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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: P705

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00799

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245540**
2.STATE VENDOR OR MEDICAID NO.
(L2) **438670100**

3. NAME AND ADDRESS OF FACILITY
(L3) **HENNING REHABILITATION & HEALTHCARE CENTER**
(L4) **907 MARSHALL AVENUE, PO BOX 57**
(L5) **HENNING, MN** (L6) **56551**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/22/0217** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Beth Nowling, HFE NE II — 06/22/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Shellae Dietrich, Certification Specialist — 07/25/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1990
(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.
01111
(L31)

30. REMARKS
Posted 07/27/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/26/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245540 July 20, 2017

Ms. Joan Gedde, Administrator
Henning Rehabilitation & Healthcare Center
907 Marshall Avenue, PO Box 57
Henning, MN 56551

Dear Ms. Gedde:

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 June 16, 2017 the above facility is recommended for:

47 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 47 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697
cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered July 20, 2017

Ms. Joan Gedde, Administrator
Henning Rehabilitation & Healthcare Center
907 Marshall Avenue, PO Box 57
Henning, MN 56551

RE: Project Number S5540027

Dear Ms. Gedde:

On May 11, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 28, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 22, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 14, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 16, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 28, 2017, effective June 16, 2017 and therefore remedies outlined in our letter to you dated May 11, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: P705

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00799

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(L1) **245540**
2.STATE VENDOR OR MEDICAID NO.
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(L3) **HENNING REHABILITATION & HEALTHCARE CENTER**
(L4) **907 MARSHALL AVENUE, PO BOX 57**
(L5) **HENNING, MN** (L6) **56551**

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) **02/01/2017**

6. DATE OF SURVEY **04/28/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susan Bachleitner HFE Nursing E II 06/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath Program Representative 06/26/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1990
(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.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

May 11, 2017

Ms. Joan Gedde, Administrator
Henning Rehabilitation & Healthcare Center
907 Marshall Avenue, PO Box 57
Henning, MN 56551

RE: Project Number S5540027

Dear Ms. Gedde:

On April 27, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 6, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 6, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 27, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 27, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Please contact me if you have questions related to this eNotice.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENNING REHABILITATION & HEALTHCARE CENTER	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 272		6/16/17

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

Electronically Signed | 05/31/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENNING REHABILITATION & HEALTHCARE CENTER	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(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 272	Continued From page 1 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately asses urinary needs for 1 of 1 resident (R11) identified to be incontinent of urine. Findings include: R11's quarterly Minimum Data Set (MDS) dated 1/16/17, identified R11 had severe cognitive impairment, required extensive assistance with transfer and toileting, was always incontinent of urine, continent of bowel and was not on a toileting plan.	F 272	F272 A comprehensive bladder assessment has been completed for R11. R11 is receiving toileting assistance as per her bladder assessment and care plan. R11's care plan and CNA care sheets have been updated to reflect his toileting needs. Other facility Residents have been reviewed to determine that bladder assessments have been completed as required and that interventions with care planning have been implemented where necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING _____ B. WING _____	04/28/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENNING REHABILITATION & HEALTHCARE CENTER	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(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 272	Continued From page 2 The undated nursing assistant care sheet identified R11 was incontinent of bladder and continent of bowel. Required limited assistance with peri cares, wore a brief at bed time and check and change every two hours during the night. On 4/27/17, at 12:47 p.m. R11 was assisted on to the toilet, urinated in the toilet and was assisted by NA-D to pull up his brief and sweat pants. At 12:54 p.m. NA-D verified R11's brief was dry and he had voided on the toilet. NA-D indicted she had assisted R11 to the toilet before dinner and R11 was dry at that time. The facility Bladder Assessment Form dated 4/10/17, identified R11 had incontinence without sensation of urine loss, most likely experienced stress and functional incontinence and was not appropriate for toileting or retraining program. The assessment form Bowel and Bladder Summary identified the following: Resident is always incontinent of bladder, reports that he is unaware of need to toilet. Per direct care staff charting, 3 day bowel and bladder record, resident is always incontinent, no pattern. Staff check and change Q 2 HR (every two hours) and PRN (as needed). Unable to alert staff of need to toilet, check and change Q 2 HR and PRN. Care plan reviewed and updated. On 4/26/17, at 12:20 p.m. nursing assistant NA-A indicated R11's usual morning routine was to use the bathroom before lunch, lay down after lunch and use the call light when he is ready to get up again. NA-A indicated R11 would ask to use the bathroom but if he has not asked and has not gone to the bathroom for a while NA-A will	F 272	Nursing staff have been in-serviced on the necessity of completing bladder assessments as required and on the program stated below. In particular, the MDS Coordinator has been in-serviced on being accurate and complete when it comes to doing bladder assessments, including the review of (3) day bladder tracking, POC documentation, staff and resident interviews. A new program has been developed which consists of a computer-based tickler file; the DON has a file on her computer that lists all resident names and the status of their bladder skills, incontinent, partially, continent. This file also lists the interventions being used for each resident. One block in the file, for each resident, allows the DON to check-off when a comprehensive bladder assessment has been done for residents for whom it is indicated. The DON will check this program weekly, update it as necessary, and review bladder assessments, whether they have been done, are pending, or still need to be done. Audits will be conducted on (3) residents weekly x 4 weeks and then monthly thereafter by the DON or her designee to validate that resident toileting needs have been accurately assessed; this will include a review of the resident status, toileting behaviors, and bladder assessments. Audit results will be reported monthly by the DON to the QA. Compliance alleged by 6-16-17	

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F 272	Continued From page 3 encourage R11 to use the bathroom. On 4/27/17, at 8:29 a.m. NA-H indicated R11 was able to make his needs known and would ask to use the bathroom if he wanted to, however; NA-H was only aware of one instance in which R11 requested to use the bathroom and voided on the toilet. NA-H indicated she would assist R11 to sit on the toilet in the morning upon waking and change his brief which was usually wet. NA-H indicated R11 was often able to stay dry during the day and his brief was not wet each time it was checked. NA-H indicated R11's brief was checked after breakfast and was usually dry. On 4/27/17, at 8:59 a.m. NA-I indicated the usual practice was assisting R11 to the bathroom when he requested it. NA-I identified R11 was able to stay dry through out the day, knew if he needed to use the bathroom and was only incontinent of urine when he was asleep. On 4/27/17, at 9:03 a.m. NA-D indicated R11 wore an incontinent brief because of accidents. NA-D identified she asked R11 every two hours if he needed to use the bathroom. NA-D indicated R11 did not answer yes or no but would sit on the toilet with encouragement and at times would be able to void when on the toilet. On 4/27/17, at 9:31 a.m. licensed practical nurse (LPN)-B indicated R11 was incontinent of urine, however: at times asked to use the toilet. LPN-B verified R11 was on a check and change plan for incontinence care. LPN-B indicated during the night R11's brief was checked and changed quickly and then he was able to go back to sleep. LPN-B was unaware of the reason R11's plan would be to check and change his brief during the	F 272		

