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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PB7Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00942

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245270**

2. STATE VENDOR OR MEDICAID NO. (L2) **823957600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WHITEWATER**
(L4) **525 BLUFF AVENUE**
(L5) **ST CHARLES, MN** (L6) **55972**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **04/01/2006**

6. DATE OF SURVEY **07/14/2016** (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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertsin, HFE NE II 7/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 7/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30) **00**
VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245270

July 22, 2016

Ms. Margaret Holm, Administrator
Golden LivingCenter - Whitewater
525 Bluff Avenue
St Charles, MN 55972

Dear Ms. Holm:

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

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

Effective July 7, 2016 the above facility is certified for:

55 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 55 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 22, 2016

Ms. Margaret Holm, Administrator
Golden Livingcenter - Whitewater
525 Bluff Avenue
St Charles, MN 55972

RE: Project Number S5270025

Dear Ms. Holm:

On June 14, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 19, 2016. (42 CFR 488.422)

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of June 2, 2016.

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 14, 2016. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on April 14, 2016 and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on June 2, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 14, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 2, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 2, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 2, 2016, as of July 7, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 7, 2016.

In addition, CMS Region V Office has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 14, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 14, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 14, 2016, is to be rescinded.

In our letter of June 14, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 14, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 7, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245270 Y1	A. Building B. Wing Y2	7/14/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280	Correction	ID Prefix F0281	Correction	ID Prefix F0282	Correction
Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(i)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	07/07/2016	LSC	07/07/2016	LSC	07/07/2016
ID Prefix F0329	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.25(l)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	07/07/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	7/22/2016	34985	7/14/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PB7Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00942

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245270**

2. STATE VENDOR OR MEDICAID NO. (L2) **823957600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WHITEWATER**
(L4) **525 BLUFF AVENUE**
(L5) **ST CHARLES, MN** (L6) **55972**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **04/01/2006**

6. DATE OF SURVEY **06/02/2016** (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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 06/21/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/22/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00454** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 14, 2016

Ms. Margaret Holm, Administrator
Golden LivingCenter - Whitewater
525 Bluff Avenue
St. Charles, MN 55972

RE: Project Number S5270025

Dear Ms. Holm:

On April 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 14, 2016. 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 2, 2016, the Minnesota Department of Health and on May 31, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 22, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on April 14, 2016. The deficiencies not corrected are as follows:

F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
F0281 -- S/S: D -- 483.20(k)(3)(i) -- Services Provided Meet Professional Standards
F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective June 19, 2016. (42 CFR 488.422)

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 14, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 14, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 14, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden Livingcenter - Whitewater is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 14, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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:

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 14, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	R 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE ST CHARLES, MN 55972**

(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 An onsite post certification revisit (PCR) was completed on May 31, 2016, June 1 & 2, 2016. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	{F 280}		7/7/16

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

Electronically Signed | 06/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	R 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE ST CHARLES, MN 55972**

(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 280}	Continued From page 1 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care according to assessed needs for 1 of 3 residents (R12) reviewed for comprehensive care plan accuracy based on the comprehensive assessments. Findings Include: R12 was admitted to the facility on 1/7/16 according to the facility face sheet. The face sheet reflected the addition of diagnoses of depression on 3/7/16. R12's quarterly Minimum Data Set (MDS) dated 3/21/16 reflected diagnoses of depression and received antidepressant medication. The MDS indicated R29 had minimal depression with a Patient Heath Questionnaire score of 2. R12's physician orders provided dated 5/31/16 included Celexa 10 milligrams (mg) daily for major depressive disorder with a start date of 3/7/16 and Remeron (anti-depressant medication with a side effect of increased appetite) 15 mg daily for appetite with a start date of 4/11/16. R12's electronic care plan provided by the facility did not reflect a plan of care for depression management and psychotropic medication monitoring of identified mood symptoms. On 6/01/2016, at 2:41 p.m. the director of nursing (DON) stated behavior monitoring for rejection of cares was implemented for R12 instead of	{F 280}	F280 -R12 care plan has been amended to include monitoring of identified mood symptoms. -Residents with a diagnosis of depression have the potential to be affected if a plan of care is not developed to address monitoring of identified mood symptoms. -RNAC has been re-educated on development of a care plan to address monitoring of identified mood symptoms. -Care plan audits will be conducted on 3 residents weekly with a diagnosis of depression to insure identified mood symptoms are addressed. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. -DNS will be responsible party. -Corrective action will be completed by 07/07/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	R 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE ST CHARLES, MN 55972**

(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 280}	Continued From page 2 identified mood symptoms and confirmed the facility had not identified mood symptom to be monitored. The DON reviewed R12's care plan confirmed a care plan for mood monitoring and interventions was not implemented.	{F 280}		
{F 281} SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin administration was performed according to manufacturer's instructions for 2 out of 3 residents (R7, R41) observed for administration of an insulin pen system. Findings include: R7 was observed on 5/31/16 at 11:37 a.m. when licensed practical nurse (LPN)-A prepared R7's Novolog insulin pen. R7's scheduled dose was five units plus eight units sliding scale for a total of 13 units. LPN-A removed the cap from the insulin pen, wiped the tip with an alcohol swab, applied the needle, twisted the dial to 13 units then twisted the dial up two units and then back down to 13 units. LPN-A administered the Novolog pen to R7. Immediately after the adminsitration LPN-A stated, "I went to 13 [units] and added two [units] then twisted back to 13 [units]. That was priming it." This was in response to being questioned about priming the pen before giving the insulin.	{F 281}	F281 -Insulin administration is being performed according to manufacturer's instructions for R7 and R41. -Residents receiving insulin administration have the potential to be affected if administration is not performed according to manufacturer's instructions. -Licensed nurses have been re-educated on performing insulin administration according to manufacturer's instructions. -Audits will be completed 3 times weekly on insulin administration. Negative findings will be corrected immediately. Results will be reviewed at QAPI. -DNS is responsible. -Corrective action will be completed by 07/07/2016	7/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	R 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE ST CHARLES, MN 55972**

(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 281}	Continued From page 3	{F 281}		

R41 had been observed on 5/31/16 at 11:47 a.m. LPN-B prepared R41's Novolog insulin pen. R41's scheduled dose was seven units plus one unit sliding scale for a total of eight units. LPN-B removed the cap, wiped the tip with an alcohol swab, applied the needle, and reapplied the cap. Twisted the dial to two units and pushed the button. Then twisted the dial to eight units and adminsitered. Immediately following the adminsitration LPN-B stated, "They told us to do it with the cap on. It would spill all over everything. I don't know that anything came out." This was in response to being questioned about priming the pen before giving the insulin.

On 5/31/16 at 3:21 p.m. the director of nursing stated, "They should be following the manufacturer's instructions. Both [LPN-B and LPN-A] were instructed on how to use the pens."

Facility All Staff In-Service Meeting-Nursing indicated LPN-A and LPN-B received insulin pen procedure training on 4/19/16 at 1:30 p.m. Facility Novolog FlexPen insulin pen competency steps 8-11 read, "Removes protective seal from new safety needle and screws on to pen. Dials a test dose of 2 units. Holds the pen upright and taps to being any bubbles to the top. press the INJECT button all the way and checks that insulin has come out of the needle. The dial will return to "0" if this occurs. This step may be repeated up to 6 times to ensure priming. If unable to prime after 6 attempts, replaces pen. Once primed, checks window is reading "0."

Manufacturer's instructions Novolog FlexPen 4 Simple Steps for Use step two reads, "Performing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	R 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE ST CHARLES, MN 55972**

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{F 281}	Continued From page 4 the airshot before injection: Turn the dial to 2 units. Holding Novolog FlexPen with the needle pointing up, tap the reservoir gently with your finger a few times. With the needle still pointing up, press the push button as far as it will go and see if a drop of insulin appears at the needle tip. If not, repeat this procedure until a drop of insulin appears. If no drop appears after 6 airshots, do not use Novolog FlexPen..."	{F 281}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan for oral cares for 2 of 3 residents (R16 and R41) reviewed for dental status. Findings include: R16's care plan dated 7/7/15, identified physical functioning deficit related to mobility impairment with interventions of personal Hygiene assistance: set up and assist resident to complete personal hygiene, does not have teeth or dentures per his request, oral care assistance set and cue to swab mouth. On 6/01/2016, 7:20 a.m. R16 was observed to be independently complete his morning cares for the day. R12 was observed to dress himself,	{F 282}	F282 -Care plans for oral care have been reviewed and revised as needed for R16 and R41. R16 and R41 are receiving oral care per their plan of care. -Residents requiring assistance with oral cares have the potential to be affected if cares are not provided per the plan of care. -Nursing assistants have been re-educated on providing oral cares per the plan of care. -Audits will be completed 3 times weekly on oral cares being provided per the plan of care. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. -DNS is responsible.	7/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	R 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE ST CHARLES, MN 55972**

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{F 282}	Continued From page 5 brush his hair, wash his hands in the sink in the bathroom, turn the light off in his room and wheel himself to the dining room. R12 was not observed to swab his mouth. On 6/01/2016, at 8:20 a.m. nursing assistant (NA)-A had assisted R16 to from his chair while in the bathroom. During this observation NA-A did not set up or cue R16 to swab his mouth. On 6/01/2016, at 8:28 a.m. NA-A stated she thought R16 had dentures and brushed his own teeth. NA-A stated she would help R16 with oral cares if he asked for help. On 6/01/2016, at 11:30 a.m. the director of nurses (DON) stated staff should have offered to assist R16 with oral care this morning per the care plan. The DON stated staff were educated to make sure they were following the care plan for resident as a part of the facility plan of correction. R41's care plan dated 4/20/16, identified physical functioning deficit related to: mobility impairment with interventions of oral care assistance: resident does not have any teeth or dentures, resident told his nurse he had lost dentures prior to admission, resident has not had any desire to get new denture, staff to offer swabs to swab out mouth, dental exams as necessary. R41's care plan also identified nutritional risk due to being on a mechanically altered therapeutic diet with interventions dated 3/11/16: aspiration precautions to be taken, supervision/assist with intake, provide oral cares 3-5 times per day, especially after eating and drinking. R41's nursing assistant care plan, undated, read; "No teeth-provide oral cares 3-5 times/day especially after eating and drinking."	{F 282}	-Corrective action will be completed by 07/07/2016	

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	245270	A. BUILDING _____ B. WING _____	R 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE ST CHARLES, MN 55972**

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{F 282}	Continued From page 6 On 6/1/16 at 7:49 a.m. morning cares were completed by nursing assistant (NA)-A. Morning cares did not include oral cares. R41 was propelled in his wheelchair to the dining room following morning cares. R41's room included a bright green sign that read, "Remember oral cares to be offered after every meal. Swab only (moistened) patient usually aspirates thin liquid." At 8:58 a.m. NA-A propelled R41 to his room, placed wheelchair near the television and gave R41 a call light. NA-A then left the room. At 11:09 a.m. NA-A stated, "We do his cares after meals. I forgot to do it this morning." adding, "He doesn't like it when we do it. he doesn't like the sponges." NA-A did not return to complete or cue resident to complete oral care. On 6/1/16 at 12:52 p.m. the director of nursing stated that R41 should at least be offered oral care.	{F 282}		
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	{F 329}		7/7/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	R 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE ST CHARLES, MN 55972**

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{F 329}	Continued From page 7 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify and monitor mood symptoms to justify the ongoing use of an antidepressant for 1 of 1 resident (R2) who used an antidepressant for depression. Findings Include: LACK OF MOOD MONITORING TO JUSTIFY THE ONGOING USE OF AN ANTIDEPRESSANT: R12 was admitted to the facility on 1/7/16 according to the facility face sheet. The face sheet reflected the addition of diagnoses of depression on 3/7/16. R12's quarterly Minimum Data Set (MDS) dated 3/21/16 reflected diagnoses of depression and received antidepressant medication. The MDS indicated R29 had minimal depression with a Patient Heath Questionnaire score of 2. R12's physician orders provided dated 5/31/16 included Celexa 10 milligrams (mg) daily for major depressive disorder with a start date of 3/7/16 and Remeron (anti-depressant medication with a side effect of increased appetite) 15 mg	{F 329}	F329 -Mood symptoms have been identified and monitoring of mood symptoms for use of an antidepressant is being completed for R12. -Residents receiving antidepressant medication have the potential to be affected if mood symptoms are not identified and monitored for ongoing use. -RNAC and SSD have been re-educated on identifying and monitoring of mood symptoms for residents receiving antidepressant medication. -Audits will be conducted weekly for monitoring mood symptoms of residents receiving antidepressant medication. Negative findings will be corrected immediately. Audit results will be reviewed at QAPI. -DNS is responsible. -Corrective action will be completed by 07/07/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	R 06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	**525 BLUFF AVENUE ST CHARLES, MN 55972**

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{F 329}	Continued From page 8 daily for appetite with a start date of 4/11/16. R12's electronic care plan provided by the facility did not reflect a plan of care for depression management and psychotropic medication monitoring of identified mood symptoms. R12's record did not reflect documentation of mood monitoring. R12's physician visit note dated 3/7/16 reported, "He has been more depressed acting, "and "he has a very flat affect," and "I am going to start him on a low dose Citalopram [Celexa]." Physician visit note dated 3/22/16 included, "He has chronic major depressive disorder." The physician remarked R12 was tolerating medication. On 6/01/2016, at 2:41 p.m. the director of nursing (DON) stated behavior monitoring for rejection of cares was implemented for R12 instead of identified mood symptoms due to depression and confirmed the facility had not identified mood symptom to be monitored. The DON reviewed R12's care plan confirmed a care plan for mood monitoring and interventions was not implemented.	{F 329}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245270 Y1	A. Building B. Wing Y2	6/2/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0155	Correction	ID Prefix F0241	Correction	ID Prefix F0250	Correction
Reg. # 483.10(b)(4)	Completed	Reg. # 483.15(a)	Completed	Reg. # 483.15(g)(1)	Completed
LSC	05/22/2016	LSC	05/22/2016	LSC	05/22/2016
ID Prefix F0278	Correction	ID Prefix F0279	Correction	ID Prefix F0309	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.25	Completed
LSC	05/22/2016	LSC	05/22/2016	LSC	05/22/2016
ID Prefix F0314	Correction	ID Prefix F0323	Correction	ID Prefix F0406	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.45(a)	Completed
LSC	05/22/2016	LSC	05/22/2016	LSC	05/22/2016
ID Prefix F0428	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.60(c)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed
LSC	05/22/2016	LSC	05/22/2016	LSC	05/22/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	6/14/2016	06/14/2016	31221	6/2/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245270	A. Building 01 - MAIN BUILDING 01 B. Wing	5/31/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0025	Correction Completed 04/12/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 6/14/2016	**SIGNATURE OF SURVEYOR** 37008	**DATE** 5/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/12/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PB7Q

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00942

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245270**

2. STATE VENDOR OR MEDICAID NO. (L2) **823957600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WHITEWATER**
(L4) **525 BLUFF AVENUE**
(L5) **ST CHARLES, MN** (L6) **55972**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **04/14/2016** (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 **55** (L18)

13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Christina Smith, HFE NE II 05/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 05/23/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(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
April 26, 2016

Ms. Margaret Holm, Administrator
Golden LivingCenter - Whitewater
525 Bluff Avenue
St Charles, MN 55972

RE: Project Number S5270025

Dear Ms. Holm:

On April 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the April 14, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5270012 that was found to be unsubstantiated.

