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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PCXS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00938

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245052**
2.STATE VENDOR OR MEDICAID NO.
(L2) **154578700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - MOORHEAD**
(L4) **2810 NORTH 2ND AVENUE**
(L5) **MOORHEAD, MN** (L6) **56560**

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 **12/31/2014** (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 **87** (L18)

13.Total Certified Beds **87** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 01/13/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/20/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1979
(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
Posted 01/27/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/16/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5052

On December 31, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify the faciliyyour facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 28, 2014. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of December 22, 2014. Based on our visit, the facility had corrected the deficiencies issued pursuant to our extended survey, completed on October 28, 2014, as of December 22, 2014.

As a result of the revisit findings, the Department discontinued the Category 1 remedy of state monitoring effective December 22, 2014.

In addition, we recommended the following action to the CMS Region V Office:

- Civil Money Penalty for the deficiency cited at F441, remain in effect.

Refer to the CMS 2567b for the results of this visit.

Effective December 22, 2014, the facility is certified for 87 skilled nursing facility beds.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24 5052

January 20, 2015

Ms. Melissa Chisholm, Administrator
Golden LivingCenter - Moorhead
2810 North 2nd Avenue
Moorhead, Minnesota 56560

Dear Ms. Chisholm:

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 December 22, 2014 the above facility is certified for:

87 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 87 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,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone #: (651) 201-4118 Fax #: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 12, 2015

Ms. Melissa Chisholm, Administrator
Golden Livingcenter - Moorhead
2810 North Second Avenue
Moorhead, Minnesota 56560

RE: Project Number S5052024

Dear Ms. Chisholm:

On November 19, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 24, 2014. (42 CFR 488.422)

In addition, on November 19, 2014, the Department recommended the following remedy to the CMS Region V office for imposition:

- Per instance civil money penalty for the deficiency cited at F441. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective January 28, 2015. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on October 28, 2014. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On December 31, 2014, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 28, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 22, 2014. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on October 28, 2014, as of December 22, 2014.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 22, 2014.

However, as we notified you in our letter of November 19, 2014, in accordance with Federal law, as

specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 28, 2015.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6357 0976

December 30, 2014

Ms. Melissa Chisholm, Administrator
Golden LivingCenter - Moorhead
2810 North 2nd Avenue
Moorhead, Minnesota 56560

RE: Project Number S5052024, H5052037

Dear Ms. Chisholm:

On November 19, 2014, this Department recommended imposed the following Category 1 remedy:

- State Monitoring effective November 24, 2014. (42 CFR 488.422)

In addition, on November 19, 2014, the Department recommended the following remedy to the CMS Region V office for imposition:

- Civil money penalty for the deficiency cited at F441 (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on October 28, 2014. that included an investigation of complaint number H5052037. At the time of the standard survey conditions in the facility constituted immediate jeopardy to resident health or safety. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On December 18, 2014, 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 October 28, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 22, 2014. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on October 28, 2014.

However, compliance with the health deficiencies issued pursuant to the October 28, 2014 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 28, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 28, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 28, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden LivingCenter - Moorhead is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective January 28, 2015. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

A copy of the Post Certification Revisit Form (CMS-2567B) from the December 18, 2014 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644

Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 April 28, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: Gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File 505270daynotice

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245052	A. Building B. Wing	12/31/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - MOORHEAD	2810 NORTH 2ND AVENUE MOORHEAD, MN 56560

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/22/2014**
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/22/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/22/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **12/22/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **12/22/2014**
ID Prefix **F0496** Reg. # **483.75(e)(5)-(7)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0501** Reg. # **483.75(i)** LSC	Correction Completed **12/22/2014**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **12/22/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/KJ	1/13/2015	31256	12/31/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 10/28/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245052	A. Building B. Wing **01 - MAIN BUILDING 01**	12/18/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - MOORHEAD	2810 NORTH 2ND AVENUE MOORHEAD, MN 56560

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # **NFPA 101** LSC K0054	Correction Completed **12/01/2014**	ID Prefix Reg. # **NFPA 101** LSC K0075	Correction Completed **12/15/2014**	ID Prefix Reg. # **NFPA 101** LSC K0130	Correction Completed **12/15/2014**
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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/mm	12/18/2014	03005	12/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/23/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245052	02 - DINING ROOM & DAYROOM ADDITION	12/18/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - MOORHEAD	2810 NORTH 2ND AVENUE MOORHEAD, MN 56560

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0054	12/01/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	PS/mm	12/18/2014	03005	12/18/2014
Reviewed By CMS RO				

Followup to Survey Completed on: 10/23/2014

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: PCXS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00938

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245052**

2.STATE VENDOR OR MEDICAID NO.
(L2) **154578700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - MOORHEAD**
(L4) **2810 NORTH 2ND AVENUE**
(L5) **MOORHEAD, MN** (L6) **56560**

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 **10/28/2014** (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 **87** (L18)

13.Total Certified Beds **87** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Miriam Thornquist, HFE NEII — 12/15/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 12/16/2014 (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
03/01/1979
(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

CCN: 24-5052

On October 28, 2014 a standard survey was completed at this facility. Coniditions in the facility constituted Immediate Jeopardy (IJ) to resident's health or safety. The condition resulting in our notification of immediate jeopardy had been removed. In addition, at the time of the Octobver 28, 2014 standard survey, investigation of complaint number H5052037, was conducted and determined to be unsubstantiated.

As a result of the survey, this Department imposed the Category 1 remedy of State monitoring, effective November 24, 2014. In addition, we recommended the following remediy to the CMS Region V Office for imposition:

- Civil Money Penalty for the deficiency cited at F441

Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6542

November 19, 2014

Ms. Melissa Chisholm, Administrator
Golden LivingCenter - Moorhead
2810 North 2nd Avenue
Moorhead, Minnesota 56560

RE: Project Number S5052024, H5052037

Dear Ms. Chisholm:

On October 28, 2014, 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. In addition, at the time of the October 28, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5052037, that was found to be unsubstantiated.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on October 24, 2014, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 24, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F441 (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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 January 28, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 28, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

Enclosure(s)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING _____ B. WING _____	10/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MOORHEAD	2810 NORTH 2ND AVENUE MOORHEAD, MN 56560

(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 A recertification survey was conducted by surveyors from the Minnesota Department of Health on October 20-24 and 27-28, 2014, the following federal deficiencies are issued. The survey resulted in Immediate Jeopardy (IJ) on 10/22/14, at 7:06 p.m. at F441 related to the facility's failure to ensure prevention of spread of infection from contaminated supplies returned to the treatment cart, which resulted in the high potential for harm or death. The IJ was removed on 10/24/14, at 5:09 p.m., however, non-compliance remained at the lower scope and severity of F. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an 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. An investigation of complaint H5052037 was completed at the time of the survey. The complaint was not substantiated.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176		

Approved
Gail A.
12/15/14

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

ED — 12/2/14

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.

RECEIVED
DEC 05 2014
MN Dept of Health
Fergus Falls

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F 176	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to conduct an assessment to determine whether residents were capable to self administer medications for 2 of 12 residents (R26, R112) observed during medication pass of oral medications. Findings include: R112's admission Minimum Data Set (MDS) dated 8/5/14 revealed R112 had diagnoses which included diabetes mellitus, heart failure and renal insufficiency. The MDS identified R112 had no cognitive impairment. Review of R112's physician order dated 10/13/14, revealed R112 was to receive Tramodol for pain. However, the record did not include an order for R112 to self administer medications. The interdisciplinary team (IDT) assessment for self administration of medications dated 7/30/14, revealed R112 did not want to self administer medications. R112's plan of care dated 10/20/14, revealed that staff were to administer the pain medication. On 10/20/14, at 5:26 p.m. license practical nurse (LPN)- G was observed to administer a medication to R112 who was in the dining room sitting at the dining room table with a male resident sitting at R112's left side. LPN-G placed the medication in a white paper medication cup, brought the Tramodol to R112, handed R112 the medication and immediately walked away. LPN-G	F 176	**F176D** -Residents #26 and #112 have had Self Administration of Medication Assessments completed to determine resident capability to self administer oral medications. -Other residents wishing to self administer medications will be assessed for cognitive and physical ability to safely self administer identified medications -Education will be conducted with licensed nursing staff to conduct a Self Administration of Medication Assessment on all residents wishing to self administer their own medication upon admission, quarterly, with significant changes, and annually. -Audits will be conducted on all residents during scheduled care conferences, to ensure completion of Self Administration of Medication Assessments have been completed/updated as required. Audits will be reviewed at QAPI and action planned as needed. -RNAC is the responsible party. -Corrective Action will be completed by 12/22/2014	

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F 176	Continued From page 2 verified she gave R112's medication, walked away and didn't watch R112 take the medication. LPN-G stated if the resident has a behavior or if they don't take the medication then she would watch the resident take the medication. R26's annual MDS dated 9/11/14, revealed R26 had diagnoses which included depression, anxiety disorder and diabetes mellitus. The MDS identified R26 had no cognitive impairment. R26's Care Area Assessment (CAA), dated 9/25/14, revealed R26 was taking antidepressant and antianxiety medications, had several medications ordered for pain on a routine basis and would ask for pain medications as needed for pain management. Review of R26's care plan reviewed 9/30/14, listed various interventions which included I need nurses to administer pain medications as ordered, administer my medications as ordered, I will need nurses to administer my medications as ordered. However, the care plan did not include orders for R26 to self administer oral medications. Review of R26's September, 2014 medication administration record (MAR) listed other orders, may administer eye drops and nasal spray. R26's MAR did not identify R26 could administer oral medications. Review of R26's physican orders revealed R26 was to receive loratin prescribed for allergies, ranitidine for stomach disorders, lasix for fluid accumulation, metformin hcl for diabetes, vitamin C used for wound healing, senna for constipation, alprazolam for anxiety,	F 176		

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F 176	Continued From page 3	F 176		

hydrocodone-acetaminophen for pain, multi vitamin used as a nutritional supplement and polyethylene glyco for constipation.

The IDT assessment for self administration of medication dated 10/19/13, indicated R26 wanted to self administer medications, but the medications were to be stored in the medication cart.

Review of R26's Order Listing Report, printed 10/28/14, listed the physican order dated 1/15/14, to self administer eye drops and nasal spray. R26's Order Listing Report did not include an order for R26 to self administer oral medications.

On 10/22/14, at 6:48 a.m. LPN-A had the medication cart in the hallway and R26 was sitting in a wheelchair in the hallway by the medication cart. LPN-A was observed to give R26 medications in a white paper medication cup and a glass of water. LPN-A turned her back on R26 and walked down the hall to get medication that wasn't in the medication cart.

LPN-A verified she had not observed R26 take the oral medications and verified R26 was out of her site when she went to get the medication surplus was located in a different hallway.

On 10/28/14,at 7:45 p.m. registered nurse (RN) -C stated if the resident can't self administer their medications they need to be observed while taking medications.

On 10/28/14, at 7:45 p.m. the director of nursing (DON) stated if a resident doesn't have an order for self administration of medications it is not acceptable for the nurse to walk away after the

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F 176	Continued From page 4 medications are given to the resident. Review of the facility policy titled Medication Administration Preparation and General Guidelines revised on 11/2011, revealed residents are allowed to self administer their medications when authorized by the attending physican and in accordance with procedures for self administration of medications. The policy titled Self Administration of medications indicated if a resident desires to self administer medications, an assessment is conducted by the IDT of the resident's cognitive ability (including orientation to time) physical and visual ability to carry out this responsibility. In addition, for those residents who do not want to self administer their medications it will be documented in the medical record the resident has deferred this right to the facility.	F 176	**F225D** -Resident #92 has been discharged from this facility. -Other alleged violations affecting residents are thoroughly investigated and are reported immediately to the facility administrator and to other officials in accordance with state law through established procedures. - Facility staff have been educated to report any incident of potential abuse/mistreatment to the charge nurse. Licensed staff have been educated regarding the requirement to initiate an incident report when an incident of potential abuse/mistreatment occurs and to report alleged violations of abuse/mistreatment immediately, to the ED. ED has been educated to initiate an OHFC report immediately upon notification of a potential abuse/neglect/mistreatment report, investigate any allegations of abuse/neglect/mistreatment, and report results of the investigation and corrective actions taken, to appropriate officials, in accordance with state law -Audits will be completed on all incident reports within 24 hours of a reported incident to ensure initiation of investigation as needed.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225		

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

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F 225	Continued From page 5 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report medication errors as potential mistreatment/neglect to the designated State agency (SA) for 1 of 4 residents (R92) in the sample reviewed for mistreatment. Findings include: R92 was admitted to the facility on 5/2/14 after referral from an acute care hospital, with diagnoses to include pneumonia, end stage renal disease, diabetes mellitus and a history of immunosuppressive therapy. An Initial Report to the SA on 5/2/14, identified	F 225	-Any required follow-up or re-education will be completed at that time. Audit results will be presented at QA&A for review. -ED or Designee is the responsible party. -Corrective action will be completed by 12/22/2014	

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

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F 225	Continued From page 6 R92's medication orders were incorrectly entered off R92's Resident Profile (referral information), opposed to R92's physician signed Resident Admission orders. The initial report indicated R92 had no noted adverse reactions caused by the error; the report indicated the error was discovered on 5/5/14. The report identfied the initial notice of the medication error was reported to the SA on 5/6/14, not immediately when discovered. The Investigative Report dated as sent to the regulatory agency on 5/7/14, recapitulated R92's physician orders were mistakenly entered from a Discharge Profile rather than the proper signed Physician Orders. The report contradicted the initial report and indicated the error in data entry was discovered by the Unit Coordinator on 5/6/14 (rather than 5/5/14). The report indicated R92 received incorrect medication and missed medications ordered in R92's most current orders. The report recapitulated R92 had no adverse reactions and nursing staff were reeducated on the process to prevent reoccurrence. On 10/28/14, at 3:30 p.m. the facility's administrator stated she reported an investigation of the incorrect transcription of medications from the Discharge Profile was completed. The administrator stated it was determined that even though an error had been made, staff were re-educated and R92 sustained no adverse effects. The administrator stated an Incident Report and a Medication Error Report were not completed related to the incident. The administrator acknowledged the incident was not reported to the SA immediately and stated she had "24 hours" to make the report. The	F 225		

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

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F 225	Continued From page 7 administator stated the only actual medication errors to report was R92 did not receive a Multivitamin and a decongestant medication. On 10/28/14, at 4:15 p.m. licensed practical nurse (LPN)- E stated at the time of R92's admission to the facility, she transcribed what she "thought were the admission orders" attached to the hospital Admission History and Physical Note dated 4/25/14. LPN-E stated no other orders were received and she assumed those were the admission orders. LPN-E stated she initiated the data entry of putting the medication list into the electronic medical record, stated a second facility nurse checked the orders and finished the transcription. LPN-E stated "later on" the resident's family member presented the facility with the signed Physician Orders. The Admission History and Physical listing of medication dated 4/25/14, the Interagency transfer orders dated 5/2/14, the electronically signed by the physician orders, and the Medication Administration Record for 5/2/14, to 5/6/14, were compared. The comparison revealed R92 did not receive: - Lasix (a diuretic medication for acute diastolic heart failure) 40 milligrams (mg) daily; - Lactulose (used for constipation) 30 milliliters (ml) twice a day; - Levofloxacin (Levaquin, a broad spectrum antibiotic) 500 mg one tablet daily; - Magnesium oxide (a suppliment) 500 mg one tablet twice a day; - Prednisone (a steriod medication) 20 mg one tablet once a day for five days. When compared to the above documents and the correct Physician's Orders, R92 received the following medications in incorrect doses:	F 225		

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	245052	A. BUILDING _____ B. WING _____	10/28/2014

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F 225	Continued From page 8 - Lisinopril (generally used to treat hypertension or heart failure) 2.5 mg once a day and instead received 20 mg once a day from 5/3/14 until 5/8/15. From 5/6/14 to 5/8/14, the resident actually got both orders of Lisinopril. R92 received 22.5 mg of Lisinopril instead of 2.5 mg, which was ordered by the physician upon discharge from the hospital. - Prilosec 20 mg twice a day and instead R92 received Nexium 40 mg daily (both medications were commonly used to treat gastroesophageal reflux disease). - Insulin (Levemir) 10 units (U) once a day, 20 U every night at bedtime and 3 U before meals. R92 received Levemir 6 U at bedtime on 5/3/14, and 5/4/14. According to R92's physician orders of 5/6/14 (a day after the medication errors were found), the consultant nurse practitioner reviewed the resident's medication regime and the Prednisone and Levaquin orders were adjusted. The facility's Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, Or Injures Of Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements, dated 3/2012, directed staff to immediately report incidents they had determined were reportable to the SA. The policy included an error that occurred during theraputic conduct with a resident and indicated the error may be reportable regardless of whether the resident is injured or harm occurred.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES	F 226		

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F 226	Continued From page 9 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement abuse prevention policy and procedures related to immediately reporting medication errors as potential mistreatment/neglect to the designated State agency (SA) for 1 of 4 residents (R92), reviewed for mistreatment; in addition, the facility failed to screen 7 of 38 (NA-D, NA-H, NA-C, NA-G, NA-T, NA-A, NA-B) nursing assistants for verification with the State's Nursing Assistant Registry. Findings include: Reporting: R92 was admitted to the facility on 5/2/14 after referral from an acute care hospital, with diagnoses to include pneumonia, end stage renal disease, diabetes mellitus and a history of immunosuppressive therapy. An Initial Report to the SA on 5/2/14, identified R92's medication orders were incorrectly entered off R92's Resident Profile (referral information), opposed to R92's physician signed Resident Admission orders. The initial report indicated R92 had no noted adverse reactions caused by the error; the report indicated the error was discovered on 5/5/14. The report identfied the initial notice of the medication error was reported to the SA on 5/6/14, not immediately when	F 226	**F226D** -Resident #92 has been discharged from this facility. - Other alleged violations affecting residents are thoroughly investigated and are reported immediately to the facility administrator and to other officials in accordance with state law through established procedures. - All Nursing Assistants have been screened for verification with the State's Nursing Assistant Registry. Hiring Managers have been educated to verify new NA hires are on the MN Nursing Assistant Registry prior to working with residents. All staff have been educated to report any incident of potential abuse/mistreatment to the charge nurse. Licensed staff have been educated regarding the requirement to initiate an incident report when an incident of potential abuse/mistreatment occurs and to report alleged violations of abuse/mistreatment immediately, to the ED. ED has been educated to initiate an OHFC report immediately upon notification of a potential abuse/neglect/mistreatment report, investigate any allegations of abuse/neglect/mistreatment, and report results of the investigation and corrective actions taken, to appropriate officials, in accordance with state law	