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F 272	Continued From page 4 day. LPN-B further indicated if R11's brief was dry he should be encouraged to go on the toilet. On 4/27/17, at 2:48 p.m. the assistant director of nursing (ADON) verified the facility practice was to asses resident's bladder control quarterly with information provided from nursing assistant charting and a three day bowel and bladder form. The ADON verified R11's bladder assessment indicted R11 was incontinent of urine and his brief was to be checked and changed every two hours and as needed. The ADON verified a check and change program was a plan for someone who did not use the toilet. With review of the three day data collection tool for 4/5/17, 4/6/17 and 4/7/17, the ADON identified it appeared a toileting plan may be appropriate for R11 to remain dry at times. The ADON verified she had completed the assessment but it may have been a different resident. The ADON indicated she would complete a new bladder assessment. On 4/27/17, at 3:06 p.m. the director of nursing (DON) identified the purpose of a toileting assessment and plan was to try to prevent skin break down, if possible reverse incontinence problems or regain bladder control. The DON indicated to accomplish this, the assessment would need to be completed as appropriately as possible. The DON identified with the assessment a plan is formed, placed in the care plan and on the nursing assistant paper copy that is carried with them for resident care.	F 272		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 282		6/16/17

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F 282	Continued From page 5 as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement interventions to prevent the further development pressure ulcers and provide oral cares as directed by the plan of care for 1 of 1 residents (R20). In addition, the facility failed to provide interventions to maintain ambulation for 1 of 1 resident reviewed (R15) who required limited assistance with ambulation. Findings include: R20's care plan dated 2/7/17, identified R20 was at risk for developing pressure ulcers and was to wear blue heel boots all the time for pressure prevention to R20's lower extremeties and staff were to elevate and offload heels from the bed. On 4/25/17, during continuous observation from 1:35 p.m. to 3:19 p.m. R20's heels were not elevated by pillows and rested directly on the mattress and both R20's feet were rotated outward in the blue heel boots which applied direct pressure to the outside of both R20's feet and heels. On 4/25/17, at 3:35 p.m. registered nurse (RN-A) confirmed R20's heels were not elevated off the bed with a pillow and stated she felt he didn't need the pillow under his heels because he wasn't sliding down in bed. RN-A also confirmed	F 282	F282 Interventions to prevent pressure ulcers including application of heel protecting boots and floating heels have been implemented for R20. Oral care is being provided routinely for R20. R15 is receiving routine assistance with ambulation to meals. Residents have been reviewed throughout the facility to see if any others are affected by these deficient practices including those in need of heel protection through the application of protective boots or heel floating, those in need of oral care, and those who require ambulation with assistance to meals. Where problems were found corrective action was taken. Staff were trained on the new heel protective program which includes the heel boot application and heel floating elements. Also, they were trained on the new oral care program explained below and the newly revised “walk to Dine” program also explained below. Nursing has developed a new “Resident Heel Protective Program” in conjunction with the National Pressure Ulcer Advisory Panel (NPUAP) guidelines on resident skin care and pressure ulcer prevention. Accordingly, residents whose Braden Scale scores (or actual jeopardy for heel	

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F 282	Continued From page 6 both R20's feet were rotated outward in the blue boots. On the side of R20's heel was an intact, darker pigmented area which measured approximately 0.3 cm x 0.2 cm and a large thick pink scar on the outside of R20's foot near his heel. On 4/26/17, during continuous observation from 7:15 a.m. to 10:15 a.m. R20's heels were not floated off the bed and R20's protective boots were not applied correctly to reduce pressure to R20's heels. On 4/26/17, at 11:27 a.m. both of R20's feet were rotated outward which put direct pressure on the outside of both R20's feet and heels. R20's heels were not floated off the bed with a pillow. On 4/27/17, at 11:00 a.m. the assistant director of nursing (ADON) confirmed R20's heels were not elevated off the bed with pillows and R20's feet were both rotated outward. She stated she has had to get on her staff and remind them to elevate R20's heels with pillows. On 4/26/17, at 2:15 p.m. NA-A stated R20 was confused and required total assistance with ADL's. She stated interventions to protect R20's heels included putting socks on him, the protective boots and to apply lotion to his skin after his baths. She stated she wasn't sure if R20's heels were supposed to be elevated off the bed or not, she stated she just found out about this a couple days ago that they were supposed to do that. On 4/26/17, at 2:48 p.m. during follow up interview NA-B stated she was unaware that R20 was supposed to have his feet elevated off the	F 282	skin breakdown) are provided with protective boots or heel floating while in bed – or both as ordered by the physician. The use of these boots goes along with turning and repositioning – as needed – to prevent skin breakdown. A review of all residents currently in house has been done to determine who has heel breakdown concerns and requires the intervention of this program. Nursing has also developed a “Resident Oral Care Program” which includes daily oral care intervention and additional care as needed for residents who are unable to provide themselves with oral care. This oral care program includes assisting residents with brushing teeth and/or swabbing the oral cavity with toothettes, providing dentures care, and any other care necessary including setting up dentistry interventions as needed. Daily review of resident oral needs is done and interventions provided as necessary which are also care-planned. Finally, a revised “Resident Walk to Dine Program” has been established. The basis for this program is a recommendation from physical therapy that any specific resident can benefit from assistance walking to the dining room for meals (and/or back to their room with assistance). A review by PT of all residents to determine who could benefit will be done and interventions will be care-planned. The Director of Nursing or her designee will conduct audits of all three of these programs to determine compliance. An audit for the new “Resident Heel	

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F 282	Continued From page 7 bed with a pillow. She stated the blue boots were to protect R20's feet and to ensure R20's feet didn't touch the foot of the bed and were to prevent sores. On 4/27/17, at 9:33 a.m. the ADON stated R20 had severe cognitive impairment and required total assistance with ADLs. She stated interventions to prevent the development of further DTI's were to continue betadine, R20 wear the protective boots all the time and R20's heels were to be elevayed off the bed with pillows. She stated if R20's heels were elevated with pillows she stated she felt their interventions would be effective. She stated she expected staff to use the pillows to elevate R20's heels all the time when he's in bed. On 4/27/17, at 3:49 p.m. the director of nurses (DON) stated R20 was supposed to wear the protective boots all the time and staff were to elevate R20's heels of the bed with a pillow to keep his heels off the bed even more. She stated she expected R20 to wear the protective boots and R20's feet would be kept in a neutral position to prevent pressure and DTI's to those areas. R20's care plan dated 2/7/17, identified R20 was at risk for dental problems and required assistance with oral cares. The care plan further identified a licensed nurse was to monitor and try oral cares every shift and as needed (PRN) and record cares in the electronic treatment record. The care plan indicated R20 would receive dental care as needed. On 4/26/17 from 7:15 a.m. to 12:30 p.m. R20 was observed to have a yellow, thick film under his top lip. R20's mouth and lips was dry and sticky.	F 282	Protective Program" will be done weekly to ensure that all residents who are to wear protective boots or who are to have their heels elevated are receiving these interventions. Additionally, an audit will be done weekly by the DON or her designee to ensure that residents for whom oral care is being provided under the new "Resident Oral Cares Program" are being done. Finally, the DON or her designee will conduct an audit weekly to determine that residents for whom it is ordered are receiving walk-to-dine assistance as per the newly revised "Resident Walk-to-Dine Program". Each of these (3) audits will continue weekly for (4) weeks and then monthly thereafter. The DON will report monthly to the QA Committee on each program. Compliance alleged by 6-16-17	