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

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

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

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

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

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

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 May 22, 2016, 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 May 22, 2016 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 14, 2016 (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 14, 2016 (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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245270	A. BUILDING _____ B. WING _____	04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WHITEWATER	525 BLUFF AVENUE ST CHARLES, MN 55972

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. "A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaint H5270012 was completed and found not to be substantiated.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's	F 155		5/22/16

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

Electronically Signed | 05/10/2016

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F 155	Continued From page 1 policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete risks and benefits for refusal to reposition for 1 of 1 resident (R10) reviewed for pressure ulcers. Finding Include: R10's record review revealed R10 had an unstageable pressure ulcer to his right heal and a stage three pressure ulcer to his right lateral calf and had a history of refusing to be turned and repositioned according to the care plan. R10's medical record lacked documentation of risks and benefits of refusal to reposition. R10's face sheet revealed R37 had diagnoses of quadriplegia C1-C4, flaccid hemiplegia affecting non-dominant left side, and major depressive disorder. The annual Minimum Data Assessment (MDS) dated 3/15/16, indicated R10 had two stage II pressure ulcers and a surgical wound. R10's most recent comprehensive skin assessment that also covered risks and benefits provided by the facility was dated 5/27/13, three years ago. R10's care plan dated 7/28/2010 included, "alteration in skin integrity related to history of	F 155	-R10 has had a risk and benefit completed for repositioning. Methods of care language are congruent with practice. -Residents wishing to refuse recommended plans of care have the potential to be affected if they acquire negative health outcomes and a risk and benefit has not been completed. -Licensed staff has been educated on completion of risk and benefit prior to allowing patterns of repositioning refusal/ non-compliance with recommended plan of care. -Random audits will be completed two times a week for 30 days on residents expressing patterns of refusal. Negative findings will be corrected immediately and will be reviewed at Quality Assurance and Performance Improvement (QAPI). -DNS/designee will be responsible. -Corrective action will be completed by 5/22/2016	

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F 155	Continued From page 2	F 155		

pressure ulcers & total assist needed with bed mobility. I tend to sweat. I tend to be noncompliant with turning and repositioning program." Interventions directed staff to, "educate me on the risks and benefits with being noncompliant with my turning and repositioning program, encourage turning and repositioning. Resident should be repositioned every 2 hours during day and every 4 hours at night. When up in chair declines to offload but shifts pressure by reclining electric wheelchair. Resident will sit in wheelchair for 8-10 hours at times per his request, offload feet when in bed and keep pressure off heels when in chair..."

R10's progress note dated 4/29/15, "included, "Skin: Resident currently has a stage II ulcer on center of left calf measuring 1.8 cm x 1.3 cm. Ulcer has a reddened area surrounding open area measuring 2.5 cm x 1.8 cm...He has a reddened area approx. [approximately] 2 inches below back of knee on left calf. Area was from cast rubbing on skin. He has a reddened heal that was from rubbing on cast...Resident is sometimes non-complaint with repositioning and gets up in his w/c [wheelchair] during the day without frequent repositioning according to his schedule. He is encouraged to off-load every 2 hours. He has a pressure redistribution mattress on his bed and Roho cushion in his chair..."

On 4/12/2016, at 2:22 p.m. licensed practical nurse (LPN)-A stated R10 will refuse to allow staff to reposition him during the day and stated he was very much in control of he cares and directed his cares. LPN-A stated R10 would allow staff to boost him in bed during the day and would allow staff to reposition him a couple of times at night.

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F 155	Continued From page 3 On 4/13/16, at 2:42 p.m. registered nurse (RN)-B asked surveyor would you have to complete a risk and benefits form on a resident that was alert and orientated and made his own decisions for repositioning, when surveyor asked RN-B if the facility had been able to locate the risk and benefits for refusal of repositioning for R10. On 4/13/2016, at 2:48 p.m. registered nurse (RN)-A stated R10 should be turned and repositioned every two hours and stated staff should notify the nurse if he did not allow staff to reposition him and a progress note should be made regarding his refusal. RN-A stated R10 directed his cares and allowed staff to reposition him when he wanted to be repositioned. On 04/14/2016, at 12:33 p.m. the DON stated she has been unable to find a risks and benefit form for ongoing refusal of turning and repositioning for R10. On 4/14/2016, at 1:51 p.m. RN-B stated R10 liked to direct his own care period, which was his right. RN-B stated R10 should have had a risks and benefits completed for his refusal to allow staff to turn and reposition him. A policy and procedure was requested for risks and benefits and was not provided.	F 155		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		5/22/16

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F 241	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure respect and dignity for a cognitively impaired resident with aggressive behaviors refused services for 1 of 1 resident (R29) and failed to ensure respect and dignity was promoted for 1 of 1 resident (R41) following a dining experience. Findings included; LACK OF HONORING RESIDENT'S REFUSAL OF MEAL: R29 was in his room laying on his back with his legs hanging over the edge of the bed during an observation on 4/12/16 at 8:44 a.m. Nursing assistant (NA)-F was in R29's room attempting to get him up to eat. R29 loudly exclaimed, "blow it out your [butt]!" and made several spitting noises at NA-F. NA-F stated, "ok" and turned and walked out of the room at 8:45 a.m. On her way out of the room registered nurse (RN)-B was standing just outside the door. NA-F reported to RN-B the resident had refused. RN-B then walked into the room and asked R29 if she could help with breakfast. R29 made a loud spitting noise in response to the question. RN-B continued to ask and rephrase the question several more times; after each question R29 became increasingly agitated and yelled, "get out of here!" Followed by a loud spitting noise. RN-B persisted until the resident called RN-B by name and loudly yelled "Get the hell out of here!". RN-B then asked the resident if she could help assist with putting his feet up in bed; R29 yelled, "I wouldn't do that if I were you, get the hell out!" RN-B then replied to	F 241	-All staff has been educated on dignity, respect, and communicating with vulnerable adults. -A therapy communication binder has been created as a tool to place recommendations in for staff to follow. -Random audits at varying meals times will be conducted two times a week for 30 days during the dining experience to monitor dignified communication and ensure resident centered care. Negative findings will be corrected immediately and will be reviewed at QAPI. -Random audits of therapy communication binder will be conducted two times per week for 30 days to ensure the follow through of therapy notices and staff knowledge and practice. -DNS/designee will be responsible. -Corrective action will be completed by 5/22/2016	

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F 241	Continued From page 5 R29, "you don't need to talk to us like that." RN-B left the room at 8:49 a.m., 4 minutes after the resident had requested to be left alone. R29's care plan provided by the facility on 4/14/16 identified diagnoses that included: psychosis, depressive type psychosis, frontotemporal dementia, major depressive disorder with psychotic behaviors, and dementia with behavioral disturbances. Target behaviors identified on the care plan included: yell and swear at others in room and out in the hallway, physical behaviors toward others, and throwing food trays onto the floor. The care plan lacked a plan of care for refusals. The care plan directed staff to: "offer choices and encourage to make decisions within ability," and "listen carefully validate verbal and non-verbal expressions", and "help me maintain my dignity," and "Please allow me to do what I am capable of doing, at my own pace in my own way even if it doesn't make sense to you," and Please remember that I am an adult and treat me accordingly." During an interview on 4/13/16, at 8:56 a.m. director of nursing (DON) indicated the nurse should have made sure the resident was safe and re-approached him at a different time. During an interview on 4/14/16, at 8:56 a.m. In response to the question, How should staff respond to refusals of care by R29?, licensed social worker (LSW) stated, "If at first he doesn't respond to redirection, staff should walk away and give a couple of minutes and re-approach at a later time." LSW indicated there should be a care plan for refusals of care. Facility policy Dignity last reviewed 3/31/16 reported, "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality." The	F 241		

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F 241	Continued From page 6	F 241		

policy indicated the social services will promote staff interactions which maintained their dignity included: speaking to residents in a friendly and patient manner, respecting residents' social status, speaking respectfully, and listening carefully, and promoting independence and dignity in dining, and assisting in daily care in a dignified manner.
Facility guideline Physical Aggression Towards Others last reviewed 11/25/15 included, "Aggression can be physical or verbal struggle to try to gain control or overcome a perceived threat from a person, situation, or an object. It is a severe behavioral symptom because of the potential harm to self or others." The guideline directed staff to separate the resident from the situation, "give the resident time and space to calm herself/himself down.", "unless care is an immediate need, have another associate attempt or try again at a later time. Try to fairly meet the needs and concerns of both parties, it does not matter who "is right ". Do not try to shame the resident. Tell the resident clearly what is and is not acceptable. "
LACK OF HONORING RESIDENT'S WISHES:

R41 was sitting in the main dining area in his wheelchair on 4/12/16, at 8:56 a.m. R41 requested to go back to his room, nursing assistant (NA)-A informed R41 he could not go back to his room because he had to stay up for a half hour after he ate. R41 then stated, "I want to go back to my room, I only ate my yogurt." Then Licensed practical nurse (LPN)-B offered R41 something else to eat. R41 refused the offer. LPN-B then offered R41 a drink of water, and R41 stated, "ok." LPN-A then reported to LPN-B that R41 had eaten one-half of his food. NA-F then informed R41, "We will take you to your

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F 241	Continued From page 7	F 241		

room in 10 minutes." R41 rolled his eyes and said "ok." During an interview on 4/14/16, at 10:00 a.m. R41 indicated the staff's response to his request made him feel like he was in jail, and it "doesn't feel very good."
During an interview on 4/12/16, at 8:59 a.m. LPN-B stated R41 had to wait to go back to his room for one-half hour because he was on aspiration precautions.
During an interview on 4/13/16, at 11:32 a.m. registered dietician (RD)-A stated R41 was on aspiration precautions related to history of silent aspiration. RD-A stated speech recommended R41 sit up after meals however, does not indicate where he needs to be sitting or required direct supervision for the one-half hours after meals.
During an interview on 4/13/16, at 11:37 a.m. director of nursing stated R41 did not require direct supervision after meals and could have sat in his room for the time recommended for speech therapy to sit up.
R41's facility face sheet included diagnoses of major depressive disorders, vascular dementia, and aspiration pneumonia. R41's significant change Minimum Data Set (MDS) identified R41 to have no cognitive impairment with a Brief Interview for Mental Status score of 13, and was dependent on two staff for transfers.
R41's care plan included provided by the facility on 4/14/16 included, "Speech recommendations 3/11/16: Aspiration precautions to be taken: supervision/assist with intake; provide oral cares 3-5 x/day, especially after eating and drinking; no straws, encourage small sips and bites; sit up right during intake and 20 minutes or more after meals. *PATIENT SILENTLY ASPIRATES*."
R41's care plan also included, "Help me maintain my preferences in my daily living", and "Offer choices and encourage to make decisions within

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F 241	Continued From page 8 ability."	F 241		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to address psychosocial needs in regards to chronic depression with desire to die for 1 of 1 resident (R41) who expressed he felt depressed and wanted to die. Findings include: R41 was admitted to the facility on 8/21/2013 and had diagnoses of major depressive disorder and vascular and frontotemporal dementia without behavioral disturbance. R41's annual Minimum Data Set (MDS) dated 3/22/16 reflected a decline or increase in frequency of depressive symptoms and development of new behavior pattern of rejecting/refusing cares when compared to previous assessments. The MDS dated 3/22/16 reflected minor depression with Resident Mood Interview (PHQ-9) score of 11; with thoughts of being better off dead 7-11 days out of a 14-day period. The quarterly MDS dated 1/5/16 reflected a PHQ-9 score of 11; with thoughts of being better off dead 2-6 days out of a 14-day period. The MDS dated 3/22/16 reflected rejection of care behavior occurred 1 to 3 days during the assessment period. The quarterly MDS dated	F 250	-R41 has received consultation from contracted psychologist, routine visit from Social Services (SS), and 1:1/weekly visits with Recreation Services. -R41 Care plan now reflects updated interventions. Provider has been updated on R41 status. SS has contributed specific approaches that include SS methods and techniques to address problems, needs and concerns. -Social Service Director, Department Managers, and Licensed staff has been educated on importance of timely and thorough documentation and appropriate follow up. Additionally, Licensed staff have been educated the importance of updating the Provider in a timely manner. -Weekly audits for 30 days on Minimum Data set (MDS) information will be conducted to ensure timely follow up with residents who reflect a decline or increase in frequency of depressive symptoms and development of new behavior pattern of rejecting/refusing cares when compared to previous assessments. Negative	5/22/16

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F 250	Continued From page 9 1/5/16 indicated no rejection of care behaviors. The 3/22/16 MDS assessment triggered a mood Care Area Assessment (CAA) for mood; the facility concluded mood required a plan of care. The facility summarized the mood condition and indicated the "Resident is at risk for further decline in mood. See care plan for details." The CAA also indicated a referral to another discipline was not warranted; no reason why was indicated. The CAA indicated the plan of care goal was to minimize risks. The mood plan of care included, "I am at risk for alteration in my mood/psychosocial wellbeing do to: diagnoses of depression, dementia, other medical diagnoses, nursing home placement, history of having thoughts of wishing I were dead, at times I feel sad, powerless, and lonely do to my medical diagnoses of dysthymic disorder as well as being far from home [town, and state] and away from my dog." The problem statement also included historical quarterly PHQ-9 scores: 10/19/15 PHQ-9 was 15, 1/5/16 PHQ-9 was 11, and 3/22/16 PHQ-9 was 11. The plan of care reflected no new interventions since 9/20/2013 and included: "Please tell my doctor if my symptoms are not improving to see if I need a change in my medication" "Psych services PRN [as needed]," and "SS [social services] to provide 1:1 visits PRN." The behavior plan of care included, "I am at risk for alteration in my behaviors as evidenced by I have medical diagnoses of delirium, dementia, other alteration in consciousness, CHF [congestive heart failure.], agent orange exposure along with other medical diagnoses. I utilize psychotropic medication. I will refuse medication/treatment at times because I do not feel that I need them or don't understand the	F 250	findings will be corrected immediately and will be reviewed at QAPI. -Social Service Director/designee will be responsible -Corrective action will be completed by 5/22/2016	

