids were sent to the dining room to help other residents to eat and then there was no one to help answer lights during that time. FM-D stated she had discussed this concern with the unit manager who informed her the facility had been having problems with his, had also explained the unit staffing pattern and assured her the facility was looking into the matter. FM-D stated the second occurrence was on an evening shift in April when she had arrived at the facility at 5:00 p.m. and had noticed the resident in the room across the hall from R190 had their call light on. FM-D stated as she walked past the nurse's station she observed a staff member seated at the desk with a meal in front of her. At 5:07 p.m. the resident's call light was still on. FM-D stated when she approached the resident and asked him if he was ok, the resident stated he needed to go to the bathroom. FM-D stated she went to report the resident care need to the staff member seated at the desk and the staff member stated	F 353		

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F 353	Continued From page 85 she was not answering the call light because she had other things to do. FM-D stated the staff member was observed to enter the residents room at 5:14 p.m., ask the resident how he was, turn the call light off and left the room. The staff member never assisted the resident to the bathroom. On 6/5/15, at 10:36 a.m. R177's call light was observed on. -At 10:38 a.m. NA-O was observed going into the, turn the call light off and exited the room. -At 10:41 a.m. R177 put the call light on again. -At 10:43 a.m. NA-O was observed seated at the nursing station. NA-O stood up, started walking down he hallway and was heard stating on the walking talkie R177's call light was on. As NA-O continued to walk down the hallway, NA-J was observed walking towards R177's room, enter the room, shut the light off and immediately exit the room. -At 10:45 a.m. when approached R177 stated she wanted someone to put her to bed. When asked if her need had been met after her call light was turned off two times, R177 stated the staff had told her they were going to find her aide to assist her. R177 stated she wanted to lay down. -At 10:52 a.m. R177 remained seated in the wheelchair with her hunched over and eyes closed. -At 10:56 a.m. R177's call light was observed on again. -At 10:59 a.m. RN-D was observed going to room and asked R177 what she needed help with. R177 stated again she wanted to lay down. -At 11:00 a.m. RN-D and TMA-D were observed to enter R177's room, briefly shut the door then reopened it. R177 was observed to remain	F 353		

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F 353	Continued From page 86 seated in her wheelchair. -At 11:03 a.m. TMA-D and two NA's were observed in room then came out of room. -At 11:06 a.m. when approached R177 indicated the staff had told her it was almost lunch time and so she was going stay up until after lunch and would be laid down after. On 6/5/15, at 11:08 a.m. when asked what R177 had requested when TMA-D was last observed in her room, TMA-D stated when she had been in the room prior with RN-D, R177 had indicated she wanted to lay down so she had left to get a transfer belt and when she returned with the other NA's, R177 had declined to be put to bed as she now had indicated she wanted to watch Jeopardy. TMA-D indicated at times R177 would change her mind when she had asked for something. When told R177 had asked since 10:36 a.m. to lay down TMA-D indicated she was not aware of that. On 6/5/15, at 10:00 a.m. when asked if the staff were supposed to answer call lights when walking past them, the DON stated "It depends on what they are doing if they are getting something for another person, but I would expect them to answer the call light if not doing anything." When asked what her expectation was when staff went to residents rooms and turned the call light off and told residents they will go find who their nursing assistant was, the DON stated "It depends the amount of staff required to assist resident but I would expect them to answer the call light and assist resident." When the DON was told staff had been observed standing down the hallways when call lights were on, the DON stated the staff was supposed to answer the call lights.	F 353		

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On 6/5/15, at 10:25 a.m. both NA-M and NA-N indicated the work load was heavy and all the time a group was split and they were not able to do their work timely which included repositioning the residents and this was a continuous problems at the facility and management was aware and was not doing anything. Both indicated this was not good for the residents when their needs were not met timely.

On 6/5/15, at 2:20 p.m. Daily Staffing Guide Layout for all the units for randomly selected days 3/5/15, 3/6/15, 3/14/15, 3/15/15, 3/16/15, 4/12/15, 4/29/15, 5/6/15, 5/29/15, and 5/30/15, were reviewed with the payroll & benefits staff who verified on numerous shifts multiple staff who were either absent or had no call no show were not replaced instead resident group assignments had to be split the groups which was all indicated in the sheets. In addition she verified on numerous days staff would either work part of the shift, left early or came in late for the shifts. When asked how resident cares/needs were supposed to be met when staff either came in late or left early she indicated the supervisor determined the level of acuity for the units. She verified on multiple shifts when staff had left early and had not been replaced and the groups had been split. In addition she verified on numerous shifts in some units staff worked short and no replacements were done and nurse manager had worked on the floor when a nurse was short of one nurse. When asked if the nurse manager had been counted as providing direct care she was not able to respond but rather indicated the nurse manager would help around the unit. When asked about staff call-in's and replacing the staff she indicated if the staff had called in a head of time it was easy to replace the staff but when they

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F 353	Continued From page 88 called in within a short time frame to shift start time it was hard at times to replace and would not be replaced. On 6/5/15, at 3:40 p.m. when asked what she would have expected her staff to do when call lights were on, the administrator stated she would expect her staff to answer call lights and not stand in the hallways talking about their personal things. During review of the Consumer Concerns Tracking logs dated from 8/5/14, through 5/18/15, it was revealed 44 complaints complaints which involved either poor cares, poor call light response during the day or at night time, positioning concerns from residents and family members. Although the logs indicated resolution had been reached the complaints continued to occur from different residents and units in the facility over time to the survey weeks as observed by staff activity. In addition during review of the facility annualized turnover rates it was revealed 2014 rate was 44.60 percent (%) and year to date (YTD) 2015 was 50.50%.	F 353		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 364	F364- Food is being served within	7/12/15

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F 364	Continued From page 89 review, the facility failed to develop a system to ensure food was served at the proper temperature for 5 of 21 residents (R365, R117, R257, R234, R515) who were interviewed regarding food quality and for 2 of 2 residents (R457 R385) who were observed to receive cold food. Findings include: R365's quarterly Minimum Data Set (MDS) dated 5/9/15, identified R365 had intact cognition. On 6/2/15, at 9:23 a.m. R365 stated the eggs were cold. R117's quarterly MDS dated 5/8/15, identified R117 had intact cognition. On 6/2/15, at 10:34 a.m. R117 stated the food was usually cold. She explained the food service distribution took between 45 minutes to an hour to complete. She stated her table was one of the last tables to be served and the food was cold. R257's quarterly MDS dated 3/27/15, identified R257 had intact cognition. On 6/2/15, at 10:57 a.m. R257 stated the food was cold. She stated her table was the last table served during the second seating in her dining room and the food did not stay warm. R234's quarterly MDS dated 4/10/15, identified R234 had intact cognition. On 6/2/15, at 11:33 a.m. R234 stated the food was sometimes cold. R515's admission MDS dated 4/8/15, identified R515 had intact cognition. On 6/2/15, at 1:50 p.m. R515 stated the eggs were cold and the vegetables were cold and mushy.	F 364	temperature guidelines and within appropriate serving texture. Current residents receiving oral nutrition have the potential to be affected by this alleged deficiency. Resident 365, 117, 257, 234, and 515 had not voiced complaints or concerns in regards to cold food. Qualified staff that assist with feeding will be re-educated by the DON/Designee on checking appropriate temperatures per community procedure. The Dietary Manager will re-educate dietary staff responsible for the serving tables to maintain appropriate temperatures per community procedure. Plate warmers have been added to assist with retaining food temperatures. Hot top serving tables temperatures have been increased. Food temperatures are taken as food leaves kitchen and when it arrives at designated dining room. Food temperatures will be taken as the food leaves the kitchen, daily x 14, weekly x 4, monthly x 3. Food temperatures will be taken when the food arrives designated dining room, daily x 14, weekly x 4, monthly x 3. A interdisciplinary food tasting committee	

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F 364	Continued From page 90 On 6/3/15, at 11:20 a.m. the main kitchen area dietary service was observed with the registered dietician (RD). -At 11:23 a.m. Cook (C)-A was observed to remove the hot meal items from the oven and check the temperatures. The hot meal choices consisted of tuna melts, chicken patties and mashed potatoes. The tuna melts were 180 degrees Fahrenheit (F), the chicken patties were 160 degrees F and the mashed potatoes were 180 degrees F. -At 11:33 a.m. C-A loaded the steam table pans into an insulated cart and dietary aide (DA)-A was observed to push the cart out of the main kitchen. DA-A transported the food to the west building, first floor dining room. -At 11:45 a.m. DA-A placed all of the hot food items onto the hot cart serving system. DA-A then rechecked the temperatures of the hot food items. The mashed potatoes were noted to be 150 degrees F, the chicken patties were 140 degrees F and the tuna melts were 142 degrees. -At 12:00 p.m. DA-A began serving the meals to the 29 residents residing on the first floor west dining room. -At 12:37 p.m. the last tray was served to the residents. DA-A rechecked the temperature of the hot food. The chicken patties were noted to be 130 degrees F and the mashed potatoes were 134 degrees. The RD and the survey staff tasted a serving of the chicken patty and mashed potatoes. The RD confirmed the taste of the food items were correct, but the food was not hot. She stated the facility did not have a system in which they monitored the food at the end of the meal service to ensure adequate temperatures were maintained throughout the meal distribution process and had not been made aware the residents had expressed concerns regarding cold	F 364	has been formed to audit test trays to ensure proper temperature and texture are maintained on a monthly basis. The first interdisciplinary food tasting committee has tested breakfast, lunch, and dinner meals on July 1st, 2015. Results of audits will be reviewed by QA&A.	

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food. She stated she would work on the concern.

R457's was fed cold food an the facility failed to reheat or provide hot food.

R457's Diagnosis Report dated 11/21/14, identified R457's diagnoses as dementia and generalized muscle weakness.

R457's significant change MDS dated 3/6/15, indicated R457 had severe cognitive impairment, was sometimes able to make herself understood and required extensive assist with meals. R457's nutritional Care Area Assessment (CAA) dated 3/10/15, identified R457's inability to perform activities of daily living (ADL)s without significant physical assistance affected her ability to eat.

R457's care plan dated 5/28/14, indicated R457 required total assistance from staff with her meals.

R457's nutritional assessment dated 5/28/15, indicated R457 relied on staff to feed her.

On 6/3/15, at 6:26 p.m. R457 was observed seated in a tilt back wheelchair at a table in the Bridgeway dining area. R457 had a tray of food placed directly in front of her and left unattended. -At 6:38 p.m. an unidentified staff member sat down next to R457. Upon request of the surveyor, dietary aide (DA)-A took the temperature of R457's mashed potatoes and squash on her tray. DA-A stated the temperature of the mashed potatoes was 93 degrees F and the temperature of the squash was 90 degrees. DA-A then proceeded to walk away and did not offer to provide R457 with a tray of warm food or warm up the food on her tray. The unidentified staff

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member proceeded to assist R457 with her meal without offering to reheat her food.

R385 was observed to have been served cold eggs.

R385's quarterly MDS dated 4/11/15, indicated R385 was cognitively intact, was on dialysis and was independent with eating after set up only.

On 6/3/15, at 7:18 a.m. R385 was observed seated in his wheelchair at the dining room table. R385 stated at times the food,especially the eggs, were served cold and this was something he had brought to the facility attention several times.

On 6/3/15, at 8:34 a.m. shortly after breakfast was served to R385 he was overheard to ask the occupational therapist (OT) who was assisting another resident at the same table to warm his eggs. R385 stated "as always the eggs are cold, can you please put them in the microwave to warm them for 45 seconds." OT staff was seen leave the table then returned and took R385's eggs, warmed them and brought them back to R385.

The Preventing Foodborne Illness-Food Handling policy revised 12/2009, directed the staff to cook potentially hazardous food to the appropriate internal temperatures and hold the food at those temperatures for the appropriate length of time to destroy harmful bacteria. The policy directed staff as to when to discard food items but it did not specifically direct the staff as to how to ensure the food was served at the proper temperature for the entire food service.

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F 431	Continued From page 93	F 431		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. 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 applicable. 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. 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:	F 431		7/12/15

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F 431	Continued From page 94 Based on observation, interview and document review, the facility failed to ensure medications were stored properly on 2 of 7 nursing units (2 north west and 2nd floor central nurses station) which involved 7 of 7 residents (R209, R492, R315, R103, R643, R533, R300) residing on the 2 Northwest nursing unit who required insulin and 1 of 1 resident (R92) who had discharged from the facility. This had the potential to affect all 79 residents residing on 2 West. Findings include: On 6/2/15, during continuous observations from 8:28 a.m. to 8:50 a.m. a plastic divided container was observed sitting on the second floor north west nurses station. The container was observed to be filled with multiple insulin pens with prescription labels on them. No staff members were observed by the station and the insulin pens were available for staff, residents and visitors to remove. Insulin pen needles were observed to be stored in the front section of the box. Unlicensed staff, residents and family members were observed on the unit. At 8:40 a.m. the State Agency staff sat at the nurse's station near the insulin pens. At 8:50 a.m. licensed practical nurse (LPN)-A was observed to walk to the nurse's desk, picked up the container of insulin pens and place it in the medication room. LPN-A then left the desk area. On 6/2/15, at 2:48 p.m. the insulin container was observed with LPN-B. Each of the insulin pens was equipped with a pharmacy label which	F 431	F431- Insulin and medications ready for disposal are being properly stored. Current residents have the potential to be affected by this alleged deficiency. Medications are being properly stored. Licensed nursing staff have been re-educated regarding medication storage and proper disposal. DON/Designee will audit the med carts and medication rooms daily M-F x 4 weeks, weekly x 4 weeks and monthly x 3 for proper storage and disposal of medications.	

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identified the resident and the directions for use. The plastic device held the following pens:

R209 had 1 Novelog Flex pen
R492 had 1 Lantus Flex pen
R209 had 1 Lantus Flex pen
R315 had 1 Lantus Flex pen and 1 Novolog Flex pen
R103 had 1 Novolog and 1 Levimure Flex pens
R643 had 1 Lantus and 1 Novolog Flex pen
R533 had 1 Novolog Flex pen
R300 had 1 Novolog Flex pen

On 6/2/15, at 3:05 p.m. LPN-B stated the container of insulin was to be in sight of the nurse or locked at all times.

On 6/2/15, at 3:10 p.m. LPN-A confirmed she had left the insulin pens on the desk. She stated she had been directed not to leave them out by her supervisors but stated the morning became very busy and the residents had begun to "pile up." She stated they were to be kept secure.

On 6/3/15, at 7:20 a.m. the west building second floor central nurses station was observed to contain a small plastic box of medication. The nurses station was not equipped with any type of system which would prevent unlicensed staff, visitors or residents from entering the nurses station and removing the medication.

On 6/3/15, at 9:10 a.m. the basket of medication remained on the desk without staff members present.

On 6/3/15, at 2:00 p.m. the second floor west central nurses station was observed with the assistant director of nurses (ADON). The

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	245183	A. BUILDING _____ B. WING _____	06/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH RIDGE HEALTH AND REHAB	5430 BOONE AVENUE NORTH NEW HOPE, MN 55428

(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 431	Continued From page 96 medication were noted to be for R92 who had been discharged from the facility. The medications included Spirva capsules and two bottles of Azopt eye drops. The ADON stated the medication should have either been sent home with the resident upon discharge or destroyed. The ADON confirmed all medications were to be kept secure. The Storage of Medication policy revised in April 2017, indicated only persons authorized to prepare and administer medications were to have access to medications and all medications were to be stored securely.	F 431		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate maintenance to resident rooms numbered (322, 366, 393, 394, 423). In addition failed to ensure 1 of 2 residents (R465) room was kept clean and free of odors reviewed for environmental concerns. Findings include: On 6/4/15, from 9:00 a.m. to 10:00 a.m. a tour of the facility was completed with the maintenance	F 465	Rooms for resident 322, 366, 393, 394, 423 have had ceiling tiles replaced. Resident 465 has had odors resolved. A whole house audit for ceiling tiles and odors has been completed. Repairs and resolution has been completed where necessary. Preventative measures have been put in place for rooms identified as being requiring more than routine cleaning. All staff have been re-educated regarding	7/12/15

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F 465	Continued From page 97 director (MD), administrator, regional nurse administration, district manager of the healthcare service group, and the director of housekeeping. The MD verified the following resident room concerns: · In room 322, two ceiling tiles were stained and needed replacing in the bathroom · In room 366, there was a broken ceiling tile in the bathroom which needed replacing · In room 393, two ceiling tiles were stained and needed replacing in the bathroom · In room 394, two ceiling tiles were stained and needed replacing in the bathroom · In room 423, bathroom wall tile behind the toilet was broken On 6/4/15, at 10:00 a.m. the MD confirmed he had not received work orders requesting repairs for the above concerns identified. No routine maintenance schedule for maintenance and up keep for resident rooms was provided. The Interior General Maintenance policy [undated] indicated the facility would be maintained in good repair at all times to include all interior surfaces and fixtures. R469's room had a strong musty offensive odor and the facility failed to reduce the odor. On 6/1/15, at around 4:30 p.m. during the initial tour, a strong musty malodorous smell was noted outside R469's room. On 6/2/15, from 8:00 a.m. until 3:10 p.m. a malodorous smell was noted just outside R469's	F 465	system for reporting environmental issues. Director of Maintenance will audit 2 rooms/unit/week for conditions, odors, and cleanliness. Audit results will be reviewed at QA&A.	