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F 226	Continued From page 10 discovered. The Investigative Report dated as sent to the regulatory agency on 5/7/14, recapitulated R92's physician orders were mistakenly entered from a Discharge Profile rather than the proper signed Physician Orders. The report contradicted the initial report and indicated the error in data entry was discovered by the Unit Coordinator on 5/6/14 (rather than 5/5/14). The report indicated R92 received incorrect medication and missed medications ordered in R92's most current orders. The report recapitulated R92 had no adverse reactions and nursing staff were reeducated on the process to prevent reoccurrence. On 10/28/14, at 3:30 p.m. the facility's administrator stated she reported an investigation of the incorrect transcription of medications from the Discharge Profile was completed. The administrator stated it was determined that even though an error had been made, staff were re-educated and R92 sustained no adverse effects. The administrator stated an Incident Report and a Medication Error Report were not completed related to the incident. The administrator acknowledged the incident was not reported to the SA immediately and stated she had "24 hours" to make the report. The administator stated the only actual medication errors to report was R92 did not receive a Multivitamin and a decongestant medication. On 10/28/14, at 4:15 p.m. licensed practical nurse (LPN)- E stated at the time of R92's admission to the facility, she transcribed what she "thought were the admission orders" attached to the hospital Admission History and Physical Note	F 226	-.Audits will be completed on all incident reports to ensure timely reporting and initiation of investigation as needed. -Any required follow-up or re-education will be completed at that time. Audit results will be presented at QA&A for review. -ED or Designee is the responsible party. -Corrective action will be completed by 12/22/2014	

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F 226	Continued From page 11 dated 4/25/14. LPN-E stated no other orders were received and she assumed those were the admission orders. LPN-E stated she initiated the data entry of putting the medication list into the electronic medical record, stated a second facility nurse checked the orders and finished the transcription. LPN-E stated "later on" the resident's family member presented the facility with the signed Physician Orders. The Admission History and Physical listing of medication dated 4/25/14, the Interagency transfer orders dated 5/2/14, the electronically signed by the physician orders, and the Medication Administration Record for 5/2/14, to 5/6/14, were compared. The comparison revealed R92 did not receive: - Lasix (a diuretic medication for acute diastolic heart failure) 40 milligrams (mg) daily; - Lactulose (used for constipation) 30 milliliters (ml) twice a day; - Levofloxacin (Levaquin, a broad spectrum antibiotic) 500 mg one tablet daily; - Magnesium oxide (a suppliment) 500 mg one tablet twice a day; - Prednisone (a steriod medication) 20 mg one tablet once a day for five days. When compared to the above documents and the correct Physician's Orders, R92 received the following medications in incorrect doses: - Lisinopril (generally used to treat hypertension or heart failure) 2.5 mg once a day and instead received 20 mg once a day from 5/3/14 until 5/8/15. From 5/6/14 to 5/8/14, the resident actually got both orders of Lisinopril. R92 received 22.5 mg of Lisinopril instead of 2.5 mg, which was ordered by the physician upon discharge from the hospital. - Prilosec 20 mg twice a day and instead R92	F 226		

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F 226	Continued From page 12 received Nexium 40 mg daily (both medications were commonly used to treat gastroesophageal reflux disease). - Insulin (Levemir) 10 units (U) once a day, 20 U every night at bedtime and 3 U before meals. R92 received Levemir 6 U at bedtime on 5/3/14, and 5/4/14. According to R92's physician orders of 5/6/14 (a day after the medication errors were found), the consultant nurse practitioner reviewed the resident's medication regime and the Prednisone and Levaquin orders were adjusted. The facility's Policies and Procedures Regarding Investigation and Reporting of Alleged Violations of Federal or State Laws Involving Maltreatment, Or Injures Of Unknown Source In Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements, dated 3/2012, directed staff to immediately report incidents they had determined were reportable to the SA. The policy included an error that occurred during theraputic conduct with a resident and indicated the error may be reportable regardless of whether the resident is injured or harm occurred. Screening A review of nursing assistant registration with the State agency (SA) indicated nursing assistant (NA)-D (hired 9/15/14), NA-H (hired 10/6/14), NA-C (hired 7/23/14), NA-G (hired 10/6/14), NA-T (hired 10/10/14), and NA-A (hired 10/6/14), were not listed on the Nursing Assistant registry. Verbal information received from the SA on 10/27/14, at 1:30 p.m. also indicated NA-B was on registry, but her registration expired as of 8/10/14. NA-B reapplied during survey and the registration was activated on 10/27/14.	F 226		

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F 226	Continued From page 13 An interview with the facility administrator was completed on 10/27/14, at 2:30 p.m and verified the findings. She indicated she was under the impression that nursing assistants had a period of 4 months to get on the nursing assistant registry upon hire. She also reported that some of the nursing assistants were on the adjoining state nursing assistant registry and were waiting for a transfer to the current states nursing registry. The facility's MN Abuse policy, revised 3/12 identified all applicants for employment in the facility shall have screening completed conducted with the appropriate licensing board or registry check.	F 226	**F253E** -R7, R67, R28, R70, R145, R26, R6, and R27 rooms have been deep cleaned. R143, R144, and R121 are not identified on the Stage 2 Sample Resident List provided by surveyors upon exit.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility was free of odors which affected 11 of 67 residents (R143, R7, R67, R28, R70, R145, R26, R6, R121, R144 and R27) in the sample. Findings include: During the initial observation on 10/20/14 and 10/21/14, strong urine odors were detected from R28, R70, R145, R26, R6, R27 and R144 rooms and corridors adjacent to the residents rooms.	F 253	-All resident rooms, as well as corridors and common user areas are checked for odors and cleanliness on a daily basis and deep cleaned as necessary. - Contracted Housekeeping and Laundry Services were changed to a different organization effective 11/3/2014 and been educated regarding the requirements maintain a sanitary, orderly, and comfortable interior and to ensure the facility is free of odors. - Audits will be conducted on a weekly and PRN basis. Audit results will be presented at QA&A for review. - ED or Designee is the responsible party. -Corrective action will be completed by 12/22/2014	

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F 253	Continued From page 14 On 10/20/14, at 4:59 p.m. R67 was interviewed and stated there was a strong urine odor by the entry door in the recent past. Review of R67's annual Minimum Data Set (MDS), completed on 7/22/14, R67 was considered cognitively intact. On 10/20/14, at 3:53 p.m. R143 reported concerns regarding a urine odor in the hallway by her room. She indicated "every couple of days it gets pretty bad." Review of R143's admission MDS dated 10/16/14, identified R143 was cognitively intact. On 10/20/14 at 6:18 p.m. R7 reported she felt there was a strong odor of urine in the facility. According to the admission MDS, completed on 9/6/14, R7 was considered to be cognitively intact. During the environmental tour on 10/27/14, at 2:00 p.m. the odors were verified. In addition, odors were detected by R143, R7, R67 and R121's rooms. An interview with Maintenance Supervisor (MS)-A and Housekeeping Supervisor (HS)-A was completed at this time (10/27/14 at 2:00 p.m.). HS-A reported there had been complaints of urine odor in the past but was not aware of the extensive problem. She indicated the nursing assistants stored soiled linens in containers in open alcoves of the hallways. These containers are not sealed, and indicated she felt this practice may lead to urine odors in the facility. The linens carts were metal frames with mesh coverings. During the tour, the linen carts were observed to have unknown substances on the sides of the mesh coverings and significant debris at the base	F 253		

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F 253	Continued From page 15 of the linen cart. HS-A verified these findings. She indicated the nursing staffs were responsible for cleaning the linen carts and did not know when the carts had most recently been cleaned. An interview with the facility administrator was completed on 10/27/14, at 4:30 p.m. She reported being told of the concern regarding the urine odors in the hallways of the facility. She reported it was the housekeeping staff responsibility to ensure the linen carts were cleaned and they had not done so.	F 253	**F272E** - R7 and R12 have been comprehensively assessed in the areas of pain management, skin conditions, medication use, ADLs, cognition, catheter use, and incontinence. Additionally, R2 has been comprehensively assessed for falls. R 38 is no longer at this facility. - All residents have the potential to be affected by the deficient practice. -Licensed Nursing staff have been educated on the requirements to conduct a comprehensive, accurate, standardized and reproducible assessment of each resident's functional capacity. RNAC has been educated regarding the documentation of summary information regarding additional assessments performed on care areas triggered and documentation of participation in assessment. -Audits will be conducted by weekly on newly admitted, annual and significant change residents during the week previous to the audit to ensure comprehensive assessments have been completed addressing all resident needs and strengths. Any re-education or follow-up will be completed at the time of the audit. Audit results will be presented at QA&A for review.	
F 272 SS=E	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit;	F 272		

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F 272	Continued From page 16 Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess 3 of 22 residents (R7, R12 and R38) in the areas of pain management, skin conditions, medication use, activities of daily living (ADL)'s, cognition, catheter use, and incontinence. In addition, the facility failed to comprehensively assess 2 of 2 residents (R2, R38) in the sample who were admitted with a history of falls. Findings include: The admission Minimum Data Set (MDS) dated 8/19/14, revealed R2 had diagnoses of COPD (chronic obstructive pulmonary disease) depression and diabetes mellitus. The MDS identified R2 had moderate cognitive impairment and required extensive assistance of two staff with ADL's which included transfers and ambulation. R2's Care Area Assessment Summary (CAA) had not been completed, including assessments at the time of the	F 272	- RNAC or Designee is the responsible party. -Corrective action will be completed by 12/22/2014.	

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F 272	Continued From page 17 admission MDS dated 8/19/14. Review of R2's record revealed R2 had been admitted to the facility on 8/13/14. R2's record lacked documentation from hospital discharge for 8/13/14 hospitalization. In addition, R2's medical record lacked documentation of a fall assessment completed for R2. R12 was admitted on 8/19/2014, with diagnoses which included partial surgical removal of the bowel due to septic infection, history of amputation of the leg above the knee, pressure ulcers, and urethral stricture. Review of R12's admission MDS dated 8/26/2014, identified R12 was moderately cognitively intact, and required the extensive assistance of two facility staff for ADL's which included bed mobility, transfer, dressing, bathing and toileting. The MDS further identified R12 had 4 stage II pressure ulcers and an indwelling urinary catheter for drainage of urine, upon admission to the facility. R12's ADL CAA, dated 9/1/2014, was a blank checklist and failed to identify factors which affected R12's ability to perform ADL's. The CAA identified R12's functional status be addressed in care plan, however the overall objective in R12's care was not identified in the CAA, and there was no input from the resident or family representative regarding R12's ADL needs. In addition, the CAA lacked identification of the impact that R12's needs with ADL's would have on the rationale for	F 272		

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F 272	Continued From page 18 care plan decisions, and any indication of whether or not a referral to another discipline was warranted. R12's urinary CAA identified R12 had an indwelling Foley catheter to drain urine from the bladder. A note under the area for referral to other disciplines identified an order from an oncologist for the catheter and an upcoming appointment with a urologist. However, the CAA lacked resident and/or representative input or any overall objective for R12's care plan. R12's pressure ulcer CAA identified R12 required extensive assistance for mobility, was at risk for developing pressure ulcers and had four stage II pressure ulcers upon admission. However, analysis of findings lacked identification of the nature of the problem/condition or any other further assessments on the checklist related to the ulcers. The CAA further lacked identification of the narcotic pain medication Norco, that was administered to R12, that could increase the risk for pressure ulcers. In addition, the CAA lacked complete identification of conditions that would present complications for pressure ulcers, such as a recent decline in ADL's. The CAA also lacked complete identification of factors that could cause complications or increase risk for pressure ulcers, such as a history of healed pressure ulcers, and the presence of an indwelling catheter. No input from the resident and/or representative was present. In the care plan consideration section of the CAA, overall objectives for care plan, and referral to another discipline were not addressed. R38's admission MDS, dated 8/10/2014, identified R38 had diagnoses which included	F 272		

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F 272	Continued From page 19 heart failure, diabetes and asthma. The MDS identified R38 was moderately cognitively impaired, required the extensive assist of two facility staff for bed mobility, transfer, dressing and toileting, and had a history of falls. R38's cognition CAA, dated 8/10/2014, failed to identify input from R38 and/or family/ representative regarding R38's cognition. In addition, the CAA lacked identification of the overall objective in the care plan, for cognitive loss or functional status, and any indication of whether or not a referral to another discipline was warranted. R38's ADL CAA lacked complete identification of underlying problems that may affect R38's functional ability such as cognitive loss, and limiting factors that could result in need for assistance with ADL's such as weakness, vision impairment, or poor balance. The CAA further lacked complete identification of risk for functional decline such as a history of falls. The section of the CAA to identify an evaluation for identified ADL problems was a blank checklist that failed to provide assessment of specific problem areas with mobility, transfer, dressing and toileting as identified in the admission MDS. The CAA further lacked any input from R38 and/or family/representative regarding R38's need for assistance with ADL's. There was also no overall objective for the care plan for the problem and no identification of whether or not R38 required referral to any other discipline. R38's CAA related to the need for extensive assistance with toileting and frequent incontinence of urine lacked identification of the type of incontinence, any input from R38 or	F 272		

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F 272	Continued From page 20 family/representative, and any overall objective for R38's care plan. The CAA also lacked identification of whether or not R38 required referral to another discipline. R38's fall CAA identified R38 had balance problems and had fallen in the month prior to admission. However, the fall analysis lacked complete identification of details for R38's fall history, identification of cardiovascular medications administered to R38, or the risk factor of a history of small strokes as indicated in R38's diagnosis list. In addition, the CAA lacked any input from R38 and/or family/representative regarding R38's falls, and an overall objective for the care plan. R7's admission MDS dated 9/6/14, indicated R7 was cognitively intact and diagnoses included chronic pain, recent colostomy placement (an opening in the abdomen into the intestines which is kept open so bowel can expel into a pouch), end stage renal disease with dialysis, depression and anxiety. The MDS identified R7 needed extensive assist with ADL's. The MDS also	F 272		

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F 272	Continued From page 21 identified R7 was in almost constant pain and was receiving scheduled pain medication, as needed pain medication and non-medicinal interventions for pain. R7's admission pain CAA dated 9/6/14, identified R7 experienced almost constant pain with a numeric rating of "7". The CAA lacked analysis of findings as the CAA did not have whether pain was a problem for R7 nor the nature of the problem/condition however, did have a checkmark in the box next to skin/wound under the diseases and conditions which may cause pain for R7 which is automatically populated by the MDS. The pain CAA for R7 also lacked characteristics of pain, frequency and intensity of pain, non-verbal indicators of pain, pain effect on R7's function, R7's input regarding pain, or the overall objective for addressing pain in R7's care plan. Other prepopulated items from the MDS checked in R7's pain CAA included: associated signs and symptoms of pain, agitation or new or increased behavior problems, which prompted the author of the CAA to describe the specific verbal or motor activity e.g. screaming, babbling, cursing, repetitive questions, pacing, kicking, scratching, etc. The last section of R7's pain CAA identified whether a referral to other disciplines was warranted, this was not answered however, the author listed in this area the following: "she does complain of surgical pain which she does request pain medication with relief, she is able to request pain medication, rates pain at a 7/10 when she will ask for medications. On 10/28/14, 5:45 p.m. RN-B revealed she had been instructed by the previous MDS coordinator to only complete the referral portion of a residents CAA, including R7's. RN-B confirmed the purpose	F 272		

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F 272	Continued From page 22 of the CAA was for a comprehensive assessment which would help to guide R7's care plan. RN-B was asked what the Resident Assessment Instrument (RAI) manual directed her to do, RN-B indicated she was not sure what the proper procedure was when completing CAA for each resident. Each facility must use its State-specified RAI (which includes the MDS, utilization guidelines and the CAAs) to assess newly admitted residents, conduct an annual reassessment and assess those residents who experience a significant change in status. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RAI does not limit the facility ' s responsibility to assess and address all care needed by the resident.	F 272	**F279D** -R4 is no longer a resident at this facility. A comprehensive care plan addressing risk factors, goals, and interventions for diabetic management and pain management for R104 has been developed. A comprehensive care plan has been developed for R76 to address depression, anxiety, and psychotic disorder, pharmocologic and non-pharmacologic interventions, monitoring of medication side effects, mood and target behaviors. -Other residents care plans are reviewed and revised as indicated with admission, quarterly, annual, and Significant Changes.	
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	F 279	-Licensed Nursing and SS staff have been educated to ensure the comprehensive care plans are developed to include measurable objectives, and timetables to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment, to include identified target behaviors, interventions, medication side effect monitoring and effectiveness. - Audits will be conducted in conjunction with scheduled care conferences to review, revise, and update comprehensive care plans as needed. Any re-education or follow-up will be completed at the	

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F 279	Continued From page 23 §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 §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 comprehensive care plans for 2 of 3 residents (R4, R104,) reviewed with problem of diabetes and pain in the sample. In addition, the facility failed to develop a comprehensive care plan which included monitoring for medication side effects, and behavior for 1 of 4 residents (R76) reviewed with unnecessary medications. Findings include: R4's care plan was not developed to identify risk factors, goals or interventions for diabetic management. R4's quarterly review Minimum Data Set (MDS) dated 9/27/14, identified R4's diagnoses of diabetes mellitus and required extensive assistance for activities of daily living (ADL's) including personal hygiene, dressing and transfers. The MDS identified R4 had cognitive impairment with both long and short term memory problems, and identified R4 received insulin injections 7 out of 7 days in the assessment period. Review of R4's current physician orders revealed an order for R4 to receive Lantus 50 units in the a.m., and 10 units at bed time for the diagnosis of diabetes.	F 279	time of the audit. Audit results will be presented at QA&A for review. - RNAC or Designee will be the responsible party. - Corrective action will be completed by 12/22/2014	

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F 279	Continued From page 24 R4's care plan revised date of 10/20/14, did not identify R4's diagnosis of DM to include interventions for staff to follow to meet the resident's diabetic needs, such as hyperglycemic (increased blood sugar levels) and hypoglycemic (decreased blood sugar levels). R104's care plan was not developed to identify risk factors, goals, or interventions for diabetic management, or pain management. R104's diagnoses included Diabetes, anxiety,and chronic renal disease. The discharge assessment with return anticipated MDS dated 8/1/14, identified the diagnoses as above, required extensive assistance for ADL's including personal hygiene, dressing and transfers, and had cognitive impairment with short term memory impairment and severely impaired decision making ability. The MDS also identified pain with scheduled daily pain medication regime, use of as needed (PRN) pain medication and non medication intervention use for pain management. Review of R104's current medication orders dated 10/1/ 14 through 10/31/14, identified R104 received Novolin insulin 28 units one time a day and 10 units in the evening, Novolog insulin 4 units as needed when blood sugars are greater than 200 for diabetes and Tramadol HCL 50 milligrams (mg) two times a day for pain. Review of R104's care plan, revised 8/11/14, identified R104 had various problems which included altered kidney function, mobility problems, had current pressure ulcer and listed various interventions to utilize with these problems. However, the care plan did not identify	F 279		