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reason I need them." The problem statement indicated no revision since 9/20/13 and the indicated goal of care as "behavior indicators will not increase" revised on 4/9/16. The plan of care reflected no new interventions since 9/20/13 and included:
"Notify MD of changes and assess the need for psych services PRN"
"Observe for any significant change in symptoms "
"Provide supportive 1:1 counseling PRN to encourage verbalization of feelings, fears, and frustration. Validate and reinforce resident's positive life experiences"
"Validate my feelings; problem solve."
The psychotropic drug plan of care included, "Potential for drug related complications associated with use of psychotropic mediations related to: Anti-depressant medication" dated 8/15/14. The plan of care reflected no new interventions since 8/15/14 and included:
"Provide medications as ordered by physician and evaluate for effectiveness."
"Refer to psychologist/psychiatrist for medication and behavior intervention recommendations."
R41's record reflected counseling services were provided by a licensed clinical psychologist on a regular basis from 8/20/15 through 1/28/16. No further services were evident after 1/28/16. The counseling case note dated 1/28/16 indicated prognosis for treatment was good and plan for monthly follow-up visits. During the time period when counseling services were provided in combination with the initiation of Celexa (antianxiety) reflected an overall improvement of mood scores when comparing the quarterly MDS dated 10/19/15 and the quarterly MDS dated 1/5/16. During the period when counseling services ended, The quarterly MDS reflected an

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increase in depressive mood symptoms and development of new rejection of care behaviors.
R41's nursing progress note dated 2/9/16, at 10:30 p.m. reported, "[R41] stated, "Ill probably be dead by the next time I see you." Asked why he said that and he said that was how he felt." R41's record did not reflect any interventions by the social worker or by nursing and did not reflect notification to the physician.
R41's nursing progress note dated 2/24/16, at 10:45 p.m. reported, "staff updated this writer that he was having a hard time breathing. Noticed increased in clear sputum. He stated he wanted to lay down in his bed. Asked if he wanted to go get evaluated he stated no, asked if he was certain and he stated that if he was going to die than I will die. Will follow up vitals." R41's record did not reflect any interventions by social worker or by nursing and did not reflect notification to the physician.
R41's nursing progress note dated, 3/31/16 included, "Resident has refused to eat much for supper for the past two nights. He doesn't like pureed food and only will eat pudding and ice cream. He also doesn't like thickened liquids." R41's record did not reflect follow-up with social services or nursing related to refusing to eat.
R41's nursing progress note dated 4/1/16 identified as annual assessment summary included, "He receives Wellbutrin SR [antidepressant] 100 mg bid [twice per day] and Celexa 20 mg for depressive disorder," and "care plan reviewed and updated appropriately." No further information pertaining to mental health status was addressed.
R41's record indicated the facility failed to ensure the care plan was followed evidenced by, the record did not reflect notification to the physician of increase in frequency of feeling of being better

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off dead obtained from the 3/22/16 MDS assessment in comparison to the previous quarter or notification to physician that mental health services had been stopped. The record did not reflect psychological services referral or involvement with the mood change or social services 1:1 one visits. R41's record did not reflect routine mood monitoring after the dose of Celexa was increased from 10 mg to 20 mg to determine effectiveness of the increased dose.
During an interview on 4/14/16 R41 stated, "I feel like I would be better off dead but I wouldn't hurt myself." R41 stated, he did not feel the facility was doing anything to help his depression. R41 reported the depression was caused form his wife and then his girlfriend left him and stated, "I don't feel like there is any joy in life." R41 explained the facility had referred me to mental health experts and the last visit was a couple of months ago, but was not sure how to tell if it was helping. R41 reported the last visit was a couple of months ago and did not know why the services had stopped. R41 stated, "Staff do not come in and talk to me about my depression, to my knowledge the social worker has not come in and visited with me about my depression." In response to the question, "Do you think if the social worker did make routine visits it would help?" R41 stated, "Well I don't know, it could. I just feel like I have no hope." With the conclusion of the interview, surveyor observed tears running down R41's left cheek.
During an interview on 4/14/16, at 12:26 p.m. social worker (SW) stated, "I don't have any documentation on 1:1 visits." In response to the question, "what was put into place after the assessment indicated an increase in frequency of symptoms and development of new behavior?" SW replied, "I can't answer if anything was put

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F 250	Continued From page 13 into place or not after the change in the MDS." SW indicated the rejection of care occurred on 3/22/16; and the resident refused a nebulizer breathing treatment that was necessary for him to maintain respiratory after recent hospitalization for pneumonia and could potentially cause a negative outcome by rejecting the treatment. SW stated R41 had thoughts of death because he is in a nursing home and there is nobody to talk to. Stated, "I don't have the documentation of any conversations." SW indicated she had notified the physician via email pertaining to the change in the MDS, however was unable to produce the email communication. SW indicated R41, did not get along with the psychologist, however the facility record and the counseling sessions did not reflect this concern or a plan to change mental health providers if there was a concern. During an interview on 4/14/16, at 1:14 p.m. director of nursing (DON) stated, changes to the mood should have been identified on the care plan and the change should have included notification to the physician. During an interview on 4/14/16, at 2:45 p.m., R41's medical doctor (MD)-A indicated typically the facility emails me with any changes but could not say for sure if she was notified following the 3/22/16 assessment. MD-A stated, "I have not been aware that there have been missed psychiatry visits." MD-A explained, "I don't think no matter what we do with him he is going to change." MD-A indicated they thought the resident was doing better despite how the resident answered the mood questions that indicated worsening depression. Facility policy Interdisciplinary Care Plan Social Services included, "Social services staff, as members of the interdisciplinary care plan team, will participate in the development of a	F 250		

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F 250	Continued From page 14 comprehensive care plan for each resident," "The interdisciplinary care plan is implemented to guide the LivingCenter in the provision of necessary care and services to attain or maintain the highest practicable, mental, and psycho-social well-being of the resident." "The social services staff will communicate mental and psychosocial problems, needs, and concerns to the interdisciplinary team for inclusion in the care plan. They will include: problems, needs, concerns, and strengths identified in the psychosocial assessment. Areas triggered on the MDS and identified on the CAA summary. Historical issues currently managed with interventions that place the resident at risk for decline in functioning. Non-triggered needs for which the resident requires on-going support." The policy also included, "The social services staff will contribute specific approaches inclusive of social services methods and techniques to address problems, needs, and concerns identified by the interdisciplinary team. The approaches will incorporate resident strengths and will be developed to enable residents to meet specific goals. The interdisciplinary care plan will be reviewed at least quarterly to evaluate effectiveness and be revised/updated as necessary to address resident needs in accordance with the most current assessment. Interventions that have proved ineffective must be changed on care plans immediately."	F 250		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		5/22/16

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F 278	Continued From page 15 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to accurately code the annual Minimum Data Set (MDS) for pressure ulcers for 1 of 2 residents (R10) reviewed for pressure ulcers. Finding Include: R10's face sheet revealed R37 had diagnoses of quadriplegia Cervical bone 1-Cervical bone 4, flaccid hemiplegia affecting nondominant left side, and major depressive disorder. The annual	F 278	-R10's MDS reflects accurate coding of wound sites. -Licensed staff have been educated on appropriate terminology and identification of wounds. Licensed staff has been educated on ramifications of falsification on documentation. -Weekly audits for 30 days to be conducted on MDS in regards to pressure ulcers to ensure coding is accurately recorded. Negative findings will be corrected immediately and will be	

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F 278	Continued From page 16 Minimum Data Assessment (MDS) dated 3/15/16, indicated R10 had two stage II pressure ulcers and a surgical wound. R10's wound monitoring that was initiated on 1/8/16, for a pressure ulcers that had developed in March 2015, revealed on 2/15/16, R10 had a stage III pressure ulcer to his right lateral calf, that measured length 2.4 centimeters (cm), width 0.3 cm, depth 0.2 cm. R10 was also identified to have a stage three right heal pressure on 2/15/16, which measured length 5.7 cm, width 4.5 cm. A right great toe wound was also being monitored by the facility, however was not identified as a pressure ulcer. On 4/13/2016, at 2:48 p.m. registered nurse (RN)-A stated she did her own measurements of R10's pressure ulcers when she completed an MDS. RN-A provided the wound measurements that she had taken, that were not a part of the medical record that she used to complete the annual MDS dated 3/15/16. The calf wound measurement was 6.4 cm x 0.3 x 0.2 and indicated it was a surgical wound. The toe area she had coded on the MDS as a stage II pressure ulcer indicated no open area, green drainage underneath the toenail. The heal measurement that she coded on the MDS as a stage II pressure ulcer was 5.7 x 4.5, no depth. On 4/13/2016, at 2:48 p.m. RN-A stated she coded the area on the right lateral calf as a surgical wound on the MDS as it had been debrided. On 4/14/2016, at 8:43 a.m. RN-A stated she had coded the MDS inaccurately for the three	F 278	reviewed at QAPI. -DNS/designee will be responsible -Corrective action will be completed by 5/22/2016	

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F 278	Continued From page 17 pressure ulcers. RN-A stated the pressure areas on the heal and the right great toe should have been coded as unstageable and the right lateral calf should have been coded as a stage three pressure ulcer. RN-A stated I just made a mistake, I do not have a good answer for it. On 4/14/2016, at 2:14 p.m. the director of nursing (DON) stated the annual MDS should have been coded a stage 3 pressure ulcer for the right heal and right lateral calf and the area on the right great toe was not caused by pressure and should have not have been coded as a pressure ulcer on the MDS. The DON confirmed by reviewing the annual MDS it was coded inaccurately as having two stage 2 pressure ulcers and a surgical pressure ulcer.	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		5/22/16

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F 279	Continued From page 18 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a comprehensive care plan to include target behaviors and mood symptoms for 1 of 5 residents (R31) reviewed for unnecessary medications. Findings include: R31 was admitted to the facility on 2/19/16. Admission Record indicated R31 carried diagnoses of dementia with behavioral disturbances, bipolar disorder (mental illness characterized by periods of depression and periods of elevated mood), major depressive disorder, and hallucinations. R31's Medication Administration Record (MAR) for 2/2016, 3/16, and 4/16 revealed he received Celexa (antidepressant), Depakote ER (mood stabilizer), Seroquel (antipsychotic) daily and Ativan (antianxiety) as needed. R31's care plan failed to identify target behaviors or mood symptoms. On 4/14/16 at 2:36 p.m. the director of nursing (DON) verified target behaviors and mood symptoms were not identified prior to surveyor bringing this to their attention on 4/12/16. A facility policy regarding comprehensive care plans was requested and not provided.	F 279	-R31's care plan reflects identification of targeted behaviors and mood symptoms -Staff has been educated on proper documentation when resident are having behavior to help identify psychosocial needs. - SS has been educated on importance of timely care planning. -Weekly audits to be completed on new admissions for 30 days to ensure accurate and timely care plan implementation. Negative findings will be corrected immediately and will be reviewed at QAPI. -DNS/designee will be responsible -Corrective action will be completed by 5/22/2016	

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F 280	Continued From page 19	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to revise the plan of care according to assessed needs for 3 of 5 residents (R16, R12 & R29) reviewed for comprehensive care plan accuracy based on the comprehensive assessments. Findings include: R16's annual Minimum Data Set (MDS) dated 3/11/16, identified R16 required extensive assist of one for transfers and ambulation and also	F 280	-R12, R16 and R29 care plans have been revised and updated from the most current comprehensive assessment. -RNAC and SS has been educated on importance of coding/documenting congruency -Audits to be completed quarterly to evaluate effectiveness and to be revised/updated as necessary to address resident needs in accordance with the most current assessment. Negative findings will be corrected immediately and	5/22/16

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F 280	Continued From page 20 received anticoagulation medication. R16's current physician orders, included an order with the start date of 4/6/16, for Coumadin (anticoagulant) 5 mg (milligrams) every Monday, Wednesday, Friday and 2.5 mg every Sunday, Tuesday, Thursday and Saturday. R16's medication administration record identified R16 was receiving coumadin as ordered. On 4/11/16, at 2:58 p.m., R16 was observed to have a dark purple bruise covering the entire top of his right hand. On 4/13/16, at 7:56 a.m., nursing assistant (NA)-C was observed to assist R16 transfer from his bed to a wheelchair. R16's care plan, dated 3/21/16, identified physical functioning deficit related to mobility impairment with interventions of extensive assistance of two for transfers using forward wheeled walker and gait belt. R16's care plan failed to include the use of Coumadin and the risk of bruising and bleeding. On 4/13/16, at 11:58 a.m., registered nurse (RN)-B verified R16 had a bruise on the top of his right hand. On 4/13/16, at 12:59 p.m.,RN-A verified R16's care plan read two assist for transfers and R16's annual MDS dated 3/11/16, read extensive assist of one for transfers. RN-A stated R16's care plan should have been revised to extensive assist of one for transfers. RN-A verified R16's care plan failed to include the use of coumadin and the risk for bruising and bleeding.	F 280	will be reviewed at QAPI. -Staff has been educated on appropriate methods/strategies for communication with vulnerable adults. DNS/designee will be responsible Corrective action will be completed by 5/22/2016	

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F 280	Continued From page 21 On 4/14/16, at 11:56 a.m., the director of nursing stated she would expect the care plan to be revised to reflect the annual MDS dated 3/11/16, for transfers and she would expect the use of Coumadin and the risk for bruising and bleeding to be care planned. The facility policy Interdisciplinary Care Plan, dated 4/1/16, indicated the interdisciplinary care plan will be reviewed at least quarterly to evaluate effectiveness and be revised/updated as necessary to address resident needs in accordance with the most current assessment. R12 was admitted to the facility on 1/7/16 according to the facility face sheet. The face sheet reflected the addition of diagnoses of depression on 3/7/16. R12's quarterly Minimum Data Set (MDS) dated 3/21/16 reflected diagnoses of depression and received antidepressant medication. R12's physician orders provided by the facility on 4/14/16 included Celexa 10 mg daily for major depressive disorder with a start date of 3/7/16 and Remeron 15 mg daily for appetite with a start date of 4/11/16. R12's electronic care plan provided by the facility on 4/14/16 did not reflect a plan of care interventions for depression management and psychotropic medication monitoring prior to 4/14/16. During an interview on 4/14/16, at 10:11 a.m. registered nurse (RN)-A indicated she was responsible for revising the care plans and stated, there should have been a plan of care for depression and psychotropic medication use. R29 was in his room laying on his back with his legs hanging over the edge of the bed during an observation on 4/12/16 at 8:44 a.m. Nursing	F 280		

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F 280	Continued From page 22	F 280		

assistant (NA)-F was in R29's room attempting to get him up to eat. R29 loudly exclaimed, "blow it out your [butt]!" and made several spitting noises at NA-F. NA-F stated, "Ok!" and turned and walked out of the room at 8:45 a.m. On her way out of the room registered nurse (RN)-B was standing just outside the door. NA-F reported to RN-B the resident had refused. RN-B then walked into the room and asked R29 if she could help with breakfast. R29 made a loud spitting noise in response to the question. RN-B continued to ask and rephrase the question several more times; after each question R29 yelled, "Get out of here!" followed by a loud spitting noise. RN-B persisted until the resident called RN-B by name and loudly yelled "Get the hell out of here!" RN-B then asked the resident if she could help assist with putting his feet up in bed and R29 yelled, "I wouldn't do that if I were you, get the hell out!" RN-B then replied to R29 "You don't need to talk to us like that." RN-B left the room at 8:49 a.m., 4 minutes after the resident had requested to be left alone.

