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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: PKIB
Facility ID: 00995

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245323**
2.STATE VENDOR OR MEDICAID NO.
(L2) **677088600**

3. NAME AND ADDRESS OF FACILITY
(L3) **WALKER REHABILITATION & HEALTHCARE CENTER**
(L4) **209 BIRCHWOOD AVENUE WEST PO BOX 700**
(L5) **WALKER, MN** (L6) **56484**

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) **02/01/2017**
6. DATE OF SURVEY **07/05/2017** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **40** (L18)
13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(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 :
Lyla Burkman, Unit Supervisor 09/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/05/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/18/2017
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5323

On June 20, 2017, the Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) and on June 23, 2017 and July 5, 2017 the Departments of Health and Public Safety completed a PCR to verify that the facility had achieved and compliance. Based on the revisits we have determined all deficiencies have been corrected. As a result of achieving compliance, we discontinued state monitoring as of June 27, 2017 and as authorized by CMS Regio V office, the following action related to the remedy outlined in our letter of September 29, 2017:

- Mandatory denial of payment for new Medicare and Medicaid admissions (DPNA), effective August 10, 2017, has been rescinded.

Since DPNA did not go into effect, the two year loss of NATCEP, which was to go into effect August 10, 2017, is also rescinded.

Effective June 27, 2017 the facility is certified for 40 skilled Nursing Facility beds.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245323

October 5, 2017

Mr. Luke St. Germain, Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West PO Box 700
Walker, MN 56484

Dear Mr. St. Germain:

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

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

Effective June 27, 2017 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 40 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.

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
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

Electronically delivered
September 29, 2017

Mr. Luke St. Germain, Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West PO Box 700
Walker, MN 56484

RE: Project Number H5323017 and S5323026

Dear Mr. St. Germain:

On June 6, 2017, as authorized by the CMS Region V Office, the Department informed you that the following enforcement remedies were being imposed:

- State Monitoring effective June 11, 2017. (42 CFR 488.422)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective August 10, 2017. (42 CFR 488.417 (b))

Also, the Department notified you in our letter of June 6, 2017, 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 August 10, 2017.

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed May 10, 2017 and a standard survey completed on May 18, 2017. The most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On June 20, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) and on June 23, 2017 and July 5, 2017, the Departments of Public Safety and Health completed a PCR by review of the facility's plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey completed on May 10, 2017 and a standard survey completed on May 18, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 27, 2017. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey completed on May 10, 2017 and a standard survey completed on May 18, 2017, as of June 27, 2017. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 27, 2017.

In addition, this Department recommended to the CMS Region V Office the following action related to the remedy outlined in our letter of June 6, 2017. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 10, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 10, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 10, 2017, is to be rescinded.

In our letter of June 6, 2017, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 10, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 27, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: PKIB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00995

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245323**

2.STATE VENDOR OR MEDICAID NO.
(L2) **677088600**

3. NAME AND ADDRESS OF FACILITY
(L3) **WALKER REHABILITATION & HEALTHCARE CENTER**
(L4) **209 BIRCHWOOD AVENUE WEST PO BOX 700**
(L5) **WALKER, MN** (L6) **56484**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2017**

6. DATE OF SURVEY **05/18/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds 40 (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	40			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Lyla Burkman, Unit Supervisor 06/21/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 07/18/2017 (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
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 6, 2017

Mr. Luke St. Germain, , Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West P.O. Box 700
Walker, MN 56484

RE: Project Number H5323017 & S5323026

Dear Mr. St. Germain:

On May 17, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated standard survey, completed on May 10, 2017 investigating complaint number H5323017. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 18, 2017, the Minnesota Department of Health and on May 17, 2017, the Minnesota Department of Public Safety completed a standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies. This standard survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

- State Monitoring effective June 11, 2017. (42 CFR 488.422)

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 August 10, 2017. (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 August 10, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective August 10, 2017. 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, Walker Rehabilitation & Health Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 10, 2017. 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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from **the abbreviated standard survey completed May 10, 2017**), the plan of correction should be directed to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64970
St Paul, MN 55164-0970
annette.m.winters@state.mn.us
Office 651-201-4204 Fax: 651-281-9796
General Info: 651-201-4201 Toll Free: 1-800-369-7994

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag, from the **standard survey completed May 18, 2017**), the plan of correction should be directed to:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

ORIGINAL DEFICIENCIES NOT CORRECTED

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

ORIGINAL DEFICIENCIES NOT CORRECTED AND NEW DEFICIENCIES FOUND DURING REVISIT

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

ORIGINAL DEFICIENCIES CORRECTED BUT NEW DEFICIENCIES FOUND DURING REVISIT

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

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

If substantial compliance with the regulations is not verified by August 10, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 10, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

209 Birchwood Ave
Walker, MN 56484
P: 218-547-1855
F: 218-547-2266

WALKER REHABILITATION AND HEALTHCARE CENTER

Fax

To: Lyla Burkman From: Dolores Guggenberger

Fax: lyla.burkman@state.mn.us Pages: 2

Phone: Date 6-19-17

Re: Request Compliance Date change cc:

☐ Urgent ☒ For Review ☐ Please Comment ☐ Please Reply ☐ Please Recycle

Comments:

Please call if you have questions.

Lyla Burkman
MDH
lyla.burkman@state.mn.us

Walker Rehabilitation and Health Care Center is requesting to adjust the compliance date for the survey completed on May 18, 2017 from June 21, 2017 to June 27, 2017.

Dolores Guggenberger, RN, MBS 6-19-17
Director of Nursing Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING _____ B. WING _____	05/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER REHABILITATION & HEALTHCARE CENTER	**209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.12(a)(3)(4)(c)(1)-(4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS 483.12(a) The facility must- (3) Not employ or otherwise engage individuals who- (i) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (ii) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or (iii) Have a disciplinary action in effect against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property.	F 225	All Completion date are changed to 6/27/17 see attached Addendum	6/21/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/15/2017

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

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	245323	A. BUILDING _____ B. WING _____	05/18/2017

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F 225	Continued From page 1 (4) Report to the State nurse aide registry or licensing authorities 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. (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. (2) Have evidence that all alleged violations are thoroughly investigated. (3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. (4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and	F 225		

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F 225	Continued From page 2 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 potential abuse/mistreatment allegation to the State agency (SA) for 1 of 3 residents (R13) reviewed for potential allegations of abuse. Findings included: R13's quarterly Minimum Data Set (MDS) dated 11/28/16, included diagnosis of Alzheimer's, was rarely or never understood, and staff assessed R13 to have severe cognitive impairment. The MDS indicated R13 was dependent on staff to complete all activities of daily living. Review of Vulnerable Adult (VA) reports revealed an initial report was made to the SA dated 12/15/16, for allegations of physical abuse. The report indicated the incident occurred on 12/14/16. The initial report explained the facility's corporate compliance department had notified the facility of an anonymous call received on 12/14/16, which reported concerns of potential abuse. The caller stated, "nurse was trying a new technique to care for [R13's] hands, which included placing new splints on [R13's] hands. [R13] began screaming for approximately 30 minutes. [R13's] hand appeared swollen." On 5/18/17, at 9:30 a.m. the director of nursing (DON) stated she had not been employed with	F 225	F225 Allegations of abuse/neglect for R13 have been reported and thoroughly investigated in accordance with state law. All residents have the potential to be affected if alleged violations are not reported immediately and thoroughly investigated in accordance with state law, through established procedures. Resident interviews were completed to determine that any allegations have been reported and investigated. Staff have been educated on reporting requirements for alleged violations involving abuse, neglect, or mistreatment. 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 Executive Director. Executive Director has been educated to initiate an OHFC report immediately upon notification of a potential abuse/neglect/mistreatment report, investigate any allegations, and report results of the investigation and corrective actions taken to the appropriate officials in accordance with state law. Progress notes, grievance reports, and incident reports will be reviewed daily to	

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F 225	Continued From page 3 the facility at the time of the incident, however, reviewed the report and indicated it appeared R13 sustained a serious injury which should have been reported within two hours of notification. An undated Investigating and Reporting of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property policy indicated it was the responsibility of each individual employee to immediately report any reasonable suspicion of a crime, and all allegations of mistreatment, neglect, abuse, injury of unknown origin and/or misappropriation of resident property to the designated supervisor in charge at the time. Employee may also elect to report directly to the center/locations executive director (ED) or director of nursing services (DNS) for purposes of reporting "immediately" means as soon as possible by not to exceed two hours in the event of serious injury or death of patient involved in a report or twenty-four hours for all other reports or shorter if State law/regulations require a report within a shorter timeframe.	F 225	ensure any alleged violations have been reported and investigations have been initiated by the IDT during morning meeting. The facility ED will audit this review twice weekly to ensure compliance. Interviews on staff treatment of residents will be conducted with residents during quarterly care conferences. Negative findings will be reported immediately and thoroughly investigated in accordance with state law. Results will be brought to QAPI for review and recommendations. ED is responsible. Compliance by 6/21/17.	
F 226 SS=D	483.12(b)(1)-(3), 483.95(c)(1)-(3) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES 483.12 (b) The facility must develop and implement written policies and procedures that: (1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 226		6/21/17

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F 226	Continued From page 4 (2) Establish policies and procedures to investigate any such allegations, and (3) Include training as required at paragraph §483.95, 483.95 (c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- (c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. (c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property (c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to operationalize their abuse policy and procedures related to the immediate reporting of potential abuse/mistreatment to the State Agency (SA) for 1 of 3 residents (R13) who were reviewed for potential allegations of physical abuse. Findings included: An undated facility policy Investigating and Reporting of Alleged Violations of Federal and	F 226	F226 Allegations of abuse/neglect for R13 have been reported and thoroughly investigated in accordance with state law. All residents have the potential to be affected if alleged violations are not reported immediately and thoroughly investigated in accordance with state law, through established procedures. Resident interviews were completed to determine that any allegations have been reported and investigated.	