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F 279	Continued From page 25 R104 had a current problem of diabetes and pain and did not include interventions to utilize for these problems. During an observation on 10/22/14, at 7:42 a.m. of a.m. cares and transfer with the full body mechanical lift, R104 hollered out with pain multiple times. During an interview on 10/22/14, at 7:42 a.m. R104 stated stated "my right foot hurts like the devil." During an interview on 10/22/2014 1:16 p.m. licensed practical nurse (LPN)A verified R104 had pain but indicated R104 did not have pain every day. Review of 104's medical administration record (MAR) identified pain monitoring daily on every shift beginning 8/8/14. The MAR identified R104 experienced pain a minimum of 3 out of 7 days. During an interview on 10/28/2014, at 9:34 a.m. registered nurse (RN)- D verified R104 had experienced pain, required pain medications and non medication interventions. RN-D verified R104's Tramadol pain medication order had been increased to two times a day on 10/16/14, from 1 time a day due to increased pain. RN-D verified a recent increase in pain in R104's right heel from debridement of a pressure ulcer on 10/21/14. The facility policy titled Diabetes Management Guidelines revised date of September 2014, identified needed monitoring and implementation of interventions for identified signs and symptoms for hyperglycemic and hypoglycemic episodes, and details regarding diet and exercise outcomes	F 279		

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F 279	Continued From page 26 and needed considerations. During an interview on 10/28/2014, at 3:30 p.m. the director of nursing (DON) verified the omission of diabetic and pain management in the care plan. The DON verified the expectation of all resident needs to be addressed in the residents care plan, including pain management and diabetic management, along with intervention. The requested facility policy regarding resident care plans was not provided. Review of R76's quarterly MDS dated 8/1/14, revealed R76 had severe cognitive impairment, exhibited symptoms of delirium such as inattention, disorganized thinning which fluctuated, lacked resident and staff interview for mood assessment, exhibited behaviors such as wandering and other behavioral symptoms not directed at others (no clarification received on	F 279		

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F 279	Continued From page 27 what this entailed). The MDS also revealed R76 had a diagnosis of Dementia, depression, psychotic disorder and anxiety. R76's Care Area Assessment (CAA) dated 3/8/14, revealed R76 had moderate cognitive impairment. The CAA further revealed R76 received an antipsychotic medication for behavior and anxiety which required monitoring for side effects and signs of improvements or changes in behaviors. Review of R76's medication order summary report signed 9/18/14 by physician revealed R76 was receiving the following medications: Ativan (an antianxiety medication) 0.25 mg by mouth three times a day for dementia/anxiety, order dated 8/5/14, as well as Zyprexa (an antipsychotic medication) 5 mg by mouth at bedtime for psychotic disorder, order dated 6/12/14. The order further directed staff to complete daily focus charting on signs of depression, anxiety and psychosis, which directed staff to chart all behaviors i.e. request for cigarettes, wandering into rooms, attempts to elope, order dated 7/22/14. R76's order summary report also directed staff to monitor for side effects for Zyprexa and Ativan, update clinical nurse practitioner (CNP) as needed, Fax nursing notes to clinic on 8/5, order dated 7/22/14 with no stop date. Another order dated 6/10/14, directed staff to monitor mood, psychotic symptoms, side effects, increased craving fro cigarettes, update 6/16/14 and 6/23/14 and as needed, follow up in 1-2 months and as needed every shift, this order did not have a stop date. R76's care plan print date of 10/28/14, initiated on 3/5/14, lacked any mention of R76's diagnosis of	F 279		

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F 279	Continued From page 28 depression, anxiety or a psychotic disorder nor any indication for monitoring R76 for side effects, mood, behavior, interventions (both non-medicinal or medicinal) for mood and/or behaviors. Review of R76's progress notes from 5/10/14 to 10/24/14 lacked evidence of daily focus charting from from 7/22/14 to 10/24/14, which had directed staff to document signs of depression, anxiety, psychosis and monitoring of potential side effects of the psychotropic medications. A form titled, Sanford Medical Center, dated 9/23/14, revealed a progress note authored by a Clinical Nurse Specialist (CNP) in the field of psychiatry. The progress note identified R76 had a diagnosis of Dementia with behavioral disturbance and psychotic disorder. The progress note directed facility staff to continue Zyprexa, Lorazapam (Ativan) and treatment plan, continue behavioral interventions and support. The note also directed staff to monitor depression, anxiety, psychotic symptoms, side effects and behavior. A second progress note dated 6/16/14, authored by the same CNP directed staff to monitor R76's mood, psychotic symptoms, side effects, increases craving for cigarettes. On 10/28/14, 3:29 p.m. the DON stated he expected residents (including R76) which exhibited behaviors, received psychotropic medications (including Zyprexa and Ativan) were to have a care plan which addressed target behaviors, interventions and monitoring for side effects of the medications. The DON verified R76's care plan lacked any mention of diagnosis, medications, mood, behaviors or interventions.	F 279		

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F 279	Continued From page 29 Facility form titled golden clinical services, Behavior Management Guideline revised 2013, directed licensed staff to complete a plan of care following any behavioral concern and any antipsychotic medication used by residents. The guidelines also directed staff to implement a monitoring system for target behaviors, interventions and medication effectiveness and side effects. A care planning policy was requested, the facility did not provide.	F 279	**F309G** -R7 has been comprehensively assessed for moderate to severe pain. Resident currently ambulates independently throughout facility and her w/c has been dc'd. SS is in the process of assisting resident to find an apartment for independent living following up-coming discharge.	
F 309 SS=G	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 comprehensively assess pain and implement interventions to relieve moderate to severe pain following an infection and surgical procedure to the right knee for 1 of 3 residents (R7) reviewed for pain. This deficient practice caused actual harm to R7. Findings include: R7's admission Minimum Data Set (MDS) dated 9/6/14, identified R7 was cognitively intact, had	F 309	-- Other residents are receiving 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, ie., pain. - Licensed Nursing staff have been educated on the requirements to conduct a comprehensive, accurate, standardized and reproducible assessment of each resident's functional capacity. RNAC has been educated regarding the documentation of summary information regarding additional assessments performed on care areas triggered and documentation of participation in assessment. -Audits will be conducted weekly on newly admitted, annual and significant change residents to ensure comprehensive assessments have been completed	

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F 309	Continued From page 30 diagnoses which included chronic pain, recent colostomy placement (an opening in the abdomen into the intestines which is kept open so bowel can expel into a pouch), depression and anxiety. The MDS identified R7 needed extensive assistance with all activities of daily living (ADLs). Further, the MDS identified R7 was in almost constant pain and was receiving scheduled pain medication, as needed pain medication and non-pharmacological interventions for pain management. Review of R7's September medication administration record (MAR) 9/1-9/26/14 revealed the resident was receiving the following medications for pain: -Lyrica (used to treat nerve pain and fibromyalgia) 25 milligrams (mg) three times a day for pain. -Acetaminophen (Tylenol) 325 (mg) two tablets as needed every four hours for pain. -Fentanyl (narcotic medication used to treat moderate to severe pain) patch 12 (micrograms) mcg every 72 hours topically (order started 8/30/14). -Oxycodone (opioid analgesic used to treat moderate to severe pain) 5 mg tablets, give 15 mg by mouth as needed (PRN) for pain. -Lidocaine patch (a numbing medication impregnated into a patch and applied topically for pain relief), apply one patch transdermally one time a day related to anxiety disorder, on at 9 a.m. off at 9 p.m. and remove per schedule. According to the record, R7 had been readmitted following a hospitalization to the facility on 9/27/14, with the following diagnoses: acute encephalopathy likely from medication error, right knee effusion with referral to orthopedics for	F 309	addressing all resident needs and strengths. Any re-education or follow-up will be completed at the time of the audit. Audit results will be presented at QA&A for review. - RNAC or Designee is the responsible party. -Corrective action will be completed by 12/22/2014	

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F 309	Continued From page 31 chronic pain. At the time of readmission, R7 had the following medications ordered for pain; -Lyrica 25 mg three times a day for pain -Tylenol 650 mg every four hours as needed for pain -Ultram (non-opioid pain medication) 50 mg every 8 hours as needed for pain, the MAR revealed the medication was discontinued on 10/6/14. Further, the hospital discharge summary dated 9/27/14, directed the facility to discontinue the following medications for R7: Fentanyl patch 12.5 mcg/hr, hydroxyzine (antianxiety), lidocaine patch, lidocaine preservative free 1% solution, Ativan (antianxiety medication) 0.5 mg tablet and oxycodone 5 mg tablet immediate release. The record indicated R7 had been readmitted to the facility 10/15/14, following another hospitalization, at which time the following diagnoses were identified: methicillin-sensitive staphylococcus aureus (MSSA- a bacteria which is resistant to antibiotics other than methicillin), right prosthetic knee septic arthritis, status post irrigation and debridement with poly exchange of right knee prosthetic. R7's admission Pain Care Area Assessment (CAA) dated 9/6/14, identified R7 experienced almost constant pain with a numeric rating of 7 (numeric scale from 0-10 with 10 worst pain). However, the CAA lacked any documentation regarding the pain characteristics including, frequency and intensity of pain, non-verbal indicators of pain, pain effect on R7's function, R7's input regarding pain nor identification of non-pharmacological interventions. The last section of the pain CAA included a place to	F 309		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 32 Indicate whether a referral to other disciplines was warranted however, the section was not answered. However, the author of the CAA had documented, "She does complain of surgical pain which she does request pain medication with relief, she is able to request pain medications, rated pain at a 7/10 when she will ask for medications." A Clinical Health Status form dated 8/30/14, identified R7 had moderate pain on a verbal descriptor scale (a verbal indicator scale used to rate pain which could be marked as: no pain, mild, moderate, severe, very severe, horrible and unable to answer.) However, the form lacked any documentation to indicate the location of R7's pain, characteristics of pain, radiation, pattern, frequency of pain, descriptors of pain, non-pharmacological interventions for pain management, or the goal for R7's pain management. The Clinical Health Status form dated 9/27/14, lacked any documentation regarding R7's pain level, and also failed to identify the location, pattern, frequency, and characteristics of the pain, and failed to identify non-pharmacological interventions utilized to treat the pain. R7's re-admission Clinical Health Status form dated 10/15/14, identified R7 rated her pain as an 8 on a numeric pain scale and severe on the verbal descriptor scale. However, the form failed to address a comprehensive assessment of R7's pain including location of pain, characteristics of pain, pattern, frequency, descriptors, non-pharmacological interventions implemented, or the goal for R7's pain management.	F 309		

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	245062	A. BUILDING _____ B. WING _____	10/28/2014

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F 309	Continued From page 33 Review of R7's care plan last revised 10/20/14, indicated: "Plan of Care-Pain/Pain Symptoms" preprinted form and had the problem of potential for pain or pain symptoms related to abdominal pain dated 8/30/14, identified R7 had "post-surgical pain Abdomen" and indicated the following interventions were to be utilized: Assess and establish current level of pain and acceptable level of pain. Implement pain control strategies of: (this portion of the form to list the strategies was blank), medications per MD order, assess effectiveness of medications for pain relief and resident response to and update MD as needed, evaluate need for administration of medications prior to treatment or therapy, therapy to eval and treat. The care plan lacked documentation of any non-pharmacological interventions to utilize for R7 and lacked documentation of R7's acceptable level of pain. R7's care plan did not address her knee pain or her recent surgery. On 10/21/14, at 11:09 a.m. R7 was observed to be seated in a wheelchair in her room, facing the window. R7 was observed rubbing her right leg around the knee area, she was grimacing and stated her knee hurt so bad it was almost unbearable. R7's brow was furrowed, lips were tight and her jaw was clenched during her interview. Subsequent review of the MAR indicated R7 had received oxycodone 5 mg at 10:35 a.m. On 10/22/14, at 8:20 a.m. R7 was seated in a wheelchair at a table in the dining room eating breakfast. R7 was observed to repeatedly rub her right leg and knee while grimacing and stating she had right knee pain. At that time, R7 stated she received pain medication as needed but the "pain never went away."	F 309		

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F 309	Continued From page 34 On 10/22/14, at 9:06 a.m. R7 was observed propelling herself in her wheelchair from the dining room to the main entrance hesitantly using her legs. She continued to have a clenched jaw and a grimace on her face. On 10/23/14, at 8:18 a.m. R7 was seated in dining room eating breakfast. R7 was observed with a frown, and teary eyes. R7 stated she had pain in the right knee. On 10/23/14, at 8:29 a.m. R7 was observed to have a clenched jaw, frown and grimace on her face while she rubbed her right knee on either side of the knee. R7 stated she was in pain all of the time and that the pain affected her daily activities, sleep and mood. R7 confirmed she had long term pain and stated her pain had become much worse when her right knee became infected following surgery. She further described the pain as a constant, strong aching pain of her right knee. R7 stated when she has complained of pain some nurses would tell her to believe the medication would work, and others would tell her the medication needed time to work. R7 also stated a few nurses would offer ice for her right knee when she was in bed. On 10/24/14, at 8:18 a.m. R7 was seated in a wheelchair by main entrance to the facility, waiting for transport for dialysis. R7 asked licensed practical nurse (LPN)-K for pain medication at that time. LPN-K stated to R7 it was not time to have scheduled medication until noon. LPN-K stated she could not send pain medication with (as R7 would not be returning until p.m. from dialysis) because the medication was a controlled medication. LPN-K did not offer an alternative to	F 309		

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F 309	Continued From page 35 controlled pain medications such as Tylenol, Ice pack or other non-medicinal interventions. Review of nursing progress notes from 9/21/14 to 10/23/14 revealed the following: -9/21/14, at 11:43 a.m. R7 complained of more pain in knee, had past knee replacement, knee was warm to touch on outer side, at times was tender to touch, stated pain increased from day prior (9/20/14), was sent to the hospital for an evaluation. Review of 9/21/14, hospital visit revealed an order for Tramadol (analgesic medication) 50 mg one tablet by mouth four times a day as needed for moderate pain, and the emergency room was to schedule a follow up appointment with orthopedics. -9/27/14, at 4:29 p.m. R7 returned to the facility, her orders remained the same except "some pills and Fentanyl were discontinued." -9/27/14, at 5:27 p.m. R7 complained of pain, received as needed Tylenol and Ultram (non-opioid analgesic) as ordered. The note lacked documentation of the effectiveness of the medications. -9/27/14, 11:31 p.m. as complained of pain, has prn tylenol and ultram for pain also takes Lyrica. The notes lacked documentation of the effectiveness of the medication. -9/28/14, at 7:56 p.m. R7 complained of pain, Tramadol (Ultram) given for pain, the notes lacked follow up documentation of the effectiveness of the medication.	F 309		

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F 309	Continued From page 36 -9/28/14, at 11:35 p.m. R7 received prn pain medication 2 times on shift, the note lacked any description of the effectiveness of the medications. -10/4/14, weepy on shift wanted something for pain, received Tylenol then later received Ultram for pain and ice pack knee area, then rested. However, the note lacked medications effectiveness overall. -10/7/14, at 2:20 a.m. the note revealed resident had pain occasionally that was well managed with scheduled Tramadol (Ultram). -10/7/14, at 9:19 a.m. R7 had received scheduled pain medications, stated effective with pain management. -10/8/14, R7 was admitted to the hospital due to an infection of her right knee. -10/15/14, returned from hospital, right knee was infected/septic, irrigated and debrided at hospital. -10/16/14, at 2:09 p.m. R7 complained of pain twice on shift, pain medications given with positive effect, ice applied to right knee, rested in bed. -10/16/14, at 11:34 p.m. R7 had received oxycodone one tab given for knee pain, effective results. -10/18/14, had frequent complaints of knee pain, had prn medications for that. The note lacked documentation of the effectiveness of medication.	F 309		

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F 309	Continued From page 37 -10/19/14, at 1:15 a.m. R7 had occasional pain that was managed well with prn oxycodone that was effective. -10/19/14, at 3:19 p.m. the note revealed pain was "usually controlled," however the note lacked documentation of location of pain, characteristics, frequency, non-pharmacological interventions or rating of the pain. -10/21/14, at 9:45 a.m. received prn oxycodone, note lacked whether medication was effective. -10/21/14, at 11:47 p.m. R7 was able to voice concerns to staff, occasionally had pain that was managed well with prn medications, had knee surgery and tolerates the pain well. -10/22/14, at 2:45 p.m. the note indicated R7's pain was controlled with occasional days of being needy and wanting one on one, was redirected with food, fluids or activities, goes to therapies, sleep varies. -10/23/14, R7 had prn pain medications twice with some relief, R7 spoke with nurse regarding pain medications, this nurse spoke with another nurse regarding pain medications and effectiveness and the possibility R7 needed an increase in dosage of oxycodone. R7's current medications per the September and October 2014 MAR revealed the following medications used to manage R7's pain: Lyrica capsule 25 mg give one capsule by mouth three times daily, however, R7's MAR revealed she had not been given the Lyrica as ordered on 7 out of 24 days.	F 309		

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F 309	Continued From page 38 Acetaminophen (Tylenol) 325 mg give two tablets by mouth every 4 hours as needed for pain, elevated temp, for mild to moderate pain. The MAR revealed R7 received this medication 6 times in 24 days. Oxycodone hydrochloride tablet 5 mg by mouth every 6 hours as needed for severe pain or breakthrough pain, ordered 10/15/14. The MAR revealed R7 received the medication on 10/15, 10/16, 10/17, 10/19 once each day (x 1), 10/18, 10/20 three times and on 10/21 twice. However, the MAR and progress notes lacked effectiveness of the medication in relieving R7's pain. The September 2014, MAR included directions to document pain with pain scale every shift. The monitoring indicated that R7's pain rating ranged from 0-7 on a numeric pain scale. This order was discontinued on 9/27/14, despite recent surgical procedure due to infection. After return on 9/27/14, the routine monitoring of R7's pain was discontinued and was no longer completed from 9/27/14 to 10/21/14. The October 2014, MAR did not direct staff to monitor pain every shift or the effectiveness of pain medication despite right knee pain and surgery. On 10/23/14, 10:54 a.m. nursing assistant (NA)-I indicated R7 complained daily of pain to her right knee since she came back from the hospital. She stated R7 had pain with movement, especially when transferring out of bed. NA-I stated R7 seemed to become anxious with pain and sometimes R7 would be teary eyed in the	F 309		

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F 309	Continued From page 39	F 309		

morning with movement. NA-I stated she would notify the nurse if R7 was in pain. NA-I indicated she had not received directions on non-pharmacological interventions that were to be attempted for R7.

On 10/23/14, at 11:00 a.m. NA-C stated R7 had pain daily, and indicated R7 identified she had pain in her right knee with movement. She stated she observed R7 in pain when transferring out of bed in the morning. NA-C stated she was unaware of any non-pharmacological interventions that were to be attempted for R7. NA-C would notify the nurse R7 had pain upon completion of cares.

On 10/23/14, at 11:02 a.m. licensed practical nurse (LPN)-A indicated she had tried non-pharmacological interventions for R7 in the past (ice pack to knee, distraction and activities as able.) LPN-A was unable to provide documentation of any non-pharmacological interventions that had been tried for R7's pain.

On 10/23/14, at 9:34 a.m. registered nurse (RN)-B confirmed the facility had not completed pain assessments for R7 on 9/27/14 and 10/15/14. RN-B indicated she expected the Clinical Health Status form to be completed for each admission.

On 10/23/14, at 9:52 a.m. LPN-A indicated her usual practice was to utilize the MAR which prompted her to evaluate a residents pain level. LPN-A stated she was not aware of what an acceptable level of pain was for R7. She stated she felt an "8" would be acceptable for R7.