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F 465	Continued From page 98	F 465		

room.

On 6/3/15, at 9:47 a.m. the same strong, offensive odor remained just outside of R469's room. Trained medication aide (TMA)-B was observed standing outside the room setting up medications.
-At 9:54 a.m. registered nurse (RN)-C was observed to enter R469's room in which R469 was heard to ask for assistance to get into his wheelchair. RN-C indicated she would get help and left the room.
-At 9:55 a.m. observed a nursing assistant enter R469's room and shut the door. The malodorous odor remained.

On 6/4/15, from 7:00 a.m. until 12:00 p.m. R469's room continued to have the same strong malodorous smell when walking outside and was overpowering when entering the room. Several staff, residents and family members were observed going back and forth past R469's to other rooms located down the hallway. No staff acknowledged R469's room needed to be cleaned.

On 6/5/15, at 9:35 a.m. the pervasive malodorous smell remained and several staff were observed walking past the room.

On 6/5/15, at 9:55 a.m. the MD, after he walked towards R469's room door, verified the smell was urine and stated he thought the odor was in R469's clothes or the carpet as the vent was working in the unit properly. The MD stated "I will have housekeeping come clean it."

On 6/5/15, at 10:07 a.m. a staff member with a carpet cleaning machine entered R469's room

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F 465	Continued From page 99 and informed R469 he was going to clean his carpet. On 6/5/15, at 10:10 a.m. the MD stated the carpet was going to be cleaned and the clothes in the room were going to also be checked.	F 465		
F 467 SS=E	483.70(h)(2) ADEQUATE OUTSIDE VENTILATION-WINDOW/MECHANIC The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain functional / adequate ventilation in resident rooms numbered (107, 245, 247, 249, 326, 350, 366), where urine odors had been detected. Findings include: On 6/4/15, from 9:00 a.m. to 10:00 a.m. a tour of the facility was completed with the maintenance director (MD), administrator, regional nurse administration, district manager of the healthcare service group and the director of housekeeping. The following rooms had been detected to have a urine odor and the MD checked the ventilation of these rooms and their adjoining bathrooms and confirmed the following: · Room 107, bathroom vent was okay, no vent in resident's room. · Room 245, bathroom vent was okay, MD	F 467	Rooms 107, 245, 247, 249, 326, 350, 366 have had ventilation restored. All rooms have had appropriate ventilation verified. All staff have been re-educated regarding notifications of ventilation concerns. Ventilation motors are on a routine weekly check for function. We have enlisted the assistance of a HVAC/Ventilation contractor to provide consult for the overall ventilation system. Director of Maintenance will audit motor function and repair requests 2 unit/week to ensure ventilation concerns remain resolved. Audit will be reviewed in QA&A.	7/12/15

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F 467	Continued From page 100 placed a Kleenex up to the vent above the door in room 245 and the Kleenex did not adhere to the vent which demonstrated improper air flow. · Room 249, MD confirmed the vent in the bathroom was not open all the way. Once the bathroom vent was opened it was okay. The vent above the door in room 249 demonstrated improper air flow. · Room 326, the vent in the bathroom and above the door in room 326 demonstrated improper air flow. · Room 350, the vent in the bathroom was okay, the vent above the door in room 350 demonstrated improper air flow. · Room 366, the vent in the bathroom was okay, the vent above the door in room 366 demonstrated improper air flow. On 6/2/15, at 10:25 a.m. family member (FM)-A stated her mother's room smelled like urine. On 6/3/15, at 11:57 a.m. there was a very strong urine odor detected in room 107 which permeated and lingered down the 100 wing hallway on the bridgeway unit. On 6/4/15, at 9:15 a.m. the administrator and MD verified room 249 had a urine odor. On 6/4/15, at 9:45 a.m. the MD verified on the bridgeway unit there were no vents in the residents' rooms or in the hallways, just in the resident's bathrooms. On 6/4/15, at 10:28 a.m. the MD confirmed he had gone down random rooms on the two southwest wing and none of the vents above the resident doors were working. The MD confirmed the venting duct work in the ceiling had been capped off at both ends on this two southwest	F 467		

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F 467	Continued From page 101	F 467		

hallway. The MD stated it appeared the facility must have aborted the project and not finished the ventilation project. The MD was unaware of when the ventilation system had been installed or why it had not been finished. The MD stated because the duct work had been capped off on both ends, this only allowed the ventilation system to work in the resident bathrooms and not in their rooms.

On 6/4/15, at 12:05 p.m. the MD stated he had gone up on the roof of the building and checked the fan. The MD confirmed the fan motor on the roof was hot and he determined that the motor of the exhaust system had gone out and needed to be replaced. The MD verified the motor which needed to be replaced would have affected the ventilation system for the bathroom in between resident rooms 324 and 326.

On 6/5/15, at 9:25 a.m. the purchasing director (PD) described the odor permeating down the 100 hallway in bridgeway smelled like dead skin, wet carpet and used incontinence pads.

On 6/5/15, at 9:34 a.m. housekeeper (H)-A stated the 100 hallway of bridgeway smelled like urine and the smell went all the way down the hallway.

The CONSUMER CONCERNS TRACKING - 2014 log indicated on 8/5/14, family members had been upset with odors. In addition, on 3/9/15, a resident had expressed concerns regarding urine smell.

The work history report [undated] indicated the exhaust fans had last been inspected on 5/31/15.

The Interior General Maintenance policy

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F 467	Continued From page 102 [undated] indicated it was the facility's policy to maintain a clean, comfortable environment for their residents, associates and visitors.	F 467		

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	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/03/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, North Ridge Health and Rehab was found not in substantial compliance with the requirements for participation in Medicare/Medicaid, 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101 , Life Safety Code (LSC), Chapter 19 Existing Health Care.. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/01/2015

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us 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. North Ridge Care Center is a 3-story building with no basement. The building was constructed in 1966 and was determined to be of Type I(332) Construction. In 1970 an addition was constructed and was determined to be of Type 1(332) construction. In 1978 an addition was constructed and was determined to be of Type 1 (332) construction. In 1981 an addition was constructed and was determined to be of Type 1(332) construction. In 1998 an addition was constructed and was determined to be of Type 1(332) construction. Because the original building and the 4 additions are of the same complying construction type, the facility was surveyed as 1 building. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for fire department notification. The facility has a full fire sprinkler system. The facility has a capacity of 351 beds. At the time of the survey the census was 310.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, the facility had corridor doors that did not meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the residents. Findings include: During facility tour between 10:00 AM and 1:30 PM on 06/03/2015, observation revealed that the	K 018	Preparation and or execution of this plan of correction does not constitute admission or agreement by the provider to the accuracy of facts alleged or conclusions set forth in the Statement of deficiencies. The plan of correction is prepared and or executed solely because it is required by the provisions of Federal and State Law.	7/12/15

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K 018	Continued From page 3 Bridgeway beauty shop dutch door leaves do not automatically latch. This deficient practice was verified by the administrator at the time of the inspection.	K 018	Corrective Actions Immediate Actions: Maintenance Director has repaired the dutch door latch on the Bridgeway South unit to ensure that the door leaves automatically latch in accordance with NFPA 101 Life Safety Code standard 19.3.6.3.6. Reoccurrence will be prevented by: Maintenance Director has implemented a preventative maintenance protocol to audit doors to ensure they are all functionally working in accordance to NFPA 101 Life Safety Codes. Maintenance Director is also notified of maintenance order requests via an electronic and paper work order system. Maintenance staff have been educated regarding door function. The correction will be monitored by: The Maintenance Director will be responsible for the ongoing compliance of this correction. Compliance will be monitored via weekly audits. Audits will be reviewed by QA&A.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		7/12/15

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K 038	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect the residents. Findings include: On facility tour between 10:00 AM and 1:30 PM on 06/03/2015, observation revealed that the exit door handle leading from the laundry room is damaged and missing. This deficient practice was verified by the administrator at the time of the inspection.	K 038	Corrective Actions Immediate Actions: Maintenance Director has replaced the damaged and missing door handle for the laundry room door. Reoccurrence will be prevented by: Maintenance Director has implemented a preventative maintenance protocol to audit all doors and door handles on campus to ensure they are all functionally working in accordance to NFPA 101 Life Safety Codes. Maintenance Director is also notified of maintenance order requests via an electronic and paper work order system. Maintenance staff have been educated regarding door handle requirements. The correction will be monitored by: The Maintenance Director will be responsible for the ongoing compliance of this correction. Compliance will be audited via weekly audits. Audit results will be reviewed at QA&A.	
K 043 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Patient room doors are arranged so that the patient can open the door from inside without using a key. (Special door locking arrangements are permitted in mental health facilities.)	K 043		7/12/15

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K 043	Continued From page 5 19.2.2.2.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain the door locks in accordance with Life Safety Code Section 18.2.2.4. This deficient practice could affect the residents. Findings include: On facility tour between 10:00 AM and 1:30 PM on 06/03/2015, observation revealed that the Bridgeway 200 wing exterior exit door keypad does not unlock the door. Testing of the special egress control devices also revealed that the perimeter door locks automatically relock upon fire alarm reset. This deficient practice was verified by the administrator at the time of the inspection.	K 043	Corrective Actions Immediate Actions: Maintenance Director repaired the Bridgeway South 200 wing exterior exit door to ensure that it is functionally working in accordance with the Life Safety Code 18.2.2.4. Reoccurrence will be prevented by: Maintenance Director has implemented a preventative maintenance protocol to audit exit doors to ensure they are functionally working in accordance to NFPA 101 Life Safety Codes. Maintenance Director is also notified of maintenance order requests via an electronic and paper work order system. Maintenance staff have been educated regarding requirements for functioning doors. The correction will be monitored by: The Maintenance Director will be responsible for the ongoing compliance of this correction. Audits will be conducted weekly, audit results will be reviewed by QA&A.	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 072		7/12/15

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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
K 072	Continued From page 6 Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of patients in an emergency situation. Findings include: On facility tour between 10:00 AM and 1:30 PM on 06/03/2015, observation revealed that there is wheeled storage in the corridors throughout the facility. This deficient practice was verified by the administrator at the time of the inspection.	K 072	Corrective Actions Immediate Actions: Maintenance Director obtained a categorical waiver to allow wheeled storage in corridors throughout the facility. Reoccurrence will be prevented by: North Ridge Health & Rehab has obtained a categorical waiver that allows for wheeled storage in corridors throughout the facility. The correction will be monitored by: The Maintenance Director will be responsible for updates regarding the categorical waiver that allows for wheeled storage in corridors.	
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.	K 076		7/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245183	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/03/2015**

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K 076	Continued From page 7 (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the medical gas storage in accordance with NFPA 99. This deficient practice could affect the residents. Findings include: During facility tour on between 10:00 AM and 1:30 PM on 06/03/2015, observation revealed that there are (3) liquid oxygen tanks in resident room 264. This deficient practice was verified by the administrator at the time of the inspection.	K 076	Corrective Actions Immediate Actions: Maintenance Director immediately removed the unnecessary oxygen tanks stored in resident room 264. Reoccurrence will be prevented by: Nursing Managers are required to audit resident rooms for unnecessary oxygen tank storage to ensure facility is in accordance to NFPA 99 Standards for Health Care Facilities. Staff has been educated on proper oxygen storage protocol to ensure facility meets the NFPA 99 Standards for Health Care Facilities. This occurrence will be monitored by: Nursing Managers will be responsible for the ongoing compliance of this correction. DON/Designee will audit 2 rooms/week/unit. Audit results will be reviewed at QA&A.	

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

July 2, 2015

Mr. Ryan Chies, Administrator
North Ridge Health And Rehab
5430 Boone Avenue North
New Hope, Minnesota 55428

Re: Enclosed State Nursing Home Licensing Orders

Dear Mr. Chies:

A complaint investigation was completed on June 4, 2015. At the time of the investigation, the investigator assessed compliance with Minnesota Department of Health Nursing Home Rules. The investigator from the Minnesota Department of Health, Office of Health Facility Complaints, noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the enclosed Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for nursing homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following investigator's findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all licensing orders are corrected, the form should be signed and returned electronically to:

Michelle Ness, Investigation Unit Supervisor
Office of Health Facility Complaints, Division of Compliance Monitoring
85 East Seventh Place, Suite 220
P.O. Box 64970
St. Paul, MN 55164-0970
Telephone: (651) 201-4217 Fax: (651) 281-9796
General Information: (651) 201-4201 or 1-800-369-7994

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

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

If you have questions or concerns you may call me at the number below.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00238	A. BUILDING: _____ B. WING _____	06/04/2015

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 6/1, 6/2, 6/3, 6/4 and 6/5/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Investigation of complaints H5183106 and H5183107 were also completed. The complaints were substantiated at F353. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 000	Continued From page 2 FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 530	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify the use of zipped backed, full body suits as a restraint and failed to follow the facility's restraint policy for 2 of 2 residents (R566, R74) observed wearing full body suits which limited access to one's body. The facility also failed to recognize the use of wheelchairs (w/c) brakes as restraint devices	2 530		

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2 530	Continued From page 3 which prevented freedom of movement for 2 of 2 residents (R327, R138) observed with engaged w/c brakes which prevented freedom of movement. Findings include: R566's Diagnosis Report dated 1/22/15, identified R566's diagnoses as Alzheimer's disease, depression, cerebrovascular disease (stroke) with hemiplegia (weakness on one side), lack of coordination and generalized muscle weakness. R566's quarterly Minimum Data Set (MDS) dated 4/17/15, indicated R566 had severe cognitive impairment, required extensive assist with dressing and personal hygiene and had upper and lower extremity impairment on one side. In addition, R566's MDS assessment for restraint use indicated "none used" for bed rail, trunk, limb or other. On 6/3/15, at 12:18 p.m. registered nurse (RN)-E, unit manager, and nursing assistant (NA)-E entered R566's room and using a mechanical lift assisted R566 from his wheelchair to his bed. R566 was observed wearing a light blue topped one piece body suit which was zipped up the back and prevented R566 access to his body. On 6/3/15, at 7:06 p.m. R566 was observed seated in his wheelchair wearing the light blue topped one piece body suit which remained zipped up the back.	2 530		

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2 530	Continued From page 4 On 6/4/15, at 9:45 a.m. R566 was observed seated in his wheelchair by the aviary dressed in a cobalt blue, one piece body suit zipped up the back. R566's Order Summary Report dated 2/10/15, revealed it was okay for R566 to be placed in a one piece outfit at all times to prevent disrobing. R566's care plan dated 2/17/15, directed staff to place R566 in a one piece garment at all times, as available, due to disrobing and smearing of feces. R566's treatment administration records from 4/1/15, thru 6/3/15, indicated R566 had been placed in a one piece garment at all times. On 6/3/15, at 7:40 p.m. NA-G confirmed R566 wore a full body suit which zipped up the back. On 6/4/15, at 10:44 a.m. RN-E verified R566 wore a one piece body suit which zipped up the back. RN-E stated the body suits were made to zip up the back in order to keep the resident from accessing part of their body. RN-E confirmed they had not identified the one piece body suits with the backed zipped enclosure as a physical restraint; however he understood they were a physical restraint as they had limited access to the resident's body.	2 530		