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F 226	Continued From page 5 State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property indicated it was the responsibility of each individual employee to immediately report any reasonable suspicion of a crime, and all allegations of mistreatment, neglect, abuse, injury of unknown origin and/or misappropriation of resident property to the designated supervisor in charge at the time. Employee may also elect to report directly to the center/locations executive director (ED) or director of nursing services (DNS) for purposes of reporting "immediately" means as soon as possible by not to exceed two hours in the event of serious injury or death of patient involved in a report or twenty-four hours for all other reports or shorter if State law/regulations require a report within a shorter timeframe. R13's quarterly Minimum Data Set (MDS) dated 11/28/16, included diagnosis of Alzheimer's, was rarely or never understood, and staff assessed R13 to have severe cognitive impairment. The MDS indicated R13 was dependent on staff to complete all activities of daily living. Review of Vulnerable Adult (VA) reports revealed an initial report was made to the SA dated 12/15/16, for allegations of physical abuse. The report indicated the incident occurred on 12/14/16. The initial report explained the facility's corporate compliance department had notified the facility of an anonymous call on 12/14/16 that reported concerns of potential abuse. The caller stated, "nurse was trying a new technique to care for [R13's] hands, which included placing new splints on [R13's] hands. [R13] began screaming	F 226	Staff have been educated on reporting requirements for alleged violations involving abuse, neglect, or mistreatment. 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 Executive Director. Executive Director has been educated to initiate an OHFC report immediately upon notification of a potential abuse/neglect/mistreatment report, investigate any allegations, and report results of the investigation and corrective actions taken to the appropriate officials in accordance with state law. Progress notes, grievance reports, and incident reports will be reviewed daily to ensure any alleged violations have been reported and investigations have been initiated by the IDT during morning meeting. The facility ED will audit this review twice weekly to ensure compliance. Interviews on staff treatment of residents will be conducted with residents during quarterly care conferences. Negative findings will be reported immediately and thoroughly investigated in accordance with state law. Results will be brought to QAPI for review and recommendations. ED is responsible. Compliance by 6/21/17.	

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F 226	Continued From page 6 for approximately 30 minutes. [R13's] hand appeared swollen." On 5/18/17, at 9:30 a.m. DON stated she had not been employed with the facility at the time of the incident, however, reviewed the report and stated it appeared R13 sustained a serious injury which should have been reported within the required two hours of notification. On 5/18/17, at 2:30 p.m. the registered nurse (RN)-consultant confirmed the report was not made timely as required and was not aware of all the circumstances surrounding the case and investigation related to a change in the administrator and director since that time.	F 226		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F 278		6/21/17

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F 278	Continued From page 7 (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document, review the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected dental status for 1 of 3 residents (R10) and accurately reflected fall history for 1 of 1 resident (R20) whose MDS assessments were incorrectly coded. Findings include: R10's dental status was incorrectly coded on the MDS. On 5/15/17, at 5:21 p.m. R10 was observed lying in bed with mouth open. The upper right side of R10's mouth revealed one missing tooth and one tooth broken off at the gum line with black/brown decay.	F 278	F278 MDS coding for R10 and R20 have been corrected to reflect an onsite accurate assessment All residents have had their MDS assessments reviewed for accuracy and corrected as necessary. Training on accurate, onsite resident assessment is being done with facility management and training on proper coding for MDS based on those assessment is being done for MDS nurses who provide MDS services to Walker Rehabilitation & Nursing. An MDS Coordinator has been designated for Walker who will complete MDSs in—house and will perform any resident assessment in person with the resident.	

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F 278	Continued From page 8 R10's admission MDS dated 2/8/17, indicated R10 had severe cognitive impairment, was dependent on staff for activities of daily living, and had no broken or loosely fitted teeth, no tooth fragments, and no dental caries. R10's significant change MDS dated 4/25/17, also indicated R10 had no broken or loosely fitted teeth, no tooth fragments, and no dental caries. On 5/16/17, at 2:21 p.m. the registered nurse (RN)-consultant confirmed both comprehensive MDS assessments were not coded accurately. RN-consultant stated the RN who had completed the MDS on 4/25/17, worked off-site and would not have viewed R10's mouth at the time of assessment and all dental concerns which occurred between assessments should have been documented in nurse progress notes. The RN-consultant reviewed R10's medical record and confirmed there was no indication R10 had lost or broken a tooth after the completion of the assessments. RN-consultant stated staff were expected to physically inspect the mouth, document any findings, and make or offer a dental referral for any identified concerns. -At 3:17 p.m. nursing assistant (NA)-E viewed R10's mouth and confirmed R10 had a missing and broken tooth on the right upper side of her mouth. NA-E reported R10's teeth had been like that on admission. R20's fall history was incorrectly coded on the MDS. R20's quarterly MDS dated 4/28/17, indicated	F 278	The Regional Vice-President for Reimbursement will do a weekly review of the coding done by the Walker MDS Coordinator to ensure that the work being done is accurate. The Regional VP for Reimbursement will report the results of his weekly review to the facility ED. Based on the review done in the paragraph above, the facility ED or his designee will audit weekly x 4 and then monthly x 3 thereafter to ensure that that the MDS Coordinator is performing on-site resident assessments for the MDS. This will be accomplished by the MDS Coordinator notifying the ED when she is doing an onsite assessment which will be verified by the ED. Audit results will be reviewed at QAPI. Compliance by 6-21-17	

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F 278	Continued From page 9 R20 was severely cognitively impaired and had diagnoses which included hypertension and Alzheimer's disease. The MDS further indicated R20 had experienced no falls since the previous assessment (dated 1/26/17). R20's post fall analysis dated 3/30/17, indicated R20 had an unwitnessed fall from bed at 11:30 p.m. and was found sitting on the floor. R20 had redness on the back of his right thigh. The analysis further indicated R20 had impaired safety awareness/judgement and required frequent turning and repositioning. R20's post fall analysis dated 4/19/17, indicated R20 had an unwitnessed fall from bed at 11:05 p.m. and was found sitting on the floor. R20 sustained no injuries. The analysis further indicated R20 had a history of falls and needed frequent repositioning. On 5/18/17, at 9:24 a.m. RN-consultant confirmed R20 had two falls and verified R20's MDS Section J-falls had not been coded accurately and should have reflected R20's two falls. RN-consultant stated the facility did not have a policy related to the MDS and coding. On 5/18/17, at 9:30 a.m. the director of nursing (DON) verified R20's MDS Section J-falls was not coded accurately and indicated R20's two falls should have been identified on the MDS. A policy related to MDS completion was	F 278		

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F 278	Continued From page 10 requested, none was provided.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 279		6/21/17

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F 279	Continued From page 11 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan related to psychoactive medication use for 3 of 5 residents (R27, R12, R20) reviewed for unnecessary medications. Findings include: R27's facility Diagnoses Report undated, included diagnoses of encephalopathy, dementia with behavior disturbance, and diabetes mellitus.	F 279	F279 The care plans for R12, R20, and R27 have been updated to include specific problems and interventions for psychotropic medication including identification of the psychotropic medication in use, target behaviors, monitoring system, and non-pharmacological interventions being used. A review has been done for other resident receiving psychotropic medications to be	

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F 279	Continued From page 12 R27's quarterly Minimum Data Set (MDS) dated 3/9/17/17, indicated R27 had severe cognitive impairment with no mood or behavioral concerns identified. The MDS indicated R27 required extensive assistance for dressing and grooming. R27's current (undated) physician orders included the following medications: Risperdal (antipsychotic) 1.0 mg two times a day, Trazadone HCL (antidepressant) 25 mg two times a day, Ativan 0.5 mg (antianxiety) every four hours as needed (PRN), and Haloperidol Lactate 1 ml, every four hours PRN for agitation. R27's care plan dated 12/16/16, did not identify R27's psychotropic medication use and potential problem for drug complications, target behaviors, and did not identify nonpharmacological interventions to be used prior to administering the PRN medication for mood and behavior. On 5/18/17, at 11:23 a.m. the director of nursing (DON) and the registered nurse (RN)-consultant verified R27's care plan was lacking the identification of the psychotropic medication use, target behaviors, monitoring system and nonpharmacological interventions to be implemented prior to the use of the PRN medications. In addition, both agreed the care plan should have been developed and should have been so the nurses would know what to do and especially since the facility currently utilized pool nurses.	F 279	sure the care plan reflects target behaviors and interventions for psychotropic medications Nursing staff will be trained on the program and on properly including information about psychotropic medications in resident care plans including identification of the psychotropic medication in use, target behaviors, monitoring system, and non-pharmacological interventions to be used. The Social Service Director will audit weekly to ensure that each care plan effectively reflects the proper psych issues for each resident in the psych program. The Social Services Director will report weekly to the IDT committee and monthly to QAPI. Compliance by 6/21/17.	

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F 279	Continued From page 13 R12's facility Diagnoses Report, print date 5/18/17, included diagnoses of a left below the knee amputation, heart transplant, diabetes mellitus and major depressive disorder. R12's quarterly MDS dated 4/27/17, indicated R12 was cognitively intact, required extensive assistance with dressing, grooming and transfers, had trouble falling asleep, had feelings of hopelessness, depression and received an antidepressant medication. R12's current physician orders, print date 5/18/17, indicated Fluoxetine (antidepressant) 20 milligrams (MG) was to be administered daily. R12's care plan dated 5/16/17, identified a potential for drug related complications associated with use of an antidepressant medication, however, the care plan lacked mood symptoms displayed by R12, a monitoring plan and interventions related to mood symptoms. On 5/17/17, at 10:50 a.m. RN-A confirmed R12's care plan lacked lacked mood symptoms displayed by R12, a monitoring plan, and interventions related to mood symptoms. R20's facility Diagnoses Report, print date 5/18/17, included diagnoses of osteoarthritis, encephalopathy (altered brain function), diabetes mellitus and major depressive disorder.	F 279		

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F 279	Continued From page 14 R20's quarterly MDS dated 4/28/17, indicated R20 had severe cognitive impairment, required extensive assistance with dressing, grooming and transfers and received an antidepressant medication. R20's current physician orders, print date 5/17/17, included the following medication: Wellbutrin extended release tablet 150 mg every day (antidepressant). R20's care plan identified a potential for drug related complications associated with use of an antidepressant medication, however, the care plan lacked mood symptoms displayed by R20, a monitoring plan and interventions related to mood symptoms. On 5/17/17, at 10:55 a.m. registered nurse (RN)-A confirmed R20's care plan lacked antidepressant use and a mood monitoring system. On 5/18/17, at 9:24 a.m. RN-consultant verified R20's care plan lacked mood monitoring related to antidepressant medication use. The facility Behavior Management Guideline, undated, directed staff to develop behavior plans and medication regimens when appropriate, to optimize the functional abilities of residents while monitoring for adverse side effects and improved behaviors.	F 279		