On 10/23/2014, at 10:08 a.m. RN-B stated she

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F 309	Continued From page 40 expected the Clinical Health Status form to be utilized to assess all residents pain. RN-B confirmed R7' current care plan and indicated R7's problem of right knee pain should have been addressed on her care plan. RN-B stated she routinely attended the facility's daily stand up meeting with other disciplines (administrator, director of nursing (DON), social services, activities and nurse supervisors,) and stated R7's problem of pain had not been discussed at any of these meetings. On 10/23/14, at 4:04 p.m. LPN-B stated due to continued reports of pain, the facility contacted R7's physician and requested scheduled pain medication for R7. LPN-B confirmed R7 had increased pain of her right knee since it had become infected which required surgical intervention. LPN-B stated in the past when she " has had the time," she had attempted spending time talking with R7 and felt it had briefly helped R7's pain. On 10/24/14, at 10:00 a.m. certified nurse practitioner (CNP)-A felt R7 had not been assessed for pain and indicated the lack of assessments for pain management was something she saw routinely at the facility. On 10/28/14, at 3:29 p.m. the DON indicated he expected pain to be assessed upon admission and with any changes that would affect pain, the resident would be reassessed. He indicated he would have expected R7's MAR to have routine pain monitoring on every shift. Review of the facility policy titled Clinical Guide: Clinical Health Status, dated July 2009 revealed: a thorough assessment of resident/patient	F 309		

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F 309	Continued From page 41 conditions on admission, quarterly and with significant change in condition. The data collected would assist in identifying risks and appropriately establish a plan of care. It is important the clinical health status and the immediate plan of care is completed within 24 hours of admission. The policy directed staff to complete all sections of the clinical health status form. Review of the facility policy titled Pain Management Guideline revised January 2011, revealed the following purpose of the policy: to provide guidance for consistent assessment, management and documentation of pain in order to provide maximum comfort and enhanced quality of life. The policy directed staff to ensure involvement of resident in pain management, to recognize and report pain, assess pain, evaluating response to pain management and non-pharmacological interventions. The policy further directed staff to provide education to residents, family and staff regarding misconception of tolerance, physical dependence and addiction in relation to pain relieving medications. The policy directed staff to complete pain assessments, utilize a method for rating pain, documentation of pain management, utilizing non-pharmacological intervention.	F 309		
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.	F 323		

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F 323	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adequate supervision for 2 of 2 residents (R146, R86) who had been determined to be at risk for elopement and left the facility without staff knowledge. The lack of supervision put both residents at risk for significant harm. In addition, the facility failed to ensure electric cords were placed in a fashion that would not increase the risk for staff, resident, or visitor tripping or falling for 1 of 1 resident (R67). Findings include: ELOPEMENT: Review of R146's face sheet revealed R146 had been admitted to the facility on 9/8/14. He was referred from a community acute care hospital, where he had been hospitalized since 8/28/14. R146's discharge summary dated 9/8/14, indicated R146 presented in the emergency room on 8/28/14, with shortness of breath and persistent productive cough. R146's initial diagnoses include chronic obstructive pulmonary disease (COPD), hypertension, and seizures. On 10/22/14, at 2:30 p.m. the administrator and director of nurses (DON) indicated on the day of R146's admission to the facility (9/8/14), R146 left the facility without staff authorization (eloped). He had told other residents he was going to a local department store. Upon discovering the resident was not at the facility, the staff did search the facility and grounds. When unable to find the resident, the facility administrator went to the reported department store and looked for the	F 323	**F323D** -Residents 146 and 86 no longer reside at the facility. Resident 67, room has been evaluated for tripping hazards and safety. Appropriate interventions have been implemented related to tripping hazards. -Other residents are provided an environment that is free of accident hazards as possible; and receives adequate supervision and assistance devices to prevent accidents. Residents are assessed upon admission, quarterly, annual and with change of condition, for risk of elopement, falls, tripping hazards and adequate supervision. -Staff have been educated on Elopement Policy as identified per assessment, and Environmental Factors affecting safety. Audits will be conducted weekly on newly admitted, quarterly, annual, and significant change residents for residents assessed at risk of elopement, and environmental audits for tripping hazards. Any re-education or follow-up will be completed at the time of the audit. Audit results will be presented at QA&A for review. The ED/Designee is the responsible party. Corrective action will be completed by 12/22/2014	

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F 323	Continued From page 43	F 323		

resident. When she was unable to find him at this location, the facility staff were directed to complete a missing person report and notify the police. The resident was found at his apartment by the police and R146 agreed to voluntarily return to the facility.

Upon R146's admission to the facility on 9/8/14, an undated and unsigned Initial Clinical Health Status form used for assessment was completed. The assessment form noted R146 had intact short-term memory, but long-term memory problems. The form noted R146 needed assistance with decisions at the time of his admission, identified R146 was able to verbally make himself understood and was able to understand others. The form identified R146 had no indication of depression, anxiety, sadness or difficulty adjusted to new conditions and had no behaviors symptoms. The assessment form for risk of elopement identified R146 was physically able to leave the building on his own and was considered cognitively impaired. According to the assessment format, if these areas were affirmatively answered; further consideration of development of a plan of care to prevent elopement was to be done. The clinical record lacked evidence R146's elopement risk was further assessed. In addition, the assessment form did not identify an immediate plan of care, or education for R146.
R146's initial care plan, dated as established on 9/8/14, identified R146 was vulnerable, ignored personal safety, was unkempt, poor hygiene, and apartment had been found to be dirty. However, the care plan did not address potential for elopement.

The hospital Discharge Summary dated 9/8/14,

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F 323	Continued From page 44 reported R146 had been assessed by the hospital Physical Therapy and needed to use a front wheel walker (FWW) when ambulating and needed close supervision of activity. Additionally, the summary indicated Occupational Therapy had recommended to provide supervision with his activities of daily living (ADLs) due to cognitive deficits. The summary indicated R146 was considered to be medically stable upon discharge from the hospital, but the resident would benefit from permanent placement in adult foster care. The summary indicated this living arrangement could not be made for a "couple weeks" and the resident was sent to the facility for short-term care until permanent placement was found. The referring hospital's occupational therapist documented she had seen R146 on 9/8/14, and recommended 24/7 (24 hours/7 days per week) level of supervision and assistance with ADLs due to cognitive deficient. The plan was for R146 was to complete his ADLs with SBA (stand by assist) and he used a FWW. The referring hospital occupational therapist noted R146 was not safe to be alone when completing his ADLs. The summary indicated the referring occupational therapist also completed the Montreal Cognitive Assessment and indicated R146 had cognitive impairment. A facility Progress Note dated 9/9/14, at 7:31 p.m. noted R146 had been pacing around the facility for the majority of the day and had increased anxiety; R146 had made phone calls to a number of case workers to arrange a ride to his apartment to check on his dogs. R146 reported he had not checked on his dogs for "days;" when he had been there the previous evening. The note indicated he had a history of alcoholism and needed monitoring to ensure he did not relapse.	F 323		

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F 323	Continued From page 45 The note indicated R146 was not to leave the facility independently without the accompaniment of staff or his case worker. The progress note indicated the "Ultimate goal is to get him into an adult foster home." On 9/11/14, a Progress Note indicated R146 had taken his dog out of the facility for toileting at approximately 1:30-2:00 a.m. The note indicated at 3:30 a.m. a nursing assistant reported R146 was not in his room, a search of the building and grounds were immediately conducted, and the resident was not located. The report indicated the police department, facility administrator, physician and guardian were notified. An interview with the facility administrator and the acting director of nursing (DON) was conducted on 10/22/14, at 2:30 p.m. Both verified F146 had left the facility on the day of his admission and stated even after his initial elopement, they had not considered R146 at risk for further elopement as he was "not confused," was "his own person," and "able to make his own decisions." Both the DON and administrator stated R146 had a guardian, but the guardian was "essentially a case manager only." They stated no legal paperwork had been received by the facility regarding guardianship and further stated it was the resident's case manager/guardian's responsibility to inform the facility if it was felt R146 was an elopement risk. The administrator and DON stated R146 was very concerned about his two dogs remaining at his apartment. The administrator and DON stated the facility made arrangements for the dogs, including having one of the dogs reside with R146 at the facility. As result, they did not implement any other elopement interventions.	F 323		

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F 323	Continued From page 46 A phone interview with the resident's guardian was completed on 10/24/14, at 8:47 a.m. The guardian reported she had been appointed as R146's legal guardian for medical purposes and legal abode. She indicated R146 was referred to the facility after the local hospital refused to discharge R146 until arrangements were made for him to be placed in a facility that could provide 24 hour supervision. The guardian reported she was hesitant about the referral to the facility as his apartment was very close to the facility. She indicated she had informed the facility he was a risk for elopement and had requested he not be allowed to leave the facility on his own. In addition, she verified the placement in the facility was temporary until R146 could be placed in a group home or an adult foster home. She reported the "current where about's" of R146 following the elopement from the facility "was unknown." Review of R146's verification of investigation form, dated 10/11/14 indicated R86 left the facility without staff knowledge on 10/11/14. The facility received a call from a friend of R86 at 3:00 p.m. on this date and informed the facility the resident had returned to his apartment because, "He was discharged." The facility and grounds were then searched and R86 was not found. It was reported he was last been seen at 12:30 p.m. The police were contacted and found the resident in his apartment, eating a meal and watching TV. R86 refused to return to the facility, or go to a local hospital emergency room. The police reportedly determined R86 was not a danger to himself or others and left him in his apartment.	F 323		

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F 323	Continued From page 47 Review of R86's face sheet revealed R86 was admitted to the facility on 9/26/14. He had been hospitalized for 8 days prior to his admission to the facility due to sepsis (a potential life threatening systemic infection) and an urinary tract infection. Upon admission to the facility, R86 also had diagnoses to include unspecified episodic mood disorder and dysthymic disorder (a long term form of depression). A Pre-Admission Screening and Resident Review assessment had been completed by an external agency on 9/19/14, and was part of the facility's medical record. This assessment reported R86 had a major mental illness of psychotic/delusional disorder and had no current symptoms of his major mental illness. R86 was prescribed Alprazolam (Xanax-a medication used to treat anxiety) and Risperdal (a medication commonly used to treat schizophrenia). He had an intellectual disability secondary to a traumatic brain injury and had substantial functional limitations of self-care, self-direction and capacity for living independently. R86's Clinical Health Status form dated 9/26/14, noted the R86 was alert, intact memory but needed assistance with decisions. R86 had no communication barriers, no indication of mood concerns and able to ambulate and transfer independently; the assessment identifed R86 had a history of wandering. R86's Clinical Health Status form also identified R86 was able to physically leave the building on his own, was cognitively impaired, impaired decision making skills, had recent medication change, and had recently moved to the facility. In	F 323		

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F 323	Continued From page 48 addition, the form identified R86 had a history of wandering or elopement, made repetitive statements wanted to go home, identified if the those questions answered affirmatively, directed to implement the elopment plan of care. The form identified a wander guard (a device which alarms when near an exit door) was placed on the resident on admission (9/26/14). The form indicated a risk brochure for elopment had been addressed. The admission Minimum Data Set (MDS) completed on 10/2/14, identified R86 had moderate cognitive impairment with no symptoms of delirium or psychosis; identified he had incidents of verbal aggression and episodes of rejecting personal cares. The MDS noted R86 had become independent with his personal cares, ambulated independently and was continent of bowel/bladder. R86's undated initial care plan identified R86 required supervision for ADLs, monitoring for shortness of breath and chest pain. However, the care plan did not address elopement risk for R86 or the use of the wander guard. The Physician Order Summary Report signed by R86's physician on 9/26/14, specified R86 could go on pass or leave of absence with his responsible party and medications. Review of R86's Progress Notes written on 9/26/14, 9/27/14, 9/28/14, and on 10/3/14 included documented statements made by R86 of wanting to leave the facility The Progress Note written on 9/28/14, at 12:33 a.m. noted R86 was confused. The Progress	F 323		

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F 323	Continued From page 49 Note on 9/30/14, at 11:44 p.m. referenced the resident was easily confused and needed prompts to use the bathroom. The progress note of 10/3/14, at 12:05 p.m. reported, "Resident is very verbal and discusses with his case managers that he" wants to get the hell out of here" Resident had threaten to cause physical harm to case managers for not giving him "enough money ..." The progress note on 10/7/14, at 6:12 p.m. noted R86 denied the black framed glasses he was wearing were not his. The progress notes on 9/26/14, 9/27/14, and on 9/28/14, had documentation R86 continued to have a wander guard on his person. The clinical record lacked further documentation of the presence of the wander gard or if the wander guard was functioning correctly. The facility's medical record also contained legal documentation of guardianship of the resident, dated 3/11/13, as R86 had been diagnosed with mild mental retardation with impaired receptive and expressive language skills, psychotic disorder, personality change secondary to brain injury. The legal appointment of guardianship documented R86 was dependent upon service providers for daily living supports and cares to meet all domestic, physical and medical needs. The documentation also noted R86 lacked the ability to care for himself and to make decisions in his own best interests. An interview with the administrator and DON was completed at 10/22/14, at 2:30 p.m. Both reported R86 was "his own person" and even though he had a guardian, the guardian was more of a case manager. They indicated the resident made his own decisions regarding healthcare. The	F 323		

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administrator and DON stated they did not consider the situation to be an elopement and R86 had a right to leave the facility and stated they could not have stopped him from leaving. The administrator and DON also reported they thought the facility's interdisciplinary team had discontinued the wander guard. Both were asked to provide this documentation and the justification (none were provided). They denied the guardian had been consulted prior to any decisions being made regarding the removal of the wander guard. DON reported it was the expected for staff to make rounds to look in on residents a minimum of every two hours. The administrator and DON stated "generally" staff knew where the residents were at all times.

An interview was completed with the Admissions Coordinator (AC) on 10/24/14 at 10:18 a.m. AC reported R86 was referred to the facility by a local hospital and his legal guardian, who voiced concerns regarding the possibility of R86 leaving the facility. AC reported the guardian was concerned about possible elopement as she felt R86 was not safe at home and efforts were being made for the referral to an assisted living facility for long-term placement. AC reported she was aware R86 was not happy about being at the facility and wanted to go home. AC indicated R86 had not made any effort to elope until 10/11/14. AC stated typically if residents were an elopement risk, a wander guard was applied. During the interview, AC reviewed the medical record and verified there was no evidence of the wander guard on the resident since 9/27/14.

A phone interview was completed with R86's guardian on 10/24/14, at 9:55 a.m. She stated R86 had been hospitalized for urinary tract

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F 323	Continued From page 51 Infection and an overdose of hydrocodone (a narcotic pain medication). The guardian reported she was told R86 was initially very weak and needed assistance of one staff with ambulation. She stated she was told R86 was to have a catheter for 4-5 weeks upon his transfer to the facility. The guardian indicated the hospital discontinued the catheter before he was transferred to the facility and she was not aware of this at the time. The guardian reported she had thought the facility was appropriate for R86 upon referral, due to his generalized weakness and the presence of a catheter. She reported she had assumed due to these issues, he would not elope. She indicated she was currently attempting to locate a secure (locked) living environment for R86. She reported R86 was not happy about his admission to the facility and was under the impression "some type of alarm was place on the resident to notify the staff if he attempted to leave." She indicated she thought the resident had observed the city bus come to a department store next to the facility. As a result, R86 got on the bus and left the facility. The guardian verified she was R86's guardian for all medical, abode and financial decisions. She verbalized being very concerned about the resident's safety as his neighbor had been verbally and emotionally abusive to him in the past. She also reported R86 had abused the narcotic medication that had been prescribed for pain. The guardian stated since R86's elopement, she had contacted "the county" and reported him as a vulnerable adut. The guardian verbalized concern regarding R86's safety as he was not living in a safe environment and concern he was not taking his medications as prescribed. She stated R86 had a history of not taking his prescribed medication or not eating for several days at a time.	F 323		

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F 323	Continued From page 52 The facility's Elopement policy, dated 5/18/06, defined elopement as a resident with impaired decision making ability, who was oblivious to his/her own safety, needs and therefore at risk for injury outside the confines of the facility, had left the facility without the knowledge of staff. The intent of the policy was to identify residents at risk for elopement, minimize the episodes of elopement, protect residents that were not capable of protecting themselves and provide the techniques and equipment to minimize safety risks. The policy directed staff to assess, upon admission the resident's potential to exit without staff knowledge and to address this in the care plan. The care plan was to address the resident's potential to elope and the measures taken to prevent the elopement. Documentation that a resident's alarm/device was in place every shift and ensure the alarm/device was functional at least once per week. The frequency of visual checks of the resident was to be established in accordance of the resident's needs. The residents, who were identified at risk of elopement, were to be assessed quarterly and as needed with behavior monitoring documentation. After an elopement, an assessment was to be completed. The assessment was to identify observed behaviors or resident's statements, objective data, underlying illness or diagnosis, physical assessment and general appearance. After the resident has been thoroughly assessed, the staff were directed to document the findings, notify the attending physician, report resident assessment and determine appropriate action to be taken, notify the family/responsible party and transfer to the hospital as necessary. Additionally, the staff were directed to update the care plan, establish visual checks and investigate causal	F 323		

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F 323	Continued From page 53 factors related to the elopement. SAFETY HAZARDS On 10/21/14, at 11:40 a.m. R67 was observed in her living environment, an extension cord was observed to be plugged into an electric outlet on the wall by the left side of the resident's bed. The extension cord ran under the resident's bed, across the floor, about six inches off the floor to a radio on the resident's bedside table. The cord was approxmiately four feet from the bedroom entry door. The clinical health status (admission assessment) completed on 7/15/13, identified R67 was at risk for falls; R67 had diagnoses to include orthostatic hypotension, Parkinson's disease and lack of coordination. The annual MDS dated 7/22/14, identified R67 was cognitively intact and was generally cooperative without rejection of personal cares incident. R67 had no signs or symptoms of delirium, psychosis or any behavioral issues. R67 needed extensive assistance of one facility staff with bed mobility, transfers, ambulation in her room, dressing toilet use, and personal hygiene. Her balance was impaired and she was not steady with movements, such as moving from seated to standing, walking, turning and any surface to surface transitions. R67 generally used a wheelchair for locomotion. The fall's Care Area Assessment (CAA) dated 7/31/14, identified R67 was at risk for falls. The CAA specified R67 required staff assistance with transferring and toileting related to her diagnosis of Parkinson's type symptoms. The care plan dated as last updated on 7/23/14, indicated R67 was at risk for falls related to a history of falls and dyskinesia (involuntary muscle	F 323		

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F 323	Continued From page 54 movements). The care plan directed the call light or personal items were to be available for easy reach and the environment was to be well lit and free of clutter. During the environmental tour on 10/27/14, at 2:00 p.m. with the Maintenance Supervisor (MS)-A and Housekeeping Supervisor (HS)-A, the extension cord was observed to remain draped under the resident's bed, across the floor to the resident's bedside table plugging into a radio. At the time of the observation, R67 was observed to be sitting in her recliner, the call light was draped across the room, parallel to the extension cord, approximately four feet in front of the bedroom entry door. R67 stated the cords were consistently placed in this manner and it was important for her to have access to her radio. R67 reported she was worried staff or visitors would trip on the cords. R67 stated she had electric outlets accessible to her on the wall by her personal recliner, so the cords could be plugged in, then she would not have to worry about staff or other visitors tripping and falling on the existing cords. At the time of the observation and interview, MS-A and HS-A verified the observed extension cords were a potential safety hazard, such as a tripping hazard for R67, staff and visitors.	F 323		
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the	F 333		

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F 333	Continued From page 55 facility failed to ensure residents were free from significant medication error for 1 of 6 residents (R7) reviewed for topical narcotic use. This deficient practice resulted in actual harm to R7 who required hospitalization for drug overdose. Findings include: R7's admission Minimum Data Set (MDS) dated 9/6/14, identified R7 was cognitively intact, had diagnoses which included chronic pain, recent colostomy placement (an opening in the abdomen into the intestines which is kept open so bowel can expel into a pouch), depression and anxiety. The MDS identified R7 needed extensive assistance with all activities of daily living (ADLs). Further, the MDS identified R7 was in almost constant pain and was receiving scheduled pain medication, as needed pain medication and non-pharmacological interventions for pain management. R7's admission Pain Care Area Assessment (CAA) dated 9/6/14, identified R7 experienced almost constant pain with a numeric rating of 7 (numeric scale from 0-10 with 10 worst pain). "She does complain of surgical pain which she does request pain medication with relief, she is able to request pain medications, rated pain at a 7/10 when she will ask for medications." R7's September, 2014 medication administration record (MAR) revealed an order for Fentanyl patch 12 micrograms (mcg) transdermally every 72 hours. R7's location of administration report revealed R7 had received the Fentanyl patch on 9/2, 9/5, 9/8, 9/11, 9/14, 9/17 and 9/20. However, the MAR lacked documentation of the removal and disposal of R7's Fentanyl patch when	F 333	**F333G** R7 has been comprehensively assessed for moderate to severe pain. Resident currently ambulates independently throughout facility and her w/c has been dc'd. SS is in the process of assisting resident to find an apartment for independent living following up-coming discharge. -The facility ensures that residents are free from significant medication errors, topical narcotic use. -Licensed staff have been educated on safe medication administration, including application, removal, destruction and documentation of Fentanyl Patches. Audits will be conducted weekly of the controlled medication documentation records. Any re-education or follow-up will be completed at the time of the audit. Audit results will be presented at QA&A for review. The DNS/Designee is the responsible party. Corrective action will be completed by 12/22/2014	

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replaced. In addition, the MAR lacked documentation of every shift check of the fentanyl patch placement from 9/1/14 to 9/22/14, when R7 was hospitalized. The record included an order initiated on 9/29/14, head to toe check every shift d/t (due to) questionable self medication with fentanyl patch, if one found, report to executive director (ED) and DON, every shift. The record revealed the head to toe body check had not been done consistently every shift on 9/30/14.