R29's quarterly Minimum Data Set (MDS) dated 3/1/16 indicated diagnoses of dementia, anxiety, depression, and bipolar disorder. The MDS reflected moderate cognitive impairment with a Brief Interview for Mental Status score of 10 and had rejection of care behaviors 4-6 days out of seven days.

R29's annual MDS dated 12/16/15 reflected rejection of care behaviors 4-6 days out of seven and triggered a Care Area Assessment (CAA) to be completed. The facility indicated the behavior required further assessment and a plan of care for the behavior. The CAA included, "Resident has been showing an increase in physical behaviors which led to hospitalized in the psychiatric unit. Resident has diagnoses of

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F 280	Continued From page 23 bipolar disorder, anxiety disorder, vascular dementia w/out behavioral disturbance, psychosis, sleep apnea, major depressive disorder w/ [with] psychotic symptoms, frontotemporal dementia, and other medical diagnoses. Resident will yell/swear at staff, will refuse oxygen to be placed on or cares being provided by CNA [certified nursing assistance]. Resident is at risk for more frequent behaviors and/or refusal of cares." The CAA indicated behavioral symptoms would be addressed in the care plan however did not indicate what the objective or goal of the behavior plan of care would be. The CAA further indicated the hospital had referred R29 to an inpatient mental health unit. The CAA gave direction to see the care plan for more information. R29's care plan provided by the facility on 4/14/16 identified diagnoses that included: psychosis, depressive type psychosis, frontotemporal dementia, major depressive disorder with psychotic behaviors, and dementia with behavioral disturbances. Target behaviors identified on the care plan included: yell and swear at others in room and out in the hallway, physical behaviors toward others, and throwing food trays onto the floor. The care plan lacked an individualized plan of care for rejection/refusal of care behaviors that would prevent or reduce the risk of increasing R29's aggressive type behaviors of yelling and swearing at staff. During an interview on 4/13/16, at 8:56 a.m. director of nursing (DON) indicated the nurse should have made sure the resident was safe and re-approached him at a different time. During an interview on 4/14/16, at 8:56 a.m. In response to the question, How should staff respond to refusals of care by R29?, licensed social worker (LSW) stated, "If at first he doesn't	F 280		

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F 280	Continued From page 24 respond to redirection, staff should walk away and give a couple of minutes and re-approach at a later time." LSW indicated there should be a care plan intervention created for refusals of care. Facility guideline Physical Aggression Towards Others last reviewed 11/25/15 included, "Aggression can be physical or verbal struggle to try to gain control or overcome a perceived threat from a person, situation, or an object. It is a severe behavioral symptom because of the potential harm to self or others." The guideline directed staff to separate the resident from the situation by giving the resident time and space to calm herself/himself down. Also includes, Unless care is an immediate need, have another associate attempt or try again at a later time. Try to fairly meet the needs and concerns of both parties, it does not matter who "is right." Do not try to shame the resident. Tell the resident clearly what is and is not acceptable."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an initial care plan for falls for 1 of 1 resident (R71) reviewed for accidents and failed to prime an insulin pen prior to adminsitration for 1 of 2 residents (R25) observed during medication pass. Findings include:	F 281	-R71 Initial plan of care (IPOC) was made implemented and available to staff. -Licensed staff has been educated on importance of timely initial plan of care, implantation and accessibility. -Weekly audits for 30 days on all new admissions to be conducted to ensure timeliness of initial plan of cares. -Licensed staff has been educated on	5/22/16

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F 281	Continued From page 25 LACK OF DIRECT CARE ACCESS TO INITIAL CARE PLAN INTERVENTION FOR PREVENTING FALL/S: R71 was admitted to the facility on 3/25/16 with diagnoses that included malignant ovarian cancer, essential hypertension, lymphedema, osteoporosis, weakness, and second degree burns of the lower extremity according to the facility face sheet. R71's Clinical Health Status assessment dated 3/25/16 identified R71 was a fall risk related to three or more falls in the past three months, required the use of a wheel chair and walker, was chair bound, balance problem while standing and walking, lower extremity weakness, had hypotension, and took antihypertensive, cathartics, diuretics, narcotics, and psychotropic medications. R71 sustained a fall that resulted in two small abrasions on outer left thigh on 4/8/16. R71's record was reviewed on 4/12/16 and did not include an initial care plan (care plan initiated on admission to address immediate concerns identified until the Comprehensive care plan is developed) even though R71 had history of falls on admission. During an interview on 4/12/16, at 2:39 p.m. director of nursing (DON) verified R71's record did not include a plan of care for falls. DON indicated an initial care plan for falls should have been in place because of the high risk for falls. The DON stated the facility does a post fall risk assessment in the interdisciplinary meetings, and changes are applied to the care plan if needed. During an interview on 4/12/16, at 2:50 p.m. registered nurse (RN)-B stated "initial plans of care is on my to do lists, I don't think I have finished it yet." RN-B indicated she did not know	F 281	manufacture's recommendations on priming insulin pens. Competencies have been completed on licensed staff. -Audits will be completed two per week for 30 days on insulin administration to be conducted to ensure insulin pens are being primed by Licensed staff as recommended. -Negative findings will be corrected immediately and will be reviewed at QAPI. DNS/designee will be responsible Corrective action will be completed by 5/22/2016	

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F 281	Continued From page 26 where the initial care plan was. During an interview on 4/13/16, at 10:17 a.m. RN-B indicated she had found the completed initial care plan in a stack a papers on her desk and indicated it had not been implemented and placed into the R71's record. However, this initial care plan had not been available for staff who provided cares for R71 until this was brought to the attention of staff by surveyor. Facility policy Medical Record Content-Additional Content Requirements last reviewed 3/17/16 included, "Falls, On admission/readmission, residents are evaluated for fall risk utilizing the Clinical Health Status Form. Residents identified at risk will have an IPOC [initial plan of care]-fall risk initiated. The interdisciplinary team evaluated the fall prevention plan of care for residents "at risk" for falls. If resident falls the licensed nurse assess the resident for injuries and provides necessary treatment and initiates the Change in Condition Report-Post Fall/Trauma; the physician, family and others, as appropriate interventions are implemented; care plan is updated." LACK OF FOLLOWING MANUFACTURERS DIRECTIONS WHEN USING INSULIN PEN: R25 had been observed during a medication pass observation on 4/14/16, at 11:38 a.m., licensed practical nurse (LPN)-A obtained R25's blood glucose level, then verified Novolog insulin order for R25. LPN-A dialed pen (FlexPen) to 7 units, again verified the order for correct amount. LPN-A was asked if it was necessary to prime the pen prior to administration. LPN-A indicated she was not aware the pens needed to be primed and had previously not primed the pens when giving insulin to residents. Surveyor asked LPN-A to prime pen before administering the insulin to R25 in the abdomen.	F 281		

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F 281	Continued From page 27 R25's physician orders included Novolog flexpen solution pen injector 5 units subcutaneously at noon meal and supper, 7 units in the morning subcutaneously, and Novolog 2 units for blood sugars over 300 three times before meals. During an interview on 4/14/16, at 12:24 p.m. director of nursing (DON) indicated manufacturer's guidelines for the insulin administration should have been followed. A faxed statement from the facility received on 4/18/16, DON indicated the nurse had been nervous, staff received education on using the insulin pens in October 2015 which included directions to prime the pen prior to administration, however no evidence was provided compentency testing's had been completed. Package insert for Novolog FlexPen included; "Small amounts of air may collect in the cartridge during normal use. To avoid injecting air and ensure proper dosing: Turn the dose selector to 2 units. Hold your FlexPen with the needle pointing up, and tap the cartridge gently a few times, which moves the air bubbles to the top. Press the push-button all the way in until the dose selector is back to 0. A drop of insulin should appear at the tip of the needle."	F 281		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 282	-R (16,20,41,48 and 51) care plans have	5/22/16

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F 282	Continued From page 28 review, the facility failed to follow the care plan for fall interventions, fluid restriction and toileting for 1 of 2 residents (R16) reviewed for accidents; failed to ensure oral cares as per plan of care for 2 of 3 residents (R16 and R20) reviewed for dental status; failed to follow the care plan for the activity of music for 1 of 1 resident (R51) reviewed for activities; and failed to utilize palm guard interventions for 1 of 1 resident (R48) who had contractures. Findings include: LACK OF FOLLOWING FALLS INTERVENTIONS, FLUID RESTRICTION AND ASSISTANCE WITH TOILETING: R16's care plan dated 3/21/16, identified physical functioning deficit related to mobility impairment with interventions of personal Hygiene assistance: set up and assist resident to complete personal hygiene, does not have teeth or dentures per his request, oral care assistance set and cue to swab mouth, toileting extensive assistance of one, transfer extensive assistance of two using FWW (forward wheeled walker) and gait belt. Risk for falls related to new environment, history of falls, legally blind with interventions of nursing assess for pain every shift, observe for side effects of medications and notify physician of adverse side effects, restorative programs as needed, rubber soled footwear or gripper socks to prevent slipping. Alteration in elimination of bowel and bladder related to diuretic use & impaired mobility with interventions of provide extensive assist of one to toilet. Gastrointestinal distress due to gastro esophageal reflux disease with interventions of diet and fluid restrictions as ordered by physician	F 282	been reviewed and updated as needed to provide the services needed by qualified staff in accordance with each of the residents written care plan. -Staff have been educated and updated of ongoing monitoring to ensure the residents care plans are being followed. -Audits will be completed three times per week for 30 days to ensure residents written care plan is followed. -Negative findings will be corrected immediately and will be reviewed at QAPI. -DNS/designee will be responsible -Corrective action will be completed by 5/22/2016	

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and encourage patient to follow nutritional and hydration program. Impaired cardiovascular status related to congestive heart failure, coronary artery disease and hypertension with intervention of diet as ordered.

R16's current physician orders identified physical therapy recommendations: resident to ambulate one to two times a day with nursing using a FWW, gait belt and CGA (contact guard assist). Currently tolerates 30 feet. 1.5 liter fluid restriction, nursing must monitor fluid intake every shift for meals, snacks and medication passes. Resident is to receive 300 ml (milliliters) with each meal, 90 ml with each snack pass, and 110 ml with a.m. med pass, 110 ml with p.m. med pass and 110 ml with night med pass. Please monitor each shift to ensure resident does not go over the allowed amount per shift. Write progress note for any education provided/non-compliance every shift.

On 4/13/16, at 7:56 a.m., R16 was observed to be sitting on the edge of the bed and had bare feet (gripper socks were not in use). Nursing assistant (NA)-C had entered the room to provide morning cares. NA-C asked R16 if he was going to brush his teeth. NA-C was looking for R16's toothbrush and toothpaste and R16 stated to NA-C you are wasting your time I do not have any teeth and NA-C stated, "Oh." NA-C then assisted R16 to transfer from his bed into his wheel chair and R16 wheeled himself out of his room. NA-C failed to provide oral cares and assist of two to transfer.

On 4/13/16, at 8:35 a.m., NA-C stated she was not aware R16 was to have set up assist to cue and to swab mouth for oral cares. NA-C verified

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F 282	Continued From page 30 she had transferred R16 with one assist. On 4/13/16, at 8:54 a.m., NA-D was observed to approach R16 in his room and ask if he needed help going to the bathroom. NA-D was observed to walk out of R16's room and R16 proceeded to go into the bathroom by himself without assist. On 4/13/16, at 9:07 a.m., observation revealed R16 had an unopened 20 ounce plastic bottle of water, an opened 20 ounce plastic bottle of water (with 90 percent of the water drank) and a subway plastic cup with soda in the cup on his night stand. Review of R16's restorative program sheets indicated ambulate resident two times per day with FWW and CGA, tolerates 30 feet: resident will be able to walk with staff for 30 feet twice daily. The sheets identified from 1/1/16 through 4/10/16, documented (one time daily) for the month of January 2016, 19 days out of 31, February, 12 days out of 29 and March, 4 days out of 31 and April, no days documented out of 10. In addition, R16's record failed to include documentation of assess for pain every shift and observe for side effects of medications. On 4/13/16, at 11:58 a.m., registered nurse (RN)-B verified R16's care plan and physician orders as above. RN-B stated R16 was not supposed to self-transfer and should have at least one assist for safety for transfers. RN-B stated she would expect staff to assist with oral cares, assist with transfers for toileting and gripper socks to be on when in bed as per the care plan. RN-B observed the water and soda in	F 282		

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R16's room and stated the water and soda should not be in R16's room. RN-B stated staff should document the risk and benefits of being non-compliant regarding the fluid restriction. RN-B reviewed R16's record and stated there was no documentation regarding the risk and benefits for non-compliance with fluid restriction. RN-B stated assess for pain and observe for side effects would be set up as a nursing measure on the physician orders and would be documented on the medication administration record for residents. RN-B verified R16's record failed to include documentation for assess for pain every shift and observe for side effects of medications.