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F 280	Continued From page 15	F 280		
F 280 SS=D	483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs.	F 280		6/21/17

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F 280	Continued From page 16 (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 280		

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F 280	Continued From page 17 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include the use of a fractured sized bedpan in order to prevent the development and/or promote healing of a pressure related ulcers for 1 of 3 residents (R1) reviewed for pressure ulcers. Findings included: R1's quarterly Minimum Data Set (MDS) dated 2/10/17, indicated R10 had a new stage II (abrasion, blister, or a shallow crater in the skin) pressure ulcer which required pressure ulcer care. R1's quarterly MDS dated 5/5/17, indicated R1 had a stage II pressure ulcer and macerated skin damage. R1's pressure ulcer care plan dated 8/25/16, indicated actual or at risk due to assistance required in bed mobility and directed staff to conduct weekly skin inspections, provide nutritional and hydration support, provide treatments as ordered and to turn and reposition R1 every two hours and as needed. The care plan also indicated R1 utilized a bedpan due to bladder and bowel incontinence, however the plan did not identify which type of bed pan was to be used. The care plan also indicated R1 chose to remain on the bedpan for prolonged periods and directed staff to check on R1 about every 15 minutes while on the bed pan and to encourage R1 to be assisted off the bed pan after 30	F 280	F280 R1's care plan has been updated to reflect her current status and any interventions. Residents have had their care plans reviewed to ensure that they reflect their current status and current interventions. IDT group will meet weekly to review resident care plans and identify any issues or interventions. Updates will be made as issues are identified. The DON or her designee will select (5) care plans weekly to review to ensure that the process of the "IDT Sub-Committee on Care Plan Accuracy" is performing their job successfully. The DON will report monthly to the QA Committee on this program. Compliance by 6-21-17	

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F 280	Continued From page 18 minutes. R1's nurse progress note dated 4/29/17, indicated a left buttock dressing was changed and the area continued to be red and raw and the bedpan used was determined to be a causal factor of the skin breakdown. A Nurse progress note dated 4/30/17, indicated the large bedpan caused pressure to the left buttock, and also impaired healing. Therefore, staff replaced the large bedpan with a smaller fracture pan, but R1 could not be on the bedpan for more than 10 minutes at a time. R1's care plan was not revised to include the wound nor the directive to use a fractured sized bedpan. On 5/17/17, at 1:05 p.m. the director of nursing (DON) and registered nurse (RN)-consultant reviewed and verified R1's care plan lacked revision pertaining to bedpan and bedpan usage.	F 280		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the individualized care plans related to the provision	F 282	F282 The range of motion for R11 and R13 has	6/27/17

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F 282	Continued From page 19 of range of motion services as directed by the care plan for 2 of 2 residents (R13, R1) reviewed for range of motion. In addition, the facility failed to provide barrier cream and the removal of a mechanical lift sling as directed by the care plan for 1 of 1 resident (R11) reviewed. Findings include: R13's quarterly Minimum Data Set (MDS) dated 4/25/17, identified R13 with diagnoses of Alzheimer's disease and depression. The MDS indicated R13 had severe cognitive impairment, required total assistance with all activities of daily living and displayed physical limitations in upper and lower extremities. R13's care plan revised 3/15/17, indicated R13 had a mobility impairment with a goal to maintain current range of motion (ROM). The care plan directed staff to provide restorative nursing services/program (RNP) three times a week for functional ROM maintenance and to monitor and report changes in R13's ROM ability. R13's physician's orders dated 5/1/17-5/31/17, included an order for passive range of motion (PROM) to upper extremities including hands and fingers within tolerance, a minimum of three times a week to maintain ROM to allow staff to complete cares. The physician's orders did not address the lower extremities. On 5/16/17, at 12:30 p.m. licensed practical nurse	F 282	been added to the ETAR. Licensed staff are responsible to ensure that range of motion is performed as care planned. Care plan for R1 has been updated to reflect barrier cream use and removal of lift sling while in bed. Application of barrier cream and removal of lift sling has been added to ETAR. Resident care sheets were reviewed updated to reflect interventions addressed in care plan. These care sheets are now being used by floor staff to provide care for residents so that appropriate care is being received by residents. Health Unit Coordinator has been educated to keep care sheets updated with care plan changes. The HUC will print out and make available for CNAs. The DON or her designee will audit ETAR daily to ensure ROM services are being completed as ordered. DON or her designee will also audit (3) care plans and care sheets weekly x4 weeks and then monthly x2 months thereafter to ensure compliance. DNS will review ETAR daily to ensure documentation of barrier cream application and removal of lift sling while in bed. Negative findings will be corrected immediately. The DON will report to the IDT weekly and QAPI monthly. Compliance by 6-27-17	

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F 282	Continued From page 20	F 282		

(LPN)-A was observed feeding R13 lunch. At 1:00 p.m. R13 was wheeled out of the dining room and transferred into bed by two staff using a mechanical lift. R13 was observed to have carrots (padded foam splints) in each of her hands with fingers holding the carrots.

On 5/17/17, at 1:10 p.m. nursing assistant (NA)-B stated R13 did not receive any ROM or have a RNP in place. NA-B stated the NA's did not complete any ROM or restorative nursing for the residents. NA-B stated when residents were dressed, their arms and legs got moved, but no further ROM was completed. NA-B also stated the facility did not have a RNP and it had been over a year since they had any staff assigned to complete and provide RNP services.

-At 1:35 p.m. registered nurse (RN)-A stated R13's hands were cleaned and fingers were opened daily in which R13 screamed and yelled allot during this, but R13 was not provided ROM service.

-At 3:20 the occupational therapist (OT) verified R13 had impairments in both upper and lower extremities and should have been receiving a ROM services. However, the OT indicated the facility did not have a RNP program and ROM was not being done which was unfortunate. The OT stated the lack of a RNP had an impact on R13's ROM abilities.

On 5/18/17, at 8:35 a.m. the director of nursing (DON) verified R13 had impairment in the upper and lower extremities, had a RNP program directive and was not receiving the ROM as

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F 282	Continued From page 21 directed. The DON confirmed the facilty did not have a restorative program for the residents. R11 was not provided ROM as directed by the care plan R11's Diagnoses Report dated 5/18/17, included diagnoses of Parkinson's disease, muscle weakness, and mild cognitive impairment. R11's quarterly MDS dated 3/7/17, indicated R11 had severe cognitive impairment, was dependent on staff for activities of daily living (ADLs) and had functional range of motion impairment in both upper extremities and both lower extremities. R11's ADL's care plan revised on 1/20/17, indicated R11 would maintain current level of physical functioning of participating in PROM three times a week at a minimum of 10 minutes to upper and lower extremities with restorative nurse. The care plan directed staff to monitor and report changes in R11's physical functioning and range of motion ability. R11's Restorative Record indicated PROM was to be provided three times a week to bilateral upper extremities as resident allowed and PROM to bilateral lower extremities in order to maintain current level of mobility. The Restorative Record indicated the last time R11 received PROM to lower extremities was on 4/8/16, and the last time R11 received PROM to upper extremities was on 4/27/16.	F 282		

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On 5/18/17, at 9:40 a.m. LPN-B stated RNP had been discontinued last year, and the residents had not received range of motion services since the program was discontinued. LPN-B stated R11 had not experienced a decline in function since that time.

-At 9:53 a.m. the DON and RN-consultant verified there was no restorative/maintenance program in place as it had been discontinued last year. RN-consultant stated providing range of motion exercises was expected as part of nursing care and dressing a resident did not count as providing range of motion. RN-consultant stated staff were expected to follow the care plan.

R1 was not provided with barrier cream after incontinent product changes and did not have the mechanical lift sling removed from underneath her when in bed, as directed by the care plan.

R1's Diagnoses Report dated 5/18/17, included diagnoses of muscle weakness, osteoarthritis, fatigue, mild cognitive impairment, epilepsy, history of stroke, cataract, obesity, and hemiplegia effecting the right dominant side.

R1's quarterly MDS dated 5/5/17, indicated R1 had moderate cognitive impairment, required extensive assistance from two staff for transfers, was always incontinent of urine, and had a stage II (abrasion, blister, or a shallow crater in the skin) pressure ulcer.

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R1's care plan last revised on 3/15/17, directed staff to use a full body mechanical lift for transfers with two staff, the lift sling was to remain under resident while up in the wheelchair, and to apply barrier cream with brief changes.

On 5/15/17, at 6:54 p.m. R1 observed in bed with a hospital gown on with the mechanical lift sling underneath her. R1 stated she was in bed for the night.

5/16/17, at 11:23 a.m. RN-A was observed to complete a dressing change to R1's left buttock. NA-B stated R1's bottom had already been washed and had a new incontinent brief applied. However, NA-B confirmed, barrier cream was not applied to R1's bottom.

-At 2:37 p.m. R1 was observed in her room, seated in her wheelchair. The mechanical lift sling was positioned underneath her. NA-C brought the lift into the room and attached the sling to the lift. NA-C proceeded to transfer R1 from the wheelchair into bed. NA-C stated R1 only required one staff member to complete transfers with the mechanical lift and were allowed to do so.

-At 3:11 p.m. R1 was observed in bed as NA-E removed R1 from the bedpan, provided perineal care, and apply a new incontinent brief. NA-E did not apply barrier cream.