R7's Individual Narcotic Record revealed R7 received a 12 mcg Fentanyl patch on 9/8, 9/11, 9/14, 9/17 and 9/20, and revealed the number of patches remaining after each administration. However, the narcotic record lacked documentation of the removal and disposal of R7's patches.

R7's discharge summary from Sanford Medical Center Fargo dated 9/27/14, and filed 10/1/14, revealed primary discharge diagnosis of: Acute encephalopathy likely from medication error with additional diagnosis which also included psychiatric problems and chronic pain. The form also revealed R7's hospital course which identified the following:

R7 was admitted to the hospital for management of questionable syncope (unresponsive) episode and low blood pressure. R7's symptoms were felt to be secondary to opiate overdose, had chronic pain complaints and was on opiates. R7 was sent to the emergency for a syncopal episode and low blood pressure. In the emergency room R7 received Narcan (a medication used to reverse the effects of opiates and completely block the opiates affects to the body including pain relief)

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GOLDEN LIVINGCENTER - MOORHEAD	2810 NORTH 2ND AVENUE MOORHEAD, MN 56560

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F 333	Continued From page 57 and "woke up." R7's blood pressure improved, however upon a check of R7's skin in the emergency room it was found that R7 had two Fentanyl patches on instead of one patch. R7's Fentanyl patches was removed, however, again upon a second search of R7's skin during the hospital course it was revealed R7 was found with an additional Fentanyl patch after being admitted to the hospital. The excess Fentanyl appeared to be 2/2 medication error at the skilled nursing facility (SNF). Orders were noted to stop the following medications for R7: Fentanyl patch 12.5 mcg/hr, hydroxyzine (antianxiety), lidocaine patch (a numbing medication impregnated into a patch and applied topically for pain relief), lidocaine preservative free 1% solution, Ativan (antianxiety medication), 0.5 mg tablet and oxycodone 5 mg tablet immediate release. On 10/22/14, 2:06 p.m. the director of nursing (DON) verified R7 had been hospitalized due to potential Fentanyl overdose. He indicated the facility had investigated the hospital reports of R7 having had 3 patches on her when she was only supposed to have 1. The DON stated R7 had been administered a Fentanyl patch on 9/17 and 9/20 in the facility. However, the DON was not able to verify the removal or the destruction of any of R7's Fentanyl patches as that was not documented in R7's individual Narcotic Record. The DON expected at the time a Fentanyl patch was applied, the nurse was to sign and date the patch, and expected 2 nurses would witness and sign the removal and disposal of Fentanyl patches. He indicated he would expect Fentanyl patch placement would be checked at least daily on all residents who received a Fentanyl patch. The DON stated he was unaware whether the extra patches found on R7 had been dated and	F 333		

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F 333	Continued From page 58	F 333		

initialed as the usual facility practice directed staff to do. The DON stated following the suspected overdose he had re-educated one nurse on the facility's process for administration and removal and waste of Fentanyl patches.

On 10/23/14, at 8:29 a.m. R7 indicated she was unsure of when the Fentanyl patches had been started, and stated she had not used them at home prior to admission to the facility. R7 stated the facility nurses did not complete skin checks for the presence of patches daily and had not done the skin checks when she was receiving the patches and stated, "They couldn't be very concerned."

On 10/24/14, at 10:00 a.m. the Certified Nurse Practitioner (CNP)-A indicated she was aware of "a lot of inconsistent information" regarding R7 and the hospitalization likely due to additional Fentanyl patches being present upon admission to the emergency room. The CNP-A stated the facility's information regarding the patches and the hospital's information were quite inconsistent and did not know which entity to believe. She indicated she did not feel R7 to have a history of opioid abuse in the past.

On 10/28/14, at 8:46 a.m. pharmacy consultant (PC) stated she had not been aware of the extra doses of Fentanyl patches for R7 prior to interview and stated she had made multiple recommendations to the DON regarding the facility's practices regarding property administration and removal of the Fentanyl patches in the facility. She stated her recommendations to the DON and the facility and to the DON included the use of a "4 step"

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F 333	Continued From page 59	F 333		

process, which required 2 nurses to sign for the removal and destruction when the patch, placement of the Fentanyl patch to be checked every shift, and the Fentanyl patch to be dated and signed by the nurse when the patch was applied to a resident. The PC stated she had made these recommendations to the DON and facility for the "poor practice" for several months. She indicated the facility had not changed their practice during her monthly reviews of residents medication regimen and chart review.

Review of nursing progress notes from 9/21/14 to 9/27/14 revealed the following:

-9/22/14, R7 was noted to be unresponsive by a staff member in the dining room, R7's blood pressure was 65/37 (average for adult 120/80) and oxygen saturation was 87% (average for adult above 95%). R7 was sent to the emergency room by ambulance.

-9/24/14, hospital contacted the facility inquiring about any visitors that R7 may have had at the facility. The writer of the progress note indicated she was unsure but would check. The progress note revealed the hospital staff completed a skin check of R7 upon emergency room admission, however, on 9/24/14 an additional 2 Fentanyl patches were found on R7 (however this does not correlate with the hospital course summary dated 9/24/14 in hospital discharge summary which stated 2 patches were found upon arrival to the emergency room and an additional patch was found during R7's hospital stay).

-9/26/14, the facility had searched R7's room and purse for Fentanyl patches, no indication whether any where found.

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F 333	Continued From page 60 -9/27/14, R7 returned to the facility after hospitalization, Fentanyl was discontinued. Upon return to the facility R7's MAR reflected an order with a start date of 9/29/14, directing staff to complete a "head to toe check every shift due to questionable self medication with Fentanyl patches, does not currently have an order for the patches, if one is found report to administrator and DON." MAR lacked documentation for the completion of the head to toe check for the presence of a Fentanyl patch on each shift 8 days out of 24. A second copy of R7's discharge summary dated 9/27/14, was provided by the facility on 10/30/14, two days after the completion of survey. Review of the second copy of R7's 9/27/14 discharge summary revealed the sentence; The excess fentanyl patches appear to be 2/2 medication errors at the SNF-had been removed from the document. The second copy of the discharge summary listed in place of the removed sentence; It is unlcear how the excess fentanyl patches got on the patient. I discussed this with SNF nursing director and we believe that someone is illegally supplying these meds to the patient. The facility policy Disposal of Medication and Medication-Related Supplies, controlled substances, dated 05/12 directed medications which are classified as controlled substances were subject to special handling, storage, disposal, and record keeping in the facility. The policy further directed staff upon the disposal of a controlled substance two licensed nurses must be present and document the disposal in the residents individual narcotic record.	F 333		

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F 333	Continued From page 61 The facility policy titled Allxa RX titled Medication Monitoring, preventing and detecting adverse consequences and medication errors, dated 5/12, defined a significant medication error as, an error that required treatment with a prescription medication, was life threatening, or required hospitalization or extending a hospitalization. The policy directed staff to follow steps when communicating when a medication error occurred. However, The policy did not address a process for the safe administration and removal/destruction of Fentanyl patches.	F 333		
F 428 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure irregularities identified by the consultant pharmacist were addressed in a timely manner for 2 of 8 residents (R104, R7); identified lack of action for high and low blood sugars for R104, did not address a recommended dosage reeducation of Zyprexa (an antipsychotic medication) for R7. In addition, the facility failed	F 428	**F428D** -R7 Drug regimen has been reviewed and revised as indicated related to Consultant Pharmacist Review.R104 Blood Glucose monitoring regimen has been reviewed and revised as indicated and is receiving insulin per Physician's order. -Licensed staff have been educated on timely follow up required with the MD/NP on recommendations made by the Consultant Pharmacist -Audits will be conducted monthly, that the Consultant Pharmacy recommendations have been addressed by the MD/NP. Any re-education or follow-up will be completed at the time of the audit. Audit results will be presented at QA&A for review. -The DNS/Designee is the responsible party. -Corrective action will be completed by 12/22/2014	

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F 428	Continued From page 62 to consistently act upon pharmacy recommendation reports, this had the potential to affect all 64 residents in the facility. Findings include: R104's admission Minimum Data Set (MDS) dated 6/26/14, identified R104 had diagnoses to include diabetes mellitus and received insulin injections seven times during the seven day review period. R104's current Physician's Orders dated 10/1/14, through 10/31/14, directed to offer Novolin insulin 28 units (U) one time a day and 10 U in the evening; 4 U of Novolog could be offered as needed (PRN) when R104's blood sugars were greater than 200. The order directed staff to hold the Novolin if R104's blood sugar was less than 110 and to call the physician if R104's blood sugar was greater than 220, and if less than 50. A Clinical Pharmacist Recommendations Detail to Nursing Services form dated 9/29/14, indicated, "9/24 BS [blood sugar] was only 87 dose was still given. Please document a med [medication] error and coach staff." A second recommendation dated 9/29/14, indicated, "Multiple times residents BS has been over 200, but not a single dose has been given. Please document multiple med errors and coach." The October Medication Administration Record (MAR) indicated R104's blood sugar levels were as follows: - On 10/5/14, at 8:00 a.m. - 106; - On 10/13/14, at 8:00 a.m. - 107; - On 10/16/14, at 8:00 a.m. - 97; at 5:00 p.m. - 97; - On 10/18/14, at 8:00 a.m. - 99; - On 10/19/14, at 8:00 a.m. - 105;	F 428		

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F 428	Continued From page 63 - On 10/22/14, at 8:00 a.m. - 77; - On 10/25/14, at 8:00 a.m. - 67. Although the most current Physician's Orders directed to hold R104's Novolin for blood sugar levels less than 110, the October MAR indicated the Novolin doses were documented as administered to R104. On 10/16/14 and 10/25/14, a "7" code was documented in the administration box which directed to "see Nurses Note." The corresponding Nurses Progress Note dated 10/16/14, at 6:53 p.m. identified R104's blood sugar "was done." The note lacked documentation of appropriate action for the low blood sugar levels. The clinical record lacked evidence of a corresponding Nurses Note from 10/24/14, as indicated on the MAR. A note dated 10/22/14, at 3:56 p.m. indicated R104 had a blood sugar of 77 and identified a nursing action of giving R104 "applesauce and 1/2 sandwich consumed." The October Nurses Progress Notes lacked documentation of the actions taken for the other identified low blood sugar levels. The MAR identified R104 had the following blood sugar levels greater than 200, which required an additional ordered 4 U of Novolin to be given: - On 10/1/14, at 5:00 a.m. - 280; - On 10/2/14, at 5:00 p.m. - 201; - On 10/3/14, at 5:00 p.m. - 206; - On 10/4/14, at 5:00 p.m. - 238; - On 10/7/14, at 8:00 a.m. - 254; - On 10/8/14, at 5:00 p.m. - 250; - On 10/9/14, at 5:00 p.m. - 366; - On 10/10/14, at 5:00 p.m. - 212; - On 10/13/14, at 5:00 p.m. - 218; - On 10/14/14, at 5:00 p.m. - 270; - On 10/19/14, at 5:00 p.m. - 215; - On 10/21/14, at 8:00 a.m. - 207;	F 428		

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F 428	Continued From page 64 - On 10/23/14, at 8:00 a.m. - 296; - On 10/26/14, at 8:00 a.m. - 206; and 5:00 p.m. - 254; - On 10/27/14, at 5:00 p.m. - 260. R104's clinical record lacked documented evidence the ordered additional 4 U of Novolin were given for the 16 blood sugars greater than 200. In addition, the record lacked documentation the physician was notified as directed by the physician's order, for the nine blood sugar readings greater than 220. On 10/28/14, at 3:30 p.m. the director of nursing (DON) stated, "If no IPN [Interdisciplinary Progress Note], then "no" the irregular blood sugars were not reported to the physician. DON stated he was unaware of facility problems regarding blood sugars/ insulin use. At 7:28 p.m. DON reviewed R104's October blood sugar readings. DON verified R104's blood sugars were below 110 and verified the Novolin insulin should have been held. DON stated, "I have not seen" medication errors regarding the incorrect administration of insulin. DON confirmed medication error reports should have been completed and staff were not following protocol. DON stated "to my knowledge" the pharmacy recommendations did not pertain to blood sugars and verified he had not reviewed all of the medication errors reported at that time. The Clinical Pharmacist Recommendations Detail to Nursing Services forms (communication forms from the consultant pharmacist) from May 2014 to September 2014, revealed the following: May 2014 * 44 separate recommendations were made by the consultant pharmacist which included: the lack of indications for the use of a medications,	F 428		

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F 428	Continued From page 65 requests to monitor blood pressure for residents on hypertension medication, directions not to crush medications that were not to be crushed, and an order for the removal of a Lidoderm patch (patch infused with a local anesthesia to relieve pain) after 12 hours, to prevent resident toxicity. - There were also five other recommendations in regard to other residents such as: directing staff to date and initial narcotic fentanyl patches prior to placement, document the site of the placement on the resident, checking patch placement every shift and upon removal to witness and document disposal of patch by two nurses. June 2014 * 39 separate recommendations were made by the consultant pharmacist which included: lack of indications for use of a medication, directions not to crush medications that were not to be crushed, a request to remove a duplicate order for nitrostat (a medication used to relieve chest pain that can drop a resident's blood pressure extremely low if double dosed). - There were other recommendations in regards to other residents using fentanyl patches, directing staff to date and initial narcotic fentanyl patches prior to placement, document the site of the placement on the resident, checking patch placement every shift and upon removal to witness and document disposal of patch by two nurses. In addition directed staff after removal of patch, the two nurses witnessing the destruction would witness/document the destruction in the black log book. Also there were directions to either place the used fentanyl patch on a tissue, flush or cut the patch up, then flush in toilet. July 2014 * 47 separate recommendations were made by	F 428		

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F 428	Continued From page 66 the consultant pharmacist which included: lack of indications for the use of a medication, directions not to crush the medications that were not to be crushed. - There was three other recommendations involving other residents such as: to follow the hypoglycemia (low blood sugar) protocol, to review when to hold administration of insulin with nursing staff. There were also recommendations made to document medication errors for not following hypoglycemia protocol, the use of Phenobarbital as a controlled substance, and blanks in the medication administration record. August 2014 * 52 separate recommendations were made by the consultant pharmacist which included: lack of indications for continued use of a medication, directions not to crush medications that were not to be crushed, hypoglycemia protocol was not being followed, and recommendation of blood pressures not being monitored for a resident on three different medications for high blood pressure. September 2014 * 61 separate recommendations were made by the consultant pharmacist which included: hypoglycemia protocol not being followed, monitoring blood pressures for residents on antihypertensive medications and notification of extremely high blood sugars. - There were recommendations made for three other residents as well, which included: the documentation of administration and disposal of narcotic fentanyl patches. On 10/28/14, at 6:45 p.m. the director of nursing (DON) stated the consultant pharmacist came to	F 428		

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F 428	Continued From page 67 the facility in September and reviewed the residents' medications. DON verified at the end of September, the consultant pharmacist re-issued 109 pages of pharmacy recommendations going back before May 2014. DON verified there were many recommendations made and not all been addressed. DON verified he was not aware of any blood sugar problems, but stated there had been "meetings" and was not sure if the problem had been addressed. On 10/23/14, at 5:30 p.m. the consultant pharmacist stated the facility had been informed of the recommendations which included: the process for administration and destruction of fentanyl patches to prevent loss or diversion of the patches. Review of the consultant pharmacy report titled GL Moorhead Acceptance ratio report, revealed from 8/1/14, to 9/30/14 there had been no response to 47.57% of pharmacist recommendations. R7's admission Minimum Data Set (MDS) dated 9/6/14, indicated R7 was cognitively intact, had diagnoses to include depression and anxiety. The MDS identified R7 needed extensive assistance with activities of daily living (ADL's) and R7 received antipsychotic medication seven out seven days during the assessment period. R7's admission Care Area Assessment (CAA) for psychotropic drug use dated 9/6/14, identified R7 received antipsychotic medication and lacked documentation of the indications for the use of the drug and lacked a summary analysis for R7's use of Zyprexa. R7's Medication Administration Records (MARs) for August, September and October 2014	F 428		