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2 530	Continued From page 5 On 6/4/15, at 11:53 a.m. RN-F stated she understood the one piece body suits with the backed zipped enclosure were restraints as they restricted access to the residents' body. RN-F confirmed R566 had not had a pre-restraint assessment completed prior to implementation of the physical restraint. RN-F stated she was not knowledgeable of the content of the facility's restraint policy. R74 utilized a full body suit which zipped up the back and prevented R74 access to body and the facility failed to recognize this as a restraint and follow their restraint policy and procedures related to the use. R74's care plan dated 3/16/15, directed staff to put R74 in a one piece outfit at night and during the day as needed. R74's Diagnosis Report dated 3/19/14, identified R74's diagnoses as cerebrovascular disease (stroke), dysphasia (difficulty in swallowing), hypertension (high blood pressure), muscle weakness and difficulty walking. R74's significant change MDS dated 4/17/15, indicated R74 had severe cognitive impairment and required extensive assist with dressing, toileting and personal hygiene. In addition, R74's MDS assessment for restraint use indicated "none used" for bed rail, trunk, limb or other. R74's Order Summary Report dated 8/6/14,	2 530		

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2 530	Continued From page 6 revealed a physician order for a one piece suit to be worn at night and as needed throughout the day. R74's treatment administration records from 4/1/15, thru 6/3/15, indicated R74 had been placed in a one piece suit every evening except for 4/24/15. On 6/3/15, at 12:30 p.m. NA-E was observed to enter R74's room. R74 was observed wearing a one piece, dark blue, neck to ankle body suit which was zipped up the back and prevented R74 access to her body. NA-E was observed to remove R74's body suit, change her incontinent brief, provide perineal-care and apply a clean brief while following infection control practices. While reapplying R74's one piece suit, NA-E noticed the one piece suit's legs were soiled. NA-E attempted to find another one piece suit in R74's closet and stated R74's other one piece suit must be in the laundry. NA-E proceeded to dress R74 in sweat pants and sweatshirt and stated he would put another one piece suit on R74 later once it was washed. On 6/3/15, at 12:30 p.m. NA-E verified R74 usually wore a one piece body suit with a backed zip enclosure every day because she picked at her incontinent brief and would tear it apart. NA-E also verified R566 wore a one piece body suit because he dug in his brief. NA-E verified R566 was currently wearing a one piece body suit which was zipped up the back. On 6/4/15, at 10:50 a.m. RN-E and social worker	2 530		

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2 530	Continued From page 7 (SW)-A both confirmed R74 wore a one piece, body suit with a backed zip enclosure. RN-E and SW-A both agreed they could see how this could be viewed as a restraint. On 6/4/15, at 12:25 p.m. RN-F confirmed the one piece body suits with the backed zip enclosures were absolutely considered a restraint. RN-F confirmed R74's care plan had not addressed the one piece body suit as a physical restraint nor had a pre-restraint assessment been completed on R74 or an informed consent obtained from R74's legal representative with regards to restraint usage. On 6/4/15, at 2:03 p.m. RN-E and RN-F confirmed it was their expectation staff followed the facility's restraint policy. RN-F confirmed R74 and R566's medical records lacked documentation of informed consent for the use of a physical restraint and documentation of monitoring of these residents while in restraints. R327 was observed with engaged w/c brakes which limited movement and the facility failed to recognize the use as a restraint device and implement their restraint policy and procedures. R327's quarterly MDS dated 5/22/15, indicated R327's diagnoses included muscle weakness, difficulty walking, restless legs syndrome and bipolar and had moderately impaired cognition. R327's Fall Care Area Assessment (CAA) dated 3/5/15, indicated R327 was at risk for falls, had falls related to attempting self transferring and	2 530		

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2 530	Continued From page 8 staff were directed to monitor for falls per protocol. R327's Communication CAA dated 3/5/15, indicated R327 was heard of hearing, was able to communicate effectively using a pocket talker and was able to let staff know when she could not hear them. R327's care plan dated 3/16/15, indicated R327 was at risk for falls, was unaware of safety needs and R327 utilized anti-roll back brakes on the w/c. On 6/3/14, at 8:24 a.m. R327 was observed in the dining room seated in a w/c next to the dining table. R327 was observed to repeatedly attempt pull self forward by gripping the table to wheel herself but the left w/c brake was noted to be engaged. When R327 attempted to wheel self backwards, the w/c would not move as an anti-roll back device was engaged on the back of R327's w/c. R327 was observed to independently stand, step over the foot pedal and as she held the pocket talker in her hand, she independently ambulated, with a steady gait, approximately 30 feet when the dietary manager intervened and asked another staff member to get her w/c. -At 8:32 a.m. R327 was observed to ambulate down the unit hallway to the nursing station where NA-C intervened and asked R327 if she wanted to use the walker or w/c for mobility in which R327 responded she wanted to use her w/c. NA-C proceeded to ambulate with R327 back to her room at which point NA-C turned around and asked another staff member if they knew where R327's w/c was which was found near the medication cart near the nursing station. NA-C stated R327 needed to use the w/c because she was a fall risk. RN-B who heard this conversation, did not respond. Upon looking at the back of the	2 530		

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2 530	Continued From page 9 w/c an anti-roll brake black bar was noted to be installed. At 8:45 a.m. R327 was observed seated in a w/c at the dining room table. The w/c brakes were observed engaged. -At 9:02 a.m. NA-B was observed to unlock R327's brakes, cleanse R327's hands and wheel R327 out of the dining room. -At 9:11 a.m. NA-B verified R327's w/c brakes were engaged and stated at times R327 would use the w/c to wheel herself around the facility and would also use the walker. When asked if R327 was able to independently release the w/c brakes, NA-B stated no, R327 would not be able to do so and added, engaging the w/c brakes would be considered a restraint and she did not know who engaged R327's w/c brakes. On 6/4/15, at 10:43 a.m. RN-D stated staff encouraged the residents to lock their w/c brakes when self transferring or standing and would not expect the staff to lock the w/c brakes while in the dining room. RN-D further stated during meal times the residents' w/c brakes would be locked while eating, however when asked who was responsible to ensure the brakes were released when the resident' were done eating, RN-D was unable to answer but indicated when the staff took the residents back to their room they would then release the brakes. RN-D verified R327 had not had a restraint assessment completed. On 6/4/15, at 2:20 p.m. the director of nursing (DON) stated she was not so familiar with R327 and indicated if R327 was able to wheel herself independently she would have expected staff to not have the brakes engaged and was not sure if R327 could release the brakes herself.	2 530		

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2 530	Continued From page 10 R138 was observed with engaged w/c brakes which limited movement and the facility failed to recognize the use as a restraint device and implement their restraint policy and procedures. R138's care plan for mobility initiated 3/7/15, indicated R138 was able to propel his wheelchair independently on the unit and directed staff to assist upon request and as needed. R138's annual MDS dated 5/15/15, indicated R138 had moderate cognitive impairment, no physical behaviors, required extensive assistance of one staff for locomotion with the wheelchair, was independent with eating and had no restraints. R138's undated Face Sheet indicated R138 had diagnoses that included cerebrovascular disease (stroke) with hemiplegia (weakness or paralysis on one side of the body), difficulty walking, muscle weakness, convulsions, dementia and anxiety. R138's Activity of Daily Living (ADL) CAA dated 5/15/15, indicated R138's primary mode of transportation was the wheelchair and R138 was able to independently propel himself and also with staff assistance. R138's medical record indicated R138 had a history of falls with majority of falls having	2 530		

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2 530	Continued From page 11 occurred during staff assisted transfers. The medical record lacked documentation of physical restraint use. On 6/3/15, at 5:42 p.m. R138 was observed seated in a w/c at the dining room table independently eating the meal. -At 5:48 p.m. upon completion of the meal, R138 was observed attempting to push his w/c back away from the table in order to leave the table. R138' w/c tipped slightly back, however did not move. R138 was observed to intermittently shift self in his w/c seat while attempting to push the w/c back. The left w/c brake was noted to be engaged therefore the w/c did not move. -At 5:53 p.m. R138 reported to a few staff members in the dining room that he could not move. RN-H was observed to release the w/c brake and wheel R138 out of the dining room. On 6/4/15, at 2:09 p.m. RN-H confirmed if a device limited or prevented movement it would be a restraint. RN-H stated she did not know why R138's w/c brake was engaged and was unaware of any type of restraint assessment or assessment for the w/c brakes to be locked that was to be completed. On 6/5/15, at 11:20 a.m. RN-H verified that locking w/c brakes at the dining table which prevented freedom of movement when the resident was unable to independently release, would be considered a restraint. The Use of Restraints policy, revision date	2 530		

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2 530	Continued From page 12 9/2012, indicated: · Defined a physical restraint as any manual method, or physical or mechanical device, material or equipment attached or adjacent to the resident's body which restricted normal access to one's body · Directed staff to compete a pre-restraint assessment prior to placing a resident in restraints · Directed staff to obtain informed consent for the use of restraints which included the risks and benefits of all options under consideration, including the use of restraints and alternatives · Care plans for residents in restraints would reflect interventions that addressed not only the immediate medical symptom(s), but the underlying problems that may be causing the symptom(s) · A resident restrained would be monitored at least every thirty minutes and the staff would document these observations SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure potential restraints are identified, comprehensively assessed and care planned to ensure they are the least restrictive restraints. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance.	2 530		

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2 530	Continued From page 13 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 530		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences.	2 540		

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2 540	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure Minimum Data Set (MDS) assessments accurately reflected the residents' dental status for 2 of 3 residents (R228, R163) reviewed for teeth/dental and accurately reflected the residents' restraint status for 2 of 2 residents (R74, R566) reviewed for restraints. Findings include: R228's significant change Minimum Data Set (MDS) dated 5/22/15, inaccurately indicated R228 had no dental issues. R228's significant change MDS dated 5/22/15, indicated R228's had "no" broken or loosely fit full or partial dentures and "no natural teeth or tooth fragments. R228's Oral Health Screening dated 4/21/2015, indicated R228 had an exam which noted multiple root tips and optional recommendations for treatment such as: leave as is, take x-rays and extractions or fill #11 tooth and make new upper partial and reline lowers. R228's care plan dated 5/2015, indicated she had her own teeth. On 6/2/15, at 11:54 a.m. R228 was observed with her front teeth missing. On 6/3/15, at 5:30 p.m. R228 stated her front teeth fell out and her power of attorney knew about it. She stated she did not know if she was	2 540		

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2 540	Continued From page 15 going to get new teeth or not. On 6/4/15, at 7:00 a.m. licensed practical nurse (LPN)-F verified staff knew R228 had missing teeth and stated R228 had lost three teeth around 2/15. On 6/4/15, at 10:10 a.m. the above identified MDS's were reviewed with RN-E, the MDS coordinator. RN-E verified the MDS information and stated they both were incorrect as R228 did have broken, missing teeth. R163's MDS dated 5/22/15, failed to accurately reflect R163's dental status. R163's quarterly MDS dated 5/22/15, and significant change MDS dated 10/6/14, indicated R163 had "no broken or loosely fitting partial or full denture." R163's care plan dated 5/28/15, indicated R163 "has her own teeth." On 6/2/15, at 8:23 a.m. R163 was observed without the lower denture in place. On 6/2/15, at 10:22 p.m. R163's family member, (FM)-A, stated R163's lower denture did not fit properly and had not fit for a couple of years. On 6/5/15, at 10:18 p.m. R163 stated she did not	2 540		

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2 540	Continued From page 16 wear her bottom dentures as they "wobbled" in her mouth and did not fit her. On 6/5/15, at 1:53 p.m. nursing assistant (NA)-U stated R163 did not have bottom dentures. On 6/5/15, at 2:06 p.m. registered nurse (RN)-D verified the care plan indicated R163 had her own teeth. 06/05/2015, at 3:19 p.m. RN-E verified the above identified MDS documentation and confirmed the MDS assessments were inaccurately coded. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, "Steps for Assessment" directed staff to: -ask the resident, family, or significant other whether the resident had or recently had dentures or partials (If resident or family/significant other reported that the resident recently had dentures or partials, but they did not have them at the facility, ask for a reason). -if the resident had dentures or partials, examine for loose fit. The coding instructions directed a denture was coded as loose if the resident complained that it was loose, the denture visibly moved when the resident opened his or her mouth, or the denture moved when the resident tried to talk. The coding instructions further directed to check "no natural teeth or tooth fragment(s) (edentulous)" if the resident was edentulous or lacked all natural teeth or part of teeth.	2 540		

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2 540	Continued From page 17 R74's MDS dated 4/17/15, failed to accurately reflect the use of a physical restraint. R74's significant change MDS dated 4/17/15, indicated R74's assessment for restraint use indicated "none used" for bed rail, trunk, limb or other. On 6/3/15, at 12:30 p.m. R74 was observed dressed in a one piece, dark blue neck to ankle body suit which was zipped up the back and prevent R74 access to own body. R74's Order Summary Report dated 8/6/14, revealed a physician order for a one piece suit to be worn at night and as needed throughout the day. R74's care plan dated 3/16/15, directed staff to put R74 in a one piece outfit at night and during the day as needed. R74's treatment administration records from 4/1/15, thru 6/3/15, indicated R74 had been placed in a one piece suit every evening except for 4/24/15. On 6/3/15, at 12:30 p.m. NA-E verified R74 usually wore a one piece body suit with a backed zip enclosure every day because she picked at her brief and would tear it apart.	2 540		

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2 540	Continued From page 18 On 6/4/15, at 10:50 a.m. RN-E and social worker (SW)-A confirmed R74 wore a one piece body suit with a backed zip enclosure. RN-E and SW-A agreed they saw how this could be viewed as a restraint. On 6/4/15, at 12:25 p.m. RN-F confirmed the one piece body suit with the backed zip enclosures were absolutely considered a restraint. On 6/4/15, at 12:25 p.m. RN-E and RN-F verified R74's MDS was inaccurate for restraint use as R74 utilized a physical restraint (one piece body suit) and this had not been reflected on the restraint section of the MDS. R566's MDS dated 4/17/15, failed to accurately reflect the use of a physical restraint. R566's quarterly MDS dated 4/17/15, indicated R566's assessment for restraint use indicated "none used" for bed rail, trunk, limb or other. On 6/3/15, at 12:18 p.m. RN-E, NA-E were observed to enter R566's room and transfer R566 from his wheelchair into bed using a mechanical lift. R566 was observed dressed in a light blue topped one piece body suit which was zipped up the back and prevented R566 access to his body. On 6/3/15, at 7:06 p.m. R566 was observed seated in his wheelchair wearing the light blue topped one piece body suit which remained	2 540		

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2 540	Continued From page 19 zipped up the back. On 6/4/15, at 9:45 a.m. R566 was observed seated in his wheelchair by the aviary dressed in a cobalt blue one piece body suit zipped up the back. R566's Order Summary Report dated 2/10/15, revealed it was okay for R566 to be placed in a one piece outfit at all times for disrobing. R566's care plan dated 2/17/15, directed staff to place R566 in a one piece garment at all times as available due to disrobing and smearing of bowel movement. R566's treatment administration records from 4/1/15, thru 6/3/15, indicated R566 had been placed in a one piece garment at all times. On 6/3/15, at 7:40 p.m. NA-G confirmed R566 wore a full body suit which zipped up the back. On 6/4/15, at 10:44 a.m. RN-E verified R566 wore a one piece body suit which zipped up the back. RN-E confirmed they had not identified the one piece body suits with the backed zipped enclosure as a physical restraint; however he understood they were a physical restraint as they limited R566 access to his body. On 6/4/15, at 11:53 a.m. RN-F stated she understood the one piece body suits with the	2 540		

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2 540	Continued From page 20 backed zipped enclosure were restraints as they restricted access to the residents' body. On 6/4/15, at 12:12 p.m. RN-E verified R566's MDS was inaccurate for restraints as R566 did utilize a physical restraint (one piece body suit) and this had not been reflected on the restraint section of the MDS. According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 dated last revised on October 2014, the "DEFINITIONS PHYSICAL RESTRAINT" was any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident ' s body that the individual cannot remove easily, which restricts freedom of movement or normal access to one ' s body. In addition, the manual provided "Steps for Assessment" and directed staff to: · Review the medical record, including physician orders, nurses notes, and NA notes to determine if physical restraints were used. · Considering the physical restraint definition, observe the resident to determine the effect the restraint has on the resident's normal function. · Evaluate if the resident can easily and voluntarily remove the device, material, or equipment. If the resident cannot easily and voluntarily remove the restraint, continue with the assessment to determine whether the device restricts freedom of movement or the resident's access to his own body. SUGGESTED METHOD OF CORRECTION:	2 540		