On 5/17/17, at 9:36 a.m. R1 was observed in her room, seated in the wheelchair. The lift sling was

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F 282	Continued From page 24 positioned underneath her. NA-A was observed to independently transfer R1 from the wheelchair and into bed with the mechanical lift. NA-A stated staff were permitted to use the mechanical lift with only one staff member. -At 10:11 a.m. NA-B was observed to provide R1 perineal care and apply a new incontinent brief. NA-B did not apply barrier cream. NA-B proceeded to independently transfer R1 from the bed into the wheelchair using the mechanical lift. NA-B stated the mechanical lift could be used with only one staff member to transfer R1. -At 10:45 a.m. the RN-consultant stated the lift sling was supposed to be removed when R1 was in bed, as directed by the care plan and barrier cream was to be applied as directed and expected staff to follow the care plan.	F 282		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers	F 314		6/27/17

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F 314	Continued From page 25 from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a weekly skin inspection and apply barrier cream as directed by the care plan for 1 of 3 residents (R1) identified as at risk for pressure related ulcers and had a recurring pressure wound. Findings included: R1's Diagnoses Report dated 5/18/17, included diagnoses of muscle weakness, osteoarthritis, fatigue, mild cognitive impairment, epilepsy, history of stroke, cataract, obesity, and hemiplegia effecting the right dominant side. R1's quarterly Minimum Data Set (MDS) dated 5/5/17, indicated R1 had moderate cognitive impairment, required extensive assistance from one staff for bed mobility and toileting and required extensive assistance from two staff for transfers. The MDS indicated R1 had functional range of motion impairment of one upper extremity and both lower extremities. The MDS also indicated R1 had a stage II (abrasion, blister, or a shallow crater in the skin) pressure ulcer and macerated skin damage and directed staff to provide wound care, pressure-reducing devices for wheelchair and bed, turning and repositioning program, and applications of ointments. R1's undated current care plan indicated R1 had bowel and bladder incontinence, utilized a	F 314	F314 R1 has weekly documentation of current skin condition including wound measurements. R1 wounds care interventions have been reviewed and updated as appropriate with MD input. Care plan for R1 has been updated to reflect barrier cream use and removal of lift sling while in bed. Other residents with impaired skin integrity have been reviewed to ensure they are receiving care and treatment as ordered with documentation. Licensed staff have been re-educated on the policy for skin/wound care and documentation requirements. Staff will now be documenting weekly on skin concerns through progress notes and/or PCC UDA system. DON will review resident wounds, documentation, interventions, and treatment daily during morning meeting for 2 weeks, then weekly after. Wounds will be discussed weekly at IDT team meeting. Wounds will be reviewed at QAPI. Compliance by 6-27-17	

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bedpan and directed staff to apply barrier cream with brief changes and to monitor skin for redness or irritation every shift. The care plan also identified R1 was at risk for alteration in skin integrity related to immobility and indicated R1 had moisture related maceration on coccyx. Interventions included: Cavilon no sting barrier every three days and as needed, monitor skin for irritation and breakdown and document and report to physician (MD) as needed and provide pressure-relieving mattress and cushion for wheelchair. The care plan further indicated R1 was at risk for pressure ulcers, had a history of a right heel pressure ulcer and directed staff to conduct weekly skin inspections, provide treatment as ordered by MD, and turn/reposition every two hours and as needed. In addition, the care plan indicated R1 chose to remain on the bedpan for prolonged periods of time which placed her at risk for skin breakdown. Interventions directed staff to check on resident about every 15 minutes while on the bed pan and to encourage R1 to be assisted off the bed pan if no output was noted after 30 minutes.

R1's Physician orders included:

-5/10/17, Allevyn border dressing (foam dressing) to pressure ulcer on coccyx, change every three days
-2/13/17, Complete weekly skin assessments every Monday day shift
-2/20/17, Wound evaluation of left upper buttocks every Monday per MD order
-1/16/17, Reposition every two hours while awake and every six hours while asleep for pressure ulcer reduction

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F 314	Continued From page 27 R1's Braden Scale (tool used to determine risk for pressure ulcers) dated 1/29/17, indicated R1 was at high risk for pressure ulcers. Review of R1's progress notes from 2/10/17, through 5/14/17, indicated R1 had a recurrent history of a stage II pressure ulcer to the left upper buttock that was most recently healed as of 5/14/17. The progress note dated 4/30/17, identified R1's use of a large bedpan caused pressure to the left buttock and was determined to be a causal factor for impaired wound healing. The progress note explained staff replaced the large bedpan with a smaller fracture pan, and R1 could not be on the bedpan for more than 10 minutes at a time. However, the directive to use a smaller sized fractured bedpan was not identified on the care plan. On 5/15/17, at 4:23 p.m. registered nurse (RN)-A verified R1 had a recurrent stage II pressure ulcer to the upper left buttock, however did not currently have a pressure ulcer. R1's nursing progress note dated 5/16/17, at 7:23 p.m. indicated R1 had a pressure area on gluteal cleft which had pinpoint openings with pinkness around it. Dressing was changed. On 5/16/17, at 11:23 a.m. R1 was observed in bed. RN-A and nursing assistant (NA)-B were observed to assist R1 to turn onto her right side. A half dollar size area of redness was noted on the left upper buttock which was not blanchable.	F 314		

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The reddened area contained two small open areas measuring approximately 2.0 millimeters in diameter, with no drainage present. RN-A confirmed the areas were open and consistent with a stage II pressure ulcer and proceeded to apply a foam dressing. RN-A confirmed the wound was the same wounds as previous. RN-A did not measure the wound. NA-B applied a new incontinent brief on R1 however, did not apply barrier cream per the care plan.

-At 2:52 p.m. R1 was observed in bed and stated she was on the bedpan. At 3:11 p.m. NA-C removed the bedpan. R1's buttocks showed bright red indented lines from bedpan placement. The bottom edge of the dressing was saturated with urine and the bottom edge of the wound could be visualized and was noted to be bright red. NA-C provided perineal care, applied a new incontinent brief on R1 and did not apply barrier cream per the care plan. According to R1's medical record, a weekly skin inspection was due to be completed 5/16/17.

On 5/17/17, the director of nursing (DON) performed a comprehensive wound assessment on R1 which indicated the wound was healed/closed and staff would continue to monitor the area as it continued to open and close, R1's care plan was reviewed and no new preventative measures were put into place.

On 5/17/17, from 9:36 a.m. until 10:11 a.m. continuous observations revealed to following:

-At 9:36 a.m. NA-A placed R1 onto the bedpan.
-At 10:11 a.m. NA-B removed the bedpan. When

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F 314	Continued From page 29 NA-B assisted R1 to role onto her right side, the bedpan stuck to R1's bottom. When NA-B removed the bedpan, R1's bottom was observed to have dark red indented lines that were slow to blanch. NA-B provided perineal care and removed the dressing that was falling off the left buttock. The open areas were healed, however, half dollar size area of redness that was not blanchable was present. NA-B put an incontinent garment on without having the dressing replaced by a nurse and did not apply barrier cream per the care plan. NA-B proceeded to transfer R1 from bed and into the wheelchair. On 5/17/17, at 1:05 p.m. the director of nursing (DON) and the RN-consultant reviewed R1's wound documentation. The RN-consultant verified R1's required weekly skin assessment was not completed on 5/16/17, when it was due. The RN-consultant stated the weekly wound assessments included measurements to ensure healing and if the wound was not found to be healing then the physician was notified and the care plan was reviewed for appropriateness. The RN-consultant confirmed the care plan lacked the interventions that pertained to the bedpan usage and stated she expected staff to follow the care plan. The undated Skin Integrity Guideline policy indicated the purpose was to provide a comprehensive approach for monitoring skin conditions and decrease pressure ulcer/or wound formation by identifying those residents who are at risk, and implementing appropriate interventions. To promote healing of wounds of any etiology, whether admitted or acquired. It also	F 314		

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F 314	Continued From page 30 indicated the DON or designee would be responsible to implement and monitor the skin integrity program. The interdisciplinary plan of care would address problems, goals, and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified. Changes in skin condition would be reported to the licensed nurse and documented. Staff may apply moisture barrier cream or follow center-specific incontinence product protocol, provide positioning, special devices, restorative plan and wound care per the individualized care plan. Licensed nurses would be responsible for performing and documenting the weekly skin evaluations/observations utilizing the weekly skin review. Licensed nurse was also to document weekly on identified wounds. Care plans were to be implemented, evaluated, and revised based on the needs of the resident. If the resident was refusing or choosing not to receive treatment, review risks, benefits, and alternatives. Re-evaluate and attempt other interventions.	F 314		
F 318 SS=E	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced	F 318		6/21/17

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F 318	Continued From page 31 by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services in order to maintain or prevent further decrease in ROM for 4 of 4 residents (R11, R13, R12, R20) who had limitations in lower and/or upper extremity range of motion and care plan directives to provide ROM exercises. Findings include: R11's Diagnoses Report dated 5/18/17, included diagnoses of Parkinson's disease, muscle weakness, and mild cognitive impairment. R11's quarterly Minimum Data Set (MDS) dated 3/7/17, indicated R11 had severe cognitive impairment, was dependent on staff for activities of daily living (ADLs) and had functional range of motion impairment in both upper extremities and both lower extremities. R11's ADL Care Area Assessment (CAA) dated 12/21/16, indicated R11 required extensive assist of two people for bed mobility, toileting, and transfer, extensive assist of one for dressing and personal hygiene and was dependent on staff for locomotion. The CAA also indicated R11 did not walk, was at risk for further decline in ADL's, contractures, further isolation, and complications of immobility such as muscle atrophy, incontinence and contractures. The CAA further indicated no referrals were required at this time and they would proceed to care plan to	F 318	F318 R11, R12, R13, and R20 have had their orders for ROM and restorative reviewed and re-instituted in keeping with physician orders. A review of other facility residents with a limitation of movement was done to determine if restorative program was needed. Restorative program initiated as needed. Nursing staff have received training in restorative program and documentation. The restorative programs have included in the PCC ETAR for licensed staff to ensure ROM is completed. The DON will review the restorative program and documentation weekly and in IDT meeting. The DON will report monthly to the QA committee. Compliance by 6-21-17	

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F 318	Continued From page 32 prevent/minimize risks. R11's ADL's care plan revised on 1/20/17, indicated R11 would maintain current level of physical functioning of participating in passive range of motion (PROM) three times a week minimum of 10 minutes to upper and lower extremities with the restorative nurse. The care plan further directed staff to monitor and report changes in physical functioning and ROM ability. R11's Restorative Record indicated PROM three times a week to bilateral upper extremities as resident would allow in order to maintain current level of mobility and PROM to bilateral lower extremities to maintain current level of mobility. The Restorative Record indicated the last time R11 received PROM to lower extremities was on 4/8/16, and the last time R11 received PROM to upper extremities was on 4/27/16. R11's record did not reveal referrals to occupational or physical therapy. On 5/18/17, at 9:40 a.m. licensed practical nurse (LPN)-B stated the nursing restorative program (RNP) was discontinued last year and the residents had not received range of motion services since that time. LPN-B stated R11 had not experienced a decline in function since that time. -At 9:53 a.m. the director of nursing (DON) and registered nurse (RN)-consultant verified there was no RNP/restorative-maintenance program in	F 318		

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place as it had been discontinued last year. RN-consultant stated providing range of motion was expected as part of nursing care and dressing a resident did not count as providing range of motion. The RN-consultant stated R11 had not experienced an actual decline and expected staff to follow the care plan.