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F 428	Continued From page 68 directed to offer olanzapine (Zyprexa, an antipsychotic medication) 2.5 mg (milligrams) po (by mouth) bid (twice daily) for depressive disorder not elsewhere classified/anxiety. A Clinical Pharmacist Letter to Physician Services form dated 9/30/14, indicated R7 had an order for Zyprexa 2.5 mg tablet, give 2.5 mg by mouth "two times a day for_____." The note further revealed the pharmacists recommendation to consider a dose reduction to 50% of the current dose, with a goal to discontinue medication. The form lacked a response from the physician. On 10/28/14, at 8:46 a.m. consultant pharmacist stated she completed her monthly visit to the facility to review all residents medication regimen and made recommendations based upon her findings. The consultant pharmacist stated she e-mailed her recommendations to DON and had recently begun calling DON to make sure the e-mails were received. The consultant pharmacist stated her recommendations were not acted upon in a timely manner and her expectation was for recommendations to be addressed by her next visit. The consultant pharmacist verified R7's recommendation to address R7's use of Zyprexa had not been addressed. On 10/28/14, 3:29 p.m. DON stated he expected the consultant pharmacist recommendations to be followed up with each residents' nurse practitioner. DON stated the consultant pharmacist had re-issued 179 pages of recommendations going back before May 2014. DON stated he had "begun working" on them.	F 428		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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F 431	Continued From page 69 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to establish a system for	F 431	**F431E** -Residents, R7, R11, R26, R69, R139 use of topical narcotics has been reviewed and are receiving medications as indicated. There is no R72 identified on the MDH Stage 2 Sample Resident List. -Other residents on topical narcotics are receiving medications as indicated. -Licensed staff have been educated on the system for application, removal, destruction and documentation of topical narcotics. -Audits will be conducted 3 times weekly, that the system for topical narcotics is being followed. Any re-education or follow-up will be completed at the time of the audit. Audit results will be presented at QA&A for review. -The DNS/Designee is the responsible party. -Corrective action will be completed by 12/22/2014	

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F 431	Continued From page 70 the safe and secure destruction of topical narcotic medications which enabled accurate reconciliation and accounting of all controlled medications, and identification of loss or diversion of controlled medications to minimize the time between loss and the detection and determination of the extent of the loss and/or diversion of narcotics for 6 of 6 residents (R7, R11, R26, R69, R139, R72) reviewed for topical narcotic use. Findings include: On 10/22/14, at 1:58 p.m. R69 was observed seated in a wheelchair, a square shaped vinyl patch was observed on R69's left shoulder area. The patch had a date of 10/21/14 written in pen on the surface of the patch, no other pen markings were observed on the patch. Licensed practical nurse (LPN)-J was present during observation and identified R69 had a Fentanyl patch on the shoulder. She confirmed the date had been written on the surface of the patch and no other information had been written on the patch. LPN-J indicated the usual facility practice was to write on the patch the date the patch had been applied and to write on the initials of the nurse who applied the patch. On 10/22/14, at 2:00 p.m. R139 was observed lying in bed, with a square vinyl patch on her left chest area. The patch had a date and initials handwritten on the surface of the patch. LPN-B confirmed R139 patch had been placed on her chest, and confirmed the date and initials had been handwritten on the patch. She indicated the usual facility practice was to check every shift for the presence of the patch.	F 431		

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F 431	Continued From page 71 On 10/22/14, at 2:02 p.m. R11 was observed seated in a wheelchair in her room. LPN-K was present during observation. LPN-K examined R11's body and stated she stated she was unable to find R11's patch. LPN-K stated the evening shift usually applied the patches, and she was not aware of where R11's patch had been placed. On 10/22/14, at 2:06 p.m. the director of nurses (DON) indicated the facility had a recent incident when 2 patches had been found on R7. The DON stated R7 had suddenly become unresponsive, and had to be sent to the hospital by ambulance for treatment. The DON stated he was not aware if the additional patch found on R7 at that time had been dated or initialed. The DON indicated an additional patch had been found on R7 while hospitalized. He indicated the usual facility practice was to hand write on the patch the date and initials of the nurse who applied the Fentanyl patch, to alternate the location of the patches and to check the presence of the patch at least daily. He indicated he had initiated an investigation of the incident and increased narcotic monitoring in the facility after the incident. The DON verified he had educated the nurse who had applied the most recent patches on 9/17 and 9/20/14, prior to the error. On 10/22/14, at 2:02 p.m. LPN-K stated she would be notifying the MD of the missing patch for R11 and stated she would also would apply another patch "early" at that time. On 10/22/14 3:13 p.m. LPN- K and LPN- H, reported R11's old patch had been found in a top drawer in her room. LPN-H stated he had found it in R11's drawer while searching for the missing	F 431		

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F 431	Continued From page 72 Fentanyl patch. A blank patch was shown to the surveyor which had old skin on it, appearing to have been used. On 10/22/14, at 3:45 p.m. LPN -I, stated the usual facility practice was to date and initial each Fentanyl patch when the nurse applied to each resident, check every shift and document the presence of each patch for the resident. On 10/22/14, at 3:45 p.m. R26 was seated in wheelchair in an activity room. LPN-I was present and verified R26 had a Fentanyl patch on right upper chest area, with clear plastic tape over the entire surface of the patch. LPN-I stated staff were to check for the presence of Fentanyl patches every shift. R11's quarterly Minimum Data Set (MDS) dated 9/23/14, identified R11 was cognitively intact and was able to understand others and make herself understood. On 10/22/14, at 3:50 p.m. R11 denied she had removed the patch herself and indicated she was not aware of when the patch had been removed. R7's admission MDS dated 9/6/14, identified R7 was cognitively intact and did not have any behaviors of inattention, disorganized thinking, altered level of consciousness, or psychomotor retardation. On 10/23/14, at 8:29 a.m. R7 stated she was not sure when the Fentanyl patches had been started and stated she had not received the patches at home prior to being admitted to the facility. A phone interview was completed with the	F 431		

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F 431	Continued From page 73 consultant pharmacist on 10/23/14, at 5:30 p.m. She stated she had concerns regarding the manner the facility used to document the administration and destruction of the Fentanyl patches. She stated on more than one time in the past, she had informed the facility they needed to implement a "4 step" process for the administration and destruction of this medication, which they had not done. She referenced these steps as 1. Date and initial patch prior to placement 2. Document site of placement on the MAR. 3. Check per shift and document 4. Upon removal, two nurses must witness/document the destruction of the patch. Destruction should be via flushing down the hopper or stool. She stated when a resident was placed on this medication, she included these steps in her pharmacy recommendations to prevent potential medication errors or problems in the facility. R7's September, 2014 medication administration record (MAR) revealed an order for Fentanyl patch 12 micrograms (mcg) transdermally every 72 hours. R7's location of administration report revealed R7 had received the Fentanyl patch on 9/2, 9/5, 9/8, 9/11, 9/14, 9/17 and 9/20. However, the MAR lacked documentation of the removal and disposal of R7's Fentanyl patch when replaced. In addition, the MAR lacked documentation of every shift check of the fentanyl patch placement from 9/1/14 to 9/22/14, when R7 was hospitalized. The record included an order initiated on 9/29/14, head to toe check every shift d/t (due to) questionable self medication with fentanyl patch, if one found, report to executive director (ED) and DON, every shift. The record revealed the head to toe body check had not been done consistently every shift on 9/30/14.	F 431		

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F 431	Continued From page 74 Review of R7's Individual Narcotic Record revealed the record listed Fentanyl 12 micrograms (mcg), with directions to change every 72 hours. The record identified one patch had been signed out for R7 on 9/8, 9/11, 9/14, 9/17 and 9/20/14, with a single signature for each entry and total remaining. However, the record lacked documentation of signatures of nurses who witnessed the disposal of the used Fentanyl patches when replaced. Review of R11's Individual Narcotic Record revealed the record listed Fentanyl 25 mcg with directions to apply one patch every 72 hours. The record identified one patch had been signed out for R11 on 9/19, 9/22, 9/28, 10/4, 10/7, 10/10, 10/13, 10/16 and 10/19/14, with a single signature for each entry and total remaining. However, the record lacked documentation of signatures of nurses who witnessed the disposal of the used Fentanyl patches when replaced. Review of R72's Individual Narcotic Record revealed the record listed Fentanyl patch 75 mcg with directions to apply one patch every 72 hours for pain. The record identified one patch had been signed out for R72 on 10/9, 10/12, 10/15, 10/18 and 10/21/14 with a single signature for each entry and total remaining. However, the record lacked documentation of signatures of nurses who witnessed the disposal of the used Fentanyl patches when replaced. Review of R69's Individual Narcotic Record revealed the record listed Fentanyl 50 mcg with directions to apply one every 72 hours. The record listed one patch had been signed out for R69 on 10/15, 10/18 and 10/21/14 with a single signature for each entry and total remaining.	F 431		

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F 431	Continued From page 75 However, the record lacked documentation of signatures of nurses who witnessed the disposal of the used Fentanyl patches when replaced. Review of R26's Individual Narcotic Record revealed the record listed Fentanyl, did not include a dose and listed directions for one every 72 hours at hour of sleep (HS). The record identified one patch had been signed out on 10/8, 10/11, 10/14, 10/17, 10/20, and 10/23/14 with a single signature and total remaining for each entry. On 10/8/14, the record revealed a note which indicated the disposal of the old one had been witnessed by two nurses. However, the remaining doses lacked documentation of signature of nurses who witnessed the disposal of the used Fentanyl patches. Review of the Clinical Pharmacist Recommendation Detail to Nursing Services reports from May 2014 to September 2014 revealed the following recommendations: May, 2014 - identified R26 had a current order for Duragesic (fentanyl) patches and recommended to date and initial patch prior to placement, document site of placement on MAR, check per shift and document, upon removal, two nurses must witness/document the destruction of the patch -identified two additional residents in the facility currently had orders for Fentanyl patches and made the same recommendations for proper administration, documentation and disposal June, 2014 -identified R11 had a current order for Duragesic	F 431		

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F 431	Continued From page 76 (fentanyl) patches and recommended to date and initial patch prior to placement, document site of placement on MAR, check per shift and document, upon removal, two nurses must witness/document the destruction of the patch -identified two additional residents in the facility currently had orders for Fentanyl patches and made the same recommendations for proper administration, documentation and disposal September, 2014 -identified R7, R69 had a current order for Duragesic (fentanyl) patches and recommended to date and initial patch prior to placement, document site of placement on MAR, check per shift and document, upon removal, two nurses must witness/document the destruction of the patch On 10/24/14 at 4:14 pm, LPN-F stated the previous evening a removed Fentanyl patch (a narcotic medication) had "vanished." She stated she had removed the patch to place a new one on R69. LPN-F stated she had placed the patch she'd removed on a table in R69's room and had left the room to find a second nurse to destroy the patch. LPN-F stated when she'd returned to the R69's room, she was unable to find the Fentanyl patch she'd removed. She indicated she'd searched R69's room for the patch and was unable to find it. She stated she'd spoken to LPN-B about the incident but LPN-B had not instructed her as to the management of the missing patch. LPN-F indicated she had completed her shift and left the facility with the narcotic medication still missing. She stated she had not completed an incident report or a medication error form, and had not informed the	F 431		

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F 431	Continued From page 77 director of nurses (DON) or the administrator of the incident of the missing Fentanyl patch for R69. On 10/24/14 at 4:30 p.m., LPN-B was interviewed. She confirmed LPN-F had reported to her on the evening of 10/23/14, at about 9 or 9:30 p.m., there was a missing used Fentanyl patch. LPN-B stated she did nothing further with the information as she was busy accomplishing her own work for the evening. In addition, LPN-B said she had been informed by LPN-F that she'd discussed the issue with the Registered Nurse Night Supervisor and had assumed the Nursing Supervisor would address the issue with LPN-F. On 10/24/14 at 4:45 p.m. an interview with the Administrator and DON was completed. Both the administrator and DON indicated they were unaware of the missing Fentanyl patch. They stated they would have expected an incident report to have been completed when the narcotic patch was noticed to have been missing, but had not received one. They indicated it was the facility's protocol that staff were to date and initial when Fentanyl patches were applied and also to have a second nurse witness the destruction of the patches. They also reported they expected the two nurses to document in the narcotic book the destruction of the medication (Fentanyl). The administrator and DON reported that since an incident when a resident accidentally overdosed on Fentanyl, the facility had changed the process of administration and removal/destruction of narcotic patches. In addition, to the changes in documentation of the administration/destruction of narcotic, body checks or periodic checks of resident's body were done to ensure the appropriate use and placement of the narcotic	F 431		

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F 431	Continued From page 78	F 431		

patches. The DON indicated he was not aware the nurses were not witnessing and signing for the disposal of Fentanyl patches on the narcotic record.

On 10/24/14, at 5:15 p.m. the DON stated four residents were currently prescribed Fentanyl patches in the facility. The DON identified R69, R72, R26 and R11 to currently have orders to receive routine narcotic patches. Accompanied by the DON, the surveyor reviewed the narcotic record books for the four residents. None of the narcotic records showed evidence of signatures of two nurses who witnessed the destruction of any of the Fentanyl patches. R69's Fentanyl patch remained missing throughout the entire survey.

On 10/28/14, at 8:28 a.m. the consultant pharmacist stated she visited the facility monthly and emailed the DON her recommendations after the monthly medication reviews were conducted for all residents. She confirmed the monthly nursing recommendations and monthly detailed recommendation reports and stated she would expect the nurses to follow pharmacy recommendations consistently. The consultant pharmacist indicated she had not been aware of the overdose for R7 and indicated the "poor practice" of not double signing the removal/disposal of used patches could potentially harm someone if patches were not removed.

The facility policy Disposal of Medication and Medication-Related Supplies, dated 11/2011, was reviewed. The policy specified when a dose of controlled medication is wasted for any reason, the destruction must be done in the presence of

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F 431	Continued From page 79 two licensed nurses and the disposal was to be documented on the accountability record/book on the time that represents that dose. The undated policy Controlled Substances Procedure Recommendations for Golden Living Centers with Suspected or Confirmed Controlled Drug Diversion was reviewed. The policy specified that if medications are discovered missing, altered or inappropriately handled, staff are not permitted to leave the facility until released by the DON or designee. Audits of all controlled substances are to be initiated, completed an audit of Change of Shift signature logs, verification of those with access to medications, conduct interviews with staff and if applicable, with alert and oriented residents and review the findings with human resources, Legal and Safety & Loss Control to determine the next steps. The pharmacy consultant should be contacted to advise on state reporting requirements. The facility failed to follow these policies.	F 431		
F 441 SS=J	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. (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	F 441		

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F 441	Continued From page 80 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 observation, interview, and document review, the facility failed to ensure appropriate infection control practices to prevent spread of infection were followed for 1 of 1 resident (R104) with an open, infectious wound. This deficient practice resulted in immediate jeopardy for R104 who had a known diagnosis of vancomycin resistant enterococci (VRE) in an open wound, and had the potential to affect any resident who received dressing changes from the facility treatment carts. In addition, the facility failed to accurately conduct ongoing surveillance of resident infections in the facility which had the potential to affect all 67 residents in the facility.	F 441	**F441J** -Resident R104 was moved to a private room and contact precautions were initiated until the wound was cultured and determined to no longer be infected with VRE or when the wound was sufficiently healed as to meet the criteria established by MDH, in the publication "Guideline for the Management of Antimicrobial Resistant Microorganisms in Minnesota Long-Term Care Facilities": Dedicated equipment was provided to this resident. Resident R104's room was cleaned using the CDC Checklist for Monitoring Terminal Cleaning daily, and #403 Occupied Isolation Room Cleaning Policy. -Staff were educated prior to the next shift worked on Infection Control policies and procedures to include; protocols for Transmission Based Isolation, Cleaning and Disinfecting Non-Critical Resident Care Items, and Environmental Surfaces. Other residents identified as requiring isolation precautions are receiving care per protocols. -Housekeeping staff were educated on using the CDS Checklist for Terminal Cleaning and the #403 Occupied Isolation Room Cleaning Policy.	

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F 441	Continued From page 81 The immediate jeopardy (IJ) began on 10/22/14, due to the systemic failure of the facility to appropriately implement infection control practices for wound care when observation of contaminated supplies with blood and body fluids from a resident with known diagnosis of VRE were returned to the treatment cart potentially causing infection to other residents. The administrator and the director of nursing (DON) were notified on 10/22/14, at 7:06 p.m. of the immediate jeopardy for R104, and the potential for spread of infection to other residents receiving wound care from the treatment carts. The IJ was removed on 10/24/14 at 5:09 p.m., however, noncompliance remained at the lower scope and severity level of F - widespread scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include: R104's admission Minimum Data Set (MDS) dated 6/26/14, identified R104 had diagnoses which included end stage renal disease, diabetes mellitus and coronary artery disease. The MDS identified R104 was cognitively intact, required extensive assistance with all activities of daily living and did not ambulate. R104's admission Care Area Assessment (CAA) signed 7/3/14, identified R104 was alert and orientated at times but did have periods of confusion and did not always remember when staff had been in room to care for her. The CAA identified R104 required extensive assist with bed mobility, transfers with mechanical lift, personal hygiene and bathing. The CAA directed staff to anticipate her needs. Review of the untitled form identified as Nursing	F 441	-Licensed staff were educated on identification of infections, and the appropriate interventions to put into place. Clean Dressing Change Protocol to include the removal of dressing from the treatment, cross contamination prevention, Cleaning and Disinfecting Non-Critical Resident Care Items and Environmental Surfaces. Education provided to continue with the identified precautions until the causative agent has been deemed no longer a threat to the health/safety of resident and or others as determined by the MD, culture of the infected area, or accepted infectious disease protocol PPE equipment is placed outside the rooms of residents identified on isolation precautions. The facility system for tracking, trending and analysis of infections has been reviewed and revised as indicated. -Monitoring to ensure compliance, 3x per week random audits that the Infection Control Procedures are being followed- to include dressing changes, isolation precautions are followed, Terminal Cleaning of isolation rooms is being completed. Line listing of infections with tracking, trending and analysis. Any re-education or follow-up will be completed at the time of the audit. Audit results will be presented at QA&A for review.	

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F 441	Continued From page 82 Assistant Care sheets listed R104 as requiring total assistance with ADL (activities of daily living), toileting every 2 hours and as needed and identified R104 was alert but confused at times. However, the care sheet lacked documentation of R104's use of an ostomy bag, and lacked directed for additional precautions to be utilized when providing care to R104. R104's current care plan, revised 10/20/14, identified R104 had skin/wound infection and identified "VRE abd. [abdominal] wound." The care plan listed various interventions which included: "Evaluate need for isolation, Use universal precaution techniques with resident, Contain infection site as much as possible." Review of R104's Infection Surveillance Data Collection Form, dated 8/8/14, indicated: cellulitis/soft tissue wound infection, pus present at a wound, skin or soft tissue site and identified "yellow milky drainage." The form identified a wound culture had been done and the form included "meets" handwritten on the top of the form. Review of an untitled form with "meets criteria" marked as "yes", revealed a wound culture had been done on 8/2/14, with results identified as "enterococcous." The form identified "isolations/precautions" marked as "yes", and identified the type as "contact." Further, the form listed interventions as "reinforce hand washing." On 10/22/14, at 7:42 a.m. R104 was observed lying in bed and nursing assistant (NA)-N was assisting R104 with morning cares. R104 wore a hospital gown, which had been moved up to her chest area and an incontinent brief laid underneath R104's buttocks area. NA-N wore vinyl type gloves on both hands. NA-N was not	F 441	-The DNS/Designee is the responsible party. -Corrective action will be completed by 12/22/2014	

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F 441	Continued From page 83	F 441		

observed to apply a gown over her uniform during the entire observation of cares. An ostomy bag was present over an abdominal wound on the center of R104's lower abdomen. R104 wore slacks on her lower legs which where pulled up to the knee area. A cloudy yellow fluid, of thin consistency, was noted to flow down the center and both sides of R104's abdomen from under the edges of the ostomy bag. The cloudy yellow fluid was observed to pool in both leg creases where the hip joined the groin. NA-N wiped the pooled drainage from the creases with dry disposable wipes and placed the wipes into a opaque garbage bag in the room. NA-N removed the vinyl gloves, placed them in the garbage bag and then alerted licensed practical nurse (LPN)-A of the leaking ostomy bag. During the entire observation R104's room area and bathroom lacked a supply of personal protective equipment including gowns, nor were containers available for contaminated waste or linen.