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F 282	Continued From page 8 R20's teeth were broken and dark yellow. Toothette's were observed to be across the room in a box on the shelf. On 4/26/17, at 2:15 NA-A stated R20 had cognitive impairment and required total assistance with ADLs. She stated R20 had toothette's to clean his mouth and she stated she thought R20's mouth was supposed to be cleaned twice per day. She stated she performed R20's morning cares this morning and stated she didn't clean R20's mouth today because she didn't have time. She stated she wasn't sure if the nurse did oral cares for R20 today or not. On 4/26/17, at 2:31 p.m. assistant director of nurses stated nursing assistants and nurses were to perform oral cares for R20 because R20's mouth "got so bad so quick". She stated oral cares were not assigned a specific number of times per day, and stated the NA's should have cleaned his mouth with the toothette this morning. On 4/26/17, at 2:48 p.m. NA-B stated she wasn't sure if oral cares were done today for R20. On 4/27/17, at 9:30 a.m. ADON stated R20 had severe cognitive impairment and was totally dependent on staff for ADLs. She stated it depended on the staff person if they used a regular tooth brush or the toothette's for R20's mouth care. She stated she thought the nurse did oral cares with morning medications before breakfast. She stated oral cares were listed on the NA care sheet under eating and confirmed the NA care sheet identified oral cares were to be done every shift.	F 282		

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F 282	Continued From page 9	F 282		

Review of the facility Interdisciplinary Care Plan policy dated 4/1/16 identified resident care plans were implemented to guide staff to provide the necessary care and services to attain their highest level of well being.
Review of R15's current care plan revised 4/7/17, revealed R15 required limited assistance with mobility in a wheelchair and used a four wheeled walker and wheelchair for assistive devices. R15's care plan lacked direction for the restorative walk to dine program.

Review of R15's quarterly Minimum Data Set (MDS) dated 3/3/17, identified R15 was cognitively intact and required limited assistance to ambulate in the corridors and her room, extensive assistance in transfers and bed mobility. Further the MDS identified R15 used a walker and a wheelchair for mobility.

R15's PT - Therapist Progress & Discharge Summary form dated 3/6/17, included a recommendation for R15 for walk to dine program. At the time of discharge R15 walked 150 feet. Pt completed a Therapy Communication to Nursing form dated 3/6/17, recommending R15 for the walk to dine program.

Review of an untitled and undated form provided by the facility, identified as the nurse aide care guide, identified multiple interventions for R15 which included assist of one staff for ambulation. It further directed R15 to walk to all meals and staff was to follow with a wheelchair. The form instructed staff to tell the nurse if R15 refused to walk.

Review of R15's progress notes from 3/20/17, to 4/26/17, lacked documentation regarding R15's

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walking program or rationale for why R15 was not walked to meals as recommended by therapy.

On 4/27/17, at 11:27 a.m. R15 was taken to the dining room by NA-C and NA-A. They had not assisted R15 to ambulate to the dining room nor had they offered assistance with ambulation.

During interview on 4/27/17, at 12:23 p.m. R15 indicated staff had not offered assistance with walking for a long time. R15 stated she would like to walk and she would like to try ambulating again.

Review of R15's task titled "walk in corridor" from 3/20/17, to 4/ 27/17, revealed R15 had received her ambulation program 4 of 39 days.

On 4/27/17, at 2:28 p.m. NA-H indicated staff did not routinely assist R15 to walk.

On 4/27/17, at 2:38 p.m. registered nurse (RN)-A indicated R15 routinely used her wheelchair to go to the dining room. RN-A indicated R15 had received therapy in the past and she understood R15 had a restorative program in place. She understood R15 was on a walk to dine program, but did not know why it was not being implemented.

On 4/27/17, at 3:02 p.m. assistant director of nursing (ADON) confirmed R15 was to have a walk to dine program in place. She confirmed R15 had not consistently received the walk to dine program.

On 4/27/17, at 3:41 p.m. R15 was seated in a standard wheelchair in her room. The ADON assisted R15 to stand and ambulate while the

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F 282	Continued From page 11 ADON held onto the gait belt with the wheelchair being pulled behind her. R15 was able to ambulate over 130 feet before asking to sit down. R15 stated she could feel it in her knees after walking, but did not appear distressed. On 4/27/17, at 4:10 p.m. the director of nursing (DON) confirmed R15's care sheet directed staff to assist R15 with the walk to dine program. The DON confirmed nursing staff had not assisted R15 with the walk to dine program and could not locate in the clinical record for why the program was not being implemented.	F 282		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide restorative walk to dine services to maintain ambulation for 1 of 1 resident reviewed (R15) who required limited assistance with ambulation. Findings include: Review of R15's quarterly Minimum Data Set (MDS) dated 3/3/17, identified R15 was cognitively intact and had diagnoses which included cerebrovascular accident (CVA) and anxiety. The MDS identified R15 required limited assistance to ambulate in the corridors and her room, extensive assistance in transfers and bed	F 311	F311 R15 has been placed on a newly revised Restorative “Resident Walk-to-Dine” Program which has also been care-planned for him. Residents have been reviewed to determine who else would benefit from a Restorative “Walk-to-Dine” Program; any resident eligible has been entered into the program and is being assisted with ambulation to the dining room. Nursing staff has been educated on the newly revised Restorative “Resident Walk-to-Dine” Program as described below.	6/16/17

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F 311	Continued From page 12 mobility. Further the MDS identified R15 used a walker and a wheelchair for mobility. The MDS revealed R15 was not steady and required assistance while walking and when turning around to face the opposite direction. Review of R15's activity of daily living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 3/6/17, identified R15 was at risk for complications of immobility, incontinence and depression due to functional decline. The CAA further identified R15 had physical limitations; weakness, limited range of motion, poor coordination, poor balance and visual impairment. Review of R15's Falls CAA dated 3/6/17, identified R15 had difficulty with balance upon rising from a seated position and when turning with ambulation. Review of R15's current care plan revised 4/7/17, revealed R15 required limited assistance with mobility in a wheelchair and used a four wheeled walker and wheelchair for assistive devices. R15's care plan lacked direction for the restorative walk to dine program. R15's PT - Therapist Progress & Discharge Summary form dated 3/6/17, indicated R15 had been discharged to SNF (skilled nursing facility). The form included a recommendation for R15 for walk to dine program. At the time of discharge R15 walked 150 feet. Pt completed a Therapy Communication to Nursing form dated 3/6/17, recommending R15 for the walk to dine program. Review of an untitled and undated form provided by the facility, identified as the nurse aide care guide, identified multiple interventions for R15 which included assist of one staff for ambulation.	F 311	A newly revised Restorative "Resident Walk-to-Dine" Program has been developed which includes reviewing residents to determine who could benefit from a walk-to-dine program as screened and recommended by physical therapy. This has been done for existing residents and will be part of the admission criterion for any newly admitted resident. According to this program, each resident entered into the restorative program will be assisted in their ambulation to the dining room for meals on a routine basis and this will be documented. Audits will be done by the DON or her designee weekly x 4 of (3) walk-to-dine residents (or all walk-to-dine residents if less than (3) exist) and then monthly thereafter to ensure that the ambulation is being done routinely for the walk-to-dine resident and that it is being documented. The DON will repot monthly to the QA Committee on this program. Compliance alleged by 6-16-17	