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2 540	Continued From page 21 The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident MDS assessments are comprehensive and include the use of physical restraints. Education could be provided to all appropriate staff and a monitoring system could be developed to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 540		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include interventions regarding pressure ulcer and incontinence care for 1 of 3 residents (R63) identified with a pressure ulcer and incontinence for 1 of 2 residents (R63) reviewed.	2 570		

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2 570	Continued From page 22 Findings include: R63's undated Diagnosis Report indicated R63 had diagnoses that included hemiplegia (total or partial paralysis of one side of the body) due to cerebrovascular disease, aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write), generalized muscle weakness, osteoarthrosis, dementia and peripheral vascular disease. R63's quarterly Minimum Data Set (MDS) dated 4/1/15, indicated R63 was rarely/never understood and had severely impaired cognitive skills for daily decision making. The MDS also indicated R63 required extensive assistance of two staff for bed mobility, transfer and toilet use. The MDS also indicated R63 was non-ambulatory and had functional limitations in range of motion of the upper and lower extremities with impairment on one side. The MDS further identified R63 as always incontinent of bowel and bladder and was at risk for the development of pressure ulcers. R63's Care Plan dated 4/10/15, lacked interventions regarding the frequency of incontinence care for bowel and bladder incontinence as well as interventions to minimize the risk of pressure ulcer development or worsening.	2 570		

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2 570	Continued From page 23 The Skin Condition Report dated 6/1/15, identified R63 had a stage II (abrasion, blister or a shallow crater in the skin) pressure ulcer to her right buttock measuring 0.6 cm x 0.4 cm x 0 cm. On 6/3/15, R63 was observed to not have been offered or assisted with positioning from 7:05 a.m. until 10:05 a.m. and was not offered or assisted with incontinence care from 7:05 a.m. until 10:24 a.m. On 6/4/15, at 10:21 a.m. registered nurse (RN)-G verified the care plan lacked specific interventions regarding the prevention of pressure ulcers or incontinence care and stated it was the minimum expectation of the facility to turn and reposition residents as well as check and change for incontinence every 2 hours. The Care Plans-Comprehensive policy dated November 2012, identified the basis of the comprehensive care plan was a thorough assessment of the resident that was ongoing and indicated care plans were revised as information about the resident and the resident's condition changed. The policy indicated one of the purposes of the care plan was to reflect treatment goals, timetables, and objectives in measurable outcomes. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could develop and implement policies and procedures related to	2 570		

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2 570	Continued From page 24 care plan revisions. The DON could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days	2 570		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient qualified nursing staff was available to meet the needs of residents observed / interviewed (R71, R285, R290, R627, R365, R376, R177) as well as family members and staff who voiced concerns regarding lack of staff to assure resident needs were met timely. This had the potential to affect all 351 residents that resided in 5 of 5 units at the facility. Findings include:	2 800		

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2 800	Continued From page 25 Complaints of inadequate staffing were received from residents, family members and staff. Residents voiced concerns that staff either do not answer the call lights or turn off the call lights and do not meet or respond to their needs. On 6/1/15, at 5:50 p.m. R71's call light was observed on. -At 5:53 p.m. registered nurse (RN)-D was overheard after being in R71's room tell an nursing assistant (NA) in the hallway that R71 needed help. -At 5:54 p.m. again R71 put her call light on. Observed a staff who was passing the room trays enter the room, turn the call light off and immediately came out. -At 5:55 p.m. R71 put her call light on again. Observed licensed practical nurse (LPN)-F go past the room wheeling another resident. -At 5:55 p.m. NA-P walked pasted the room. At the same time NA-A was observed passing room trays down the same hallway and walked past the light and another staff again went past the light. -At 5:58 p.m. LPN-F and NA-A both walked past the room call light never went to room to answer it. -At 5:59 p.m. another staff again approached R71 stated she was going to see if someone was available to help her. -At 6:00 p.m. another staff was observed go to R71's room shut the door then call light was off again, then came out. -At 6:05 p.m. R71's call light was on again and LPN-F was observed in the hallway setting up medications as she stood by the medication cart. -At 6:06 p.m. LPN-F and NA-A both were observed to walk past R71's call light and never offered to assist her. -At 6:07 p.m. another staff came to R71 and	2 800		

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2 800	Continued From page 26 stated somebody was going to assist her. R71 at this time was observed to be distressed and angry and yelled "I want somebody to put me to bed." -At 6:09 p.m. NA-L was observed standing at the end of the hallway by the nursing station. At the same NA-P again went past R71's room and never offered to help. R71's call light was still on and the signal was audible when standing in the hallway. -At 6:10 NA-L was observed go to R71's room, shut the call light off then came out of the room and went and stood at the nursing station. NA-L was observed carrying a towel and gown and went into R71's room and shut the door. -At 6:45 p.m. when approached R71 stated this was even better and sometimes she would be begging at staff to use the toilet or be put to bed. R71 indicated the staff were slow, rude and at times did things that would benefit them not the residents. When asked how long it would take for assistance to come when she had put her call light on, R71 stated 45 minutes to over an hour and this had gotten worse since the new company took over and thought the staff were short and overworked. On 6/1/15, at 7:20 p.m. activity aide (AA)-A stated the nursing floors were always busy as there usually was not enough staff members to assist with resident cares. She stated the facility frequently did not have enough staff members. On 6/1/15, at 7:20 p.m. LPN-B stated the Bridgewater memory care area was always busy in the evening. She stated the residents frequently displayed behaviors in the evening and they were busy. She stated the facility did not	2 800		

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2 800	Continued From page 27 have enough staff members to assist the residents. On 6/2/15, at 10:06 a.m. R285 stated she had been at the facility for several different admissions. R285 also stated it took staff forever to answer call lights and she had waited for one and a half hours the previous night for her leg to be wrapped. R285 further stated staff would not answer call lights if it was not their hall they were assigned to work. R285 stated weekends were the worse for answering call lights. As R285 was still talking to surveyor RN-G entered the room and R285 stated "oh crap, I'm in trouble now." R285 stated she thought she was going to be "treated like crap now" and confirmed she was concerned of retaliation. On 6/2/15, at 10:20 a.m. family member (FM)-A stated she frequently visited the facility and the staff members do not always respond to resident requests timely. She stated when she visited her family member, she may put the light on for the staff to assist her family member to the bathroom, but the staff were slow and she usually ended up taking her family member to the bathroom herself. She stated the facility did not seem to have enough staff to care for the residents On 6/3/15, at 9:35 a.m. RN-A who was working on the second floor of the west building stated when she had arrived at the facility for the morning shift, she had been informed the second floor west building would be working with three nurses instead of five. She stated normally the second floor was staffed with one nurse on each of the four medication carts and a charge nurse	2 800		

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2 800	Continued From page 28 during the day. RN-A stated in order to cover all of the areas, a trained medication aide (TMA) had been assigned to pass medications on an assigned wing. She stated the charge nurse would then be required to complete the medications the TMA was unable to complete such as injections and complete any treatments for the wing. She stated when the charge nurse was completing other assignments, the charge duties were not completed as effectively as she wished. She indicated this problem occurred frequently and the staff were not made aware of their assignments until they arrived at the facility for the day. On 6/3/15, at 10:00 when asked if she was able to do her work load TMA-B stated since the new company took over a lot of the original people quit and they were hiring, however; the people just don't stay. TMA-B stated they worked a lot and at times we work a lot of doubles and they will be calling you to work all the time. TMA-B stated at times they were floated around the units which also included the nurses and when you go to a unit you are not familiar with the resident care was very hard to do as you don't know the routine and if someone was passing medications it took a long time to do so in a different unit because you have to be careful to not get medication errors and have to keep checking and checking. I will tell you the truth and if you asked the other staff they will tell you the same. "I feel like sometimes resident care is sacrificed because of the short staff problem." On 6/3/15, at 10:10 a.m. R290's call light was observed on. R290's room was located right across from the nursing station and the call light	2 800		

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2 800	Continued From page 29 sound was audible and even louder when standing at the station. -At 10:14 a.m. RN-J was observed seated at the nursing station as NA-B and another NA were observed standing at the nursing station. -At 10:16 a.m. NA-B walked past R290's room with call light still going off. NA-B then returned to the nursing desk and all three staff were observed and heard talking to each other about their hours of work as the call light was still going. -At 10:17 a.m. RN-J stood up from the desk and was observed go into R290's room, immediacy exit the room and stated to NA-B R290 wanted to get out of bed. -At 10:18 a.m. NA-B and another NA went to R290's room with a transfer lift to assist R290. On 6/3/15, at 11:32 a.m. RN-B stated the facility could use more help and thought the only thing that really bothered her was the split groups as she felt the residents were neglected "I want residents to have a nurse assigned to them and so is a nursing assistant. It just bugs me with the split shift." On 6/3/15, from 12:00 p.m. until 12:09 p.m. R627's call light was observed to be on. NA-B was observed to walk past the call light and walk towards the dining room area. A family member in the room was observed peeking outside the hallway then went back in the room at 12:06 p.m. -At 12:08 p.m. to 12:09 p.m. the call light remained on. NA-B and another NA-T were both observed to stand outside of room 240 and overheard talking about the double hours they were working and what they had done on recent days off. -At 12:09 p.m. NA-T went to R627's room, a	2 800		

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2 800	Continued From page 30 family member remained in the room and was overheard informing NA-T R627 needed to use the toilet. NA-T responded "let me find someone for you" then came out of the room and straight to room 240 and came out with another NA who then went to R627's room to assist R627 to the toilet at 12:12 p.m. R627's admission MDS dated 4/30/15, indicated R627 had memory impairment, required extensive physical assistance of two staff with toilet use and used the wheelchair for mobility. On 6/3/15, at 1:05 p.m. RN-B stated the facility frequently did not have enough licensed nurses to cover all of the areas of the building. She stated she was informed when she came to work as to what area of the building she would be working and the facility was short staffed on an regular basis ("almost every day.") On 6/3/15, at 1:22 p.m. R120's daughter stated her father was not getting straight catheterized (cath) in a timely manner therefore he would start leaking and get sore and right now R120 was sore in the groin, more so on the left. She stated R120 had a neurogenic bladder, had been straight catheterizing himself for eight years and now a physician order was obtained by the facility which clarified staff could straight cath R120 when R120 felt the need to be. She further stated, it took 45-50 minutes after he asked staff to be straight cathed before staff would return and straight cath him. R120's daughter stated she / he would put the call light on and the staff would come in, turn the call light off and tell him they would be back. R120's daughter stated last night,	2 800		

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2 800	Continued From page 31 (6/2/15) R120 did not get cathed until after the change of shift and R120's urine output was 700 cubic centimeters (cc) and was normally 300-400 cc's. R120's nurse progress note dated 6/2/15, verified R120's urine output was 700 cc's. when cathed. R120's admission MDS dated 4/25/15, indicated R130 had moderately impaired cognition, required extensive assistance with toileting, transferring and required intermittent catheterization. On 6/3/15, at 2:38 p.m. a staff member who wished to remain anonymous stated both the licensed nurses and the nursing assistants worked short staffed on a daily basis. He/she stated the nursing assistants attempted to divide the unstaffed work load as best they could but stated this caused the staff members to work harder and they may not get patient cares completed timely. On 6/4/15, at 6:05 a.m. NA-D stated the work was very heavy and we have to split group one and sometimes we have 13 residents and we don't even take our breaks because we are short staffed. They fire people here like all the time and can't keep people they even hire. They would fire good staff for very little things and sometimes we are not able to do all the work like repositioning all the residents on time. We try to do the best and they know it's bad. On 6/4/15, at 7:38 a.m. from the hallway, R365's call light was observed on. At the time TMA-E	2 800		

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2 800	Continued From page 32 was observed in the hallway, two doors down standing by the medication cart setting up medications. -At 7:41 a.m. a NA was observed to walk past R365's room. -At 7:44 a.m. the NA was observed to enter R365's room, turn the call light off, inform R365 "today is your shower" then left the room. -At 7:47 a.m. R365 was observed lying in bed and stated about 10-15 minutes ago he had put his call light on and someone had been in his room, shut the call light off and told him they were coming back to assist me to get up for breakfast. R365 stated he put his call light back on and one of the staff who had been to his room he did not even understand and that staff member left the room without R365 receiving assistance. R365 went on to state "I hope this light is going to the nursing station and the nurse sees someone is screwing up, this is what they do, I am always waiting for a long time for help and nobody comes or they would turn the light off, leave and not come back again. R365 stated he was now going to be late for breakfast. R365 appeared sad, upset and closed his eyes. -At 7:58 a.m. NA was observed to enter R365's room to assist which was more than 20 minutes since he had initially asked for assistance. R365's quarterly MDS dated 5/9/15, indicated resident had moderately impaired cognition and required extensive assistance with toileting, transferring, bed mobility, dressing and personal hygiene and used the wheelchair for mobility. On 6/4/15, at 8:05 a.m. R376's call light was observed on. -At 8:08 a.m. a NA was observed enter the room	2 800		

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2 800	Continued From page 33 and informed R376 she would find their NA and left the room. NA turned the call light off. -At 8:22 a.m. still nobody came back to the room to assist R376. On 6/4/15, at 10:21 a.m. when the surveyor requested the facility call light logs the administrator and director of nurses (DON) indicated the facility did not have a system that logged call light use and response times. The surveyor requested the facility call light audits but none were provided. On 6/4/15, at 12:00 p.m. The DON and the staffing coordinator (SC) were both interviewed. The SC stated the facility staffing pattern was determined by resident census. When asked about the split group shifts on 2 West and other units, as posted on the white boards in the units, the DON stated the nurse managers determined how the groups were to be split and they looked at the groups individually as well as the resident care needs. The DON stated she would check with the nurse managers regarding the split shifts to determine if this was related to the staffing concerns. When SC was asked who did staffing when she was not at the facility, the SC stated there were two other girls who worked evenings and shared the job, however, recently one had left. When asked who handled the sick calls, the SC stated the staffing office did and would notify the department and supervisor who would manage the calls and re-arrange staff if need be. When asked what happened when the census was low and if the facility staffed down, the DON nodded and stated "yes." The SC added, at times when the census was low a NA would be floated to another unit where they were needed. Both the	2 800		

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2 800	Continued From page 34 DON and the SC indicated the facility did not use supplemental agency staffing (pool nursing). When asked if there were any employee injuries in the last 3 months, the DON indicated she was going to find out and would provide information. When asked what the facility turnover rate was, the DON stated it was 43% as of 6/3/15. When asked the number of open positions, the SC stated she would provide that information. When asked if the turnover rate had been reported to quality assurance (QA) at the last meeting, the DON confirmed staffing was discussed. When asked if staff had brought to her attention concerns about the workloads, the DON stated staff had not indicated being able to finish their work but had complained about the staffing so we pulled them in to help problem solve. The DON further stated the facility was reinforcing their multiple call-in's policy and were educating staff on facility core values and some of the staff who had problems with staffing were those that had been working at the facility when the facility was a non-profit and would reflect the previous staffing levels which has changed since Mission Health for profit management had taken over. Even though the facility had indicated the insufficient staffing was being addressed, the facility continued to have complaints from residents and family members reporting poor resident care which included grooming, positioning and call lights not being answered timely among others which were being reported to the surveyors during the standard survey days. On 6/5/15, at 9:45 a.m. R376 stated sometimes the staff would come turn the call light off, leave come back half hour later. R367 stated "I used to work in a place like this as a nurse and I have learned to wait on them they do come eventually.	2 800		