On 4/14/16, at 11:56 a.m., the director of nursing (DON) stated she would expect care plan to be followed for oral cares, transfers, gripper socks and fluid restriction. The DON stated R16 should not have free water in his room due to the fluid restriction. The DON stated if R16 was non-complaint with the fluid restriction she would expect staff to encourage R16 to follow the fluid restriction and staff to document R16's response. The DON stated she would expect the care plan to be followed to what the care plan directs and if staff were noticing something different, needs to be evaluated. The DON stated regarding the restorative program for R16, she would expect staff to document when they walk R16 anytime and if R16 refused staff should document the refusal. The DON stated she would expect pain and side effects of medications to be monitored as per the care plan.

The facility policy Restorative Guideline, dated 2/20/15, indicated Monitoring Compliance, The following elements are in place for the living center to demonstrate satisfactory compliance

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F 282	Continued From page 32 with guide: Documentation of treatment matches frequency and content as per plan of care. LACK OF FOLLOWING CARE PLAN INTERVENTIONS FOR ACTIVITIES OF DAILY LIVING: R20's care plan, dated 3/21/16, identified I have a physical functioning deficit related to impaired cognition: self-care impairment with interventions of oral care assistance: set up and cue resident to brush own dentures, soak dentures, and rinse mouth. Personal Hygiene: set up for personal hygiene and limited assist of one with all cares. On 4/13/16, at 8:40 a.m., R20 was observed to have his upper dentures in place. When queried if staff assisted him to brush his dentures this morning R20 replied the staff did not help, I usually do them myself, but too many mornings like that I do not do it. On 4/14/16, at 9:44 a.m., nursing assistant (NA)-B when queried if she assisted to brush R20's teeth this morning, replied she had provided a water cup and toothpaste and tooth brush to R20 and he attempted to brush the teeth in his mouth. When queried if R20 had removed his dentures from his mouth to brush them NA-B replied I did not think he wore dentures, he just brushed the teeth in his mouth. NA-B stated I do not work down here often. On 4/14/16, at 11:48 a.m., the DON stated she would expect if dentures are in they need to be cleaned and she would expect staff to know the resident had dentures. The facility policy Oral Hygiene, dated 1/20/16, indicated Dentures 2. Ask resident to remove	F 282		

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dentures or remove dentures for resident by gently lifting edge of denture to release. 3. Place dentures in container, brush under cool water with toothpaste. Inspect dentures for rough or broken areas. Report any repairs needed to charge nurse. 5. Assist resident to rinse mouth.

LACK OF PROVIDING ASSESSED MUSIC ACTIVITY WHEN IN ROOM:
R51's care plan, dated 3/25/16, identified I enjoy visits with my husband and children, eating ice cream, watching t.v. and eating lunch with him. I like to rest often and listen to music. Offer 1-1 short visits, I do enjoy music and watching what is going on. I need extra time to communicate. I cannot always answer. Offer musical, special events, socials, happy hour, parties, bingo, and religious services. Impaired neurological status related to dementia with interventions involve in activities that don't depend on patient's ability to communicate: music, parties, games. Involve in enjoyable activities which orient to reality and don't depend on orientation.

Review of R51's activity log sheets for the months of 11/15 through 3/16, identified the activity written as "music" had no documented marks to indicate the activity was provided.

On 4/13/16, at 10:01 a.m., observation of R51's room revealed a cassette disc (CD) player with a stack of CD's in front of the player and hand written note on top of the player that read, "Please play her cd's for her when she is resting, she likes that thank you."

On 4/13/16, at 11:09 a.m., R51 was awake and sitting in a Broda chair in her room. No music or television was on in the room.

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F 282	Continued From page 34 On 4/13/16, at 12:35 p.m., NA-D stated R51 enjoyed going to singing activities and ball exercise, but R51 mainly enjoys music activities. On 4/13/16, at 1:35 p.m., R51 was awake and sitting in a Broda chair in her room. No music or television was on in the room. At 2:55 p.m., R51 was laid in bed awake and no music or television was on in the room. On 4/12/16, at 3:23 p.m., activity director (AD)-A stated basically doing one to one activities with R51, real short visits. R51's husband visits frequently. AD-A stated R51 liked music on in her room and R51 really enjoys music. On 4/13/16, at 12:35 p.m., NA-D stated R51 enjoyed going to singing activities and ball exercise, but R51 mainly enjoys music activities. On 44/14/16, at 11:50 a.m., the DON stated she would expect staff to check with R51 if she wanted music on, because she can answer yes and no. The facility Individual Programming, dated 2/24/15, indicated programming will be offered to all residents who are unable or choose not to attend group activities. Individual programming ensures that all residents who are unable to or choose not to participate in group programs have consistent, goal-orientated and individualized recreation opportunities. The individual program will be scheduled based on resident preference as to day, time of day and duration. Each resident's individual program will include interventions which meet the resident's assessed social, emotional, physical, and cognitive	F 282		

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functioning needs. Activities should be adapted in various ways to accommodate the resident's change in functioning due to physical or cognitive limitations.

The facility policy Interdisciplinary Care Plan, dated 4/1/16, indicated the interdisciplinary care plan is implemented to guide the living center in the provision of necessary care and services to attain or maintain the highest practicable physical, mental, and psycho-social well-being of the resident and to promote the participation of the resident, family, or legal representative in planning care.

LACK OF FOLLOWING CARE PLAN IN REGARDS TO PALM GUARDS USED FOR CONTRACTURES:

R48's Admission Record revealed diagnoses to include spastic quadriplegic cerebral palsy, contracture of muscle, and profound intellectual disabilities.

R48's care plan dated 7/10/15 read, "I have a physical functioning deficit related to: self care impairment, mobility impairment secondary to spastic quadriplegic cerebral palsy...Bilateral palm guard on/am [a.m.] off/pms [p.m.]-change palm guards twice per shift and Hands washed with palm guard changes." The nursing assistant care plan undated read, "Bilateral palm guard on/am off/pms-change palm guards twice per shift and hands washed every am/pm."

R48 was observed on 4/14/16 at 8:24 a.m., 8:58 a.m. and 10:09 a.m., without palm guards on bilateral hands. At 2:23 p.m. R48 was observed to be wearing bilateral palm guards.

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F 282	Continued From page 36 On 4/14/16 at 10:23 a.m. the director of nursing stated, "She may not have her [palm] guards on because they are being washed." On 4/14/16 at 1:35 p.m. nursing assistants (NA) B and E stated R48 had braces for both of her hands, she wasn't wearing her hand braces because of cuts from the braces. NA-B read from the nursing assistant care plan, "The braces are on in the a.m. and off in the p.m." A facility policy on care plans was requested and not provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure monitoring of bruising for 1 of 3 residents (R16) reviewed for skin conditions. Findings include: R16's annual Minimum Data Set (MDS) dated 3/11/16, identified R16 received anticoagulation medication.	F 309	-R16's is being monitored. R16's care plan includes the use of Coumadin and the risk of bruising -Licensed staff have been educated of the importance of bruise monitoring and documenting the finding and additional follow up. RNAC have been educated and updated on the importance of timely care planning. Negative findings will be corrected immediately and will be reviewed at QAPI.	5/22/16

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F 309	Continued From page 37 R16's current physician orders, included an order with the start date of 4/6/16, for Coumadin (anticoagulant) 5 mg (milligrams) every Monday, Wednesday, Friday and 2.5 mg every Sunday, Tuesday, Thursday and Saturday. R16's medication administration record identified R16 was receiving the medication as ordered. On 4/11/16, at 2:58 p.m., R16 was observed to have a dark purple bruise covering the entire top of his right hand. R16's progress notes, identified R16 had a fall on 4/11/16, and R16 had a large bruise on top of his right hand. However, R16's record failed to include documentation of monitoring of the bruise and R16's care plan, dated 3/21/16, failed to include the use of Coumadin and the risk of bruising. On 4/13/16, at 11:58 a.m., registered nurse (RN)-B verified R16 had a bruise on the top of his right hand and stated the bruise occurred due to a fall the resident had on 4/11/16. RN-B stated the facility system for monitoring bruising was once identified there should be a nursing measure set up on the physician order to monitor the bruise until healed. RN-B reviewed R16's record and verified monitoring of the bruise had not been implemented. RN-B verified R16 was on Coumadin and R16's care plan failed to include the use of Coumadin and the risk of bruising. On 4/13/16, at 12:59 p.m., RN-A verified R16's care plan failed to include the use of Coumadin and the risk for bruising. RN-A stated she was responsible for revision of the care plans.	F 309	-DNS/designee will be responsible -Corrective Action will be completed by 5/22/2016	

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F 309	Continued From page 38 On 4/14/16, at 11:56 a.m., the director of nursing stated she would expect R16's bruise on top of his right hand to be monitored and the care plan to include the use of Coumadin and risk for bruising.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to document the start of a newly identified pressure ulcer, failed to complete comprehensive skin assessments and failed to initiate weekly wound monitoring at the time new pressure ulcers were identified for 1 of 2 residents (R10) reviewed for pressure ulcers. Finding Include: R10's face sheet revealed R37 had diagnoses of quadriplegia C1-C4, flaccid hemiplegia affecting nondominant left side, and major depressive disorder. The annual Minimum Data Assessment (MDS) dated 3/15/16, indicated R10 had two stage II pressure ulcers and a surgical wound.	F 314	-R10 receives weekly monitoring and measurements during wound rounds -R10's medical record contains recent comprehensive skin assessment that covers risk and benefits. -Licensed staff has been educated on re-or new admission residents entering the facility without pressure sores do not develop sores unless residents clinical condition demonstrates unavoidable. -Weekly audits will be completed for 30days to ensure current wounds are being documented. Negative findings will be corrected immediately and will be reviewed at QAPI. -DNS/designee will be responsible -Corrective Action will be completed by	5/22/16

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F 314	Continued From page 39 R10's record review for pressure ulcers during stage one of the survey process revealed R10 had an unstageable pressure ulcer to his right heal and a stage three pressure ulcer to his right lateral calf. R10's medical record lacked documentation of when the pressure ulcer was identified to his right heal, lacked a new comprehensive skin assessment after the pressure ulcers to his right heal and right lateral calf were identified, and lacked weekly wound monitoring by the facility for the two newly identified pressure sores until 1/8/16, when wound monitoring was implemented by the new director of nursing (DON) at the facility after she identified wound monitoring was not being completed for R10's pressure ulcers. However, record review revealed even after the DON implemented weekly wound monitoring on 1/8/16, measurements of the pressure ulcers were not completed on a weekly basis by the facility up to this survey. R10's physician nursing home visit documentation from one year ago dated 4/5/15, included, "Patient is seen for 2 issues today. Followup [sic] of multiple decubitus ulcers on his right lower leg. He is a tetraplegic [quadriplegia] from a previous spinal cord injury...skin is remarkable for the fact that he has this large open area on his right lateral calf. There is still a small area of necrotic tissue at the superior aspect of the wound...He has an ulceration on his right heel that is also improved...Assessment/Plan: 1. Multiple decubitus ulcers right leg. High risk for limb loss. Discussed with patient today..." R10's physician nursing home visit documentation dated 5/5/15, included, "Patient is	F 314	5/22/2016	

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F 314	Continued From page 40 seen today for ongoing issues related to right posterior thigh [calf] ulceration after a previous surgery, cast placement and subsequent fall with a fracture of his femur ...We have been having a hard time getting the posterior calf to heal. He stay is bed much of the time due to previous quadriplegia ...Extremities: Right posterior calf shows this is a central ulceration with a lot of dead tissue in it. It is actually red around the circumference than I had noticed previously ...Assessment/Plan: 1. Nonhealing ulceration of his right posterior calf. I am going to have him set up to see the wound clinic ... " R10's most recent comprehensive skin assessment that also covered risks and benefits provided by the facility was dated 5/27/13, three years ago. R10's wound monitoring that was initiated on 1/8/16, for a pressure ulcers that were developed in of March 2016, revealed on 4/12/16, R10 had a stage III pressure ulcer to his right lateral calf, that measured length 7 centimeters (cm), width 1.9 cm, depth 0.4 cm, with exposed tendons and a 1.3 cm x 0,9 cm area of eschar, exudate was bloody, consistency was thick, tissue surrounding the wound area was 1.3 cm of red tissue. R10 was also identified to have an unstageable right heal pressure on 4/12/16, which measured length 0.7 cm, width 0.4, dry eschar. R10's care plan dated 7/28/2010 included, "Alteration in skin integrity related to history of pressure ulcers & total assist needed with bed mobility. I tend to sweat. I tend to be noncompliant with turning and repositioning program." Interventions directed staff to, "Educate me on the risks and benefits with being	F 314		

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noncompliant with my turning and repositioning program, encourage turning and repositioning. Resident should be repositioned every 2 hours during day and every 4 hours at night. When up in chair declines to offload but shifts pressure by reclining electric wheelchair. Resident will sit in wheelchair for 8-10 hours at times per his request, offload feet when in bed and keep pressure off heels when in chair..."

On 4/12/2016, at 2:22 p.m. licensed practical nurse (LPN)-A stated R10 will refuse to allow staff to reposition him during the day and stated he was very much in control of his cares and directed his cares. LPN-A stated R10 would allow staff to boost him in bed during the day and would allow staff to reposition him a couple of times at night.

On 4/13/16, at 2:42 p.m. registered nurse (RN)-B asked surveyor would you have to complete a risk and benefits form on a resident that was alert and orientated and made his own decisions for repositioning, when surveyor asked RN-B if the facility had been able to locate the risk and benefits for refusal of repositioning for R10.

On 4/13/2016, at 2:48 p.m. RN-A stated she had identified lack of weekly wound monitoring for R10's pressure ulcers and had brought the lack of wound monitoring to the attention of the facility. RN-A stated the staff had started to do a better job of wound monitoring and stated it fell to the way side again. RN-A stated the facility had been completing wound monitoring sporadically. RN-A stated the facility should have been completing weekly wound monitoring of R10's pressure ulcers and stated weekly measurements were not completed. RN-A stated she did her own

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measurements of R10's pressure ulcers when she completed an MDS. RN-A stated R10 should be turned and repositioned every two hours and stated staff should notify the nurse if he did not allow staff to reposition him and a progress note should be made regarding his refusal. RN-A stated R10 directed his cares and allowed staff to reposition him when he wanted to be repositioned.

On 4/14/2016, at 9:24 a.m. the DON stated my expectation is wound monitoring and measurements of the wounds should be completed on a weekly basis if not more. The DON stated she noticed staff were not completely documenting on the wounds and stated they were not documenting the measurements. The DON had stated she was here about a month a before it became very apparent to her.

On 4/14/2016, 2:50 p.m. the DON stated a comprehensive skin assessment should be completed on a quarterly basis and when there was a change in a resident's skin condition. The DON stated at the time R10's cast was removed and the pressure ulcers were identified on R10's calf and heal, a comprehensive skin assessment should have been completed. The DON confirmed a comprehensive skin assessment was not completed at the time the cast was removed.