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F 311	Continued From page 13 It further directed R15 to walk to all meals and staff was to follow with a wheelchair. The form instructed staff to tell the nurse if R15 refused to walk. Review of R15's progress notes from 3/20/17, to 4/26/17, lacked documentation regarding R15's walking program or rationale for why R15 was not walked to meals as recommended by therapy. On 4/27/17, at 11:27 a.m. R15 was seated in a standard wheelchair in her room with her feet on the floor. No foot pedals were attached to the wheelchair. Nursing assistant (NA)-C entered R15's room and informed her it was time to eat. R15 independently propelled herself with her feet in her wheelchair while NA-C walked beside her down the hall to the nursing station. NA-C walked away from R15 when they were near the nursing station. NA-A then pushed R15 down the hall into the dining room to her table. NA-C and NA-A had not assisted R15 to ambulate to the dining room nor had they offered assistance with ambulation. During interview on 4/27/17, at 12:23 p.m. R15 indicated she routinely used her wheelchair to move around the facility. She stated sometimes she used her walker, when staff assisted her. However she indicated staff had not offered assistance with walking for a long time. R15 stated she would like to walk and she would like to try ambulating again. Review of R15's task titled "walk in corridor" from 3/20/17, to 4/ 27/17, revealed R15 had received her ambulation program 4 of 39 days. All entries were documented as non applicable with the exception of the following:	F 311		

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F 311	Continued From page 14 -3/20/17, two persons physical assistance with support provided -3/25/17, day shift resident refused -3/31/17, at 2:35 p.m. total dependence; full staff performance -4/4/17, at 2:59 p.m. resident refused -4/9/17, at 1:11 p.m. independent,-no help or staff oversight at any time -4/10/17, at 5:05 p.m. limited assistance -4/11/17, at 9:39 a.m. Resident Refused -4/13/17, at 8:19 p.m. Resident Refused On 4/27/17, at 2:28 p.m. NA-H indicated staff did not routinely assist R15 to walk. NA-H indicated R15 used her wheelchair to get around the facility and the walker to transfer from bed. On 4/27/17, at 2:38 p.m. registered nurse (RN)-A indicated R15 routinely used her wheelchair to go to the dining room. RN-A indicated R15 had received therapy in the past and she understood R15 had a restorative program in place. She understood R15 was on a walk to dine program, but did not know why it was not being implemented. On 4/27/17, at 3:02 p.m. assistant director of nursing (ADON) confirmed R15 was to have a walk to dine program in place. She confirmed R15 had not consistently received the walk to dine program. The ADON stated they did not have a "true restorative program" at this time. The ADON also stated there was a new computer program and was unaware how to access the information. The ADON stated she would expect the nursing staff to offer to ambulate R15 to the dining room or notify the nurse if R15 refused. On 4/27/17, at 3:41 p.m. R15 was seated in a	F 311		

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F 311	Continued From page 15	F 311		

standard wheelchair in her room. Her feet were on the floor, no foot pedals were on the wheelchair. The ADON applied a gait belt (devise staff hold onto when transferring or ambulating a resident) to R15's waist and placed her walker in front of her. The ADON assisted R15 to stand and ambulate while the ADON held onto the gait belt with the wheelchair being pulled behind her. R15 was able to ambulate over 130 feet before asking to sit down. R15 stated she could feel it in her knees after walking, but did not appear distressed.

On 4/27/17, at 4:10 p.m. the director of nursing (DON) indicated she would expect therapy recommendations for a restorative program to be implemented. The DON stated if a resident refused the program she would expect the nurse to discuss the risks and benefits of the program with the resident.

On 4/28/17, at 9:04 a.m. during follow up interview, the DON confirmed R15's care sheet directed staff to assist R15 with the walk to dine program. The DON confirmed nursing staff had not assisted R15 with the walk to dine program and could not locate in the clinical record for why the program was not being implemented. The DON indicated if R15 refused, she would expect then nursing staff to notify the nurse and document. The DON confirmed the walk in corridor task documentation. She indicated she felt the staff did not know how to utilize the form and would educate them.

On 4/28/17,at 4:40 p.m. director of rehabilitation (DOR) stated during telephone interview when a resident is discharged from their therapy program, therapy notified the charge nurse of any

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F 311	Continued From page 16 recommendations that needed to be added to the care plans. The DOR stated she would expect nursing staff to follow the recommendations given or contact the therapy department if unable to follow them. A facility policy titled Restorative Guideline, last reviewed 7/21/16, included: The living center provides a restorative nursing program with interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible. Nursing rehab/restorative care includes interventions that assist or promote the resident to maintain or improve his or her functional status.	F 311		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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 record review the facility failed to provide assistance with oral cares for 1 of 3 residents (R20) who was totally dependent on staff for activities of daily living (ADLs). Findings include: R20's quarterly minimum data set (MDS) dated 4/5/17, identified R20 had severe cognitive impairment and was totally dependent on staff for activities of daily living (ADLs). R20's care area assessment (CAA) dated	F 312	F312 R20 is receiving assistance with his oral cares as per a new “Resident Oral Cares” Program; this care is done Q-shift for R20. Residents throughout the facility have been evaluated for oral cares needs and where found, interventions have been instituted including putting them into the new “Resident Oral Cares” Program. Nursing staff have been trained on the elements of the new “Resident Oral Cares” Program described below. Nursing has also developed a “Resident	6/16/17