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2 800	Continued From page 35 I have told them if am in bed I want to get up and if I fall asleep it's okay for them to wake me up as I like to get out of bed early." R376's quarterly MDS dated 4/10/15, indicated R327 had intact cognition, had no rejection of cares and required extensive assistance of one to two staff with activities of daily living. On 6/5/1, at 10:25 a.m. via a telephone interview, R190's FM-D stated every time she came the facility there were call lights on. FM-D stated one of two specific incidents she recalled was last fall when R190's call light had taken over 45 minutes to get answered. FM-D stated she had arrived at the facility at approximately 5:30 p.m. and at that time R190 indicated her call light had been on for about 10 minutes. FM-D stated she waited until 6:20 p.m. at which time she went to the nurses desk to look for help and had come across a NA by the nurse's station. FM-D stated when she told the NA R190 had been waiting for her call light to be answered, the NA responded by saying "they know we can't help during dinner." The NA further stated they could not assist residents' during dinner as they were too busy feeding people. FM-D stated during meal time, the aids were sent to the dining room to help other residents to eat and then there was no one to help answer lights during that time. FM-D stated she had discussed this concern with the unit manager who informed her the facility had been having problems with his, had also explained the unit staffing pattern and assured her the facility was looking into the matter. FM-D stated the second occurrence was on an evening shift in April when she had arrived at the facility at 5:00 p.m. and had noticed the	2 800		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 800	Continued From page 36 resident in the room across the hall from R190 had their call light on. FM-D stated as she walked past the nurse's station she observed a staff member seated at the desk with a meal in front of her. At 5:07 p.m. the resident's call light was still on. FM-D stated when she approached the resident and asked him if he was ok, the resident stated he needed to go to the bathroom. FM-D stated she went to report the resident care need to the staff member seated at the desk and the staff member stated she was not answering the call light because she had other things to do. FM-D stated the staff member was observed to enter the residents room at 5:14 p.m., ask the resident how he was, turn the call light off and left the room. The staff member never assisted the resident to the bathroom. On 6/5/15, at 10:36 a.m. R177's call light was observed on. -At 10:38 a.m. NA-O was observed going into the, turn the call light off and exited the room. -At 10:41 a.m. R177 put the call light on again. -At 10:43 a.m. NA-O was observed seated at the nursing station. NA-O stood up, started walking down he hallway and was heard stating on the walking talkie R177's call light was on. As NA-O continued to walk down the hallway, NA-J was observed walking towards R177's room, enter the room, shut the light off and immediately exit the room. -At 10:45 a.m. when approached R177 stated she wanted someone to put her to bed. When asked if her need had been met after her call light was turned off two times, R177 stated the staff had told her they were going to find her aide to assist her. R177 stated she wanted to lay down. -At 10:52 a.m. R177 remained seated in the wheelchair with her hunched over and eyes	2 800		

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	00238	A. BUILDING: _____ B. WING _____	06/04/2015

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2 800	Continued From page 37 closed. -At 10:56 a.m. R177's call light was observed on again. -At 10:59 a.m. RN-D was observed going to room and asked R177 what she needed help with. R177 stated again she wanted to lay down. -At 11:00 a.m. RN-D and TMA-D were observed to enter R177's room, briefly shut the door then reopened it. R177 was observed to remain seated in her wheelchair. -At 11:03 a.m. TMA-D and two NA's were observed in room then came out of room. -At 11:06 a.m. when approached R177 indicated the staff had told her it was almost lunch time and so she was going stay up until after lunch and would be laid down after. On 6/5/15, at 11:08 a.m. when asked what R177 had requested when TMA-D was last observed in her room, TMA-D stated when she had been in the room prior with RN-D, R177 had indicated she wanted to lay down so she had left to get a transfer belt and when she returned with the other NA's, R177 had declined to be put to bed as she now had indicated she wanted to watch Jeopardy. TMA-D indicated at times R177 would change her mind when she had asked for something. When told R177 had asked since 10:36 a.m. to lay down TMA-D indicated she was not aware of that. On 6/5/15, at 10:00 a.m. when asked if the staff were supposed to answer call lights when walking past them, the DON stated "It depends on what they are doing if they are getting something for another person, but I would expect them to answer the call light if not doing anything." When asked what her expectation was when staff went to residents rooms and turned the call light off	2 800		

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2 800	Continued From page 38 and told residents they will go find who their nursing assistant was, the DON stated "It depends the amount of staff required to assist resident but I would expect them to answer the call light and assist resident." When the DON was told staff had been observed standing down the hallways when call lights were on, the DON stated the staff was supposed to answer the call lights. On 6/5/15, at 10:25 a.m. both NA-M and NA-N indicated the work load was heavy and all the time a group was split and they were not able to do their work timely which included repositioning the residents and this was a continuous problems at the facility and management was aware and was not doing anything. Both indicated this was not good for the residents when their needs were not met timely. On 6/5/15, at 2:20 p.m. Daily Staffing Guide Layout for all the units for randomly selected days 3/5/15, 3/6/15, 3/14/15, 3/15/15, 3/16/15, 4/12/15, 4/29/15, 5/6/15, 5/29/15, and 5/30/15, were reviewed with the payroll & benefits staff who verified on numerous shifts multiple staff who were either absent or had no call no show were not replaced instead resident group assignments had to be split the groups which was all indicated in the sheets. In addition she verified on numerous days staff would either work part of the shift, left early or came in late for the shifts. When asked how resident cares/needs were supposed to be met when staff either came in late or left early she indicated the supervisor determined the level of acuity for the units. She verified on multiple shifts when staff had left early and had not been replaced and the groups had been split. In addition she verified on numerous shifts in some units staff worked short and no	2 800		

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2 800	Continued From page 39 replacements were done and nurse manager had worked on the floor when a nurse was short of one nurse. When asked if the nurse manager had been counted as providing direct care she was not able to respond but rather indicated the nurse manager would help around the unit. When asked about staff call-in's and replacing the staff she indicated if the staff had called in a head of time it was easy to replace the staff but when they called in within a short time frame to shift start time it was hard at times to replace and would not be replaced. On 6/5/15, at 3:40 p.m. when asked what she would have expected her staff to do when call lights were on, the administrator stated she would expect her staff to answer call lights and not stand in the hallways talking about their personal things. During review of the Consumer Concerns Tracking logs dated from 8/5/14, through 5/18/15, it was revealed 44 complaints complaints which involved either poor cares, poor call light response during the day or at night time, positioning concerns from residents and family members. Although the logs indicated resolution had been reached the complaints continued to occur from different residents and units in the facility over time to the survey weeks as observed by staff activity. In addition during review of the facility annualized turnover rates it was revealed 2014 rate was 44.60 percent (%) and year to date (YTD) 2015 was 50.50%. SUGGESTED METHOD OF CORRECTION:	2 800		

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2 800	Continued From page 40 The administrator or designee could review and revise policies, review and adjust scheduling needs in order to ensure the residents services are provided. Education could be provided to all staff. The administrator or designee could develop an auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure appropriate positioning was provided during meal time for 3 of 3 (R152, R19, R287) residents reviewed for positioning.	2 830		

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2 830	Continued From page 41 Findings include: R152 was observed seated parallel to her evening meal during the evening meal observation on 6/3/15. R152's Diagnosis Report dated 7/25/14, identified R152's diagnoses as esophageal reflux, Alzheimer's disease and dementia. R152's quarterly Minimum Data Set (MDS) dated 3/6/15, indicated R152 had severe cognitive impairment, required extensive assist with transfers and required staff to assist with setting up her meal tray. The Activities of Daily Living Care Area Assessment (CAA) identified R152 as having difficulty maintaining a sitting balance and impaired balance during transitions. On 6/3/15, at 6:06 p.m. R152 was observed seated off to the right of the open dining area in a high wing backed chair parallel to a large wooden desk. R152's meal tray was observed to be placed on the desk. R152 was observed repeatedly twisting at her waist in order to reach her food on the tray. -At 6:08 p.m. R152 grabbed the bowl of squash off of the tray, held it over her lap and proceeded to take a few bites. R152 again had to twist at the waist in order to place the bowl back on the table / tray. R152 took a forkful of mashed potatoes and while holding a napkin under the fork brought it to her mouth. Each time R152 took items of food off of her tray she needed to twist at the waist and brought the eating utensil and morsel of food across her body and up to her mouth. -At 6:15 p.m. R152 was observed to have turned her tray slightly so the corner of the tray was hung	2 830		

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2 830	Continued From page 42 off of the desk. -At 6:22 p.m. R152 was observed holding her ice cream cup over her lap with a napkin placed under the cup. R152's care plan directed staff to assist R152 in setting up her meal tray. R152's nutritional assessment dated 5/20/15, indicated R152 required assistance with setting up her meal tray. In addition, R152 had showed a gradual non-significant weight loss at 30, 90, 180 days and that further weight loss was not desired. R152's meal intake form indicated she consumed 51-75% of her evening meal on 6/3/15. R19 was observed seated at a table which was too high during the evening meal on 6/3/15. R19's Diagnosis Report dated 5/15/15, identified R19's diagnoses as dementia, muscle weakness, depression and difficulty walking. R19's admission MDS dated 5/15/15, indicated R19 had severe cognitive impairment, required extensive assist with transfers and required staff assist with setting up her meal tray. On 6/3/15, at 6:11 p.m. R19 was observed seated in the dining area at a high table. Her meal tray was positioned directly in front of her. The height of the table was approximately two inches away from R19's chin. When asked, R19 stated it was difficult for her to eat at this table as she thought her chair was "really low." From 6:11 p.m. until 6:45 p.m. R19 was observed to have to raise her right arm (the arm/hand she used to feed herself) up even with her shoulder in order to reach the	2 830		

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2 830	Continued From page 43 food on her tray. R19's care plan directed staff to assist R19 in setting up her meal tray. R19's nutritional assessment dated 5/20/15, indicated R19 was 63 inches in height, and she required assistance with setting up her tray. R19's meal intake form indicated she consumed 0-25% of her evening meal on 6/3/15. R287 was observed seated parallel to her meal during the evening meal on 6/3/15. R287's Diagnosis Report dated 10/26/11, identified R287's diagnoses as dementia, dysphasia (difficulty in swallowing), esophageal reflux and muscle weakness. R287's quarterly MDS dated 5/15/15, indicated R287 had severe cognitive impairment, moderately impaired vision, was on a mechanically altered die, and required staff to assist with setting up her meal tray. The Activities of Daily Living CAA identified R287 as having difficulty maintaining a sitting balance and impaired balance during transitions. On 6/3/15, at 6:26 p.m. R287 was seated off to the right of the open dining area in a high winged back chair parallel to a large wooden desk. R287 was seated across from R152. R287's meal tray was placed on the desk by therapeutic aide (TA)-L. R287 continued to be positioned facing towards the open dining area and parallel to her meal tray. R287 was observed during the meal time 6:26 p.m. until 6:45 p.m. as having to twist at her waist, bring the food across her body and up towards her mouth. At 6:31 p.m. registered nurse	2 830		

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2 830	Continued From page 44 (RN)-E, R287 and slightly repositioned her chair towards the desk, however, R287 remained parallel to her meal tray. R287 was observed spilling Jello on her clothing protector as she was tried to bring the Jello across her body and to her mouth. R287's care plan directed staff to assist R287 in setting up her meal tray. R287's nutritional assessment dated 5/15/15, indicated R287 required assistance with setting up her meal tray. R287's meal intake form indicated she consumed 51-75% of her evening meal on 6/3/15. On 6/3/15, at 6:43 p.m. RN-E confirmed the table R19 was seated at was too high for her. In addition, the two residents (R152 and R287) seated at the wooden desk were positioned parallel and facing away from their meal trays. Policies on positioning, positioning during meals, and dining experience were not provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could work with the QA Committee to update policies and procedures for adequate positioning was provided to enhance independent eating. The facility could also perform meal time observation audits to ensure adequate positioning is maintained. The DON or designee could review results of the audits at the QA meetings. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 840	Continued From page 45	2 840		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be	2 840		

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2 840	Continued From page 46 completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely toileting assistance for 1 of 2 residents (R63) reviewed for incontinence. Findings include: R63's Diagnosis Report indicated R63 had diagnoses that included hemiplegia (total or partial paralysis of one side of the body) due to cerebrovascular disease, aphasia (an impairment of language, affecting the production or comprehension of speech and the ability to read or write), generalized muscle weakness, osteoarthrosis, dementia and peripheral vascular disease. R63's quarterly Minimum Data Set (MDS) dated 4/1/15, indicated R63 was rarely/never understood and had severely impaired cognitive skills for daily decision making. The MDS also indicated R63 required extensive assistance of 2 staff for transfer and toilet use. The MDS also indicated R63 was non-ambulatory and had functional limitations in range of motion of the upper and lower extremities with impairment on one side. The MDS further identified R63 as always incontinent of bowel and bladder and was	2 840		

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2 840	Continued From page 47 at risk for the development of pressure ulcers. R63's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 10/15/14, indicated R63 remained incontinent of bowel and bladder, did not verbalize the need to use the toilet, was aphasic and had some dementia. The CAA indicated staff assisted R63 to use the toilet and managed/changed incontinence pad per protocol. R63's Bladder Incontinence Evaluation dated 12/31/14, identified R63 was totally dependent for ADLs and wore adult briefs at all times. The evaluation indicated the care plan had been updated. R63's Care Plan dated 4/10/15, identified R63 was at risk for skin breakdown related to incontinence, weakness, immobility, aphasia, and hemiplegia and directed staff to complete skin treatments as ordered and to monitor for signs and symptoms of urinary tract infection. The Care Plan also identified R63 required extensive assist of two staff for toilet use. The care plan lacked interventions regarding incontinence care for bladder incontinence. The Skin Condition Report dated 6/1/15 identified R63 had a stage II pressure ulcer (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater) to her right buttock measuring 0.6 centimeters (cm) x 0.4 cm x 0 cm.	2 840		

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2 840	Continued From page 48 On 6/3/15, from 7:05 a.m. until 10:24 a.m. continuous observation revealed the following: -At 7:05 a.m. R63 was seated in her wheelchair at a table in the 1SW dining room. -At 7:56 a.m. breakfast was delivered and set up for R63. -At 8:32 a.m. R63 had independently completed her meal. Volunteer (V)-A approached R63 and asked if she would like to have her hair done. V-A then transported R63 directly from the dining room to the 2nd floor beauty shop. -At 8:54 a.m. R63 was observed having her hair done in the beauty shop. -At 8:56 a.m. R63 remained in the beauty shop. -At 10:04 a.m. R63 was assisted back to her room and was observed wheeling her wheelchair independently in her room. -At 10:05 a.m. nursing assistant (NA)-I and NA-J entered R63's room and adjusted her posture as R63 was leaning in the wheelchair. -At 10:06 a.m. NA-I confirmed they had just adjusted R63 so she wasn't leaning in her chair. NA-J confirmed they had not checked R63 for incontinence since they got her up that morning, but would be doing so later. -At 10:11 a.m. R63 was assisted to the dining room for a musical activity. -At 10:24 a.m. NA-I approached R63 during the activity and requested to check her for incontinence which R63 refused. -At 10:27 a.m. NA-J stated R63 preferred to sit up during the day and would often refuse incontinence cares. NA-J stated they were to check on R63 every 2 hours. NA-I stated R63 required two staff assistance for transfers. On 6/3/15 at 2:38 a.m. registered nurse (RN)-G confirmed R63 currently had a stage II pressure	2 840		

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2 840	Continued From page 49 ulcer to her right gluteal fold and stated R63 should have been checked and changed for incontinence at least every two hours or more frequently and incontinence cares should have at least been offered/attempted every two hours. On 6/4/15, at 10:21 a.m. RN-G verified 63's care plan lacked specific interventions regarding incontinence care and stated it was the minimum expectation of the facility to check, change and provide incontinence care to an incontinent resident every 2 hours. The Prevention of Pressure Ulcers Guidelines dated May 2013, indicated a risk factor of bowel and bladder incontinence recommended interventions and preventive measures that included check resident for incontinence at least every 2 hours and clean skin when soiled. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could review policies and procedures, revise as needed, train staff, assess the system, monitor, evaluate to assure residents who are incontinent of urine, receive the necessary services and care following each episode of incontinence. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be	2 905		

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2 905	Continued From page 50 positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to act upon a physician's order for a physical and occupational therapy evaluation and treatment for 1 of 3 residents (R228) reviewed for ambulation. Findings include: R228's annual Minimum Data Set (MDS) dated 2/6/15, indicated R228's diagnoses included, non-Alzheimer's dementia, arthritis and osteoporosis. The MDS indicated R228 had memory loss, impaired decision making skills, required limited assist with walking and transferring used a walker and wheelchair for mobility. R228's significant change MDS dated 5/22/15, indicated R228's diagnoses included non-Alzheimer's dementia, arthritis, osteoporosis and hip fracture. The MDS indicated R228 had memory loss, impaired decision making skills and was totally dependent on two staff for transfers and was non-ambulatory. The MDS indicated R228 had	2 905		