R10's record review revealed sporadic wound measurements were completed by the facility, however were not completed according to the undated Skin Integrity Guideline that instructed staff, "...The DNS [director of nursing] or designee will be responsible to implement and monitor the skin integrity program. Wound status

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F 314	Continued From page 43 is monitored on a weekly basis...Licensed nurse to document weekly on identified wounds using the wound evaluation flow sheet ..."	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure personal safety interventions were operationalize according to the care plan related to falls and mobility to prevent or decrease the risk of falls for 1 of 2 residents (R16) and failed to implement an initial care plan for 1 of 2 residents (R71) reviewed for accidents. Findings include: LACK OF FOLLOWING CARE PLAN INTERVENTIONS IN REGARDS TO FALLS PREVENTION: R16's annual Minimum Data Set (MDS) dated 3/11/16, identified R16 required extensive assist of one for transfers and ambulation. R16's care plan dated 3/21/16, identified physical functioning deficit related to mobility impairment with interventions of toileting extensive assistance of one, transfer extensive assistance of two using	F 323	-R16 care plan reviewed and updated as needed to ensure the environment remains as free of accident hazards as is possible and supervision/devices given if needed. -R71 care plan for falls was initiated and added to chart immediately when found. -Staff has been educated on the importance of initial care plan interventions for falls. -Licensed staff has been educated on documenting any changes seen in the resident and the proper team member to update for timely update of care plans. -Licensed staff has been educated on the post fall/trauma requirements and the care plans that need to be in place after the completion of the Clinical Health Status Form for new admission/readmitted residents. -Audits will be completed two times per	5/22/16

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F 323	Continued From page 44 FWW (forward wheeled walker) and gait belt. Risk for falls related to new environment, history of falls, legally blind with interventions of nursing assess for pain every shift, observe for side effects of medications and notify physician of adverse side effects, restorative programs as needed, rubber soled footwear or gripper socks to prevent slipping. Alteration in elimination of bowel and bladder related to diuretic use & impaired mobility with interventions of provide extensive assist of one to toilet. R16's current physician orders identified physical therapy recommendations: resident to ambulate one to two times a day with nursing using a FWW, gait belt and CGA (contact guard assist). Currently tolerates 30 feet. On 4/13/16, at 7:56 a.m., R16 was observed to be sitting on the edge of the bed and had bare feet (gripper socks were not in use). Nursing assistant (NA)-C had entered the room to provide morning cares. NA-C assisted R16 to transfer from his bed into his wheel chair and R16 wheeled himself out of his room. NA-C failed to provide assist of two to transfer. On 4/13/16, at 8:35 a.m., NA-C verified she had transferred R16 with one assist. Even though the care plan states to use two for transfer for safety. On 4/13/16, at 11:58 a.m., registered nurse (RN)-B verified R16's care plan and physician orders as above. RN-B stated she would expect staff to assist with transfers for toileting and gripper socks to be on when in bed as per the care plan. On 4/14/16, at 11:56 a.m., the director of nursing	F 323	week for 30 days to ensure environment remains free of accident hazards and new admission has appropriate IPOC in place for staff to review. Negative findings will be corrected immediately and will be reviewed at QAPI. -DNS/designee will be responsible -Corrective Action will be completed by 5/22/2016	

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F 323	Continued From page 45 (DON) stated she would expect care plan to be followed for transfers and gripper socks. The DON stated she would expect the care plan to be followed to what the care plan directs and if staff were noticing something different, needs to be evaluated. The facility policy Interdisciplinary Care Plan, dated 4/1/16, indicated the interdisciplinary care plan is implemented to guide the living center in the provision of necessary care and services to attain or maintain the highest practicable physical, mental, and psycho-social well-being of the resident and to promote the participation of the resident, family, or legal representative in planning care. LACK OF DEVELOPING AN INITIAL CARE PLAN INTERVENTIONS FOR FALLS AND LACK OF DEVELOPING A COMPREHENSIVE CARE PLAN IN REGARDS TO THE COMPREHENSIVE ASSESSMENT IDENTIFYING HIGH RISK FOR FALLS: R71 was admitted to the facility on 3/25/16 with diagnoses that included malignant ovarian cancer, essential hypertension, lymphedema, osteoporosis, weakness, and second degree burns of the lower extremity according to the facility face sheet. R71's Clinical Health Status assessment dated 3/25/16 identified R71 was alert and orientated, required continuous oxygen, had an indwelling urinary catheter, and was continent of bowel The health assessment identified R71 had a fall risk score of 17 related to three or more falls in the past three months, required the use of a wheel chair and walker, was chair bound and required assistance with elimination, balance problem while standing and walking, lower extremity	F 323		

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F 323	Continued From page 46 weakness, had hypotension, and took antihypertensive, cathartics, diuretics, narcotics, and psychotropic medications. The falls assessment also indicated a change or dosage change to medication within previous five days of the assessment. R71's record was reviewed on 4/12/16 and did not include an initial care plan (is to be completed on admission and used until the comprehensive assessment and comprehensive care plan interventions is developed) to prevent or reduce the risk for falls even though R71 had a history of falls prior to admission. Also following the comprehensive falls assessment lacked comprehensive care plan interventions to reduce or prevent falls. R71's admission Minimum Data Set (MDS) dated 4/1/16 identified R71 to have no cognitive impairment with a Brief Interview for Mental status score of 15, required extensive assist from two staff for bed mobility, transfers, locomotion, toilet use, and personal hygiene. The MDS indicated R71 was not stable during transitions and walking without assistance from staff and reported shortness of breath or trouble breathing with excursion. The MDS also identified R71 had a fall 30 days prior to admission to the facility. As a result of the assessed data, a Care Area Assessment (CAA) was triggered for falls. The falls CAA was dated 4/6/16 and indicated a care plan for falls was necessary. The CAA indicated R71 had balance problems, had a fall history, and received an antidepressant medication. The nature of the problem was summarized as, "CAA triggered for resident who is at risk for falls r/t [related to] mobility and impaired balance complicated by ovarian cancer with need for assist with all transfers. Staff to assist resident to transfer between all surfaces	F 323		

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and to assist her to any specific destination. Staff to anticipate resident wants/needs and assist as needed. See care plan for additional interventions."
R71's record did not reflect development or implementation of a any fall interventions in the comprehensive care plan based off the assessed data from the CAA even though the CAA referred to the care plan.
R71 sustained a fall that resulted in two small abrasions on outer left thigh on 4/8/16 at 2:45 p.m. according to the Post Fall Analysis/Plan dated 4/8/16. The post fall analysis indicated R71 had attempted self-transfer to the restroom without staff assist because she thought she could do it herself. The analysis further indicated R71 had lost strength and was not using adaptive equipment at the time of the fall, and the fall occurred "next to transfer surface (possible postural hypotension)." The report included R71 was administered cardiovascular medication 8 hours prior to the fall and had several incontinent episodes of stool three hours prior to the incident. The report identified "felt that she can help herself" as the possible cause/contributing factors of the fall and the interventions included "remind her to use call light" and the care plan was not revised.
R71's medication administration record (MAR) on 4/8/16 indicated administration of Hydromorphone at 9:36 p.m. for pain rated five out of 10 on a 0-10 scale and was effective. The MAR further indicated administration of Coreg at 8:00 p.m., and administration of Cholestyramine, Etoposide, Lasix, Potassium, Zoloft at 8:00 a.m.
R71's post fall analysis on the record did not reflect postural hypotension was assessed post fall despite the fall occurring next to a transfer surface, nor did the analysis identify the

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administration of a narcotic mediation within 8 hours of the fall or the dosage change of Coreg or start of Cholestyramine Powder on 4/5/16. In addition, the post fall analysis lacked a comprehensive analysis or evaluation of the identified potential causative factors (lost strength, cardiovascular medications, occurred next to transfer surface) included on the analysis tool.

R71's progress note dated 4/8/16 at 2:58 a.m. included, "staff heard a noise then the bathroom light came on, found resident in the bathroom on her buttocks, on the floor with her back against the door frame, was admitted on 3/25/16, has not fallen before. BP [blood pressure] 118/66, P [pulse] 90, R [respirations] 20, Temp 97.6, O2 sat [oxygen saturations] 97% on R/A [room air], had gripper socks on, denied hitting her head, has 2 abrasions on outer left thigh, both are 2.5 cm. areas cleansed bacitracin and bandaids applied will notify MD [medical doctor] and DNS [director of nursing services].

R71's progress note dated 4/8/16 at 11:16 a.m. indicated occupational therapy recommended, "Resident to ambulate with contact guard assist, four wheeled walker, and gait belt to the toilet. Nursing aware."

R71's progress note dated 4/8/16 at 12:20 p.m. reported, "Review of recent fall. No further injuries, resident stated that she was attempted to do for herself. Care plan followed reminded to use call light to ask for assistance to help prevent injury. Stated she understood."

R71's progress note dated 4/11/16, at 5:06 p.m. reported how family member had found resident after a fall at her home the resident's reluctance to get help and indicated, "Safety continues to be an issue as she has attempted to transfer herself."

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During an interview on 4/12/16, at 2:39 p.m. R71 stated she had been on her way to the bathroom when she got to the bathroom sink and fell. In response to the question, "What do you think caused you to fall?", R71 stated, "I felt light headed and dizzy and fell." In response to the question, "what did the facility do or teach you in response to your fall or how did your care plan change?" R71 stated, "They clarified and made me promise not to move without assistance, they didn't really teach anything, in not so many words they said 'This is what is going to happen' [referring to transferring without assist] and gave me a hug."

During an interview on 4/12/16, at 2:46 p.m. director of nursing (DON) verified R71's record did not include plan of care interventions for falls. DON indicated an initial care plan for falls should have been in place because of the high risk for falls. The DON stated the facility does not immediately complete a post fall risk assessment; however, the interdisciplinary team reviews the results of the fall investigation and if additional interventions need to be in plan the care plan is revised. DON indicated there was not documentation of a full analysis and evaluation of all of information collected to determine root cause of fall.

During an interview on 4/12/16, at 2:50 p.m. registered nurse (RN)-B stated "Initial plans of care is on my to do lists, I don't think I have finished it yet." RN-B then indicated she did not know where the initial care plan was located.

During an interview on 4/12/16, at 4:10 p.m. facility RN-A a consultant, provided the completed initial fall care plan dated 3/25/16 and indicated it had been on RN-B's desk in a stack of papers.

During an interview on 4/13/16, at 10:17 a.m. RN-B indicated she had found the completed

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F 323	Continued From page 50 initial care plan in a stack a papers on her desk and indicated it had not been implemented and placed into the R71's record. Facility policy Falls Management Guideline last reviewed 10/21/15 included, "Each living center implements the falls prevention and intervention program." The guidelines included, "Newly admitted/readmitted residents are assessed for fall risk by means of the Clinical Health Status tool. The Immediate Plan of Care at Risk-Falls Risk is initiated.", and "the interdisciplinary team evaluates the fall prevention plan of care for residents "at risk" for falls. This evaluation may include screening by rehab services representative and pharmacy consultant for medications that could affect balance and gait.", and "following a residents fall the licensed nurse assess the resident for injuries and provides necessary treatment and initiates the change in condition report", and "appropriate interventions are implemented and the care plan is updated. " , and "The interdisciplinary team reviews the change of condition report- Post Fall/Trauma and makes additional recommendations within 72 hours of the fall." The policy further indicated elements required to demonstrate satisfactory compliance included, "residents at risk for falls are care planned with individualized interventions. Licensed nurse completes change of condition-Post fall analysis following a resident fall, IDT evaluation is completed on the change of condition report-post fall and validation of individualized interventions." Facility policy Medical Record Content-Additional Content Requirements last reviewed 3/17/16 included, "Falls, On admission/readmission, residents are evaluated for fall risk utilizing the Clinical Health Status Form. Residents identified at risk will have an IPOC [initial plan of care]-fall	F 323		

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F 323	Continued From page 51 risk initiated. The interdisciplinary team evaluated the fall prevention plan of care for residents "at risk" for falls. If resident falls the licensed nurse assess the resident for injuries and provides necessary treatment and initiates the Change in Condition Report-Post Fall/Trauma; the physician, family and others, as appropriate interventions are implemented; care plan is updated."	F 323		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced	F 329		5/22/16

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F 329	Continued From page 52 by: Based on observation, interview, and document review the facility failed to identify and track target/mood behaviors and complete a sleep assessment before starting a hypnotic for 1 of 5 residents (R31); failed to monitor mood symptoms to justify the ongoing use of an antidepressant for 2 of 6 residents (R12 & R52) who used an antidepressant for depression; failed to complete a sleep assessment and attempt non-pharmacological interventions before starting a hypnotic for 1 of 6 residents (R37) who used Trazodone for sleep. Findings include LACK OF TRACKING MOOD, TARGET BEHAVIORS, AND COMPLETE SLEEP ASSESSMENT TO JUSTIFY THE USE OF MEDICATION THAT WAS PRESCRIBED: R31 was admitted to the facility on 2/19/16. Admission Record indicated R31 carried diagnoses of dementia with behavioral disturbances, bipolar disorder (mental illness characterized by periods of depression and periods of elevated mood), major depressive disorder, and hallucinations. R31's Medication Administration Record (MAR) for 2/16, 3/16, and 4/16 revealed R31 received Celexa (antidepressant), Depakote ER (mood stabilizer), Seroquel (antipsychotic) daily, Ativan (antianxiety) as needed, and Melatonin (supplement for sleep) as needed. R31's medical record lacked target behavior monitoring, mood symptom monitoring, sleep assessments, and non-pharmacological interventions prior to the use of as needed anxiety	F 329	-R(12,31,52,37) have been evaluated and documentation plan in place to better monitor specific targeted/mood/behaviors to help eliminate or reduce the occurrence of any behaviors and the resident's response to any non-pharmacological/pharmacological interventions, the proper assessment and mood monitoring completion before the initiation and justification for ongoing use of unnecessary drugs. -Staff has been educated to offer non-pharmacological interventions before the use of medications and document the effects of such medications and monitor mood and targeted behaviors. -Licensed staff has been educated on the proper comprehensive sleep assessment and analysis to be completed to justify the start of a sleep medication. -Audits will be completed one per week for three months to ensure the proper tracking; monitoring and assessments are in place with start or continuation of found unnecessary drugs. Negative findings will be corrected immediately and will be reviewed at QAPI. -DNS/designee will be responsible -Corrective Action will be completed by 5/22/2016	

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and sleep medications.