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F 312	Continued From page 17 1/18/17, identified R20 was unable to swallow or eat food. The CAA further identified R20 had broken teeth and the facility was unable to find a dentist. R20's care plan dated 2/7/17, identified R20 was at risk for dental problems and required assistance with oral cares. The care plan further identified a licensed nurse was to monitor and try oral cares every shift and as needed (PRN) and record cares in the electronic treatment record. The care plan indicated R20 would receive dental care as needed. On 4/26/17 from 7:15 a.m. to 12:30 p.m. R20 was observed to have a yellow, thick film under the top lip. R20's mouth and lips appeared dry sticky. R20's teeth were broken and dark yellow. Toothette's were observed to be across the room in a box on the shelf. On 4/26/17, at 2:15 NA-A stated R20 had cognitive impairment and required total assistance with ADLs. She stated R20 had toothette's to clean his mouth and thought R20's mouth was supposed to be cleaned twice per day. She stated she performed R20's morning cares this morning and she didn't clean R20's mouth today because she didn't have time. She stated she wasn't sure if the nurse did oral cares for R20 today or not. On 4/26/17, at 2:31 p.m. the assistant director of nurses (ADON) stated nursing assistants and nurses were to perform oral cares for R20 because R20's mouth "got so bad so quick". She stated oral cares were not assigned a specific number of times per day, and the NA's should have cleaned his mouth with the toothette this	F 312	Oral Care Program" which includes daily oral care intervention and additional care as needed for residents who are unable to provide themselves with oral care. This oral care program includes assisting residents with brushing teeth and/or swabbing the oral cavity with toothettes, providing dentures care, and any other care necessary including setting up dentistry interventions as needed. Daily review of resident oral needs is done and interventions provided as necessary which are also care-planned. The DON or her designee will perform weekly audits x 4 and then monthly thereafter to ensure that each resident on the new "Resident Oral Cares" Program is receiving the oral care required by the program. The DON will report monthly to the QA Committee on this program. Compliance alleged by 6-16-17	

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F 312	Continued From page 18 morning. On 4/26/17, at 2:48 p.m. NA-B stated R20 required total assistance with ADLs and had cognitive impairment. She stated staff used the toothette's to clean R20's teeth and thought oral cares were to be done in the a.m. and p.m. NA-B stated she wasn't sure if oral cares were done today for R20. On 4/27/17, at 9:30 a.m. the ADON stated R20 had severe cognitive impairment and was totally dependent on staff for ADLs. She stated it depended on the staff person if they used a regular tooth brush or the toothette's for R20's mouth care. She stated she thought the nurse did oral cares with morning medications before breakfast. She stated oral cares were listed on the NA care sheet under eating and confirmed the NA care sheet identified oral cares were to be done every shift. She stated she thought he needed oral cares even more often than per shift. She confirmed R20 had a history of the green thick ring on the upper lip from phlegm coughed up and couldn't get out of his mouth so it sat there. She stated R20 mouth breathed so his mouth dried out. She stated R20 really needed all of his teeth pulled. She stated she wanted the nurses to perform all oral cares because they can check his mouth and monitor for problems each shift. She stated she expected oral cares for R20 to be done each shift and PRN for R20's comfort. Review of the facility Oral Hygiene policy dated 1/20/16, identified oral hygiene was to be performed to clean resident's mouths and teeth, prevent infection and irritation, moisten mucous membranes and promote personal hygiene.	F 312		

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F 314	Continued From page 19	F 314		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to implement interventions to prevent the further development pressure ulcers for 1 of 1 residents (R20) who had reoccurring deep tissue injuries (DTIs) to his left heel. Findings include: R20's heels were not elevated off the bed with pillows and protective heel boots were not used according to manufacturer's instructions to reduce pressure to R20's heels. R20's quarterly minimum data set (MDS) dated 4/5/17, identified R20 had severe cognitive impairment and was totally dependent on staff for	F 314	F314 Interventions have been re-established to protect R20's heels from breakdown which include changing his position while in bed on a (2) hour time-table, applying blue protective boots to protect his heels from breakdown and the feet from rotating outward, thereby preventing any pressure and resulting damage to the outer aspect of the heel and foot and the nerves and vessels of the same area (the boots are designed to do this). Additionally, based on the training below, staff is applying the boots for R20 properly and performing any physician required treatments to the heels. Residents throughout the facility have	6/16/17

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F 314	Continued From page 20 activities of daily living (ADLs). The MDS further identified R20 had developed a DTI/unstageable pressure ulcer since his last assessment. R20's care area assessment (CAA) dated 1/12/17, identified R20 was at risk for developing pressure ulcers due to immobility, had a history of pressure ulcers and used boots to protect his feet and for positioning. R20's care plan dated 2/7/17, identified R20 was at risk for developing pressure ulcers and was to wear blue heel boots all the time for pressure prevention to R20's lower extremities and staff was to elevate and offload heels from the bed. On 4/25/17, during continuous observation from 1:35 p.m. to 3:19 p.m. R20's heels were not elevated by pillows and rested directly on the mattress. Both R20's feet were rotated outward in the blue heel boots which applied direct pressure to the outside of both R20's feet and heels. The following was observed: - 1:35 p.m. R20 was in his bed flat on his back with his eyes closed. R20 was dressed in a hospital gown and had blue protective boots on both feet. R20's heels were not elevated off the bed with pillows and R20's feet were rotated outward in the blue protective boots on the bed which applied direct pressure to both R20's feet and heels. - 1:57 p.m. no change in R20's position - 2:19 p.m. R20's feet remained rotated outward and R20's left foot had slight tremors resting on the mattress	F 314	been evaluated to determine if any other has been effected by this deficient practice; this includes determining if any other resident requires turning and repositioning to prevent skin breakdown, any of them require protective heel boots to protect the skin of their heels and/or to keep the feet from rotating outward, thereby compromising the skin of the outer heels, the nerves, and the vessels. Nursing has developed a new “Resident Heel Protective Program” in conjunction with the National Pressure Ulcer Advisory Panel (NPUAP) guidelines on resident skin care and pressure ulcer prevention. Accordingly, residents whose Braden Scale scores (or actual jeopardy for heel skin breakdown) are provided with protective boots or heel floating while in bed – or both as ordered by the physician. The use of these boots goes along with turning and repositioning – as needed – to prevent skin breakdown. A review of all residents currently in house has been done to determine who has heel breakdown concerns and requires the intervention of this program. The DON or her designee will conduct an audit weekly x 4 weeks and then monthly thereafter to ensure that any resident for whom an order for protective heel boots has been initiated is receiving application of the boots as ordered, floating, turning and repositioning, and any other relevant application in accordance with the National Pressure Ulcer Advisory Panel (NPUAP) guidelines for preventing skin breakdown and maintain skin integrity. The DON will report on this program	

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F 314	Continued From page 21 - 2:44 p.m. R20's feet remained rotated outward and R20 continued to slightly tremor on the mattress - 3:19 p.m. there was no change in R20's position. On 4/25/17, at 3:35 p.m. registered nurse (RN-A) stated R20 had a sore on his left heel but it was healed now. She stated interventions to protect R20's heels was for R20 to wear the blue protective boots on both feet all the time and paint the left heel with betadine twice per day. She stated she felt R20 could either wear the boots or have his heels elevated with a pillow. She stated it was hit or miss when they elevated R20's heels with a pillow. RN-A confirmed R20's heels were not elevated off the bed with a pillow and stated she felt he didn't need the pillow under his heels because he wasn't sliding down in bed. RN-A also confirmed both R20's feet were rotated outward in the blue boots. On the side of R20's heel was an intact, darker pigmented area which measured approximately 0.3 cm x 0.2 cm and a large thick pink scar on the outside of R20's foot near his heel. On 4/26/17, during continuous observation from 7:15 a.m. to 10:15 a.m. R20's heels were not floated off the bed and R20's protective boots were not applied correctly to reduce pressure to R20's heels. The following was observed: - 7:15 a.m. R20 was in his bed with his eyes closed and was dressed in a hospital gown. R20 laid flat on his back and wore blue protective boots on both bare feet. R20 had a pillow under his calves which flexed R20's legs at the knees and both heels rested directly on the mattress.	F 314	monthly to the QA. Compliance alleged 6-16-17.	