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2 905	Continued From page 51 impairment in range of motion on one side in lower extremity and used a wheelchair. R228's Activities of Daily Living (ADL) Care Area Assessment (CAA) dated 5/29/2015, indicated R228 was at risk of functional decline due to complications of immobility such as contractures, incontinence and depression. The CAA indicated R228's physical limitations consisted of weakness, limited range of motion, poor coordination, poor balance, visual impairment and pain. The 2/14/15, Fall Report indicated R228 had gait imbalance, impaired memory, non-compliant, weakness/fainted and had ambulated without assistance. The medical record indicated R228 sustained a right hip fracture on 2/14/15. R228's physician's order dated 5/18/15, physician's order indicated R228 was to receive physical therapy (PT)/occupational therapy (OT) services. On 5/19/15, an order was received to re x-ray the hip for healing. On 5/20/15, the PT/OT order was clarified with an "Ok" for full weight bearing. However, the order was never received in the PT/OT department. R228's care plan revised 5/27/15, indicated R228 was weak and had a recent history of right hip fracture requiring assist of two staff for transfers and was non-ambulatory.	2 905		

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2 905	Continued From page 52 On 6/3/15, at 8:10 p.m. nursing assistant (NA)-T was observed to wheel R228 to the bathroom. NA-T and another NA were observed to transfer R228 onto the toilet. When R228 was done using the toilet, both NA's were observed to transfer R228 back into the wheelchair and wheeled her out of the bathroom. On 6/4/15, at 11:10 a.m. registered nurse (RN)-D verified R228 had a physician's order for PT to evaluate and treat R228, however, was unable to find any additional information in R228's medical record as to whether the order was fully process or not. On 6/4/15, at 11:30 a.m. physical therapist (PT)-O stated there was some miscommunication and PT had not evaluated R228 but would get right on it. On 6/5/15, at 8:45 a.m. PT-L, stated the 5/18/15, physician order to evaluate and treat R228 should have been completed the day it was written or the next day. On 6/5/15, at 9:25 a.m. PT-N stated he could recall writing down some questions for the physician regarding R228's weight bearing status for the physician (around 5/18/15) to answer and had not heard anything further until yesterday (6/4/15-during survey). PT-N stated he thought the order was lost in communication as they had not received the order in the therapy department. PT-N stated when there was an order written for therapy evaluation and treatment the orders were considered completed when it would show up on their schedule which was made out by the Assistant Rehabilitation Director/COTA. PT-N	2 905		

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2 905	Continued From page 53 stated R228 was on the schedule for an evaluation today (6/5/15). On 6/5/15, at 9:33 a.m. the Assistant Rehabilitation Director/COTA stated she never got the 5/18/15, PT evaluate and treat order for R228. She stated nursing should have faxed the order to the therapy department and the order was never received. She stated she was aware PT-N had left questions for R228's physician to answer during rounds and she had been looking in the computer system for the next couple days for a physician response, however by the next week she stated she had forgotten about R228's case. On 6/5/15, at 3:50 p.m. the administrator and DON were interviewed. The DON stated they would expect a PT evaluate and treat to be acted on that day or the next. The administrator stated it sounded like a "mix-up" had occurred. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise the policy and procedures related to interdisciplinary communication. Education could be provided to all staff to ensure each resident received the appropriate care and services. The DON or designee could establish a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 905		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at	21025		

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21025	Continued From page 54 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a system to ensure food was served at the proper temperature for 5 of 21 residents (R365, R117, R257, R234, R515) who were interviewed regarding food quality and for 2 of 2 residents (R457 R385) who were observed to receive cold food. Findings include: R365's quarterly Minimum Data Set (MDS) dated 5/9/15, identified R365 had intact cognition. On 6/2/15, at 9:23 a.m. R365 stated the eggs were cold. R117's quarterly MDS dated 5/8/15, identified R117 had intact cognition. On 6/2/15, at 10:34 a.m. R117 stated the food was usually cold. She explained the food service distribution took between 45 minutes to an hour to complete. She stated her table was one of the last tables to be served and the food was cold. R257's quarterly MDS dated 3/27/15, identified R257 had intact cognition. On 6/2/15, at 10:57	21025		

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21025	Continued From page 55 a.m. R257 stated the food was cold. She stated her table was the last table served during the second seating in her dining room and the food did not stay warm. R234's quarterly MDS dated 4/10/15, identified R234 had intact cognition. On 6/2/15, at 11:33 a.m. R234 stated the food was sometimes cold. R515's admission MDS dated 4/8/15, identified R515 had intact cognition. On 6/2/15, at 1:50 p.m. R515 stated the eggs were cold and the vegetables were cold and mushy. On 6/3/15, at 11:20 a.m. the main kitchen area dietary service was observed with the registered dietician (RD). -At 11:23 a.m. Cook (C)-A was observed to remove the hot meal items from the oven and check the temperatures. The hot meal choices consisted of tuna melts, chicken patties and mashed potatoes. The tuna melts were 180 degrees Fahrenheit (F), the chicken patties were 160 degrees F and the mashed potatoes were 180 degrees F. -At 11:33 a.m. C-A loaded the steam table pans into an insulated cart and dietary aide (DA)-A was observed to push the cart out of the main kitchen. DA-A transported the food to the west building, first floor dining room. -At 11:45 a.m. DA-A placed all of the hot food items onto the hot cart serving system. DA-A then rechecked the temperatures of the hot food items. The mashed potatoes were noted to be 150 degrees F, the chicken patties were 140 degrees F and the tuna melts were 142 degrees. -At 12:00 p.m. DA-A began serving the meals to	21025		

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21025	Continued From page 56	21025		

the 29 residents residing on the first floor west dining room.
-At 12:37 p.m. the last tray was served to the residents. DA-A rechecked the temperature of the hot food. The chicken patties were noted to be 130 degrees F and the mashed potatoes were 134 degrees. The RD and the survey staff tasted a serving of the chicken patty and mashed potatoes. The RD confirmed the taste of the food items were correct, but the food was not hot. She stated the facility did not have a system in which they monitored the food at the end of the meal service to ensure adequate temperatures were maintained throughout the meal distribution process and had not been made aware the residents had expressed concerns regarding cold food. She stated she would work on the concern.

R457's was fed cold food an the facility failed to reheat or provide hot food.

R457's Diagnosis Report dated 11/21/14, identified R457's diagnoses as dementia and generalized muscle weakness.

R457's significant change MDS dated 3/6/15, indicated R457 had severe cognitive impairment, was sometimes able to make herself understood and required extensive assist with meals. R457's nutritional Care Area Assessment (CAA) dated 3/10/15, identified R457's inability to perform activities of daily living (ADL)s without significant physical assistance affected her ability to eat.

R457's care plan dated 5/28/14, indicated R457 required total assistance from staff with her

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21025	Continued From page 57 meals. R457's nutritional assessment dated 5/28/15, indicated R457 relied on staff to feed her. On 6/3/15, at 6:26 p.m. R457 was observed seated in a tilt back wheelchair at a table in the Bridgeway dining area. R457 had a tray of food placed directly in front of her and left unattended. -At 6:38 p.m. an unidentified staff member sat down next to R457. Upon request of the surveyor, dietary aide (DA)-A took the temperature of R457's mashed potatoes and squash on her tray. DA-A stated the temperature of the mashed potatoes was 93 degrees F and the temperature of the squash was 90 degrees. DA-A then proceeded to walk away and did not offer to provide R457 with a tray of warm food or warm up the food on her tray. The unidentified staff member proceeded to assist R457 with her meal without offering to reheat her food. R385 was observed to have been served cold eggs. R385's quarterly MDS dated 4/11/15, indicated R385 was cognitively intact, was on dialysis and was independent with eating after set up only. On 6/3/15, at 7:18 a.m. R385 was observed seated in his wheelchair at the dining room table. R385 stated at times the food,especially the eggs, were served cold and this was something he had brought to the facility attention several times.	21025		

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21025	Continued From page 58 On 6/3/15, at 8:34 a.m. shortly after breakfast was served to R385 he was overheard to ask the occupational therapist (OT) who was assisting another resident at the same table to warm his eggs. R385 stated "as always the eggs are cold, can you please put them in the microwave to warm them for 45 seconds." OT staff was seen leave the table then returned and took R385's eggs, warmed them and brought them back to R385. The Preventing Foodborne Illness-Food Handling policy revised 12/2009, directed the staff to cook potentially hazardous food to the appropriate internal temperatures and hold the food at those temperatures for the appropriate length of time to destroy harmful bacteria. The policy directed staff as to when to discard food items but it did not specifically direct the staff as to how to ensure the food was served at the proper temperature for the entire food service. SUGGESTED METHOD OF CORRECTION: The food service manager or designee could develop policies and procedures to ensure potentially hazardous foods are held at the proper temperature to avoid food borne illness. The food service manager or designee could educate all appropriate staff on these policies and procedures. The food service manager or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty -one (21) days	21025		

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21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 6 employees had proper tuberculin skin test (TST) induration/ millimeters (mm) and documentation interpretation (negative or positive) reviewed for Tuberculosis Screening State regulations. Findings include: Personnel records for registered nurse (RN)-K indicated a hire date of 5/4/15, and a tuberculosis (TB) screening was completed on 4/28/15. In addition the TB screening sheet indicted RN-K received the first step TST on 4/28/15, and the	21426		

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21426	Continued From page 60 results were read as 0 mm with a "Negative" interpretation of reading - on 4/30/15. RN-K then received the second step TST on 5/5/15, results were read on 5/7/15, as 0 mm, however lacked documentation of interpretation. Personnel records for therapeutic recreation staff (TR)-B indicated a hire date of 4/16/15, and a tuberculosis (TB) screening was completed on 4/13/15. In addition the TB screening sheet indicted TR-B received the first step of her TST on 4/13/15, and the results were read as "Negative" interpretation of reading. However lacked documentation of the induration. Personnel records for maintenance staff (M)-B indicated a hire date of 2/12/15, and a tuberculosis (TB) screening was completed on 1/22/15. In addition the TB screening sheet indicted M-B received the first step TST on 1/27/15, and the results were read as a "Negative" interpretation of reading - on 1/30/15. M-B then received the second step TST on 2/17/15, results were read on 2/19/15, as "Negative." However both results lacked documentation of the induration. On 6/3/15, at 1:12 p.m. the occupational health registered nurse (RN)-C verified all the three employees TB Screening forms lacked either the induration or the interpretation. RN-C stated she would be educating the nurses on proper documentation and as she was not at the facility all the time to read the results of the TST given to the staff. -At 2:12 p.m. RN-C indicated she was going to modify the form to have a spot for the induration and interpretation moving forward to prompt staff to fill both.	21426		

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21426	Continued From page 61 Tuberculosis, Employee Screening for policy revised April 2013, directed: "a. If the reaction to the first skin test is negative, the facility will administer a second skin test 1 to 2 weeks after the first test. The employee may begin duty assignments after the first skin test (if negative) unless prohibited by state regulations..." Although the policy directed the staff to read the results interpretation, it did not indicate the result induration was supposed to be included. The policy did not indicate who was responsible for ensuring the personnel records were accurate and complete. Regulation for Tuberculosis Control in Minnesota Health Care Settings dated July 2013, directed "TST documentation should include the date of the test (i.e., month, day, year), the number of millimeters of induration (if no induration, document "0" mm) and interpretation (i.e., positive or negative)." SUGGESTED METHOD OF CORRECTION: The infection control nurse or designee could review and revise the policy and procedures related to tuberculosis skin test documentation and provide staff education. The quality assurance and assessment committee could establish a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty -one (21) days	21426		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin	21565		

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21565	Continued From page 62 Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess for the safe practice of self administration of nebulizer medication (a inhalation treatment of respiratory medication) for 1 of 1 resident (R270) observed self-administering a nebulizer treatment / medication (SAM). Findings include: R270's Discharge Orders and Information dated and electronically signed by physician 5/4/15, directed albuterol- Ipratropium 2.5-0.5 milligrams / 3 milliliters (ml) solution vial (Duoneb) 3 ml inhale orally via nebulizer every four hours for COPD. The Order did not indicate R270 could self-administer this medication nor any others. R270's significant Minimum Data Set (MDS) dated 5/15/15, indicated R270's diagnoses included chronic obstructive pulmonary disease (COPD) and dementia. R270's care plan dated 5/22/15, indicated R270 had behavior problems related to yelling out, refusing medications/oxygen secondary to dementia with delusions and narcissistic	21565		

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21565	Continued From page 63 personality disorder. The care plan directed staff to administer R270's medications as ordered, however did not address R270's self administration of medication ability. On 6/4/15, at 6:10 a.m. R270 was observed in his room, laying on his back on the edge of the bed with his legs stretched out to the floor, sleeping. R270's a nebulizer mask was resting loosely on his forward. The nebulizer machine was turned on and running with liquid medication noted in the nebulizer chamber. R270 was did not easily arouse to voice or noise. -At 6:13 a.m. licensed practical nurse (LPN)-E was observed to wheel a medication cart past R270's room and came to the nursing station. -At 6:20 a.m. LPN-E remained at the desk administering pain medication to R508. -At 6:23 a.m. when asked if R270 had a self-administration order for the nebulizer medication, LPN-E indicated she would check. After LPN-E reviewed R270's electronic physician orders, she verified R270 did not have an order to self-administer medications. LPN-E confirmed R270 required a SAM order and an assessment completed to determine R270's ability to safely practice self administration of medication. -At 6:27 a.m. both the surveyor and LPN-E walked into R270's room and found the nebulizer still running. LPN-E remained in the room for the rest of the treatment. On 6/4/15, at 2:13 p.m. the direct of nursing (DON) stated this was poor practice and verified R270 required a self administration assessment and physician order prior to self administering medications.	21565		

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21565	Continued From page 64 Administering Medication policy revised December 2009, directed "Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. SUGGESTED METHOD OF CORRECTION: The director of nurses could review and revise the policy and procedure related to self-administration of medication and provide education to the staff. Audits could be conducted to identify and assess residents who have the capability to participate in self-administration. This could be part of the quality assurance plan. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21565		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were stored properly on 2 of 7 nursing units (2	21610		

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21610	Continued From page 65 north west and 2nd floor central nurses station) which involved 7 of 7 residents (R209, R492, R315, R103, R643, R533, R300) residing on the 2 Northwest nursing unit who required insulin and 1 of 1 resident (R92) who had discharged from the facility. This had the potential to affect all 79 residents residing on 2 West. Findings include: On 6/2/15, during continuous observations from 8:28 a.m. to 8:50 a.m. a plastic divided container was observed sitting on the second floor north west nurses station. The container was observed to be filled with multiple insulin pens with prescription labels on them. No staff members were observed by the station and the insulin pens were available for staff, residents and visitors to remove. Insulin pen needles were observed to be stored in the front section of the box. Unlicensed staff, residents and family members were observed on the unit. At 8:40 a.m. the State Agency staff sat at the nurse's station near the insulin pens. At 8:50 a.m. licensed practical nurse (LPN)-A was observed to walk to the nurse's desk, picked up the container of insulin pens and place it in the medication room. LPN-A then left the desk area. On 6/2/15, at 2:48 p.m. the insulin container was observed with LPN-B. Each of the insulin pens was equipped with a pharmacy label which identified the resident and the directions for use.	21610		

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21610	Continued From page 66 The plastic device held the following pens: R209 had 1 Novelog Flex pen R492 had 1 Lantus Flex pen R209 had 1 Lantus Flex pen R315 had 1 Lantus Flex pen and 1 Novolog Flex pen R103 had 1 Novolog and 1 Levimure Flex pens R643 had 1 Lantus and 1 Novolog Flex pen R533 had 1 Novolog Flex pen R300 had 1 Novolog Flex pen On 6/2/15, at 3:05 p.m. LPN-B stated the container of insulin was to be in sight of the nurse or locked at all times. On 6/2/15, at 3:10 p.m. LPN-A confirmed she had left the insulin pens on the desk. She stated she had been directed not to leave them out by her supervisors but stated the morning became very busy and the residents had begun to "pile up." She stated they were to be kept secure. On 6/3/15, at 7:20 a.m. the west building second floor central nurses station was observed to contain a small plastic box of medication. The nurses station was not equipped with any type of system which would prevent unlicensed staff, visitors or residents from entering the nurses station and removing the medication. On 6/3/15, at 9:10 a.m. the basket of medication remained on the desk without staff members present.	21610		

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21610	Continued From page 67 On 6/3/15, at 2:00 p.m. the second floor west central nurses station was observed with the assistant director of nurses (ADON). The medication were noted to be for R92 who had been discharged from the facility. The medications included Spirva capsules and two bottles of Azopt eye drops. The ADON stated the medication should have either been sent home with the resident upon discharge or destroyed. The ADON confirmed all medications were to be kept secure. The Storage of Medication policy revised in April 2017, indicated only persons authorized to prepare and administer medications were to have access to medications and all medications were to be stored securely. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure that medications are stored appropriately. The director of nursing or her designee could then monitor the licensed staff for adherence to the policies and procedures. TIME PERIOD FOR CORRECTION: Twenty - one (21) days	21610		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant,	21685		