R13's quarterly MDS dated 4/25/17, identified R13 with diagnoses of Alzheimer's disease and depression. The MDS indicated R13 had severe cognitive impairment, required total assistance with all activities of daily living and displayed physical limitations in upper and lower extremities.

R13's most recent Restorative Nurse Monthly Evaluation dated 4/30/15, indicated the goal of R13's RNP was to prevent further rigidness and contractures to maintain restorative care goals. R13's medical record lacked any additional Restorative Nursing Monthly Evaluation documentation.

R13's Therapy Communication To Nursing form dated 7/7/16, indicated R13's goal was to maintain ROM to upper extremities to allow staff to complete cares and to continue with splints for hands. The occupational therapist (OT) recommended PROM to both upper extremities including hands and fingers, within tolerance, a minimum of three times a week.

R13's Restorative Record flow sheets revealed R13 had not received ROM services since 2016:

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F 318	Continued From page 34 -1/1/16 to 1/31/16: PROM to upper and lower extremities - the form was blank and lacked staff signatures to indicate ROM had been completed -4/1/16 to 4/30/16: PROM upper extremities - completed 7 times. PROM lower extremities form was blank and lacked staff signatures to indicate ROM had been completed. -7/1/16 to 7/31/16: PROM to upper extremities - the form was blank and lacked staff signatures to indicate ROM had been completed. R13's medical record lacked any additional Restorative Record flow sheet documentation. R13's care plan revised 3/15/17, indicated R13 had a mobility impairment with a goal to maintain current ROM. The care plan directed staff to provide RNP three times a week for functional ROM maintenance and to monitor and report changes in R13's ROM ability. R13's physician's orders dated 5/1/17-5/31/17, included an order for PROM to upper extremities including hands and fingers within tolerance, a minimum of three times a week to maintain ROM to allow staff to complete cares. The physician's orders did not address the lower extremities. R13's progress note dated 5/15/17, indicated R13 had bilateral contractures to hands. R13 received daily hand care which involved cleaning, drying, and applying gauze. R13 also had stuffed carrots that were placed in between fingers and the palms of hands to alleviate pressure from fingers on the palms of hands.	F 318		

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F 318	Continued From page 35 On 5/16/17, at 12:30 p.m. LPN-A was observed feeding R13 dinner. -At 1:00 p.m. R13 was observed being wheeled out of the dining room and transferred into bed by two staff using a mechanical lift. R13 was observed to have carrots (padded foam splints) in each of her hands with fingers wrapped around them. On 5/17/17, at 1:10 p.m. NA-B stated R13 did not receive any ROM or RNP. NA-B stated the NA's did not perform ROM or restorative nursing services. NA-B stated when residents were dressed, their arms and legs got moved but no further ROM program was completed. NA-B stated the facility did not have a RNP and it had been over a year since they had any assigned staff completing RNP services. -At 1:35 p.m. RN-A stated R13's hands were cleaned daily and fingers were opened, however R13 yelled and screamed allot during this but other than that, R13 did not have ROM plan provided. -At 3:20 the occupational therapist (OT) verified R13 had impairments in both upper and lower extremities and should have been receiving a ROM program. However, OT indicated the facility did not have a RNP program and ROM was not being provided which was unfortunate. The OT stated having no RNP had an impact on R13's ROM status as R13's lower extremities were tight. On 5/18/17, at 8:35 a.m. the DON verified R13's	F 318		

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care plan was correct and R13 had impairment in the upper and lower extremities. The DON also verified R13 was not receiving ROM in the upper or lower extremities because the facility did not have a restorative program for the residents.

R12's facility Diagnoses Report, print date 5/18/17, included diagnoses of left below the knee amputation, heart transplant, diabetes mellitus and major depressive disorder.

R12's quarterly MDS dated 4/27/17, identified R12 as cognitively intact and indicated R12 required extensive assistance with dressing, grooming and transfers. The MDS further indicated R12 had functional limitation in range of motion of a lower extremity on one side.

R12's current physician orders, print date 5/18/17, included the following: PROM to bilateral lower extremities (BLE) to maintain mobility in BLE. Requires caregiver assist to complete range of motion exercises one time daily.

On 5/17/17,at 3:41 p.m. R12 confirmed he had not received any ROM or therapy services for the past six months.

On 5/18/17, at 8:36 a.m. NA-A stated they had not had a restorative aide for a year. NA-A stated she did not provide ROM services and no ROM services were being provided to any resident.

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F 318	Continued From page 37 On 5/18/17, at 9:24 a.m. the RN-consultant confirmed R12's physician orders for PROM therapy had not been implemented and PROM services were not being provided. On 5/18/17, at 9:27 a.m. the DON confirmed R12's physician orders for PROM had not been implemented and stated it should have been. The DON confirmed the facility should have been providing a restorative program, however, the facility did not have the staff to provide a program. R20's facility Diagnoses Report, print date 5/18/17, included diagnoses of osteoarthritis, encephalopathy (altered brain function), diabetes mellitus and major depressive disorder. R20's quarterly MDS dated 4/28/17, identified R20 as severely cognitively impaired and indicated R20 required extensive assistance with dressing, grooming and transfers. R20's current physician orders, print date 5/17/17, included the following orders: -Active range of motion (AROM) to bilateral upper extremities (BUE) three times weekly to maintain strength for propelling wheelchair and self feeding and assist staff with self cares. -AROM to bilateral lower extremities (BLE) to allow patient to continue with assist with bed mobility- requires cues to stay on task to complete full ROM-minimum three times weekly.	F 318		

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F 318	Continued From page 38 On 5/17/17, at 11:35 a.m. R20's family member (FM)-A confirmed the facility had not provided ROM services to her husband for months. FM-A stated she tried to complete exercises with him, but it was difficult as he was a big man. FM-A stated she wanted to make sure he stayed as strong as possible. On 5/18/17, at 8:36 a.m. NA-A stated they had not had a restorative aide for a year. NA-A stated she did not provide ROM services and no ROM services were being provided to any resident. On 5/18/17, at 9:24 a.m. the RN-consultant confirmed R20's physician orders for PROM therapy had not been implemented and PROM services were not being provided. On 5/18/17, at 9:27 a.m. the DON confirmed R20's physician orders for PROM had not been implemented and should have been. The DON confirmed the facility should have been providing a restorative program, however, the facility did not have the staff to provide a program. A policy related to related physician orders/provision of restorative services was requested, none was provided.	F 318		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		6/27/17

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F 323	Continued From page 39 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure a comprehensive assessment was completed prior to the use of a full body mechanical lift according to the lift's manufacture's recommendations for 1 of 4 residents (R1) reviewed for lift transfers and observed to be transferred with the mechanical lift not in accordance with the care plan. Findings included: R1's Diagnoses Report dated 5/18/17, included	F 323	F323 R1 Has had a comprehensive assessment completed for appropriate lift use for transfers. All residents have been reviewed to determine if a mechanical lift is needed for transfer. If mechanical lift is indicated, a comprehensive assessment has been completed. Nursing staff have been trained on the importance of ensuring that any resident	

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F 323	Continued From page 40 diagnoses of muscle weakness, osteoarthritis, fatigue, mild cognitive impairment, epilepsy, history of stroke, cataract, obesity, and hemiplegia affecting the right dominant side. R1's quarterly Minimum Data Set (MDS) dated 5/5/17, indicated R1 had moderate cognitive impairment, required extensive assistance from two staff for transfers, and had functional range of motion impairment of one upper extremity and both lower extremities. R1's care plan last revised on 3/15/17, directed two staff to transfer R1 with the use of a full body mechanical lift. R1's Lift Mobility Status worksheets dated 11/9/16, and 2/12/17, indicated R1 could tolerate a semi-reclined position and weighed less than 500 pounds. However, the sheets lacked an assessment of the information in order to determine the amount of assistance required for R1 to safely transfer via a mechanical lift. On 5/16/17, at 2:37 p.m. R1 was observed in her room, seated in a wheelchair. The mechanical lift sling was positioned underneath her. Nursing assistant (NA)-C brought the lift into the room and attached the sling to the lift and proceeded to independently transfer R1 out of the wheelchair and into bed. NA-C performed the transfer with ease and without difficulty. NA-C stated R1 only required one staff member to transfer with the mechanical lift, therefore, staff were allowed to independently use the lift.	F 323	who is being transported as per a mechanical lift has had a comprehensive assessment completed. The following policies have been updated “Safe Lifting and Movement of Residents” and “Lifting Machine, Using a Portable”. Staff have been updated on these policy changes. The IDT committee will review lift mobility assessment, with therapy, weekly. Discrepancies will be correct as needed. Findings will be brought to QAPI for review. Compliance by 6-27-17	

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F 323	Continued From page 41	F 323		

On 5/17/17, at 9:36 a.m. R1 was observed in her room, seated in her wheelchair. The lift sling was positioned underneath her. NA-A positioned the mechanical lift and attached the sling to the lift and proceeded to independently transfer R1 from the wheelchair to the bed. NA-A completed the transfer without difficulty. NA-A stated R1 could be transferred with one staff and mechanical lift and staff were permitted to do so.

-At 9:59 a.m. NA-B independently transferred R1 from the bed back to the wheelchair using the mechanical lift. NA-B completed the transfer without difficulty. NA-B stated the mechanical lift could be used with only one staff member therefore R1 was transferred by one staff member using the mechanical lift.

-At 10:45 a.m. the DON stated all lift transfers were performed with two staff and staff should not be transferring anybody without using two people. The DON stated every resident had a lift assessment in their medical record. The RN-consultant stated a comprehensive lift assessment was supposed to be based on physical observation, behaviors, diagnoses, resident weight, and environmental factors in order to determine the appropriate sling type and size, and how many staff would be required to transfer the resident safely. The RN-consultant stated the size of sling and amount of assistance should be identified on the care plan and staff were expected to follow the care plan. The RN-consultant confirmed a comprehensive mechanical lift assessment for safe transfers was not completed for R1.