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F 314	Continued From page 22	F 314		

Both of R20's feet were rotated outward which applied direct pressure to the outside of R20's feet and heels.

- 7:45 a.m. no change in R20's position

- 8:20 a.m. nursing assistant (NA-A) entered R20's room and closed the door

- 8:30 a.m. NA-A left R20's room and walked down the hallway toward the nurses station

- 8:46 a.m. R20 was in his bed with eyes closed. R20 laid flat on his back, was now dressed and had thin black socks and blue protective boots on both feet. Both of R20's feet were rotated outward which put direct pressure on the outside of both R20's feet and heels. R20's heels were not floated off the bed with pillows.

- 9:18 a.m. no change in R20's position

- 9:26 a.m. no change in position

- 10:15 a.m. no change in position

On 4/26/17, at 11:00 a.m. the assistant director of nursing (ADON) confirmed R20's heels were not elevated off the bed with pillows and R20's feet were both rotated outward. She stated the pillows were to prevent new pressure ulcers and prevent reoccurring DTI's. She stated she didn't know why R20's heels were not elevated with pillows and stated they should have been. She said she has had to get on her staff and remind them to elevate R20's heels with pillows. On the side of R20's heel was an intact, blanchable slightly darker pigmented area which measured 0.3 cm x 0.2 cm and a large thick pink scar on the outside

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F 314	Continued From page 23 of R20's left foot near his heel. On 4/26/17, at 11:27 a.m. R20 had on black thin socks and blue protective boots on both feet. Both of R20's feet were rotated outward which put direct pressure on the outside of both R20's feet and heels. R20's heels were not floated off the bed. At 12:30 p.m. there was no change in R20's position. On 4/25/17, at 3:52 p.m. NA-B stated she was unaware R20 ever had any problems with the skin on his heels or feet. She also stated R20 had moderate cognitive impairment and required total assistance with his ADLs. On 4/25/17. at 3:55 p.m. during follow-up interview RN-A stated the sores on R20's feet were likely caused from pressure. She stated R20 had problems with his left foot in the past and stated she wasn't sure if he was admitted with them or not. She stated she felt R20 had severe cognitive impairment and required total assistance with ADLs. On 4/26/17, at 2:15 p.m. NA-A stated R20 was confused and required total assistance with ADL's. She stated R20's heels and foot had broken down in the past and they started to use the blue protective boots for R20's feet. She stated R20's heels and foot had broken down because R20 rubbed his foot on the wooden footboard on the end of his bed. She stated interventions to protect R20's heels included putting socks on him, the protective boots and to apply lotion to his skin after his baths. She stated she wasn't sure if R20's heels were supposed to be elevated off the bed or not, she stated she just found out they were supposed to do that a couple	F 314		

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	245540	A. BUILDING _____ B. WING _____	04/28/2017

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F 314	Continued From page 24 days ago. On 4/26/17, at 2:48 p.m. during follow up interview NA-B stated she was unaware R20 was supposed to have his feet elevated off the bed with a pillow. She stated the blue boots were to protect R20's feet and to ensure R20's feet didn't touch the foot of the bed and were to prevent sores. On 4/27/17, at 9:33 a.m. the assistant director of nurses (ADON) stated R20 had severe cognitive impairment and required total assistance with ADLs. She stated R20's skin was intact on admission and R20 was at risk for developing pressure ulcers. She stated R20 developed a DTI which measured 4.9 centimeters (cm) by 3.4 cm. to the outer part of his left foot on 8/20/16 from pressure as R20 rubbed and pushed his feet on the footboard of his bed. They implemented the blue protective boots after R20 developed the first DTI 8/20/16, and R20 developed a second DTI 9/2/16, while wearing the boots. She stated interventions to prevent the development of further DTI's were to continue betadine, the protective boots at all times and R20's heels were to be elevated off the bed with pillows. She stated both DTI's were healed on 12/8/16. They continued to use the protective blue boots and R20 developed another DTI on 2/7/17. She stated she wasn't sure what the source of pressure was which caused the DTI. The DON stated they started using pillows to elevate R20's heels and ensure his heels were kept off the bed after he developed the DTI on 2/7/17. She stated if R20's heels were elevated with pillows she felt their interventions would be effective. She stated she expected staff to use the pillows to elevate R20's heels all the time when he's in bed.	F 314		

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F 314	Continued From page 25 On 4/27/17, at 3:49 p.m. the director of nurses (DON) stated she was aware R20 had recurrent DTI's and they were all caused from pressure. R20 pushed his feet against the footboard of his bed. She stated R20 was supposed to wear the protective boots all the time and staff were to elevate R20's heels off the bed with a pillow to keep his heels off the bed. She stated she expected R20 to wear the protective boots and R20's feet would be kept in a neutral position to prevent pressure and DTI's to those areas. The DON stated she felt their previous interventions were not totally successful and didn't prevent the reoccurrence of DTIs for R20. She stated she expected staff to follow R20's care plan to reduce pressure to his heels and prevent further development of DTI's. Review of the manufacturers guidelines for the Prevalon Heel Protector I identified to prevent pressure ulcers the boot prevented the foot from rotating outward and protected the nerves in the foot and leg. Review of the facility policy Skin Integrity Guideline dated 2014, identified the facility would decrease pressure ulcer and wound formation in residents who were at risk by implementing appropriate interventions.	F 314		
F 315 SS=D	483.25(e)(1)-(3) NO CATHETER, PREVENT UTI, RESTORE BLADDER (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is	F 315		6/16/17

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F 315	Continued From page 26 or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently provide toileting services to maintain bladder function to the highest extent possible for 1 of 1 residents (R11) reviewed for urinary incontinence. Findings include:	F 315	F315 A comprehensive bladder assessment has been completed for R11. R11 is receiving toileting assistance as per her bladder assessment and care plan. R11's care plan and CNA care sheets have been updated to reflect his toileting needs.	