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21685	Continued From page 68 including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide appropriate maintenance to resident rooms numbered (322, 366, 393, 394, 423). In addition failed to ensure 1 of 2 residents (R465) room was kept clean and free of odors reviewed for environmental concerns. Findings include: On 6/4/15, from 9:00 a.m. to 10:00 a.m. a tour of the facility was completed with the maintenance director (MD), administrator, regional nurse administration, district manager of the healthcare service group, and the director of housekeeping. The MD verified the following resident room concerns: · In room 322, two ceiling tiles were stained and needed replacing in the bathroom · In room 366, there was a broken ceiling tile in the bathroom which needed replacing · In room 393, two ceiling tiles were stained and needed replacing in the bathroom · In room 394, two ceiling tiles were stained and needed replacing in the bathroom · In room 423, bathroom wall tile behind the toilet was broken	21685		

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21685	Continued From page 69 On 6/4/15, at 10:00 a.m. the MD confirmed he had not received work orders requesting repairs for the above concerns identified. No routine maintenance schedule for maintenance and up keep for resident rooms was provided. The Interior General Maintenance policy [undated] indicated the facility would be maintained in good repair at all times to include all interior surfaces and fixtures. R469's room had a strong musty offensive odor and the facility failed to reduce the odor. On 6/1/15, at around 4:30 p.m. during the initial tour, a strong musty malodorous smell was noted outside R469's room. On 6/2/15, from 8:00 a.m. until 3:10 p.m. a malodorous smell was noted just outside R469's room. On 6/3/15, at 9:47 a.m. the same strong, offensive odor remained just outside of R469's room. Trained medication aide (TMA)-B was observed standing outside the room setting up medications. -At 9:54 a.m. registered nurse (RN)-C was observed to enter R469's room in which R469 was heard to ask for assistance to get into his wheelchair. RN-C indicated she would get help and left the room. -At 9:55 a.m. observed a nursing assistant enter R469's room and shut the door. The malodorous	21685		

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21685	Continued From page 70 odor remained. On 6/4/15, from 7:00 a.m. until 12:00 p.m. R469's room continued to have the same strong malodorous smell when walking outside and was overpowering when entering the room. Several staff, residents and family members were observed going back and forth past R469's to other rooms located down the hallway. No staff acknowledged R469's room needed to be cleaned. On 6/5/15, at 9:35 a.m. the pervasive malodorous smell remained and several staff were observed walking past the room. On 6/5/15, at 9:55 a.m. the MD, after he walked towards R469's room door, verified the smell was urine and stated he thought the odor was in R469's clothes or the carpet as the vent was working in the unit properly. The MD stated "I will have housekeeping come clean it." On 6/5/15, at 10:07 a.m. a staff member with a carpet cleaning machine entered R469's room and informed R469 he was going to clean his carpet. On 6/5/15, at 10:10 a.m. the MD stated the carpet was going to be cleaned and the clothes in the room were going to also be checked.	21685		

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21685	Continued From page 71 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could work with the director of maintenance to develop a maintenance program to ensure damaged walls, floors, ceilings, and bedroom and bathroom fixtures are managed/repaired to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21685		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).	21980		

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21980	Continued From page 72 (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to report timely to the State agency and /or investigate allegations of abuse, neglect, injuries of unknown origin and accidents with serious injury for 3 of 5 incidents involving 3 of 3 residents (R138, R228, R152) reviewed for abuse.	21980		

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21980	Continued From page 73 Findings include: An incident report dated 5/7/15, at 7:40 p.m. indicated R138 fell during a one staff assisted transfer from the wheelchair to the toilet when R138 lost his balance and fell against the wall. The report indicated R138 bumped his left arm and the left side of his head. The report also indicated the director of nursing (DON) and the nursing supervisor were notified. The nursing note on the incident report dated 5/8/15, indicated R138's care plan was updated to indicated two staff assist was needed for transfers and ambulation. The predisposing physiological factors were identified as weakness/fainted. The report also indicated R138's responsible party was notified on 5/7/15, at 7:50 p.m., and the physician was notified on 5/8/15, at 2:04 p.m. The incident report lacked indication of State agency notification, as required. R138's undated Face Sheet and Diagnosis List printed 6/4/15, indicated R138's diagnoses included hemiplegia (paralysis on one side of the body) due to cerebrovascular disease (stroke), convulsions (seizures), difficulty in walking, muscle weakness, dementia without behavioral disturbance, depressive disorder and anxiety. A Fall Risk Evaluation dated 5/6/15, indicated R138 was at high risk for falls and had 1-2 falls in the 90 days prior. The fall risk evaluation indicated R138 had no cognitive changes, ambulated with problems and a device, his gait was unsteady and he required physical assistance to stabilize.	21980		

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21980	Continued From page 74 R138's Progress note dated 5/8/15, indicated R138 complained of pain in ribs from the fall. R138's Progress note dated 5/10/15 at 2:41 p.m., indicated R138 complained of pain in his chest on both sides. R138's Progress note dated 5/10/15, at 10:30 p.m. indicated R138 complained of left side pain, pointing to the rib area. No bruising or swelling was noted. An order by the nurse practitioner (NP) dated 5/11/15, directed an x-ray of the right and left ribs and chest x-ray for diagnosis of pain. A radiology report dated 5/11/15, indicated R138 had acute rib fractures of the left third, fourth, and fifth ribs. R138's Progress note dated 5/11/15, at 9:40 p.m. indicated a chest x-ray result included rib fractures of 3 ribs. The note indicated a call was placed to the assistant director of nursing (ADON) to report the injury (fracture) and the fall report was reviewed. The report also indicated R138 was spoken to and he reported the fractures occurred when he had fallen the previous week and reported his pain level as 10 on a scale of 1-10, which indicated almost unbearable pain. R138's NP progress note dated 5/12/15, indicated	21980		

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21980	Continued From page 75 R138 had falls with injury and noted R138 had left rib fractures. In addition, the NP noted R138 had a 10 pound weight loss and his blood pressures were too low and the blood pressure medication had just been decreased and labs had been ordered. The note also indicated the NP had ordered R138's blood pressures and heart rate checks twice daily for one week. R138's annual Minimum Data Set (MDS) assessment dated 5/15/15, indicated R138 had moderate cognitive deficit, displayed no rejection of care and required extensive assistance of two staff for transfers and ambulation. The MDS also indicated R138 had balance problems and was unsteady with position changes. In addition, the MDS indicated R138 had almost constant pain rated at 10 out of 10, which indicated almost unbearable pain. R138's Fall Care Area Assessment (CAA) dated 5/15/15, indicated R138 was potentially at risk for falls due to balance problems during position changes and receiving an antidepressant medication. The CAA indicated R138 required assistance with transfers and would ambulate short distances in his room with staff assist and the use of a walker, but the wheelchair was his primary mode of transportation. R138's Progress note dated 5/29/15, at 7:45 a.m. indicated R138 reported, "someone busted up my neck." The note indicated when R138 was asked what was going on, he talked about how no one helped him the previous night, something was wrong with his neck and he wanted an x-ray. The progress note indicated R138 was told the	21980		

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21980	Continued From page 76 charge nurse would be notified to schedule an x-ray and the doctor would be informed. R138's Progress note dated 5/29/15, at 8:54 a.m. indicated R138 complained of pain in the lower neck, running along upper shoulder blade region. R138 stated he felt pain when moved by NA that morning and said that he was moved in such a way as to cause pain in his neck. The progress indicated the nurse assessed the location of R138's pain. R138's medical record lacked any documentation of the State agency notification related to the fall with resultant rib fractures. In addition, R138's medical record lacked any documentation related to R138's report of neck pain and rough movement. R138's falls care plan initiated 6/12/14, and revised 2/9/15, indicated R138 was at risk for falls and directed staff to follow the facility's fall protocol, review the information on past falls and attempt to determine cause of falls, record possible root causes of the fall, and then to alter or remove any potential causes, if possible. The care plan further directed staff to educate the resident, family and staff regarding the causes. R138's care plan for activities of daily living (ADLs), initiated 3/7/15, and revised 5/8/15, indicated R138 required the assistance of two staff for transfers, bed mobility and toilet use. R138's care plan dated 4/24/15, indicated R138	21980		

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21980	Continued From page 77 had the potential for pain related to arthritis and was able to call for assistance when in pain, was able to reposition self, ask for medication, communicate how much pain he was experiencing and what increased or alleviated the pain. R138's care plan for mobility initiated 3/7/15, indicated R138 required the assistance of two staff for ambulation with a quad cane (a cane with 4 ends, hemi cane) with a goal for R138 to ambulate daily with the quad cane and assist of one staff. R138's previous care plan printed 12/20/13, and updated as recently as 1/15/15, indicated R138 was to ambulate with restorative nursing up to 300 feet with the assistance of one staff using the quad cane on the right side. The care plan indicated R138 was at risk for falls, required extensive assistance of 1 to 2 staff for pivot transfers with the quad cane and assistance needed varied daily due to weakness, pain and confusion. R138's care plan updated on 12/5/14, indicated R138 had a fall and the care card was updated. R138's Resident Care Card (the care plan used by nursing assistants) printed 6/4/15, directed the use of two staff for transfers, two staff assist with the quad cane for ambulation and two staff assist for toilet use. The Resident Care Card printed 3/9/15, indicated R138 required two staff for transferring. A note by the registered nurse (RN)-H dated 12/16/14, indicated R138's resident	21980		

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	00238	A. BUILDING: _____ B. WING _____	06/04/2015

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21980	Continued From page 78	21980		

care card dated 12/5/14, directed staff to transfer R138 with two staff assist and also indicated the care plan was not followed during R138's incident of 12/5/14, when R138 fell during a transfer with only one staff assist. RN-H stated this indicated R138's care card had been changed prior to 12/5/14, directing the use of two staff assist for transfer.

The undated nursing assistant (NA) group sheet provided by RN-H indicated the NAs were to refer to the Care Card for transfers and toilet use guidance. The group sheet did not indicate how R138 was to ambulate or if he could ambulate.

The facility Minnesota Department of Health Tracking Form for vulnerable adult (VA) reports made by the facility lacked documentation which indicated R138's incident of 5/7/15, rib fractures and the report of neck pain alleged to be caused by treatment by staff.

On 6/3/15, at 2:17 p.m. R138 stated some staff were rough in the morning because they were in a hurry. R138 also stated he was more sore in the morning and at times, felt staff were disrespectful and ignored his needs. R138 also stated he was not afraid of staff and did not feel the staff purposefully tried to hurt him. R138 confirmed he had had broken bones and bruises from falls.

On 6/4/15, at 2:09 p.m. RN-H stated since prior to 12/5/14, R138 had required the assist of two staff. RN-H stated the facility reported falls with major injuries, bruises of unknown cause, bruises

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21980	Continued From page 79	21980		

in odd spots and altercations as well as allegations of abuse, neglect and mistreatment to the State agency. RN-H stated R138's rib fractures were probably related to the fall that had occurred that week during a transfer, however was unaware if the incident was reported to the State agency. RN-H verified the allegations related to the neck pain should have been reported to the State agency, immediately.

On 6/4/15, at 4:35 p.m. the director of nursing (DON) stated she would expect staff to follow the resident care cards when providing cares as the care card was the individual resident care plan for NA's to use. The DON stated staff called the DON with all falls and stated R138's fractured ribs were related to his fall on 5/7/15. The DON verified R138's care plan was not followed during the incident and the fall with a fracture should have been reported to the State agency, as required. In addition, the DON verified R138's allegation of neck pain and mistreatment by staff was not reported the next day because R138's pain had diminished. The DON stated the nurse was to protect the resident first, pull the alleged staff member from the floor and report the allegation to the State agency right away.

R228 sustained an unwitnessed right hip fracture and the facility failed to report and investigate the incident as required.

R228's annual MDS dated 2/6/15, indicated R228's diagnoses included, non-Alzheimer's dementia, arthritis and osteoporosis. The MDS indicated R228 had memory loss, impaired decision making skills, required limited assist with

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21980	Continued From page 80 walking and transferring and used a walker and wheelchair for mobility. R228's significant change MDS dated 5/22/15, indicated R228's diagnoses included non-Alzheimer's dementia, arthritis, osteoporosis and hip fracture. The MDS indicated R228 had memory loss, impaired decision making skills, was totally dependent on two staff for transfers and was non-ambulatory. The MDS indicated R228 had impairment in range of motion on one side in lower extremity and used a wheelchair. R228's Nurse Progress note dated 2/14/15, at 7:39 a.m. indicated R228 was found on the floor, lying on right side between the bathroom door. The note indicated R228 was yelling out and screamed when right leg was touched. The note further revealed R228's right leg was shorter and rotated therefore a telephone call placed to physician and supervisor. The 9:29 a.m. nurse progress note indicated x-ray showed hip fracture. The 2/14/15, Fall report indicated R228 had a fall in her room, was confused, incontinent, had gait imbalance, impaired memory, was non-compliant, had weakness/fainted. The report indicated R228's predisposing situation factors were ambulating without assistance. The report indicated R228 was alone and unattended, and call light was not in use at time of fall. Review of the facilities Fall Log report on 6/4/15, indicated R228's fall/fractured hip was not on the	21980		

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21980	Continued From page 81 report. On 6/4/15, at 12:30 p.m. RN-D stated R228 would not be on the Fall log because an incident report was not completed because the facility was following R228's care plan at the time of the fall. RN-D added, it was not facility practice to report an incident such as R228's hip fracture because staff were following the resident's care plan. RN-D also verified the facility did not complete an investigation related to R228's fall and fracture because staff were following the care plan. On 6/5/15, at 3:00 p.m. the administer and DON were interviewed. The administrator stated it was not their policy to report an incident such as R228's fall and hip fracture because staff were following R228's care plan at the time of the fall. R152 sustained a fractured rib of unknown origin and the facility failed to timely report the incident to the State agency, as required. R152's undated Transfer/Discharge report indicated R152 had diagnoses of Alzheimer's Dementia, generalized pain, coronary arteriosclerosis and depression. A facility Investigation Report dated 5/4/15, indicated on 5/3/15, R152 had complained of right sided pain, R152 denied falling, an X-Ray was ordered and revealed an acute right 7th fractured rib. The section of the report form titled, date	21980		

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21980	Continued From page 82 administrator and medical director notification was blank. The Summary of Investigation section was also blank. The Investigation Report-undated indicated R152's incident occurred/or was noted on 5/4/15, and location of incident was "unknown." The VA report filed with the State agency was dated 5/5/15, therefore was not reported immediately, as required. On 6/5/15, at 3:00 p.m. the administer and DON were interviewed. The administrator verified the VA report was not reported timely and stated the RN supervisor should reported the incident as required. The administrator stated the RN supervisor involved was given disciplinary action and education was provided. The facility policy and procedure for Reporting Abuse to the State Agencies and Other Entities/Individuals revised 2006, directed if a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility will promptly notify the State agency. The facility policy and procedure for Recognizing Signs and Symptoms of Abuse/Neglect revised 2006, indicated neglect was defined as "failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness". The policy identified some signs of	21980		

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21980	Continued From page 83 abuse or neglect including inadequate provision of care and caregiver indifference to resident's personal care and needs. The facility policy and procedure for Reporting Abuse to Facility Management revised 9/12, indicated it was the responsibility of the employees to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The policy and procedure directed employees must immediately report any suspected abuse or incidents of abuse to their direct supervisor, abuse coordinator and/or administrator. In addition the administrator or DON must be immediately notified of suspected abuse or incidents of abuse regardless of the time lapse since the incident occurred. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON), or designee could review and update policies related to vulnerable adult abuse and neglect. The administrator, DON or designee could educate all facility staff on the policies and procedures for reporting and investigating allegations of mistreatment and / or injuries of unknown origin. The administrator, DON or designee could develop monitoring systems to ensure ongoing compliance is attained and maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21980		

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22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows	22000		