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F 323	Continued From page 42 Maxi Move manufacture's Instructions for Use indicated the need for a second attendant to support the patient must be assessed in each individual case. The instruction book further read, "ArjoHuntleight's passive and active series of lifts are designed for safe usage with one caregiver. There are circumstances, such as combativeness, obesity, contracture, etc. of the individual that may dictate the need for a two-person transfer. It was the responsibility of each facility or medical professional to determine if a one or two person transfer was more appropriate, based on the task, resident load, environment, capability, and skill level of the staff member. Instructions for the lift slings indicated a warning which directed: Before using the Maxi Move, a clinical assessment of the patient's suitability for transfer must be carried out by a qualified health professional considering that, among other things, the transfer may induce substantial pressure on the patient's body. A transfer conducted when it should not can degrade a patient's health condition. The instructions further indicated failure to understand and follow these instructions may result in injury to yourself and others. A facility policy was requested and not received.	F 323		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used--	F 329		6/21/17

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F 329	Continued From page 43 (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system was in place for monitoring and analyzing behaviors and moods in order to determine the effectiveness and necessity of psychotropic	F 329	F329 R11, R27, R2, R12, and R20 have had their psych medications reviewed and corrections made with regard to the use of	

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F 329	Continued From page 44 medications and/or failed to develop nonpharmacological interventions to be attempted prior to the use of as needed psychotropic medications for 5 of 5 residents (R11, R27, R2, R12, R20) reviewed for unnecessary medications. Findings include: R11's facility Diagnoses Report dated 5/18/17, indicated R11's diagnoses included Parkinson's disease, major depressive disorder, anxiety disorder, mild cognitive impairment, and hallucinations. R11's annual Minimum Data Set (MDS) dated 12/12/16, indicated R11 had severe cognitive impairment and had minimal or no symptoms of depression. The MDS indicated R11 received antidepressant medications and did not have signs or symptoms of delirium, no behaviors, and did not have any hallucinations or delusions during the assessment reference period. R11's quarterly MDS dated 3/7/17, indicated R11 had an increase in symptoms of depression scored as mild depressive symptoms. The MDS also indicated R11 did not have signs and symptoms of delirium, did not have hallucinations or delusions, and did not display any behaviors. R11 received an antipsychotic and antidepressant medications. R11's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/21/17, indicated R11 received an antidepressant medication to	F 329	non-pharmacological measures for psych interventions, analysis of behaviors using behavioral tracking with target behaviors, and an analysis by the IDT committee of the effectiveness and needfulness of the psych medications they are receiving. Any other residents receiving psych medications have been reviewed on the same basis as those (5) residents above, looking at the use of non-pharmacological measures for psych interventions, analysis of behaviors using behavioral tracking, and an analysis by the IDT committee of the effectiveness and needfulness of the psych medications they are receiving. Corrections were made as needed. Staff were trained on the proper elements of a psych program for residents on psychotropic medications, including specific training on the program explained below. A new “Resident Psych Program” has been created that includes numerous steps to be processed for each resident. The steps of that program are as follows: 1. Identify each resident with a psych diagnosis – and/or psychotropic medications 2. Verify that there is supporting evidence for the psych diagnosis and/or supporting symptoms for the psych medication 3. Ensure that non-pharmacological interventions have been used for any	

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F 329	Continued From page 45 manage depression, was at risk for adverse reactions, and the pharmacist reviewed R11's medications monthly. The goal of the CAA was R11 would not experience drug related side effects. R11's behavioral care plan last revised 6/1/16, identified diagnosis of depression, anxiety, and hallucinations with the associated psychotropic medication. R11's target behaviors and moods to be monitored included: fearful statements, sad facial expression, repetitive physical movements, and hallucinations. However, the care plan lacked identification of non-pharmacological interventions to be implemented prior to the use of the as needed Clonazepam medication. R11's physician orders included an order for Clonazepam 0.25 mg once daily as needed (PRN) for anxiety/agitation which was started on 4/9/17. R11's Medication Administration Record (MAR) reflected only one dose of the Clonazepam had been administered which was on 5/1/17, at 3:39 p.m. which was effective, however, the medical record lacked documentation of the symptoms of anxiety displayed and non-pharmacological interventions attempted prior to the administration of the medication. R11's medication administration records (MAR) reviewed from March 2017, through May 18, 2017, indicated R11 did not display any of the identified monitored target behaviors. R11's Consultant Pharmacist's Medication Reviews included:	F 329	resident who has a supported psych diagnosis and that these interventions have been tried prior to putting any resident on a psych medication 4. Where non-pharmacological interventions are not sufficient to meet the psych needs and a psych medication has been prescribed, ensure that there is a method for monitoring the effectiveness and continued need for the use of the medication. 5. Ensure that appropriate nursing/social services psych documentation is being done to support the use of psychotropic medication and that interventions are being documented on. Additionally, ensure that documentation is being entered about resident behaviors and effectiveness and side effects of psych medications. 6. The IDT committee meets weekly to discuss all issues relevant to the psych residents. The weekly meetings are "update" meetings whereby they ensure that all the steps listed here continue to be in place. 7. Ensuring that each resident who has the cognitive ability is receiving psych services if needed. 8. The IDT committee will ensure that residents in the psych program have their care plans updated in areas involving psych treatment, medications, and interventions with goals. 9. The psych program is reviewed monthly by the QA Committee. IDT monitors this program through auditing of each of the (9) steps above to ensure that they are in place for each	

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F 329	Continued From page 46 -3/21/17-no irregularities identified. -4/17/17-no irregularities identified. -5/17/17, recommendation for a reduction trial of Seroquel 12.5 mg (antipsychotic) in the morning and 25 mg in the evening and recommended documenting a continued need. However, the report did not identify the initiation of the clonazepam for anxiety symptoms or the lack of documentation supporting its use. R11's physician visit note dated 1/26/17, indicated R11's mood and behaviors were well controlled and alertness had improved since previous psychotropic dose reductions. R11's physician visit note dated 3/23/17, indicated R11 was very stable on current doses of medications. R11's progress note dated 4/7/17, indicated R11's family member brought it to the staff's attention that R11 was more anxious and wanted the physician contacted to obtain medication for anxiety. The note indicated staff faxed the physician which indicated staff had noticed R11 was more alert and awake, was more conversational and lucid, was feeding herself, could identify staff by name, and even joked with staff. The note also also indicated R11 would hand staff objects but there was nothing there. The fax requested a PRN medication order for anxiety, as she currently did not have one prescribed.	F 329	resident in the program. Items found not in compliance will be corrected during the IDT meeting. Pharmacy recommendations will be reviewed during IDT meeting for psychotropic medications. If changes are needed, physician will be contacted for further orders. The IDT reviews the psychotropic medication weekly to ensure that it is being managed properly. The Social Services Director reports monthly to the QA on this program. Compliance 6-21-17	

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F 329	Continued From page 47	F 329		

R11's physician visit note dated 4/13/17, indicated R11 was recently started on clonazepam 0.25 mg once daily PRN for anxiety per family member's request.

On 5/16/17, at 3:02 p.m., R11 was observed seated in her room with family member (FM)-1 holding her hand. FM-1 indicated he was there every day to visit and felt R11 was much better than she was a few months ago and explained the medication had caused R11 to be frequently sedated. FM-1 stated R11's mood was even, had not seen fluctuations, had not witnessed any hallucinations.

On 5/18/17, at 9:15 a.m. the licensed social worker (LSW) stated she had performed the depression/mood assessment for the March 2017, MDS in which R11 did not feel good at the time of the assessment and thought the reason for the increased symptoms was not related to depression rather, R11's illness. LSW reviewed R11's behavior documentation and confirmed the lack of documented anxiety symptoms that would justify a new order for PRN clonazepam. The LSW confirmed there was a lack of behavior and/or mood monitoring and a system in place for assessments of behaviors and psychotropic medications.

-At 9:40 a.m. licensed practical nurse (LPN)-B stated R11 had previously been on scheduled clonazepam, however, with the tapering of her Seroquel doses, R11 was much more alert, assisted with her cares, and sometimes even fed

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F 329	Continued From page 48	F 329		

herself. LPN-B stated there were days R11 was sleepier and required more encouragement and did not think R11 had had hallucinated anytime recently, didn't think R11 was depressed and R11 had not had any episodes of anxiety.

-At 12:10 p.m. the director of nursing (DON) and registered nurse (RN)-consultant confirmed the lack of a system for comprehensive analysis of mood/behaviors and psychotropic medication management. The RN-consultant verified documentation did not support the use of the clonazepam

R27's facility Diagnoses Report dated 5/18/17, included diagnoses of encephalopathy, dementia with behavior disturbance, and diabetes mellitus.

R27's quarterly MDS dated 3/9/17, indicated R27 had severe cognitive impairment, had delusions, wandered daily and behaviors not directed toward others daily.

R27's Psychotropic Drug Use CAA dated 12/8/16, indicated R27 had an increased risk for falls with the usage of an antidepressant and antipsychotic medication and risk for sedation and disturbance of balance, gait, and positioning ability due to use of antianxiety medication.