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F 315	Continued From page 27 R11's quarterly Minimum Data Set (MDS) dated 1/16/17, identified R11 had severe cognitive impairment, required extensive assistance with transfer and toileting, was always incontinent of urine, continent of bowel and was not on a toileting plan. R11's care plan revised 4/10/17, identified R11 was blind, hard of hearing and had the potential for alteration in elimination of bladder due to required extensive assistance with toileting tasks and frequent incontinence of bladder. The care plan contained conflicted directions: assistance of one to two staff to toilet, check and change every two hours and as needed, and scheduled toileting plan of offer toileting every two hours and as needed, check and change at the same time. The undated nursing assistant care sheet identified R11 was incontinent of bladder and continent of bowel. Required limited assistance with peri cares, wore a brief at bed time and check and change every two hours during the night. On 4/26/17, at 12:15 p.m. nursing assistant (NA)-A propelled R11 in his wheel chair to his room from the dining room. NA-A pulled back the blankets on the bed, removed R11's foot peddles from the wheelchair, applied a gait belt around R11's midsection and assisted him to stand with the use of a walker. R11 walked a few steps to the bed and sat on the edge. NA-A removed the gait belt, lifted R11's legs on to the bed, clipped the call light on to R11's shirt and pulled the blankets up. R11 asked where the call light was, and what time and day it was. NA-A answered R11's questions, offered R11 head phones and to turn off the overhead light and left the room.	F 315	Other facility Residents have been reviewed to determine that bladder assessments have been completed as required and that interventions with care planning have been implemented where necessary. Nursing staff have been in-serviced on the necessity of completing bladder assessments as required and on the program stated below. In particular, the MDS Coordinator has been in-serviced on being accurate and complete when it comes to doing bladder assessments, including the review of (3) day bladder tracking, POC documentation, staff and resident interviews. A new program has been developed which consists of a computer-based tickler file; the DON has a file on her computer that lists all resident names and the status of their bladder skills, incontinent, partially, continent. This file also lists the interventions being used for each resident. One block in the file, for each resident, allows the DON to check-off when a comprehensive bladder assessment has been done for residents for whom it is indicated. The DON will check this program weekly, update it as necessary, and review bladder assessments, whether they have been done, are pending, or still need to be done. Audits will be conducted on (3) Residents weekly x 4 weeks and then monthly thereafter by the DON or her designee to validate that resident toileting needs have been accurately assessed; this will include a review of the resident status, toileting	

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F 315	Continued From page 28 On 4/27/17, at 12:47 p.m. R11 was seated in a wheelchair in the television area by the nurses desk. R11 stated, "I should go to the bathroom." NA-D propelled R11 to his room, applied the gait belt around his midsection and walked R11 to the bathroom with a walker. R11 was assisted on to the toilet, urinated in the toilet and was assisted by NA-D to pull up his brief and sweat pants. At 12:54 p.m. NA-D verified R11's brief was dry and he had voided on the toilet. NA-D indicted she had assisted R11 to the toilet before dinner and R11 was dry at that time. The facility Bowel and Bladder Record Data Collection Tool dated 4/5/17, identified R11 was incontinent of urine three times and aware of the need to void five times in a 24 hour period. 4/6/17, was incontinent 4 times and aware of the need to void six times in 24 hours. 4/7/17, identified R11 was incontinent three times and aware of the need to void seven times in 24 hours. The facility Bladder Assessment Form dated 4/10/17, identified R11 had incontinence without sensation of urine loss, most likely experienced stress and functional incontinence and was not appropriate for toileting or retraining program. The assessment form Bowel and Bladder Summary identified the following: Resident is always incontinent of bladder, reports that he is unaware of need to toilet. Per direct care staff charting, 3 day bowel and bladder record, resident is always incontinent, no pattern. Staff check and change Q 2 HR (every two hours) and PRN (as needed). Unable to alert staff of need to toilet, check and change Q 2 HR and PRN. Care plan reviewed and updated.	F 315	behaviors, and bladder assessments. Audit results will be reported monthly by the DON to the QA. Compliance alleged by 6-16-17	

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On 4/26/17, at 12:20 p.m. nursing assistant NA-A indicated R11's usual morning routine was to use the bathroom before lunch, lay down after lunch and use the call light when he is ready to get up again. NA-A indicated R11 will ask to use the bathroom but if he has not asked and has not gone to the bathroom for a while NA-A will encourage R11 to use the bathroom.

On 4/27/17, at 8:29 a.m. NA-H indicated R11 was able to make his needs known and would ask to use the bathroom if he wanted to, however; NA-H was only aware of one instance in which R11 requested to use the bathroom and voided on the toilet. NA-H indicated she would assist R11 to sit on the toilet in the morning upon waking and change his brief which was usually wet. NA-H indicated R11 was often able to stay dry during the day and his brief was not wet each time it was checked. NA-H indicated R11's brief was checked after breakfast and was usually dry. NA-H indicated R11 would be changed if the brief was wet because he was to be checked and changed every two hours.

On 4/27/17, at 8:59 a.m. NA-I indicated the usual practice was assisting R11 to the bathroom when he requested it. NA-I identified R11 was able to stay dry through out the day, knew if he needed to use the bathroom and was only incontinent of urine when he was asleep.

On 4/27/17, at 9:03 a.m. NA-D indicated R11 wore an incontinent brief because of accidents. NA-D identified she asked R11 every two hours if he needed to use the bathroom. NA-D indicated R11 did not answer yes or no but would sit on the toilet with encouragement and at times would be

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F 315	Continued From page 30 able to void when on the toilet. On 4/27/17, at 9:31 a.m. licensed practical nurse (LPN)-B indicated R11 was incontinent of urine, however: at times asked to use the toilet. LPN-B verified R11 was on a check and change plan for incontinence care. LPN-B indicated during the night R11's brief was checked and changed quickly and then he was able to go back to sleep. LPN-B was unaware of the reason R11's plan would be to check and change his brief during the day. LPN-B further indicated if R11's brief was dry he should be encouraged to go on the toilet. On 4/27/17, at 2:48 p.m. the assistant director of nursing (ADON) verified the nursing assistants cared for each resident using the provided care sheets. The ADON verified the facility practice was to asses resident's bladder control quarterly with information provided from nursing assistant charting and a three day bowel and bladder form. The ADON verified R11's bladder assessment indicted R11 was incontinent of urine and his brief was to be checked and changed every two hours and as needed. The ADON verified a check and change program was a plan for someone who did not use the toilet. With review of the three day data collection tool for 4/5/17, 4/6/17 and 4/7/17, the ADON identified it appeared a toileting plan may be appropriate for R11 to remain dry at times. The ADON verified she had completed the assessment but it may have been a different resident. The ADON indicated she would complete a new bladder assessment. On 4/27/17, at 3:06 p.m. the director of nursing (DON) identified the purpose of a toileting assessment and plan was to try to prevent skin break down, if possible reverse incontinence	F 315		

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F 315	Continued From page 31 problems or regain bladder control. The DON indicated to accomplish this, the assessment would need to be completed as appropriately as possible. The DON identified with the assessment a plan is formed, placed in the care plan and on the nursing assistant paper copy that is carried with them for resident care. The DON verified she would like residents to remain as continent as possible. The facility policy titled Incontinence Management/Bladder Function Guideline, reviewed 1/19/15, identified the purpose of a bladder management program as follows: Enable the resident to control urination without a catheter whenever possible, Avoid possibility of urinary infection, Prevent skin problems such as pressure areas and excoriation, Improve morale of the resident, Restore the residents dignity, Manage urinary incontinence, restore of maintain as much normal bladder function as possible, and Prevent skin problems.	F 315		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and	F 322		6/6/17