On 10/22/14, at 7:50 a.m. NA-N verified R104's ostomy bag had leaked during morning cares. She indicated the ostomy bag "does that sometimes" and indicated her usual practice was to notify the nurse when this occurred. She stated she had cleansed R104's groin and abdomen area because of the drainage that leaked from the bag. NA-N indicated she did not follow any additional precautions when she handled the excretions and leakage from the ostomy bag. NA-N was not aware the drainage from R104's wound was an infection.

On 10/22/14, at 7:55 a.m. LPN-A entered R104's room with various dressing supplies in her hands. The dressing supplies included 5 packages of barrier film, a pair of metal scissors and a vinyl

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F 441	Continued From page 84 type ostomy bag. LPN-A wore vinyl type gloves on both hands. LPN-A was not observed to apply and wear a gown over her uniform for the entire observation. LPN-A approached R104's bed, set the supplies on the bed next to R104's right thigh, (next to where the drainage was leaking) just below the crease of her leg and abdomen. The 5 packages of barrier film rested against R104's right thigh, just below the the crease of her leg and abdomen. LPN-A measured the ostomy base plate by holding it next to the wound opening. LPN-A then cut the base plate with the metal scissors. LPN-A repeated this procedure of placing the ostomy bag over the abdominal wound opening 3 times using the metal scissors to trim the ostomy plate. LPN-A proceeded to wipe the wound opening and surrounding skin with a disposable wet wipe and then placed another wet wipe over the wound. LPN-A picked up a package of barrier film with both gloved hands, opened the package, removed the wipe from the wound, and proceeded to apply the barrier film and the ostomy bag to the area surrounding the wound. LPN-A removed her gloves, and without washing her hands, picked up the remaining 4 unopened packages of barrier film and medical bandage scissors and immediately placed the supplies and scissors into her front left uniform pocket. LPN-A then washed her hands and left the room. On 10/22/2014, at 9:59 a.m. LPN-A entered R104's room, in her gloved hands she carried a pair of metal scissors, a role of dressing tape, gauze pads and a spray bottle of wound cleanser. R104's gauze type dressing on the right foot was saturated with frank red blood around the entire heel. LPN-A cut R104's gauze dressing off with the metal scissors. LPN-A tore pieces of tape	F 441		

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F 441	Continued From page 85 from the roll and placed them on the side of the bed side table, picked up the bottle of wound cleanser, sprayed a gauze pad and cleansed the heel. LPN-A redressed the heel wound with gauze and wrapped the foot and heel with 2 rolls of gauze. LPN-A then removed her gloves, washed her hands and immediately picked up the bottle of wound cleanser, extra gauze pad in paper wrapping, partial roll of gauze tape and metal scissors (which were contaminated). LPN-A immediately walked out of the room and approached the treatment cart located near the nurse's desk, LPN-A opened the top drawer of the treatment cart and placed the partial roll of tape, unused gauze pads and metal scissor in the top drawer. LPN-A was not observed to disinfect the metal scissor or discard the partially used supplies during the entire observation. On 10/22/2014, at 1:16 p.m. LPN-A verified the returning partially used supplies and scissors to the treatment cart was the usual practice. LPN-A verified the wound care supplies and scissors used for both R104's dressing changes had been returned to the cart and the items had not been disinfected prior to return to the treatment cart after either use. LPN-A stated the packages and scissors "should have" been disinfected with a bleach or germicidal wipe. LPN-A verified the treatment cart contained wound care supplies used for any of the 24 residents in her care, and stated 3 residents were currently received routine dressing changes with the supplies on the treatment cart. LPN-A stated R104 "had a lot of problems," had a current abdominal wound and in the past dressings to cover the wound have been used "but did not work" to contain the drainage. She stated "so now" the ostomy bag was used for the drainage.	F 441		

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F 441	Continued From page 86 On 10/22/14, at 3:14 p.m. registered nurse (RN)-C stated the usual facility practice was implementation of "isolation precautions" for wounds infected with VRE. RN-C verified R104 did not have any additional precautions in place and verified R104 had a wound with VRE infection upon recent hospital discharge, however, was not aware that R104 currently had a wound infection positive for VRE. RN-C stated she "would think" a culture of the wound would be completed to check for the VRE status again. RN-C verified no documentation of a follow up culture nor documentation of a resolution of the VRE infection had been found in R104's medical chart. On 10/22/2014, at 3:31 p.m. the director of nursing (DON) stated the following precautions would be initiated for a resident with a VRE infection: resident would be set up in a private room, or cohabit with an appropriate person, a person who is not compromised. The DON verified staff would be expected to use contact precautions for dressing changes with VRE including gown and gloves, and depending on what type of drainage may utilize a mask as well. The DON verified the precautions would continue until the doctor tells the facility everything is good, and stated "typically a culture" of the wound would be completed, however, it depends on the doctor. On 10/22/2014, at 5:22 p.m. the DON verified he was not aware if R104 currently had a positive VRE infection. The DON stated he would believe that possibly the VRE no longer was present. However, there would be the potential to spread other types of infection due to practice of not disinfecting supplies/equipment contaminated	F 441		

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F 441	Continued From page 87 with body fluids from residents. On 10/22/2014, at 5:33 p.m. NA-J stated "a couple times a week" fluid drained from around R104's ostomy bag and was cleaned with soap, water and a disposable wipe. NA-J verified disposable cloths were placed around the area when fluid leaked and the soiled wipes were placed in the garbage receptacle in R104's room. NA-J was not aware R104 had an infection in the drainage from the abdominal wound. On 10/22/14, at 5:35 p.m. LPN-H stated the pouch placed over R104's abdominal wound site, " drains a lot " and frequently leaks from the pouch placed to collect the drainage. LPN-H further stated unawareness of an infection or any specific precautions utilized to prevent infection. LPN-H indicated there were two treatment carts in the facility and staff used the cart that was closest to the resident's room. On 10/22/14, at 5:36 p.m. LPN-I verified the ostomy bag was utilized at the abdominal wound site to attempt to contain the drainage. She indicated sometimes it is contained by the bag but other times "it leaks," sometimes it has an odor, and stated "quite a pungent odor." LPN-I verified gauze was used around the ostomy bag base plate in an attempt to manage any potential leakage and stated sometimes "the whole gauze is soaked." LPN-I stated "standard precautions" were used with care of the ostomy bag and abdominal wound. LPN-I indicated being unaware if R104 had VRE in the abdominal wound and her usual practice when discarding the dirty dressings was to place the dirty dressings from the ostomy bag site in the trash can in the room, and placed bloody drainage in a red (biohazard) bag.	F 441		

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F 441	Continued From page 88 Review of R104's Hospital Discharge Summary dated 8/8/14, revealed R104 was discharged to facility with diagnoses of open abdominal incision with drainage, VRE culture positive and confusion. Review of R104's abdomen wound culture results dated 8/2/14, revealed the identified associated diagnosis of abscess or cellulitis of abdominal wall. The culture results identified "Enterococcus Durans/Hirae" and susceptibility results identified the organism was resistant to Vancomycin and Ampicillin. Review of physician visit notes revealed the following: -On 8/19/14, "recent hospitalization for fevers, chills, urinary tract infection, and previous history of fistula. CT followup shows improvement of her fistula and abscess area." -On 9/16/14, "recent abdominal fistula secondary to previous dialysis catheter placement. Followup CT scans have shown improvement of her fistula. She continues to have a urocutaneous fistula, which is draining minimally." Review of R104's progress notes from 10/1/14 to 10/22/14 revealed the following: -On 10/11/14, "collection bag intact to abdomen-no drainage noted in bag." -On 10/14/14, "urostomy pouch and flange changed as it is leaking and very foul smelling." -On 10/18/14, "collection bag intact to abdomen and contains small amount of yellowish liquid returns."	F 441		

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F 441	Continued From page 89 -On 10/21/14, "dressing dry et [and] intact to abdomen. Collection bag intact to abdomen et [and] contains a small amount of yellowish liquid. -On 10/22/14, "clean dressing at abdomen, collection bag intact et [and] contains a small amount of yellowish liquid. On 10/22/2014, at 3:50 p.m. the DON verified the treatment cart contained wound care supplies. The DON verified staff were expected to take only enough supplies into a residents room to provide the wound care. The DON stated wound cleanser would not be multi-use, and small bottles would be filled from the central supply and be kept in the resident's bedside stand or in Tupperware tubs kept in resident's room. The DON verified it would be inappropriate to return items to the treatment cart that were brought in to a resident's room for wound care, and scissors should be cleansed appropriately with a disinfecting wipe or alcohol. The DON verified contact precautions would be utilized in addition to standard precautions when VRE infections were present and scissors would be used for that resident only. The DON verified R104 was determined to require contact precautions following R104's hospital return in August. Review of R104's medical record revealed the lack of documentation of the initiation of additional precautions and lacked documentation of when the precautions had been discontinued. R104's record lacked documentation of further culture results of the abdominal wound. During an interview on 10/22/2014, at 4:23 p.m. the DON verified R104's medical record lacked	F 441		

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F 441	Continued From page 90 documentation of when R104's contact precautions were discontinued. The DON verified R104's record lacked documentation of any followup culture of wound. Review of the Guideline for the Management of Antimicrobial Resistant Microorganisms in Minnesota Long-Term Care Facilities, October 2000, listed various factors that favor the spread of Antibiotic Resistant Microorganisms (ARMs) in long term care facilities (LTCFs) which included lack of attention to basic infection control measures and use of common equipment without disinfection between residents. The document identified there is no proven decolonization regimen for VRE and indicated among LTCF residents VRE colonization is likely to persist for extended periods of time. Residents for whom Contact Precautions, in addition to Standard Precautions were residents who have ARM infected or colonized wounds that cannot be covered fully by dressings or who have drainage that cannot be contained by dressings. The guidelines for use of Contact Precautions with residents with ARMs directed the use of gowns when caring for residents if direct care (bathing, lifting) will be provided or when substantial contact with secretions/excretions (linen changes) is anticipated and when contact with environmental surfaces and items in the resident's room which are likely to be contaminated (those close to or used by the resident) is anticipated. This is particularly true if the resident has wound drainage which can not be contained by a dressing. In addition, the document directed to dedicate patient care equipment to a single resident and if the equipment is be shared it must be cleaned and disinfected before use by another resident. The	F 441		

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document identified when the condition of the resident with an ARM changes (e.g., drainage is contained) standard precautions can be used. However, if the resident continues to have secretions or excretions that are not contained, Contact Precautions should be continued.

The guidelines also identified surveillance should include the regular review of all microbiology culture and susceptibility data to detect methicillin resistant staphylococcus aurous (MRSA), VRE and other epidemiologically important microorganisms. Monitoring culture and susceptibility data will provide information on antimicrobial susceptibility and resistance patterns in a particular facility. The facility can use surveillance data in educational programs to reinforce infection control practices and prioritize infection control activities. A confidential line list of residents with ARMS should be maintained by the facility.

The Immediate Jeopardy that began on 10/22/14, was removed on 10/24/14 5:09 p.m., when the facility moved R104 to a private room and initiated contact precautions; disinfected the treatment cart and provided dedicated equipment for R104; educated all facility staff including Nursing, Dietary, Housekeeping and Maintenance on facility protocols for Transmission Based Isolation, Cleaning and Disinfecting Non-Critical Resident Care Items and Environmental Surfaces; educated all staff on the placement of a Transmission Based Isolation Grid highlighting the type of isolation, placed in a folder on the top of the isolation carts; and educated Housekeeping staff on CDC checklist for Monitoring Terminal Cleaning, Occupied Isolation Room Cleaning and checklists monitored by

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F 441	Continued From page 92 Housekeeping Supervisor and IC preventionist daily; licensed nurses educated Clean Dressing Protocol, including removal of dressing from the treatment cart, disposal of any unused supplies that have been taken into the resident's room, cross-contamination prevention, Cleaning and Disinfecting Non-Critical Resident Care Items, Environmental Surfaces, and also on the need to continue identified precautions until no longer necessary; CNA assignments sheets updated to identify precautions to be utilized, PPE equipment placed outside of resident rooms identified to need transmission based precautions. However, the noncompliance remained at the lower scope and severity level of F - widespread with no actual harm with potential for more than minimal harm that is not immediate Jeopardy. The facility policy titled Elements of an Infection Control Program Guideline, dated revised 2013, identified policies, procedures, and practices which promote consistent adherence to evidence based infection control practices. No other information was provided by the facility. Review of the facility's forms titled, Golden Clinical Services Line Listing of Resident Infections for the months of March 2014 to September 2014, revealed the following information: Forms included listings of residents' name, room number, unit, admission date, type of infection, residents' symptoms, onset date, cultures:	F 441		

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F 441	Continued From page 93 date/site/results, treatment, other actions if needed, indication if illness met criteria of an infection and whether the infection was community acquired (CAI) or healthcare associated infections (HAI). No noted analysis of the infections for each month were noted on the forms, nor provided by the facility. The facility was also unable to provide any information in regards to the month of October's line listings of infections. The facility line listing forms also lacked cultures completed for urinary tract infections (UTI) and also wounds which had drainage and were being treated with antibiotics in all of the months reviewed for infections. On 10/27/14, at 3:44 p.m. the DON and the administrator revealed the following regarding the facility's practice for ongoing monitoring/surveillance of infections within the facility: The DON confirmed he was responsible for completing the line listing forms for all residents identified to have an infection, and stated "he completes at the end of the month." The DON stated he would obtain this information a variety of ways such as: verbally by the nurses during a daily "stand up meetings", reading all residents progress notes for the last 24 hours (on Mondays he reads all residents progress notes from the entire weekend), and a weekly risk management meeting. The DON also verified he would monitor for trends or patterns by reading all resident progress notes and verbal communication with staff. It was asked how the DON would obtain the information if he did not have a chance to read the progress notes and was not verbally notified a resident had an infection, the DON nor the administrator were able to answer. The DON	F 441		

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	245052	A. BUILDING _____ B. WING _____	10/28/2014

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F 441	Continued From page 94 further revealed he would have expected UTI's and wound drainage to be cultured whenever possible so the appropriate antibiotic could be used. The DON verified this had not been done in all cases. The DON also revealed the facility did not always document when a resident's infection was resolved. It was asked to both the administrator and the DON how staff is educated when a resident had an infection which required staff to utilize special precautions, neither answered. However, the administrator stated all staff is educated regarding infection control upon hire, monthly via Internet courses and when an outbreak occurs. The DON revealed verbal communication with the staff would be completed as needed. The DON stated an outbreak would be noticed before it spread. Upon completion of the interview the DON verified he did not utilize the line listings other than monthly, nor were either able to provide documentation or evidence of adequate monitoring for trends or patterns, analysis of findings or practice when implementing special precautions when it was warranted. The facility policy titled, Elements of an Infection Control Program Guideline, revised 2013, identified policies, procedures, and practices which promote consistent adherence to evidence based infection control practices.	F 441		
F 496 SS=E	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency	F 496		

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F 496	Continued From page 95 evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 7 of 38 nursing assistants (NA-D, NA-H, NA-C, NA-G, NA-T, NA-A, NA-B) currently employed by the facility were listed on the State's Nursing Assistant Registry as required. This had the potential to affect all 64 residents who resided at the facility. Findings include: A review of nursing assistant registration with the	F 496	**F496E** -All Nursing Assistants not registered with the MN Nursing Assistant Registry have been removed from their duties. - All Nursing Assistants currently employed at this facility have been screened for verification with the State's Nursing Assistant Registry. - Hiring Managers have been educated to verify new NA hires are on the MN Nursing Assistant Registry prior to working with residents. - All New Hires personnel files will be audited for completion of verification of Registry with the MN Nursing Assistant Registry as they are on-boarded. Any re-education or follow-up will be completed at the time of the audit. Audit results will be presented at QA&A for review. -Scheduling Coordinator/Bookkeeping Asst. is the responsible party. - Corrective action will be completed by 12/22/2014	

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F 496	Continued From page 96 State Agency indicated nursing assistant (NA)-D (hired 9/15/14), NA-H (hired 10/6/14), NA-C (hired 7/23/14), NA-G (hired 10/6/14), NA-T (hired 10/10/14), and NA-A (hired 10/6/14), was not listed on the nursing assistant registry. A representative from the State Agency, on 10/27/14 at 1:30 p.m., per telephone interview indicated NA-B was on registry but her registration expired as of 8/10/14. NA-B reapplied during survey and the registration was activated on 10/27/14. An interview with the facility administrator was completed on 10/27/14, at 2:30 p.m and verified the findings. She indicated she was under the impression that nursing assistants had a period of 4 months to get on the nursing assistant registry upon hire. She also reported that some of the nursing assistants were on the adjoining state nursing assistant registry and were waiting for a transfer to the current states nursing registry.	F 496	**F501E** -The Living Center's Medical Director provides and collaborates with facility staff to address pharmacy recommendations that have not been addressed and concerns related to lack of adequate resident assessments. -This has the potential to affect all residents. -Medical Director has been educated that recommendations not addressed by the primary MD or the assigned NP in a timely manner will be forwarded to and addressed by the Medical Director. Additionally, any concerns related to inadequate assessments will be addressed, as needed, by the Medical Director and Nursing Administration. -Pharmacy recommendations will be audited monthly by the Pharmacy Consultant. Any re-education or follow-up will be completed at the time of the audit. Audit results will be presented at QA&A for review. -Pharmacy Consultant is the responsible party. -Corrective action will be completed by 12/22/2014	
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility medical director failed to provide and collaborate with facility staff to address pharmacy recommendations that had not been addressed,	F 501		

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F 501	Continued From page 97 and concerns related to lack of adequate resident assessments This had the potential to affect all 64 residents who resided in the facility. Findings include: Review of consulting pharmacy forms titled, Clinical Pharmacist Recommendations Detail to Nursing Services, from May 2014 to September 2014, revealed the following: May 2014 * 44 separate recommendations were made by pharmacy which included: the lack of indications for the use of a medications, requests to monitor blood pressure for residents on hypertension medication, directions not to crush medications that were not to be crushed, and an order for the removal of a Lidoderm patch (patch infused with a local anesthesia to relieve pain) after 12 hours, to prevent resident toxicity. There were also five other recommendations in regard to other residents such as: directing staff to date and initial narcotic Fentanyl patches prior to placement, document the site of the placement on the resident, checking patch placement every shift and upon removal to witness and document disposal of patch by two nurses. June 2014 * 39 separate recommendations were made by pharmacy which included: lack of indications for use of a medication, directions not to crush medications that were not to be crushed, a request to remove a duplicate order for nitrostat (a medication used to relieve chest pain that can drop a resident's blood pressure extremely low if double dosed). There was other recommendations in regards to	F 501		