R27's current (undated) physician orders included the following medications:

-Risperdal (antipsychotic) 1.0 mg two times a day
-Trazadone HCL (antidepressant) 25 mg two times a day

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F 329	Continued From page 49 -Ativan 0.5 mg (antianxiety) every four hours PRN -Haloperidol Lactate 1.0 ml (antipsychotic) every four hours PRN for agitation R27's care plan dated 12/16/16, indicated at times, R27 wandered and rejected cares. However, the care plan lacked identification of R27's potential for drug complications related to antidepressant and antianxiety medication use lacked identification of nonpharmacological interventions to be attempted prior to the use of the PRN medications. R27's Behavior Monthly documentation flow sheet dated 5/17, identified behaviors of wandering, uncooperativeness, and continuous pacing, however, the forms were void of any documentation. On 5/18/17, at 10:30 a.m. NA-A stated the NA's did not document on R27's mood and behaviors. At 11:00 a.m. the LSW stated she had recently developed the Behavior Monthly documentation sheets and verified R27's sheets were lacking documentation of her behaviors. the LSW also stated the staff required additional education on completing the forms because the monitoring forms were fairly new for staff to use. On 5/18/17, at 11:23 a.m. the DON and RN-consultant verified the Behavior Monthly documentation forms were recently developed and were lacking R27's mood and behaviors	F 329		

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F 329	Continued From page 50 symptoms. Both also verified R27's care plan lacked identification of the use of psychotropic medication. In addition, both verified non-pharmacological interventions had not been developed in order to be implemented prior to the use of the PRN Haldol and Ativan and should have been especially since the facility currently utilized pool staff. R2's diagnoses report included major depressive disorder and an anxiety disorder. R2's annual MDS dated 4/17/17, indicated R2 had moderate cognitive impairment and "feeling down" and "feeling tired" never or one day a week. No other mood or behavioral concerns were identified. The MDS indicated R2 was dependent on one staff for assistance for dressing, grooming, transfers and locomotion. R2's Psychotropic Drug Use CAA dated 4/28/17, indicated R2 received antidepressant medication to manage diagnosis of depressive disorder. The assessment noted psychotropic drug use would be addressed in the care plan with a goal to have no drug related side effects. The assessment did not indicate what symptoms were present related to the mood disorder. The assessment also failed to address the utilization of the antianxiety medication. R2's current (undated) physician orders included the following: -sertraline HCl (antidepressant) 100 mg daily in the morning (start date 12/14/15)	F 329		

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WALKER REHABILITATION & HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

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F 329	Continued From page 51 -buspirone (antianxiety) 50 mg two times a day (start date 12/9/16) R2's care plan dated 4/27/15, identified R2 had a potential problem for drug complications related to antidepressant and antianxiety medication. The goal was for R2 to be free from psychotropic drug related complications. Interventions included staff to continue to monitor for effectiveness as well as any side effects. Interventions on 3/15/17, indicated staff were to monitor for target behaviors/symptoms, however, did not identify specific target behaviors/symptoms. R2's Behavior Monthly Flow Sheet for May 2017, identified the use of the buspirone and sertraline due to major depression with target mood/behaviors identified as compulsiveness and false beliefs and any mood changes. However, this form was void of any staff documentation. R2's Center of Psychiatric Care progress note dated 10/29/15, indicated R5 had been receiving Zoloft (sertraline HCl) 100 mg since 8/28/14. The note indicated R5 was worried about family, woke up early, but had no behaviors or no significant change since last seen on 8/13/15. The medical record lacked any further visits or documentation from the psychiatric care team. On 5/17/17 at 9:43 R2 was observed in the hallway, alert and seated in a wheelchair. When staff asked R2 to go to physical therapy, R2 pleasantly agreed.	F 329		

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F 329	Continued From page 52 On 5/17/17, at 1:32 p.m. the LSW stated behavioral/mood monitoring had not yet been initiated for R2 but would be monitored for compulsive false beliefs and any mood changes. On 5/18/17, at 10:15 a.m. the DON and RN consultant verified the facility was not monitoring behaviors or moods. The pharmacist consultant was not available for interview. R12's facility Diagnoses Report print date 5/18/17, included diagnoses of left below the knee amputation, heart transplant, diabetes mellitus and major depressive disorder. R12's quarterly MDS dated 4/27/17, identified R12 as cognitively intact, required extensive assistance with dressing, grooming and transfers. The MDS indicated R12 had trouble falling asleep, had feelings of hopelessness, depression and received an antidepressant medication. R12's Activity of Daily Living CAA dated 1/19/17, indicated R12 was at risk for functional decline due to depression. R12's current physician orders, print date 5/18/17, included an order for fluoxetine (antidepressant) 20 mg daily.	F 329		

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F 329	Continued From page 53 R12's care plan dated 5/16/17, identified a potential for drug related complications associated with use of psychotropic medications related to antidepressant medication taken daily for diagnosis of depression. The care plan lacked mood symptoms displayed by R12 related to depression. R12's Behavior Monthly Flow Sheet for May 2017, directed staff to monitor for and document any mood changes and restlessness. However, the form was void of any staff documentation. On 5/17/17, at 10:50 a.m. RN-A stated R12 did not have a current mood monitoring program in place and she had not received any training related to the completion of the behavior flow sheets/behavior monitoring program. On 5/18/17, at 9:24 a.m. the registered nurse consultant verified there were no behavioral monitoring programs in place, however, the facility had been working on implementing a behavior monitoring program. On 5/18/17, at 9:30 a.m. the DON confirmed the facility LSW was working on developing and implementing a behavioral/mood monitoring program. On 5/18/17, at 1150 a.m. the LSW confirmed R12's Behavior Monthly Flow Sheet dated May 2017, identified R12's antidepressant use and directive to monitor for mood changes and	F 329		

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F 329	Continued From page 54 restless behavior and were blank of any documentation. The LSW state she would expect staff to document a "0" if behavior/moods were not exhibited per shift. R20's facility Diagnoses Report, print date 5/18/17, included diagnoses of osteoarthritis, encephalopathy (altered brain function), diabetes mellitus and major depressive disorder. R20's quarterly MDS dated 4/28/17, identified R20 as severely cognitively impaired, required extensive assistance with dressing, grooming and transfers. The MDS further indicated R20 received an antidepressant medication. R20's Falls CAA and Psychotropic Drug Use CAA print date 5/18/17, indicated R20 received antidepressant medication for depression . R20's current physician orders, print date 5/17/17, included the following medication: Wellbutrin extended release tablet 150 mg (antidepressant) every day. R20's care plan dated 3/4/17, identified potential for drug related complications associated with use of psychotropic medications related to antidepressant medication taken daily for depression. The care plan directed staff to evaluate for effectiveness. However, the care plan did not identify a monitoring method or mood symptoms and interventions related to those moods.	F 329		

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F 329	Continued From page 55 On 5/17/17, at 10:50 a.m. RN-A confirmed R20 did not have a current behavior monitor program in place for monitoring R20's antidepressant medication. RN-A confirmed he had not had training for a behavior monitoring program. On 5/18/17, at 9:24 a.m. the RN-consultant verified there were no behavioral monitoring programs in place and indicated they were working on implementing a behavior monitoring program. On 5/18/17, at 9:30 a.m. the DON confirmed the facility was working on implementing a behavior/mood monitoring program. DON indicated the LSW was developing behavior monitoring plans and would be implementing the program. On 5/18/17, at 11:50 a.m. the LSW provided R20's Behavior Monthly Flow sheet for May 2017, which identified R20 received Wellbutrin for recurrent major depression and directed staff to monitor for angry behavior and mood changes. However, the forms were void of any documentation. The LSW verified documentation had not been completed and would have expected staff to document a "0" if behaviors/mood concerns were not exhibited during the shift. The undated Behavioral Management Guidelines policy indicated staff were to observe the resident and review for possible reversible causes that could be causing the behavior and	F 329		

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F 329	Continued From page 56 nonpharmacological intervention were to be implemented and assessed for effectiveness prior to considering initiation of any psychoactive medication. The policy further indicated medications to control behaviors should always be considered a last resort to assist with managing a resident's behavior, target behaviors must be clearly and specifically identified, documented and monitored. The consultant pharmacist would review the resident's medication regime and document medication/dosage recommendations to the physician's and interdisciplinary team.	F 329		
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations;	F 412		6/27/17

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F 412	Continued From page 57 (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to coordinate dental services for 1 of 3 resident (R3) reviewed for dental. Findings include: R3's annual Minimum Data Set (MDS) dated 4/28/17, indicated R3 was moderately cognitively impaired and had diagnoses which included hypertension and diabetes mellitus. The MDS further indicated R3 required supervision with personal hygiene and had no dental problems. R3's Clinical Health Status form received 5/18/17, indicated R3 had full upper and lower dentures, however, R3's dentures were missing. R3's clinical record lacked any dental assessments. The facility nursing assistant care guide provided 5/18/17, indicated R3 had full dentures. On 5/15/17, at 2:24 p.m. R3 stated he would like to have dentures again. R3 stated he previously had and utilized dentures but they went missing	F 412	F412 R3 has been scheduled with a dentist and his dental needs will be met. Residents throughout the facility have been evaluated for dental needs and where needs exist, they have been offered dental services. Social Services has received training on provision of dental services for residents. A new Resident Dental Program has been reviewed which includes the following: 1. Dental assessments for residents every (3) months via MDS and additionally as needed where dental problems arise. These assessments will be completed by social services. 2. Dental services will be available for any dental concern that requires a dentist. 3. Dental care is provided routinely to residents who need assistance with brushing their teeth and managing their dentures. Oral care is part of this program. The DON or her designee will review the dental services provided for (3) residents weekly x 4 weeks and then monthly to ensure dental services are being provided. Results will be reviewed at QAPI. Compliance by 6-27-17	

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F 412	Continued From page 58 and he is unaware of what happened to them. R3 stated he had not been asked if he wanted the dentures replaced. On 5/17/17, at 8:30 a.m. nursing assistant (NA)-A stated R3 was independent with eating and did not know if he had his own teeth or wore dentures. On 5/17/17, at 10:13 a.m. the registered nurse (RN)- consultant confirmed R3's medical record revealed the last dental assessment completed was in 2015, and R3 had not been to the dentist or offered to have dentures replaced or not. On 05/17/17, at 11:27 a.m. the director of nursing (DON) confirmed R3 was admitted to the facility with his dentures missing and R3's medical record lacked any further intervention or assessments regarding the lost dentures. The DON confirmed she would expect staff to follow up on or offer the choice of replacing the dentures. A policy related to Dental Services was requested, none was provided.	F 412		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		6/27/17

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F 428	Continued From page 59 (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen	F 428		

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F 428	Continued From page 60 review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the consulting pharmacist (CP) failed to identify the use of an as needed antianxiety medication without mood and/or behavioral symptoms and appropriate justification of its use identified for 1 of 5 residents (R11) reviewed for unnecessary medications. Findings include: R11's facility Diagnoses Report dated 5/18/17, indicated R11's diagnoses included Parkinson's disease, major depressive disorder, anxiety disorder, mild cognitive impairment, and hallucinations. R11's annual Minimum Data Set (MDS) dated 12/12/16, indicated R11 had severe cognitive impairment and had minimal or no symptoms of depression. The MDS indicated R11 received antidepressant medications and did not have signs or symptoms of delirium, no behaviors, and did not have any hallucinations or delusions during the assessment reference period. R11's quarterly MDS dated 3/7/17, indicated R11 had an increase in symptoms of depression scored as mild depressive symptoms. The MDS also indicated R11 did not have signs and symptoms of delirium, did not have hallucinations or	F 428	F428 R11 has had her psychotropic medications reviewed by the consulting pharmacist, physician has reviewed recommendations. Residents receiving anti-anxiety medication have had their medications for use reviewed to ensure that there are supporting symptoms for the administration of the anti-anxiety medication. Licensed nurses have been educated on the importance of ensuring residents receiving psychotropics have supporting symptoms including mood and behavior symptoms and non-pharmacological interventions have been attempted prior to administration. DNS will review PRN psychotropic use during daily meeting to ensure specific behaviors and non-pharmacological interventions are documented prior to PRN administration. Results will be reviewed weekly at IDT meeting and monthly at QAPI. Compliance 6-27-17	

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F 428	Continued From page 61	F 428		

delusions, and did not display any behaviors. R11 received an antipsychotic and antidepressant medications.