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F 322	Continued From page 32 (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the enteral/ gastric tube (G-tube) was flushed with water prior to and after medication administration. In addition, failed to ensure medications were given separately and with water flushes between each medication for 1 of 1 residnets (R20) who received medications via a G-tube. Findings include: On 4/24/2017, at 5:23 p.m. registered nurse (RN)A dispensed R20's metoprolol (heart medication) 100 mg (milligrams) and liquid Keppra (seizure medication) 12.5 ML (milliliters). RN-A crushed the metoprolol and gathered the items needed for R20's medication administration. RN-A placed the crushed metoprolol into a disposable cup with the Keppra liquid. RN-A disconnected R20's tube feeding, checked placement of the G-tube by placing air in to the tubing with the medication syringe and listening with a stethoscope. RN-A placed the medication syringe into the G-tube and poured the mixture of Keppra and metoprolol into the syringe. The mixture did not flow through the tubing. RN-A added water to the syringe, lowered the head of the bed, attempted the push the medication into the tubing, however it did not flow	F 322	F322 R20 is receiving medication and water flushes via G-tube according to policy. Licensed staff have received education on administration of medications via G-tube. Return demonstration of administration of medication via G-tube will be completed on all licensed nurses. Audits of administration will be completed twice weekly. Negative results will be addressed immediately. Results of audits will be reviewed at QAPI for need to continue. DON is responsible.	

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through. RN-A expelled the medication mixture into an empty container and flushed the G-tube with water which did flow through the tubing. RN-A poured the medication mixture into the G-tube, reconnected the tube feeding and gathered items used for administering medications.

On 4/24/17, at 5:30 p.m. RN-A verified the observation as accurate. RN-A identified the usual practice was to complete the water flush after the medication mixture went through the G-tube, however, it ended up getting mixed with the medications.

On 4/27/17, at 11:31 a.m. the pharmacy consultant (PC) was interviewed via telephone. The PC indicated for correct G-tube medication administration the facility staff would be expected to follow the the facility policy.

On 4/27/17, at 3:17 p.m. the director of nursing (DON) indicated facility staff was to follow the facility policy for medication administration by a G-tube. The DON identified the G-tube should be flushed with 15 milliliters (ml) of water prior to medication administration, between each medication and after the final medication. The DON indicated crushed medications were to be dissolved in water and not dissolved in a liquid medication.

The facility policy titled General Guidelines for Administering Medication Via Enteral Tube dated 6/15, identified Enteral tubes are flushed with at least 15 ml of purified or sterile water before administering medications, between each medication, and after all medications have been administered. Use purified or sterile water for

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F 322	Continued From page 34 mixing and diluting medications, and for flushing. Crushed medications are not mixed together. The powder from each medication is mixed with 15 - 30 ml water (purified or sterile) before administration. Each medication is administered separately to avoid interaction and clumping. The enteral tubing is flushed with at least 15 ml of water between each medication to avoid physical interaction of the medications.	F 322		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		6/6/17

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F 431	Continued From page 35 (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure resident medication labels were only altered by appropriate personnel for 3 of 3 medications reviewed. findings include: On 4/27/17, at 9:52 a.m. during medication administration with licensed practical nurse (LPN)-B, R24 was observed to have a medication card with an altered label. The medication label was Risperdone 0.5 mg take 1 tablet by mouth	F 431	F431 All medications not properly labeled have been removed from the medication cart. Licensed staff have received education on the policy/procedure for medication labeling. Audits will be completed weekly on medication labels to insure they are properly labeled. Medications with altered labels will be removed from the medication cart. Direction change stickers will be used on labels until pharmacy can provide new labels. Audit	

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	245540	A. BUILDING _____ B. WING _____	04/28/2017

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F 431	Continued From page 36 twice daily (BID). The card had been altered with the following: give 2 tabs 4/25/17 dose (with an arrow pointing up) written with black magic marker. On 4/27/17, at 10:07 a.m. during medication administration with licensed practical nurse (LPN)-B, R3 was observed to have two medication cards with altered labels. The two medication labels were Gabapentin 100 mg take 1 capsule by mouth twice a day (BID). The card had a medication change label on it. The medication change label had 2 caps BID written on it with a black marker. On 4/27/17, at 3:17 p.m. the director of nursing (DON) reviewed the facility medication label policy. The DON verified her understanding was only pharmacy personnel can relabeled medications. On 4/27/17, at 10:40 a.m. the director of nursing (DON) indicated when medication directions changed, the medications were sent back to the pharmacy to be repackaged or staff would use a pink or orange highlighter on the medication label. The DON indicated when the next supply of medications came in the directions would be correct. The DON verified the medication labels had been altered. On 4/27/17, at 11:31 a.m. via telephone the pharmacy consultant (PC) explained, only pharmacy can change medication labels and pharmacy can not come to the facility to relabeled medications. However; a sticker could be applied to the medication by staff to alert of a change and to direct to the MAR (medical administration record) for the new direction for the medication	F 431	results will be reviewed at QAPI for continued need. DON is responsible.	

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F 431	Continued From page 37 administration. The PC identified it was not appropriate for facility staff to alter labels with highlighter's or relabeled medications, as it is not within their scope of practice. The PC identified the expectation was for facility staff to be educated to use an axillary sticker to alert of a change. It is not appropriate for them to highlight the labels. The facility policy titled Medication Labels dated 5/2012, identified Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy/registered pharmacist can modify, change, or attach prescription labels.	F 431		

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	245540	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/26/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Henning Rehab & RHCC 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Healthcare Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/31/2017

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

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K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Henning Rehab & RHCC is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II (111) construction. In 1963 an addition was constructed to the north of the original building, is 1-story, without a basement and Type II (111). In 1988, an addition was constructed to the south that was determined to be of Type II (000) construction which is not separated from the original building. The building is protected throughout by an automatic fire sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems. The	K 000		

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K 000	Continued From page 2 facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" . The facility has a capacity of 42 beds and had a census of 21 at time of the survey. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET	K 000		
K 321 SS=D	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A	K 321		6/6/17

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K 321	Continued From page 3 a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of staff . Findings include: On the facility tour between 8:30 am to 12:00 pm on 04/26/2017 observations and staff interview revealed the storage room in the basement did not have an automatic or self closer. This was confirmed by the facility Maintenance Manager.	K 321	K321 – A new door closer was purchased and installed 5-12-17	
K 363 SS=F	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least	K 363		6/6/17

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K 363	Continued From page 4 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide two sets of corridor doors with a means suitable for keeping the door closed and resist the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting all of the 21 residents and an undetermined amount of staff and visitors.	K 363	K363 – Latches have been purchased. These are exactly the same as were installed in Moorhead Rehabilitation & Healthcare Center and inspected by the Fire Marshall. They will be installed by 6-6-17 by Maintenance Director.	

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K 363	Continued From page 5 Findings include: On the facility tour between 8:30 am to 12:00 pm on 04/26/2017 observations and staff interview revealed the clean linen storage spaces on both the north and south wings did not have a means suitable for keeping the doors closed or resist the passage of smoke. This was confirmed by the facility Maintenance Manager.	K 363		