On 4/13/16 at 3:01 p.m. the facility's nurse consultant stated, "There isn't a sleep assessment on him. I identified it was missing on Monday [4/11/16]."

On 4/14/16 at 2:36 p.m. the director of nursing (DON) stated that every resident should have non-pharmacological interventions for as needed anxiety and sleep medication, verified R31 did not have non-pharmacological interventions in place for as needed Ativan and Melatonin. The DON added that nursing assistants were monitoring behavior symptoms but was unable to produce the documentation.

On 4/14/16 at 2:10 p.m. the consultant pharmacist stated a sleep log would identify if a resident was sleeping and identify if the sleep medication was needed. Added the nurses should know what is being tracked for target behaviors.

Facility policy, Mood/Behavior Management effective 3/31/16 reads, "Evaluating/Documenting Plan. A system to evaluate and document the implementation of the behavior management plan will be established. At a minimum, the monitoring system will document: The specific behavior problem, the specific intervention/action taken to eliminate or reduce the occurrence of the behavior problem, and the resident's response to the intervention."

LACK OF MOOD MONITORING TO JUSTIFY THE ONGOING USE OF AN ANTIDEPRESSANT:

R12 was admitted to the facility on 1/7/16 according to the facility face sheet. The face

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F 329	Continued From page 54 sheet reflected the addition of diagnoses of depression on 3/7/16. R12's quarterly Minimum Data Set (MDS) dated 3/21/16 reflected diagnoses of depression and received antidepressant medication. The MDS indicated R29 had minimal depression with a Patient Heath Questionnaire score of 2. R12's physician orders provided by the facility on 4/14/16 included Celexa 10 milligrams (mg) daily for major depressive disorder with a start date of 3/7/16 and Remeron (anti-depressant medication with a side effect of increased appetite) 15 mg daily for appetite with a start date of 4/11/16. R12's electronic care plan provided by the facility on 4/14/16 did not reflect a plan of care for depression management and psychotropic medication monitoring prior to 4/14/16. In addition, the nutrition plan of care did not reflect addition of an antidepressant medication for appetite stimulation. R12's record did not reflect documentation of mood monitoring or monitoring for side effects of the psychotropic medications. R12's physician visit note dated 3/7/16 reported, "He has been more depressed acting," and "he has a very flat affect," and "I am going to start him on a low dose Citalopram [Celexa]." Physician visit note dated 3/22/16 included, "He has chronic major depressive disorder." The physician remarked R12 was tolerating medication. During an interview on 4/13/16, at 12:14 p.m. director of nursing stated the care plan should be in place for depression and indicated mood and side effect monitoring was not in place. During an interview on 4/14/16, at 10:11 a.m. registered nurse (RN)-A indicated she was responsible for revising the care plans and stated, there should have been a plan of care for depression and psychotropic medication use.	F 329		

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F 329	Continued From page 55 During an interview on 4/14/15, at 2:24 p.m. the consultant pharmacist stated, "the facility should be monitoring for depressive mood symptoms and side effects of the psychotropic medications." LACK OF MOOD MONITORING TO JUSTIFY THE ONGOING USE OF AN ANTIDEPRESSANT: R52 was admitted to the facility on 3/24/15 with diagnoses that included major depressive disorder and dementia with behavioral disturbance. R52's significant change Minimum Data Set (MDS) dated 2/23/16 reflected moderately impaired cognitive skills for daily decision making, staff assessed R52 to have moderate depression with a resident mood score of 10. The MDS identified diagnosis of depression and use of antidepressant medication. As a result, of the mood score and use of antidepressant medication a Care Assessment Areas (CAA) were triggered for mood state and psychotropic drug use. The facility indicated the areas required further assessment and a plan of care. R52's mood state CAA reflected diagnoses of dementia with behavioral disturbance and major depressive disorder. The CAA informed R52 had decrease in communication and, "resident is at risk for further decline in mood and agitation. Will proceed to the care plan to minimize risks." R52's Psychotropic drug use CAA informed, "CAA triggered for resident who is at risk for development of side effects related to use of Remeron. Nursing to assess resident for adverse side effects and notify physician." The CAA further instructed to, "See the care plan for additional interventions." R52's physician orders provided by the facility on 4/13/16 included Remeron 7.5 milligram (mg) by mouth at bedtime for depression; with a start date	F 329		

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of 10/27/15.
R52's care plan reviewed on 4/12/16 and a printed copy provided by the facility on 4/13/16 did not reflect psychotropic drug monitoring until 4/13/16 which was after the surveyor requested this information.
R52's record did not reflect documentation of mood monitoring for effectiveness or monitoring for side effects of the psychotropic medications.
During an interview on 4/13/16, at 12:14 p.m. director of nursing indicated mood and side effect monitoring were not in place and should be.
During an interview on 4/14/15, at 2:24 p.m. the consultant pharmacist stated, "the facility should be monitoring for depressive mood symptoms per the physician's indication and monitor for side effects of the psychotropic medications."
R37 LACK OF COMPREHENSIVE SLEEP ASSESSMENT AND ANALYSIS TO JUSTIFY THE USE OF A SLEEP MEDICATION:

R37's face sheet revealed R37 was admitted on 2/15/12 with insomnia, major depressive disorder with psychotic symptoms. The quarterly Minimum Data Assessment (MDS) dated 2/16/16, indicated R37 did not display behavior problems and did not have difficulty sleeping, feeling tired or having little energy.

R37's signed physician orders dated 3/7/16 included Trazodone (antidepressant, but is used as a hypnotic for R37) 50 milligrams (mg) give 0.5 tablet by mouth at bedtime related to insomnia.

R37's medical record lacked comprehensive sleep assessments and analysis of sleep monitoring to initiate and continue the use of Trazadone and none were provided when

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F 329	Continued From page 57 requested of staff. R37's care plan did not include insomnia or address non-pharmacological interventions for sleep. On 4/14/2016, at 9:32 a.m. the director of nursing (DON) stated comprehensive sleep assessments had not been completed for R37. The DON stated she expected a comprehensive sleep assessment to be completed, upon admission, start of a medication used for sleep, quarterly, change of resident condition that identified a resident was having difficulty with sleep. The DON stated I would expect a care plan to be followed up on, to include monitoring of sleep patterns and non-pharmacological interventions to help promote sleep. The DON confirmed a comprehensive sleep assessment should have been completed for R37. A policy and procedure was requested for comprehensive sleep assessment and development of a resident care plan and were not provided.	F 329		
F 406 SS=D	483.45(a) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.	F 406		5/22/16

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F 406	Continued From page 58 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to integrate activities to meet the needs for 1 of 1 resident (R48) who was identified on a PASRR (preadmission Screening & Resident Review) level II to need specialized services. Findings include: R48's Admission Record revealed diagnoses to include spastic quadriplegic cerebral palsy, contracture of muscle, and profound intellectual disabilities. R48's quarterly Minimum Data Set (MDS) dated 2/19/16 indicated R48 required total dependence for bed mobility, transfer, dressing, toileting, locomotion on/off unit and had a bilateral upper and lower extremity impairment. R48 was intermittently observed on 4/13/16 from 8:03 a.m. to 2:38 p.m. (six hours and thirty five minutes). During each observation R48 was observed to be in her bed with humidified oxygen on. Room lights on, window curtains closed, and the humming of R48's humidified oxygen concentrator was the only noise in the room. At 12:29 p.m. a massage therapist was observed giving R48 a body massage. R48 was observed on 4/14/16 at 8:24 a.m. sitting in her wheelchair across from the front door in the dining room area. R48 was sitting by herself with no interaction from staff. R48 made eye contact with surveyor. At 8:58 a.m. R48 remained in the	F 406	-R48's care plan has been updated reflecting activity preferences and weekly goals of activity participation. -Activity Director has implemented new charting system that provides more thorough capturing of residents daily activity. -Audits to be completed two times/week for 30 days to ensure activity participation. Negative findings will be corrected immediately and will be reviewed at QAPI. -Activity Director/designee will be responsible -Corrective Action will be completed by 5/22/2016	

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F 406	Continued From page 59	F 406		

same position chewing on her cheek with her hands raised to her face. At 10:09 a.m. R48 was moved across the dining room/TV area, wheelchair was positioned next to a radio on the outer wall of the room. Across the room the TV was on. R48 would intermittently look at the TV and close her eyes. Once again no staff interaction with R48.

R48's care plan dated 10/26/15 read, "I am unable to communicate my wants and need/I do enjoy music, TV, and watching what is going on/Please help get to and from group act. [activities] areas/watch for signs of distress. I want to be involved in group activities." Interventions included; "Offer group act. assist to and from activity areas. I enjoy watching what is going on. I am unable to communicate, but watch for me for visual expressions, I am able to blink or nod by head to answer. Offer religious services for spiritual needs. Please have me sit in common dining areas during meals for interaction with others, even I cannot have food by mouth. Supply [me] with independent [sic.] leisure material i.e. TV, radio, Elmo."

Review of R48's activity documentation revealed bi-weekly 1:1 visits and weekly massage therapy as R48's primary source of activities. From 4/1/16 through 4/13/16; R48 attended 7 out of 52 activity opportunities, 3/16 attended 11 out of 106 activity opportunities, and 2/16 attended 20 out of 91 activity opportunities.

On 4/13/16 at 9:18 a.m. the activity director (AD) stated, "She [R48] likes to sit and watch the birds, sitting in on religious activities. You can tell when she doesn't enjoy it she will kick her feet. her guardian said the more you involve her the better.

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F 406	Continued From page 60 She gets massages on Wednesdays and she loves them. Sometimes her tube feeding gets in the way of getting her up for activity. I have gone in her room and had short conversations with her, turned the TV on her her, turned music on. you can tell with her eyes that she is watching TV." On 4/14/16 at 2:24 p.m. the AD added, "April she probably doesn't have too much [activities], when she first came she had more. She seems to be in bed, resting more often. She went to church on 4/12/16, she was at the Christmas party with her guardian. She has attended card bingo, she sits and watches." On 4/14/16 at 10:23 a.m. the director of nursing (DON) stated, "Yesterday the massage therapist was here, but typically she is out of bed and up in her wheelchair every morning; sitting in the day room so people can interact with her as they go by. When there is activities or TV on they move her to the center of the room so she can be nearby." The DON attempted to find activity progress notes but was unable to provide any.	F 406		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		5/22/16

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F 428	Continued From page 61 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the consulting pharmacist identified and reported these irregularities to the physician and director of nursing to identify and track target/mood behaviors and complete a sleep assessment before starting a hypnotic for 1 of 5 residents (R31); failed to monitor mood symptoms to justify the ongoing use of an antidepressant for 2 of 6 residents (R12 & R52) who used an antidepressant for depression; failed to complete a sleep assessment and attempt non-pharmacological interventions before starting a hypnotic for 1 of 6 residents (R37) who used Trazodone for sleep. Findings include LACK OF TRACKING MOOD, TARGET BEHAVIORS, AND COMPLETE SLEEP ASSESSMENT TO JUSTIFY THE USE OF MEDICATION THAT WAS PRESCRIBED: R31 was admitted to the facility on 2/19/16. Admission Record indicated R31 carried diagnoses of dementia with behavioral disturbances, bipolar disorder (mental illness characterized by periods of depression and periods of elevated mood), major depressive disorder, and hallucinations. R31's Medication Administration Record (MAR) for 2/16, 3/16, and 4/16 revealed R31 received Celexa (antidepressant), Depakote ER (mood stabilizer), Seroquel (antipsychotic) daily, Ativan (antianxiety) as needed, and Melatonin (supplement for sleep) as needed.	F 428	-R(12,31,52,37) have been evaluated and documentation plan in place to better monitor specific targeted/mood/behaviors to help eliminate or reduce the occurrence of any behaviors and the resident's response to any non-pharmacological/pharmacological interventions, the proper assessment and mood monitoring completion before the initiation and justification for ongoing use of unnecessary drugs. -Staff have been educated on proper assessments, documenting and tracking that needs to occur with medications used for sleep, depression, etc. -Pharmacy consultant has been met with to help identify any irregularities in assessments, mood/behavior tracking with drug regimens. -Audits will be completed once a month for three months to ensure the reports on irregularities are being reported to the physicians and Director of Nursing/designee. Negative findings will be corrected immediately and will be reviewed at QAPI. -DNS/designee will be responsible -Corrective Action will be completed by 5/22/2016	

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F 428	Continued From page 62 R31's medical record lacked target behavior monitoring, mood symptom monitoring, sleep assessments, and non-pharmacological interventions prior to the use of as needed anxiety and sleep medications. On 4/13/16 at 3:01 p.m. the facility's nurse consultant stated, "There isn't a sleep assessment on him. I identified it was missing on Monday [4/11/16]." On 4/14/16 at 2:36 p.m. the director of nursing (DON) stated that every resident should have non-pharmacological interventions for as needed anxiety and sleep medication, verified R31 did not have non-pharmacological interventions in place for as needed Ativan and Melatonin. The DON added that nursing assistants were monitoring behavior symptoms but was unable to produce the documentation. On 4/14/16 at 2:10 p.m. the consultant pharmacist stated a sleep log would identify if a resident was sleeping and identify if the sleep medication was needed. Added the nurses should know what is being tracked for target behaviors. Facility policy, Mood/Behavior Management effective 3/31/16 reads, "Evaluating/Documenting Plan. A system to evaluate and document the implementation of the behavior management plan will be established. At a minimum, the monitoring system will document: The specific behavior problem, the specific intervention/action taken to eliminate or reduce the occurrence of the behavior problem, and the resident's response to the intervention." LACK OF MOOD MONITORING TO JUSTIFY	F 428		

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F 428	Continued From page 63 THE ONGOING USE OF AN ANTIDEPRESSANT: R12 was admitted to the facility on 1/7/16 according to the facility face sheet. The face sheet reflected the addition of diagnoses of depression on 3/7/16. R12's quarterly Minimum Data Set (MDS) dated 3/21/16 reflected diagnoses of depression and received antidepressant medication. The MDS indicated R29 had minimal depression with a Patient Heath Questionnaire score of 2. R12's physician orders provided by the facility on 4/14/16 included Celexa 10 milligrams (mg) daily for major depressive disorder with a start date of 3/7/16 and Remeron (anti-depressant medication with a side effect of increased appetite) 15 mg daily for appetite with a start date of 4/11/16. R12's electronic care plan provided by the facility on 4/14/16 did not reflect a plan of care for depression management and psychotropic medication monitoring prior to 4/14/16. In addition, the nutrition plan of care did not reflect addition of an antidepressant medication for appetite stimulation. R12's record did not reflect documentation of mood monitoring or monitoring for side effects of the psychotropic medications. R12's physician visit note dated 3/7/16 reported, "He has been more depressed acting," and "he has a very flat affect," and "I am going to start him on a low dose Citalopram [Celexa]." Physician visit note dated 3/22/16 included, "He has chronic major depressive disorder." The physician remarked R12 was tolerating medication. During an interview on 4/13/16, at 12:14 p.m. director of nursing stated the care plan should be in place for depression and indicated mood and side effect monitoring was not in place. During an interview on 4/14/16, at 10:11 a.m.	F 428		