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22000	Continued From page 85 of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed operationalize their abuse prohibition policy and procedures related to timely reporting to the State agency and / or investigate allegations of abuse, neglect, injuries of unknown origin and accidents with serious injury for 3 of 5 incidents reviewed which involved 3 of 3 residents (R138, R228, R152). Findings include: An incident report dated 5/7/15, at 7:40 p.m. indicated R138 fell during a one staff assisted transfer from the wheelchair to the toilet when R138 lost his balance and fell against the wall. The report indicated R138 bumped his left arm and the left side of his head. The report also indicated the director of nursing (DON) and the nursing supervisor were notified. The nursing note on the incident report dated 5/8/15, indicated R138's care plan was updated to indicated two staff assist was needed for transfers and ambulation. The predisposing physiological factors were identified as weakness/fainted. The	22000		

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22000	Continued From page 86 report also indicated R138's responsible party was notified on 5/7/15, at 7:50 p.m., and the physician was notified on 5/8/15, at 2:04 p.m. The incident report lacked indication of State agency notification, as required. R138's undated Face Sheet and Diagnosis List printed 6/4/15, indicated R138's diagnoses included hemiplegia (paralysis on one side of the body) due to cerebrovascular disease (stroke), convulsions (seizures), difficulty in walking, muscle weakness, dementia without behavioral disturbance, depressive disorder and anxiety. A Fall Risk Evaluation dated 5/6/15, indicated R138 was at high risk for falls and had 1-2 falls in the 90 days prior. The fall risk evaluation indicated R138 had no cognitive changes, ambulated with problems and a device, his gait was unsteady and he required physical assistance to stabilize. R138's Progress note dated 5/8/15, indicated R138 complained of pain in ribs from the fall. R138's Progress note dated 5/10/15 at 2:41 p.m., indicated R138 complained of pain in his chest on both sides. R138's Progress note dated 5/10/15, at 10:30 p.m. indicated R138 complained of left side pain, pointing to the rib area. No bruising or swelling was noted.	22000		

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22000	Continued From page 87 An order by the nurse practitioner (NP) dated 5/11/15, directed an x-ray of the right and left ribs and chest x-ray for diagnosis of pain. A radiology report dated 5/11/15, indicated R138 had acute rib fractures of the left third, fourth, and fifth ribs. R138's Progress note dated 5/11/15, at 9:40 p.m. indicated a chest x-ray result included rib fractures of 3 ribs. The note indicated a call was placed to the assistant director of nursing (ADON) to report the injury (fracture) and the fall report was reviewed. The report also indicated R138 was spoken to and he reported the fractures occurred when he had fallen the previous week and reported his pain level as 10 on a scale of 1-10, which indicated almost unbearable pain. R138's NP progress note dated 5/12/15, indicated R138 had falls with injury and noted R138 had left rib fractures. In addition, the NP noted R138 had a 10 pound weight loss and his blood pressures were too low and the blood pressure medication had just been decreased and labs had been ordered. The note also indicated the NP had ordered R138's blood pressures and heart rate checks twice daily for one week. R138's annual Minimum Data Set (MDS) assessment dated 5/15/15, indicated R138 had moderate cognitive deficit, displayed no rejection of care and required extensive assistance of two staff for transfers and ambulation. The MDS also indicated R138 had balance problems and was	22000		

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22000	Continued From page 88 unsteady with position changes. In addition, the MDS indicated R138 had almost constant pain rated at 10 out of 10, which indicated almost unbearable pain. R138's Fall Care Area Assessment (CAA) dated 5/15/15, indicated R138 was potentially at risk for falls due to balance problems during position changes and receiving an antidepressant medication. The CAA indicated R138 required assistance with transfers and would ambulate short distances in his room with staff assist and the use of a walker, but the wheelchair was his primary mode of transportation. R138's Progress note dated 5/29/15, at 7:45 a.m. indicated R138 reported, "someone busted up my neck." The note indicated when R138 was asked what was going on, he talked about how no one helped him the previous night, something was wrong with his neck and he wanted an x-ray. The progress note indicated R138 was told the charge nurse would be notified to schedule an x-ray and the doctor would be informed. R138's Progress note dated 5/29/15, at 8:54 a.m. indicated R138 complained of pain in the lower neck, running along upper shoulder blade region. R138 stated he felt pain when moved by NA this morning and said that he was moved in such a way as to cause pain in his neck. The progress indicated the nurse assessed the location of R138's pain. R138's medical record lacked any documentation of the State agency notification related to the fall	22000		

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22000	Continued From page 89 with resultant rib fractures. In addition, R138's medical record lacked any documentation related to R138's report of neck pain and rough movement. R138's falls care plan initiated 6/12/14, and revised 2/9/15, indicated R138 was at risk for falls and directed staff to follow the facility's fall protocol, review the information on past falls and attempt to determine cause of falls, record possible root causes of the fall, and then to alter or remove any potential causes, if possible. The care plan further directed staff to educate the resident, family and staff regarding the causes. R138's care plan for activities of daily living (ADLs), initiated 3/7/15, and revised 5/8/15, indicated R138 required the assistance of two staff for transfers, bed mobility and toilet use. R138's care plan dated 4/24/15, indicated R138 had the potential for pain related to arthritis and was able to call for assistance when in pain, was able to reposition self, ask for medication, communicate how much pain he was experiencing and what increased or alleviated the pain. R138's care plan for mobility initiated 3/7/15, indicated R138 required the assistance of two staff for ambulation with a quad cane (a cane with 4 ends, hemi cane) with a goal for R138 to ambulate daily with the quad cane and assist of one staff.	22000		

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22000	Continued From page 90 R138's previous care plan printed 12/20/13, and updated as recently as 1/15/15, indicated R138 was to ambulate with restorative nursing up to 300 feet with the assistance of one staff using the quad cane on the right side. The care plan indicated R138 was at risk for falls, required extensive assistance of 1 to 2 staff for pivot transfers with the quad cane and assistance needed varied daily due to weakness, pain and confusion. R138's care plan updated on 12/5/14, indicated R138 had a fall and the care card was updated. R138's Resident Care Card (the care plan used by nursing assistants) printed 6/4/15, directed the use of two staff for transfers, two staff assist with the quad cane for ambulation and two staff assist for toilet use. The Resident Care Card printed 3/9/15, indicated R138 required two staff for transferring. A note by the registered nurse (RN)-H dated 12/16/14, indicated R138's resident care card dated 12/5/14, directed staff to transfer R138 with two staff assist and also indicated the care plan was not followed during R138's incident of 12/5/14, when R138 fell during a transfer with only one staff assist. RN-H stated this indicated R138's care card had been changed prior to 12/5/14, directing the use of two staff assist for transfer. The undated nursing assistant (NA) group sheet provided by RN-H indicated the NAs were to refer to the Care Card for transfers and toilet use guidance. The group sheet did not indicate how R138 was to ambulate or if he could ambulate.	22000		

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22000	Continued From page 91 The facility Minnesota Department of Health Tracking Form for vulnerable adult (VA) reports made by the facility lacked documentation which indicated R138's incident of 5/7/15, rib fractures and the report of neck pain alleged to be caused by treatment by staff. On 6/3/15, at 2:17 p.m. R138 stated some staff were rough in the morning because they were in a hurry. R138 also stated he was more sore in the morning and at times, felt staff were disrespectful and ignored his needs. R138 also stated he was not afraid of staff and did not feel the staff purposefully tried to hurt him. R138 confirmed he had had broken bones and bruises from falls. On 6/4/15, at 2:09 p.m. registered nurse (RN)-H stated since prior to 12/5/14, R138 had required the assist of two staff. RN-H stated the facility reported falls with major injuries, bruises of unknown cause, bruises in odd spots and altercations as well as allegations of abuse, neglect and mistreatment to the State agency. RN-H stated R138's rib fractures were probably related to the fall that had occurred that week during a transfer, however was unaware if the incident was reported to the State agency. RN-H verified the allegations related to the neck pain should have been reported to the State agency, immediately. On 6/4/15, at 4:35 p.m. the director of nursing (DON) stated she would expect staff to follow the resident care cards when providing cares as the care card was the individual resident care plan for	22000		

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	00238	A. BUILDING: _____ B. WING _____	06/04/2015

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22000	Continued From page 92 NA's to use. The DON stated staff called the DON with all falls and stated R138's fractured ribs were related to his fall on 5/7/15. The DON verified R138's care plan was not followed during the incident and the fall with a fracture should have been reported to the State agency, as required. In addition, the DON verified R138's allegation of neck pain and mistreatment by staff was not reported the next day because R138's pain had diminished. The DON stated the nurse was to protect the resident first, pull the alleged staff member from the floor and report the allegation to the State agency right away. R228 sustained an unwitnessed right hip fracture and the facility failed to report timely to the State agency and investigate the incident as required. R228's annual MDS dated 2/6/15, indicated R228's diagnoses included, non-Alzheimer's dementia, arthritis and osteoporosis. The MDS indicated R228 had memory loss, impaired decision making skills, required limited assist with walking and transferring and used a walker and wheelchair for mobility. R228's significant change MDS dated 5/22/15, indicated R228's diagnoses included non-Alzheimer's dementia, arthritis, osteoporosis and hip fracture. The MDS indicated R228 had memory loss, impaired decision making skills, was totally dependent on two staff for transfers and was non-ambulatory. The MDS indicated R228 had impairment in range of motion on one side in lower extremity and used a wheelchair.	22000		

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22000	Continued From page 93 R228's Nurse Progress note dated 2/14/15, at 7:39 a.m. indicated R228 was found on the floor, lying on right side between the bathroom door. The note indicated R228 was yelling out and screamed when when right leg was touched. The note further revealed R228's right leg was shorter and rotated therefore a telephone call placed to physician and supervisor. The 9:29 a.m. nurse progress note indicated x-ray showed hip fracture. The 2/14/15, Fall report indicated R228 had a fall in her room, was confused, incontinent, had gait imbalance, impaired memory, was non-compliant, had weakness/fainted. The report indicated R228's predisposing situation factors were ambulating without assistance. The report indicated R228 was alone and unattended, and call light was not in use at time of fall. Review of the facilities Fall Log report on 6/4/15, indicated R228's fall/fractured hip was not on the report. On 6/4/15, at 12:30 p.m. RN-D stated R228 would not be on the Fall log because an incident report was not completed because the facility was following R228's care plan at the time of the fall. RN-D added, it was not facility practice to report an incident such as R228's hip fracture because staff were following the resident's care plan. RN-D also verified the facility did not complete and investigation related to R228's fall and fracture because staff were following the care plan.	22000		

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22000	Continued From page 94 On 6/5/15, at 3:00 p.m. the administer and DON were interviewed. The administrator stated it was not their policy to report an incident such as R228's fall and hip fracture because staff were following R228's care plan at the time of the fall. R152 sustained a fractured rib of unknown origin and the facility failed to report timely to the State agency, as required. R152's undated Transfer / Discharge report indicated R152 had diagnoses of Alzheimer's Dementia, generalized pain, coronary arteriosclerosis and depression. A facility Investigation Report dated 5/4/15, indicated on 5/3/15, R152 had complained of right sided pain, R152 denied falling, an X-Ray was ordered and revealed an acute right 7th fractured rib. The section of the report form titled, date administrator and medical director notification was blank. The Summary of Investigation section was also blank. The Investigation Report-undated indicated R152's incident occurred / or was noted on 5/4/15, and location of incident was "unknown." The VA report filed with the State agency was dated 5/5/15, therefore was not reported immediately, as required.	22000		

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22000	Continued From page 95 On 6/5/15, at 3:00 p.m. the administer and DON were interviewed. The administrator verified the VA report was not reported timely and stated the RN supervisor should reported the incident as required. The administrator stated the RN supervisor involved was given disciplinary action and education was provided. The facility policy and procedure for Reporting Abuse to the State Agencies and Other Entities/Individuals revised 2006, directed if a suspected violation or substantiated incident of mistreatment, neglect, injuries of an unknown source, or abuse (including resident to resident abuse) be reported, the facility will promptly notify the State agency. The facility policy and procedure for Recognizing Signs and Symptoms of Abuse/Neglect revised 2006, indicated neglect was defined as "failure to provide goods and services as necessary to avoid physical harm, mental anguish, or mental illness. The policy identified some signs of abuse or neglect including inadequate provision of care and caregiver indifference to resident's personal care and needs. The facility policy and procedure for Reporting Abuse to Facility Management revised 9/12, indicated it was the responsibility of the employees to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The policy and procedure directed employees must immediately report any suspected abuse or incidents of abuse to their	22000		

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22000	Continued From page 96 direct supervisor, abuse coordinator and/or administrator. In addition the administrator or DON must be immediately notified of suspected abuse or incidents of abuse regardless of the time lapse since the incident occurred. SUGGESTED METHOD OF CORRECTION: The administrator could develop policies and procedures regarding reporting and investigating all alleged abuse/neglect/mistreatment. The administrator could educate all staff on those policies and procedures. The administrator could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	22000		
23240	MN Rule 4658.5405 Ventilation Requirements; Existing Constructn Existing facilities must have mechanical exhaust ventilation in the kitchen, laundry, soiled linen collection room, soiled utility rooms, and toilet areas, except if the toilet area is private or semiprivate, and is provided with window ventilation. Ventilation must be provided according to part 4658.4520. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain functional / adequate ventilation in resident rooms numbered	23240		

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23240	Continued From page 97 (107, 245, 247, 249, 326, 350, 366), where urine odors had been detected. Findings include: On 6/4/15, from 9:00 a.m. to 10:00 a.m. a tour of the facility was completed with the maintenance director (MD), administrator, regional nurse administration, district manager of the healthcare service group and the director of housekeeping. The following rooms had been detected to have a urine odor and the MD checked the ventilation of these rooms and their adjoining bathrooms and confirmed the following: · Room 107, bathroom vent was okay, no vent in resident's room. · Room 245, bathroom vent was okay, MD placed a Kleenex up to the vent above the door in room 245 and the Kleenex did not adhere to the vent which demonstrated improper air flow. · Room 249, MD confirmed the vent in the bathroom was not open all the way. Once the bathroom vent was opened it was okay. The vent above the door in room 249 demonstrated improper air flow. · Room 326, the vent in the bathroom and above the door in room 326 demonstrated improper air flow. · Room 350, the vent in the bathroom was okay, the vent above the door in room 350 demonstrated improper air flow. · Room 366, the vent in the bathroom was okay, the vent above the door in room 366 demonstrated improper air flow. On 6/2/15, at 10:25 a.m. family member (FM)-A stated her mother's room smelled like urine. On 6/3/15, at 11:57 a.m. there was a very strong	23240		

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23240	Continued From page 98 urine odor detected in room 107 which permeated and lingered down the 100 wing hallway on the bridgeway unit. On 6/4/15, at 9:15 a.m. the administrator and MD verified room 249 had a urine odor. On 6/4/15, at 9:45 a.m. the MD verified on the bridgeway unit there were no vents in the residents' rooms or in the hallways, just in the resident's bathrooms. On 6/4/15, at 10:28 a.m. the MD confirmed he had gone down random rooms on the two southwest wing and none of the vents above the resident doors were working. The MD confirmed the venting duct work in the ceiling had been capped off at both ends on this two southwest hallway. The MD stated it appeared the facility must have aborted the project and not finished the ventilation project. The MD was unaware of when the ventilation system had been installed or why it had not been finished. The MD stated because the duct work had been capped off on both ends, this only allowed the ventilation system to work in the resident bathrooms and not in their rooms. On 6/4/15, at 12:05 p.m. the MD stated he had gone up on the roof of the building and checked the fan. The MD confirmed the fan motor on the roof was hot and he determined that the motor of the exhaust system had gone out and needed to be replaced. The MD verified the motor which needed to be replaced would have affected the ventilation system for the bathroom in between resident rooms 324 and 326. On 6/5/15, at 9:25 a.m. the purchasing director (PD) described the odor permeating down the	23240		

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23240	Continued From page 99 100 hallway in bridgeway smelled like dead skin, wet carpet and used incontinence pads. On 6/5/15, at 9:34 a.m. housekeeper (H)-A stated the 100 hallway of bridgeway smelled like urine and the smell went all the way down the hallway. The CONSUMER CONCERNS TRACKING - 2014 log indicated on 8/5/14, family members had been upset with odors. In addition, on 3/9/15, a resident had expressed concerns regarding urine smell. The work history report [undated] indicated the exhaust fans had last been inspected on 5/31/15. The Interior General Maintenance policy [undated] indicated it was the facility's policy to maintain a clean, comfortable environment for their residents, associates and visitors. SUGGESTED METHOD OF CORRECTION: The director of maintenance (DM) could review and revise procedures related to regular maintenance and monitoring of the exhaust ventilation system. The DM could train all staff on these procedures and how to report concerns. The DM could monitor for continued compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	23240		