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F 501	Continued From page 98 other resident using Fentanyl patches, directing staff to date and initial narcotic Fentanyl patches prior to placement, document the site of the placement on the resident, checking patch placement every shift and upon removal to witness and document disposal of patch by two nurses. In addition, directed staff after removal of patch, the two nurses witnessing the destruction would witness/document the destruction in the black log book. Also there were directions to either place the used Fentanyl patch on a tissue, flush or cut the patch up, then flush in toilet. July 2014 * 47 separate recommendations were made by pharmacy which included: lack of indications for the use of a medication, directions not to crush the medications that were not to be crushed. There was three other recommendations involving other residents such as: to follow the hypoglycemia (low blood sugar) protocol, to review when to hold administration of insulin with nursing staff. There were also recommendations made to document medication errors for not following hypoglycemia protocol, the use of Phenobarbital as a controlled substance, and blanks in the medication administration record. August 2014 * 52 separate recommendations were made by pharmacy which included: lack of indications for continued use of a medication, directions not to crush medications that were not to be crushed, hypoglycemia protocol was not being followed, and recommendation of blood pressures not being monitored for a resident on three different medications for high blood pressure. September 2014	F 501		

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F 501	Continued From page 99 * 61 separate recommendations were made by pharmacy which included: hypoglycemia protocol not being followed, monitoring blood pressures for residents on antihypertensive medications and notification of extremely high blood sugars. There were recommendations made for three other residents as well, which included: the documentation of administration and disposal of narcotic Fentanyl patches. On 10/24/14, 10:00 a.m. certified nurse practitioner (CNP)-A verbalized concerns over the facility nurses providing accurate information, properly assessed information for residents, timely information and the overall reliability of information provided by the staff. CNP-A further stated this had been an ongoing issue in the facility. CNP-A stated she had reviewed the concerns with the director of nursing (DON) and the medical director regarding the lack of reliable, accurate assessments, information and timely updates. She also indicated that residents had not been accurately assessed for pain and that was something she had seen routinely and had voiced those concerns to the medical director. On 10/28/14, at 6:25 p.m. the medical director verified he attended all of the facility Quality Assessment and Assurance (QA&A) meetings. The medical director stated he was not aware of the numerous pharmacy recommendations until the previous meeting in August 2014. However, the medical director verified there were pharmacy recommendation sheets that were to be reviewed by either the physician or the nurse practitioner responsible for the individual resident, and stated if the nurse practitioner is unable to handle them all then he gets involved after that. The medical director stated he was aware the consulting	F 501		

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F 501	Continued From page 100 pharmacist had reviewed facility recommendations with the DON in the past, he was not sure what the facility had been doing with pharmacy recommendations until now, and stated he hadn't seen them until recently. He confirmed the recommendations had not been reviewed at the routine QA&A meetings until August, 2014. The medical director verified he was aware of the nurse practitioner concerns and was aware those concerns had been reviewed with the DON in the past. He confirmed he had received complaints regarding resident assessments, pain management from various physicians in the facility in the past. The medical director indicated he had reviewed the complaints with the DON in the past. He confirmed he talked with individual nurses at times when he made rounds on his residents in the facility regarding assessments. He confirmed he continued to receive complaints from on call physicians when residents were transferred because of the quality of the information shared during transfer and stated the facility was "struggling."	F 501		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and	F 520		

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F 520	Continued From page 101 develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility Quality Assessment and Assurance (QA&A) committee failed to implement action plans for previously identified areas of concern related to resident care and consultant pharmacist recommendations in the facility. Findings include: Review of consulting pharmacy forms titled, Clinical Pharmacist Recommendations Detail to Nursing Services from May 2014 to September 2014, revealed the following: May 2014 * 44 separate recommendations were made by pharmacy which included: the lack of indications for the use of a medications, requests to monitor blood pressure for residents on hypertension medication, directions not to crush medications that were not to be crushed, and an order for the removal of a Lidoderm patch (patch infused with a local anesthesia to relieve pain) after 12 hours,	F 520	**F520F** -The facility Quality Assessment and Assurance Committee does implement action plans for previously identified areas of concern related to resident care and pharmacist recommendations. -This has the potential to affect all residents. -All members of the QAPI committee have been educated on the requirements to review and action plan concerns brought forward to the committee. -Monthly review of QAPI minutes will be conducted by the ED and DNS or designee for completeness of minutes to include action planning. Any re-education or follow-up will be completed at the time of the review. Results will be presented at QA&A for review. - ED or Designee is the responsible party. - Corrective action will be completed by 12/22/2014	

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F 520	Continued From page 102 to prevent resident toxicity. There were also five other recommendations in regard to other residents such as: directing staff to date and initial narcotic Fentanyl patches prior to placement, document the site of the placement on the resident, checking patch placement every shift and upon removal to witness and document disposal of patch by two nurses. June 2014 * 39 separate recommendations were made by pharmacy which included: lack of indications for use of a medication, directions not to crush medications that were not to be crushed, a request to remove a duplicate order for nitrostat (a medication used to relieve chest pain that can drop a resident's blood pressure extremely low if double dosed). There was other recommendations in regards to other resident using Fentanyl patches, directing staff to date and initial narcotic Fentanyl patches prior to placement, document the site of the placement on the resident, checking patch placement every shift and upon removal to witness and document disposal of patch by two nurses. In addition directed staff after removal of patch, the two nurses witnessing the destruction would witness/document the destruction in the black log book. Also there were directions to either place the used Fentanyl patch on a tissue, flush or cut the patch up, then flush in toilet. July 2014 * 47 separate recommendations were made by pharmacy which included: lack of indications for the use of a medication, directions not to crush the medications that were not to be crushed. There was three other recommendations involving other residents such as: to follow the	F 520		

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F 520	Continued From page 103	F 520		

hypoglycemia (low blood sugar) protocol, to review when to hold administration of insulin with nursing staff. There were also recommendations made to document medication errors for not following hypoglycemia protocol, the use of Phenobarbital as a controlled substance, and blanks in the medication administration record.

August 2014
* 52 separate recommendations were made by pharmacy which included: lack of indications for continued use of a medication, directions not to crush medications that were not to be crushed, hypoglycemia protocol was not being followed, and recommendation of blood pressures not being monitored for a resident on three different medications for high blood pressure.

September 2014
* 61 separate recommendations were made by pharmacy which included: hypoglycemia protocol not being followed, monitoring blood pressures for residents on antihypertensive medications and notification of extremely high blood sugars. There were recommendations made for three other residents as well, which included: the documentation of administration and disposal of narcotic Fentanyl patches.

On 10/28/14, at 6:45 p.m. the director of nurses (DON) verified the consultant pharmacist came to the facility monthly, most recently in September. The DON verified that at the end of September, the facility consultant pharmacist had reissued 109 pages of recommendations going back to May 2014, or before. However, the DON verified there were many recommendations and they had not all been addressed. The DON indicated he started in the facility in August, 2014, and there

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were so many recommendations he had not had time to review all of the recommendations from the pharmacist. The DON verified he was not aware of the blood sugar problems, he thought there had been meetings, but was unsure if this had been addressed.

On 10/23/14, at 5:30 p.m. the consultant pharmacist stated the facility had been informed of recommendations which included the process for administration and destruction of Fentanyl patches to prevent loss or diversion. She indicated she had made recommendations regarding her concerns

On 10/28/14, at 6:25 p.m. the medical director verified he attended all of the facility QA&A meetings. The medical director stated he was not aware of the numerous pharmacy recommendations until the previous meeting in August 2014. However, the medical director verified there were pharmacy recommendation sheets that were to be reviewed by either the physician or the nurse practitioner responsible for the individual resident, and stated if the nurse practitioner is unable to handle them all then he gets involved after that. The medical director stated he was aware the consulting pharmacist had reviewed facility recommendations with the DON in the past, he was not sure what the facility had been doing with pharmacy recommendations until now, and stated he hadn't seen them until recently. He confirmed the recommendations had not been reviewed at the routine QA&A meetings until August, 2014. The medical director verified he was aware of the nurse practitioner concerns and was aware those concerns had been reviewed with the DON in the past. He confirmed he had received complaints regarding resident

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F 520	Continued From page 105 assessments, pain management from various physicians in the facility in the past. The medical director indicated he had reviewed the complaints with the DON in the past. He confirmed he talked with individual nurses at times when he made rounds on his residents in the facility regarding assessments. He confirmed he continued to receive complaints from on call physicians when residents were transferred because of the quality of the information shared during transfer and stated the facility was "struggling." On 10/28/14, at 6:44 p.m. the administrator verified the attendance record for QA&A meetings. Review of the records revealed the DON, administrator, medical director and consultant pharmacist routinely attended the monthly meetings. The administrator stated she was aware the pharmacist had made recommendations in the past regarding psychotropic meds, pain management and controlled substances in the facility and stated she had concerns the pharmacy recommendations may be "overstepping" by the pharmacist. Review of the consultant pharmacy report titled GL Moorhead Acceptance ratio report, revealed from 8/1/14 to 9/30/14 there had been no response to 47.57% of pharmacist recommendations.	F 520		

12/15/14 approved addendum

Addendum to 2567 POC; GOLCEN LIVING CENTER MOORHEAD

F176:Random audits will be conducted 3x weekly to ensure completion of Self Administration of Medication assessments are completed on residents that wish to self administer their medication. Audit results will be presented at QAPI for review and action planning as needed.

F226: Audits will be conducted on all incident reports as they are received to ensure timely and appropriate reporting.
Audits are conducted (see F496 audits) on all CNA's at the time of hire to ensure they are on the MN Nursing Assistant Registry. Audit results will be presented at QAPI for review and action planning as needed.

F253: R143, R144, and R121 have been discharged from the facility.

F279: Random observational audits will be conducted 2x weekly to ensure that residents identified as having pain, diabetes, or behaviors have a comprehensive care plan in place to address those areas. Current listing of residents will be reviewed for diabetes, pain, and behaviors and new resident reviewed upon admission to have appropriate items completed. Audit results will be presented at QAPI for review and action planning as needed.

F309: All residents with diagnosis of pain or pain related conditions have the potential to affected by the cited practice. Current listing of residents have been reviewed and new admissions reviewed at clinical start-up.
Random audits will be conducted 2x weekly to ensure a comprehensive pain assessment has been completed for those residents with a diagnosis of pain or a pain related condition. Audit results will be presented at QAPI for review and action planning as needed.

F323: Random weekly observational audits will be conducted to assure all current residents at risk of elopement are included in the elopement book and have interventions in place to decrease risk of elopement. Additionally, these audits will also include observations of random resident rooms to identify and remove tripping hazards. Current listing of residents have been reviewed and assessments completed appropriately.

F333: Current listing of all residents receiving narcotic pain patch have been reviewed at this time.

F428: The facility has a new Consultant Pharmacist. Monthly audits will be conducted following Consultant Pharmacist visits to review and address recommendations as needed. Audit results will be presented at QAPI for review and action planning as needed.

F431: R72 use of topical narcotics has been reviewed and is receiving medications as indicated.

F441: Random observational audits will be conducted 3x weekly to ensure infection control procedures are being followed in areas such as TX cart cleaning, maintaining isolation precautions, terminal cleaning of rooms, direct care provision & dressing changes. Treatment carts were disinfected.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MOORHEAD	2810 NORTH 2ND AVENUE MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Golden Livingcenter Moorhead Building 01 Main Building 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: DEC - 8 2014 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 RECEIVED MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION DC: 12-7-14 EXIT: 10-28-14	K 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth or any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. POC ok RS 12-10-14	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
ED	12/2/14	

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - MOORHEAD	2810 NORTH 2ND AVENUE MOORHEAD, MN 56560

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as 2 seperate buildings: Golden Livingcenter Moorhead was built in three stages. In 1963 the original 1-story building was constructed without a basement and was determined to be Type II (111) construction. In 1998 a 1-story addition was constructed to the north east of the east wing of the original building and was determined to be Type V (111) construction. In 2009 a dayroom addition was constructed to the north east corner of the original building and a dining room addition to the south east of the original dining room was constructed. These additions are Type II (000), 1-story without a basement. The entire building is sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system that includes 30-foot on center corridor smoke detection, with	K 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition, with automatic fire department notification. All hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 87 beds and had a census of 65 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	**K 054 - Smoke Detectors Sensitivity Testing** Of all Golden Living Center Moorhead's smoke detectors, four smoke detectors were inadvertently omitted from the sensitivity testing that was conducted by an outside contracted organization on 1-13-14. The Maintenance Manager immediately made arrangements with the outside vendor to conduct sensitivity testing on the four smoke detectors that were omitted in the initial test. The count for the smoke detectors from one year to the next will be cross- checked with the new annual testing performed to ensure that no smoke detectors were omitted from the testing. Maintenance Manager will conduct annual checks to ensure that smoke detectors have proper testing completed. Summary report regarding sensitivity testing completed will be reviewed at quarterly Quality Assurance Committee Meeting for the committee review and recommendations as warranted until compliance. Date of Correction - 12-1-14	
K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted a complete sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 10:30 AM to 3:30 PM on 10/23/2014, during a review of the facility's available fire alarm maintenance and testing documentation it was revealed that there were	K 054		

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K 054	Continued From page 3 discrepancies in the number of fire alarm system devices being tested between 2012 and 2014. It was also revealed by comparing all the fire alarm test reports that there has been 4 photo smoke detectors that were not tested during the 01/13/2014 smoke detector sensitivity test. The smoke detectors that were not tested included 3 photo smoke detectors located in the 2009 addition and one that is located in the hall to the Rehab office. This was confirmed by the Facility Administrator (MC).	K 054	**K 075 - Linen and Trash Receptacles** Facility removed the multi-compartment linen and trash containers from the hallways.	
K 075 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Soiled linen or trash collection receptacles do not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space does not exceed .5 gal/sq ft (20.4 L/sq m). A capacity of 32 gal (121 L) is not exceeded within any 64 sq ft (5.9-sq m) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) are located in a room protected as a hazardous area when not attended. 19.7.5.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to store large trash and linen carts in properly protected rooms in accordance with the NFPA 101 "The Life Safety Code" 2000	K 075	The Maintenance Manager and Administrator has purchased 2 storage barrels one 20 gallon and one 10 gallon for each hallway unit not to exceed the 32 gallons in a 64 square foot area and a mobile 20 gallon trash compartment that will be utilized on the floor throughout the hallway attended by staff. When not utilized, all bags will be removed from the barrel with no bag actively engaged for use and placed next to the other barrels. Maintenance Manager will conduct weekly audits for compliance with the Minnesota State Fire Code regarding the linen and trash receptacles upon the purchase and receipt of new containers. Audits will be completed through the end of January.	

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 075	Continued From page 4 edition (LSC) section 19.7.5.5. This deficient practice could affect the safety of all residents, staff and visitors if smoke or fire from one of these carts rendered the corridors untenable. Findings include: On facility tour between 10:30 PM and 3:30 PM on 10/23/2014, it was found in that the facility was storing multiple connected mobile solid linen container that are greater than 32 gallons in aggregate that are being stored in spaces that are greater than 64 square feet (in area) and that are open to the corridors and not in the required hazardous storage areas. This was confirmed by the Facility Administrator (MC).	K 075	Audits will be reviewed at Quality Assurance Committee Meetings for committee review and recommendations as warranted until compliance. Date of Correction - 12-15-14 **K 130 - Miscellaneous Other** The lint in the access area and within the combustion area in the back of the dryers was cleaned immediately by facility Maintenance Assistant on 10-23-14 subsequent to the observation of the lint.	
K 130 SS=D	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility had an excessive amount of lint and other combustibles that are in violation of the Minnesota State Fire Code (07). This deficient condition could result in an explosive flash fire that could affect residents, visitors, and staff. Findings include: On facility tour between 10:30 AM and 3:30 PM on 10/23/2014, there are 2 cloths dryers that are located in the facility's laundry room which had an	K 130	Weekly Alert to facility Building Engines Program was added to weekly cleaning. Untimely Compliance with the cleaning will generate email alert to Facility Administrator.	

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

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K 130	Continued From page 5 excessive lint in the access area and within the combustion area in the back of the dryers. The lint was observed to be between 3/8 to 1/2 of an inch in thickness. The condition is in violation of the Minnesota State Fire Code (07) sections 305.1. This was confirmed by the Facility Administrator (MC).	K 130	Cleaning will be the responsibility of the Maintenance Manager and Maintenance Assistant. Audits of the lint combustion area will be conducted by the Facility Administrator three times per month beginning November 2014 through January of 2015. Summary of results reporting results will be reviewed at quarterly Quality Assurance Committee Meeting for the committee review. Date of Correction - 12-15-14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING 02 - DINING ROOM & DAYROOM ADDITIONS B. WING _____	10/23/2014

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RECEIVED
DEC 8 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
ED		12/2/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING 02 - DINING ROOM & DAYROOM ADDITIONS B. WING _____	10/23/2014

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GOLDEN LIVINGCENTER - MOORHEAD	2810 NORTH 2ND AVENUE MOORHEAD, MN 56560

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	245052	A. BUILDING **02 - DINING ROOM & DAYROOM ADDITIONS** B. WING _____	**10/23/2014**

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K 054 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on staff interview and a review of the available documentation, the facility has not conducted a complete sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 National Fire Alarm Code (99), Sec. 7-3.2.1. This deficient practice could affect all residents, visitors, and staff. Findings include: On facility tour between 10:30 AM to 3:30 PM on 10/23/2014, during a review of the facility's available fire alarm maintenance and testing documentation it was revealed that there were	K 054	**K 054 - Smoke Detectors Sensitivity Testing** Of all Golden Living Center Moorhead's smoke detectors, four smoke detectors were inadvertently omitted from the sensitivity testing that was conducted by an outside contracted organization on 1-13-14. The Maintenance Manager immediately made arrangements with the outside vendor to conduct sensitivity testing on the four smoke detectors that were omitted in the initial test.	

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 6542

November 19, 2014

Ms. Melissa Chisholm, Administrator
Golden LivingCenter - Moorhead
2810 North 2nd Avenue
Moorhead, Minnesota 56560

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5052024, H5052037

Dear Ms. Chisholm:

The above facility was surveyed on October 20, 2014 through October 28, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5052037, that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to this office at:

Gail Anderson, Unit Supervisor
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Gail.anderson@state.mn.us

Phone: (218) 332-5140
Fax: (218) 332-5196

We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at the email or phone number detailed above.

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

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

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

Sincerely,

Mark Meath

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

Enclosure(s)

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 20-24 and 27-28, 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program; PO Box 64900, Saint Paul, MN 55164-0900 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the correction orders has been attained in accordance with your verification. An investigation of complaint H5052037 was completed at the time of the survey. The complaint was not substantiated.	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO	

2 000	Continued From page 1	2 000	SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	