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F 428	Continued From page 64 registered nurse (RN)-A indicated she was responsible for revising the care plans and stated, there should have been a plan of care for depression and psychotropic medication use. During an interview on 4/14/15, at 2:24 p.m. the consultant pharmacist stated, "the facility should be monitoring for depressive mood symptoms and side effects of the psychotropic medications." LACK OF MOOD MONITORING TO JUSTIFY THE ONGOING USE OF AN ANTIDEPRESSANT: R52 was admitted to the facility on 3/24/15 with diagnoses that included major depressive disorder and dementia with behavioral disturbance. R52's significant change Minimum Data Set (MDS) dated 2/23/16 reflected moderately impaired cognitive skills for daily decision making, staff assessed R52 to have moderate depression with a resident mood score of 10. The MDS identified diagnosis of depression and use of antidepressant medication. As a result, of the mood score and use of antidepressant medication a Care Assessment Areas (CAA) were triggered for mood state and psychotropic drug use. The facility indicated the areas required further assessment and a plan of care. R52's mood state CAA reflected diagnoses of dementia with behavioral disturbance and major depressive disorder. The CAA informed R52 had decrease in communication and, "resident is at risk for further decline in mood and agitation. Will proceed to the care plan to minimize risks." R52's Psychotropic drug use CAA informed, "CAA triggered for resident who is at risk for development of side effects related to use of Remeron. Nursing to assess resident for adverse side effects and notify physician." The CAA further instructed to, "See the care plan for	F 428		

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F 428	Continued From page 65 additional interventions." R52's physician orders provided by the facility on 4/13/16 included Remeron 7.5 milligram (mg) by mouth at bedtime for depression; with a start date of 10/27/15. R52's care plan reviewed on 4/12/16 and a printed copy provided by the facility on 4/13/16 did not reflect psychotropic drug monitoring until 4/13/16 which was after the surveyor requested this information. R52's record did not reflect documentation of mood monitoring for effectiveness or monitoring for side effects of the psychotropic medications. During an interview on 4/13/16, at 12:14 p.m. director of nursing indicated mood and side effect monitoring were not in place and should be. During an interview on 4/14/15, at 2:24 p.m. the consultant pharmacist stated, "the facility should be monitoring for depressive mood symptoms per the physician's indication and monitor for side effects of the psychotropic medications." R37 LACK OF COMPREHENSIVE SLEEP ASSESSMENT AND ANALYSIS TO JUSTIFY THE USE OF A SLEEP MEDICATION: R37's face sheet revealed R37 was admitted on 2/15/12 with insomnia, major depressive disorder with psychotic symptoms. The quarterly Minimum Data Assessment (MDS) dated 2/16/16, indicated R37 did not display behavior problems and did not have difficulty sleeping, feeling tired or having little energy. R37's signed physician orders dated 3/7/16 included Trazodone (antidepressant, but is used as a hypnotic for R37) 50 milligrams (mg) give 0.5 tablet by mouth at bedtime related to insomnia.	F 428		

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F 428	Continued From page 66 R37's medical record lacked comprehensive sleep assessments and analysis of sleep monitoring to initiate and continue the use of Trazadone and none were provided when requested of staff. R37's care plan did not include insomnia or address non-pharmacological interventions for sleep. On 4/14/2016, at 9:32 a.m. the director of nursing (DON) stated comprehensive sleep assessments had not been completed for R37. The DON stated she expected a comprehensive sleep assessment to be completed, upon admission, start of a medication used for sleep, quarterly, change of resident condition that identified a resident was having difficulty with sleep. The DON stated I would expect a care plan to be followed up on, to include monitoring of sleep patterns and non-pharmacological interventions to help promote sleep. The DON confirmed a comprehensive sleep assessment should have been completed for R37. A policy and procedure was requested for comprehensive sleep assessment and development of a resident care plan and were not provided.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		5/22/16

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F 441	Continued From page 67 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to document resolution of urinary tract infections for 2 of 3 residents (R32 and R51) who had received antibiotic medication and failed to ensure surveillance and analysis of infections. This had the potential to effect all residents, staff	F 441	-R (32,51,15,17,43) have been evaluated to have an established infection control program in place to provide a safe, sanitary and comfortable environment to help prevent the spread of disease and infections.	

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F 441	Continued From page 68 and visitors. In addition, the facility failed to ensure inhalation nebulizer equipment was cleaned and stored appropriately to decrease and/or prevent the risk of infection for 3 of 3 residents (R15, R17 and R43) observed to have nebulizers. Findings include: RESOLUTION OF INFECTION: The facility Line Listing of Resident Infections sheets identified the following: R32's culture results dated 10/16/15, indicated positive for urinary tract infection (UTI). Symptoms: complaints of pain, burning, increased urination, odor and increased confusion. Treatment Amoxicillin (antibiotic) 500 mg [milligrams] TID [three time daily] times seven days. R32's medication administration record (MAR), dated 10/15, identified R32 had received the medication. However, R32's record failed to include documentation of the resolution of symptoms such as pain, burning, increased urination, odor and increased confusion. R51's culture results 12/2/15 for UTI. Symptoms odor, altered mental status and lethargy. Treatment Cipro (antibiotic) 500 mg BID [two time daily] times five days. R51's MAR, dated 12/15, identified R51 had received the medication. However, R51's record failed to include documentation of the resolution of symptoms odor, altered mental status and lethargy. LACK OF SURVEILLANCE AND ANALYSIS OF	F 441	-Staff has been educated on the proper cleaning and storage of nebulizer machines and equipment's. -Licensed staff has been educated of the proper procedure and documentation following the completion of an antibiotic and the resolution of symptoms. -Negative findings will be corrected immediately and will be reviewed at QAPI. -DNS/designee will be responsible -Corrective Action will be completed by 5/22/2016	

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F 441	Continued From page 69 INFECTIONS: The facility monthly Line Listing of Resident Infections sheets were obtained from August 2015 through March 2016. The following information of infections was indicated: 8/15, two upper respiratory infections (URI), two skin, one gum, two osteomyelitis 9/15, eight URI, two urinary tract infections (UTI), three Bronchitis, two admitted with URI 10/15, four UTI, two pneumonia, one c-diff (stool infection), four admit surgical 11/15. One pneumonia, one UTI 12/15, six URI pneumonia/bronchitis, three UTI, two sepsis, 1/16, one UTI, one c-diff, six URI/bronchitis, one toe 2/16, seven URI (one resident influenza A) - 40 residents given Tamiflu (Flu prevention medication) 3/16, one URI, one skin However, the facility failed to document surveillance and analysis of the information, which included infection control precautions used to prevent the spread of the infections and the effectiveness/outcomes of the precautions implemented. On 4/14/16, at 10:23 a.m., registered nurse (RN)-B stated for resolution of UTI documentation we monitor temperatures for any infections. The nurse should document if they see any increase or decrease of signs and symptoms of a UTI. RN-B verified R32 and R51's records failed to include documentation of resolution of signs and symptoms of UTI. RN-B stated at the time infections were noted from the Line Listing of	F 441		

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	245270	A. BUILDING _____ B. WING _____	04/14/2016

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F 441	Continued From page 70	F 441		

Resident Infections sheets, staff were reminded regarding handwashing practices and practices for URI's, etc. through the facility communication book. RN-B stated she had no documentation regarding analysis of infection control information, which included infection control precautions used to prevent the spread of the infections and the effectiveness/outcomes of the precautions implemented. When queried how do you monitor implementation of program (staff practices/ensure consistent implementation of established infection prevention based on current standards of practice), RN-B stated I follow the director of nursing recommendations, watch staff frequently on different things they do, however RN-B stated she does not document any of the information.

The facility policy Urinary Tract infections/Bacteriuria-Clinical Protocol, dated 8/14, indicated Monitoring and Compliance: 1. The physician and nursing staff will review the status of individuals who are being treated for UTI and adjust treatment accordingly. 2. Decisions should be made primarily on the basis of clinical signs and symptoms. The goal of treatment in most cases is to control signs and symptoms of infection, not to eliminate bacteriuria.

The facility policy Elements of an Infection Control Program Guideline, dated 1/11/16, indicated an effective infection prevention and control program incorporates at least the following components: Program oversight including planning, organizing, implementing, operating, monitoring, and maintaining all of the elements of the program and ensuring that the facility ' s interdisciplinary team is involved in infection prevention and control. Surveillance,

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F 441	Continued From page 71 including process and outcome surveillance, monitoring, data analysis, documentation and communicable diseases reporting (as required by State and Federal law and regulation). Education, including training in infection prevention and control practices, to ensure compliance with facility requirements as well as State and Federal regulation. Antibiotic review including reviewing data to monitor the appropriate use of antibiotics in the resident population. Monitoring Compliance Evidence of Infection Control Programs with routine (daily, weekly, monthly) surveillance records. LACK OF FOLLOWING MANUFACTURERS RECOMMENDATION TO SANITIZE AND STORE NEBULIZER EQUIPMENT TO PREVENT SPREAD OF INFECTION/S: R15's room was checked during the initial tour on 4/11/16, at 12:05 p.m., R15's nebulizer machine was sitting on a table. The nebulizer accessories were connected to the machine with the reservoir chamber empty, and the mask laying on top of the machine. R15 was not in the room at the time. R15's physician orders did not reflect an order for a nebulized inhalation medication. R17's room was checked during the initial tour on 4/11/16, at 12:07 p.m., R15's nebulizer machine was sitting on a table. The nebulizer accessories were connected to the machine. The reservoir chamber contained approximately 1 cubic centimeters of clear liquid. R17's physician orders included "Albuterol sulfate nebulization solution 2.5 milligrams (mg)/3 milliliter (ml) 0.083% 1 unit inhale orally via nebulizer four times a day" R43's room was checked during the initial tour on 4/11/16, at 12:05 p.m. R43's nebulizer machine	F 441		

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F 441	Continued From page 72 was sitting on the a table. The nebulizer accessories were connected to the machine with the reservoir chamber empty, and the mask was touching the table. R43 was not in the room at the time. R43's physician orders included "Albuterol Sulfate nebulization solution 2.5 mg/3 ml 0.083% 1 vial inhale orally via nebulizer every 6 hours as needed for COPD [chronic obstructive pulmonary disease]." During an interview on 4/11/15, at 12:20 p.m. the director of nursing verified neb machines equipment was stored inappropriately and should have been washed and stored. Facility policy Specific Medication Administration Procedures Oral Inhalation Administration included: "When treatment is complete, turn off nebulizer and disconnect T-piece, mouth piece and medication cup." and "Rinse and disinfect the nebulizer equipment according to manufacturer's recommendations, or: 1) Wash pieces (except tubing) with warm, soapy water daily. Rinse with hot water. Allow to air dry completely on a paper towel." and "When equipment is completely dry, store in a plastic bag with the resident's name and the date on it."	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 465	-R8's lambs wool on walker has been	5/22/16

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F 465	Continued From page 73 review, the facility failed to ensure clean equipment for 1 of 30 residents (R8) observed during stage one for equipment unclean. Findings include: R8 on 4/11/16, at 2:10 p.m., had been observed to have a walker with the handles of the walker had lamb's wool wrapped over the handles and secured with clear tape. The lamb's wool on both handles was soiled with black and brownish colors over the surface of the lamb's wool on both handles. On 4/13/16, at 11:24 a.m., registered nurse (RN)-B verified R8's lamb's wool on both handles of the walker were soiled. RN-B verified the facility did not have a system in place to change the lamb's wool on R8's walker for when the lamb's wool would become soiled. On 4/14/16, at 11:47 a.m., the director of nursing (DON) observed R8's walker and verified the lamb's wool was dirty and was not a surface you could wipe off every day. The DON stated the lamb's wool will have to be taken off and washed and the lamb's wool should be washed when soiled. The facility Engineer Walker and Cane Inspection, undated, indicated inspecting the equipment and clean or replace any rubber tips that are dirty or excessively worn. The inspection failed to address cleaning of material (lamb's wool) attached to the walker.	F 465	removed and replaced with a cleanable material that is acceptable to resident's wishes. -Environmental Services and Licensed staff have been educated on the necessity and protocol for clean resident equipment. -Environmental Services has implemented a resident equipment cleaning schedule. -Resident equipment will be audited three times per week for 30 days to ensure functional and clean standards. Negative findings will be corrected immediately and results will be reviewed at QAPI. -House Keeping Manager/designee will be responsible -Corrective action will be completed by 5/22/2016	

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	245270	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2016**

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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 ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Living Center Whitewater was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/04/2016

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	K 000		

By email to:
Marian.Whitney@state.mn.us and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Golden Living Center Whitewater is a 1-story building. The building was constructed at 2 different times. The original building was constructed in 1967, with a partial basement and was determined to be of Type II(111) construction. In 1969, an addition was constructed to the West Wing that was determined to be of Type II(111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully sprinklered. The facility has a fire alarm system with corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 55 beds and had a census of 43 at the time of the survey.

The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:

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K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: K25: Based on observations and interview, the facility has failed to properly construct and maintain a required 2-hour fire separation, in accordance with NFPA 101 (2000), Chapter 19, Sections 19.1.1.4 and 19.1.2.1. In a fire emergency, this deficient practice could adversely affect the safety of (55) residents, staff and visitors. FINDINGS INCLUDE: During the facility tour between the hours of 09:30 AM and 11:30 PM on 04/12/2016, observation revealed: wires passing through a penetration in the smoke barrier wall located next to the administration office. Penetration was not fire stop with approval fire caulking. This finding was confirmed with the Chief Building Engineer at the time of discovery.	K 025	Penetration of wires passing through the smoke barrier wall has been remedied by the Maintenance Director. The opening around the wires was completely sealed with UL tested firestop sealant on 4/12/16. The Maintenance Director will be responsible to complete follow up inspections to any future work to be done by outside contractors that may create pentrations in the smoke barrier wall. Necessary manitenance to follow in event of negative inspection results.	4/12/16