R11's Psychotropic Drug Use Care Area Assessment (CAA) dated 12/21/17, indicated R11 received an antidepressant medication to manage depression, was at risk for adverse reactions, and the pharmacist reviewed R11's medications monthly. The goal of the CAA was R11 would not experience drug related side effects.

R11's behavioral care plan last revised 6/1/16, identified diagnoses of depression, anxiety, and hallucinations with the associated psychotropic medication. R11's target behaviors and moods to monitor included: fearful statements, sad facial expression, repetitive physical movements, and hallucinations. However, the care plan lacked individualized target behaviors and/or moods for the use of the Clonazepam and also lacked identification of non-pharmacological interventions for its use.

R11's physician orders included an order for Clonazepam 0.25 mg once daily as needed (PRN) for anxiety/agitation which was started on 4/9/17. R11's Medication Administration Record (MAR) reflected only one dose had been administered which was on 5/1/17, at 3:39 p.m. which was effective, however, the medical record lacked documentation of symptoms of anxiety and non-pharmacological interventions to be attempted prior to the administration of the medication.

R11's Consultant Pharmacist's Medication Reviews included:

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F 428	Continued From page 62 -3/21/17-no irregularities identified. -4/17/17-no irregularities identified. -5/17/17, recommendation for a reduction trial of Seroquel 12.5 mg (antipsychotic) in the morning and 25 mg in the evening and recommended documenting a continued need. However, the report did not identify the initiation of the Clonazepam for anxiety symptoms or the lack of documentation supporting its use. R11's physician visit note dated 1/26/17, indicated R11's mood and behaviors were well controlled and alertness had improved since previous psychotropic dose reductions. R11's physician visit note dated 3/23/17, indicated R11 was very stable on current doses of medications. R11's progress note dated 4/7/17, indicated R11's family member brought it to the staff's attention that R11 was more anxious and wanted the physician contacted to obtain medication for anxiety. The note indicated staff faxed the physician which indicated staff had noticed R11 was more alert and awake, was more conversational and lucid, was feeding herself, could identify staff by name, and even joked with staff. The note also also indicated R11 would hand staff objects but there was nothing there. The fax requested a PRN medication order for anxiety, as she currently did not have one prescribed. R11's physician visit note dated 4/13/17, indicated R11 was recently started on Clonazepam 0.25 mg	F 428		

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F 428	Continued From page 63 once daily PRN for anxiety per family member's request. On 5/16/17, at 3:02 p.m., R11 was observed seated in her room with family member (FM)-1 holding her hand. FM-1 indicated he was there every day to visit and felt R11 was much better than she was a few months ago and explained the medication had caused R11 to be frequently sedated. FM-1 stated R11's mood was even, had not seen fluctuations, had not witnessed any hallucinations. On 5/18/17, at 9:15 a.m. the social worker (LSW) stated she had performed the depression/mood assessment for the MDS completed March 2017, in which R11 did not feel good at the time of the assessment and thought the reason for the increased symptoms was not related to depression rather, R11's illness. The LSW reviewed R11's behavior documentation and confirmed the lack of documented anxiety symptoms that would justify a new order for PRN Clonazepam. The LSW confirmed there was a lack of behavior and/or mood monitoring and a system in place for assessments of behaviors and psychotropic medications. -At 9:40 a.m. licensed practical nurse (LPN)-B stated R11 had previously been on scheduled Clonazepam, however, with the tapering of her Seroquel doses, R11 was much more alert, assisted with her cares, and sometimes even fed herself. LPN-B stated there were days R11 was sleepier and required more encouragement and did not think R11 had had hallucinated anytime recently, didn't think R11 was depressed and R11 had not had any episodes of anxiety.	F 428		

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F 428	Continued From page 64 -At 12:10 p.m. the director of nursing (DON) and registered nurse (RN)-consultant confirmed the lack of a system for comprehensive analysis of mood/behaviors and psychotropic medication management. The RN-consultant verified documentation did not support the use of the Clonazepam. -At 2:42 p.m. The CP stated if there was a lack of documentation and analysis to support the continued use of the medication, then a recommendation for taper or gradual dose reduction should have been made. The undated Behavioral Management Guidelines policy indicated the policy directed staff to observe the resident and review for possible reversible cause that could be causing the behavior and non-pharmacological intervention were to be implemented and assessed for effectiveness prior to considering initiation of any psychoactive medication. The policy further indicated medications to control behaviors should always be considered a last resort to assist with managing a resident's behavior, target behaviors must be clearly and specifically identified, documented and monitored. The consultant pharmacist would review the resident's medication regime and document medication/dosage recommendations to the physician's and interdisciplinary team.	F 428		
F 465 SS=F	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions	F 465		6/21/17

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WALKER REHABILITATION & HEALTHCARE CENTER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

(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 465	Continued From page 65 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure facility carpet was maintained free of worn of stained areas in order to provide a safe, sanitary and comfortable environment for all residents, staff and the public. Findings include: During the entrance tour on 5/15/17, at 1:00 p.m. the carpet in the entry way, carpet in the resident's hallways, and the carpet in the hallway to the dining room was observed to have numerous stains, dark spots, and many worn areas. On 5/17/17, at 8:25 a.m. licensed practical nurse (LPN) - A verified the carpet was stained and worn in several areas. The LPN stated housekeeping staff were always cleaning the carpet, but the stains would not come out and stated the residents deserved to have nice flooring because this was their home. On 5/17/17 at 10:15 a.m. registered nurse (RN-A)	F 465	F465 Healthcare Services has developed a new program for deep cleaning the carpet which involves a new procedure never used before at this facility and a new product that is better than the previous carpet cleaning solutions used. Existing products that have already been used at the facility are also being used but in a new way. The new procedure and products are used as follows: Step 1: The carpet stains are pre-treated with a product called Triple Action. The entire carpet is not treated with this product because it stresses the carpet fibers but only those areas that are filthy and/or stained are treated. The hottest water is used in the application of the Triple Action product □ in the past warm water has been used. The hottest water in the facility comes from laundry which is where housekeeping will acquire water from. An Extractor machine is used in this step of the process which is the most viable carpet cleaning tool for lifting stains and removing them as well as routine	

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F 465	Continued From page 66 confirmed the carpet was stained and stated the carpet was should be replaced. On 5/18/17, at 9:31 a.m. the maintenance director verified the carpet was worn and stained and should be removed. The director stated housekeeping staff did clean the carpet and vacuumed it daily but the stains and spots would not come out or if they had come out, as soon as the weather turned humid the stains reappeared. The director stated there was no padding under the carpet as the carpet was put down directly on the concrete floor and when the concrete started to sweat, the spots would reappear. On 5/18/17, at 10:00 a.m. the housekeeper stated the carpet was vacuumed and spot cleaned every day and even though it looked stained and old, it really was clean. On 5/18/17, at 10:25 a.m. the housekeeping supervisor stated the carpet was vacuumed every day and then shampooed one time a month. The housekeeping supervisor stated the stains appeared to be gone but would then reappear when the weather turned humid. On 5/18/17, at 9:40 a.m. the executive director verified the carpet was stained and worn and needed to be replaced. A facility policy related to flooring and carpet was requested	F 465	carpet dirt. Step 2: This is an additional process along with the first step and it involves a new product to this facility called Demolish which is a heavy duty, industrial strength stain remover. Half a bottle of this product is used for the amount of stains in the carpet of this facility which is a very potent amount. This product goes a step beyond the Triple Action and uses a powerful industrial strength enzyme to break down the dirt in the stains and removing them with use of the Extractor machine. Step 3: A slow stripper machine is used with a special cleaning white pad that is designed to lift the carpet fibers as the machine goes over it to remove any dirt or stain material left behind by the first (2) steps. The schedule for this cleaning process is detailed but requires a first phase and a second phase. Phase (1) is a weekly cleaning using the heavy attack approach described in the (3) step process for (4) weeks after which housekeeping management and the facility ED will determine whether the current system should be continued weekly, bi-weekly, or monthly. The problem with too many detailed cleanings is that it creates the tendency for mildew to build up under the carpet from too much water being applied in too frequent of a timeframe. Spreading cleanings out reduces this potential and actually provides better results. This process is what is known in the housekeeping industry as a Heavy Detailed Attack and it has never been used in the history of this facility with the	

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F 465	Continued From page 67	F 465	carpet cleaning procedure. Until the carpets are replaced with tile, a process ownership is considering over the next year, this new approach holds promise for removing stains and keeping the carpet the cleanest it has ever been for the sake of ensuring a safe, clean, and healthy environment for the residents. Findings will be brought to QAPI for review. Compliance by 6-21-17	

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	245323	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/17/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey the Walker Rehabilitation & Healthcare Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/15/2017

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

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K 000	Continued From page 1 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 This facility was surveyed as a single building. Golden Living Center of Walker is a 1-story building with a partial basement. The building was constructed at two different times. The original building was constructed in 1967 and was determined to be of Type II(222) construction. In 1994, an addition was constructed to the east side of the building that was determined to be of Type II(111) construction and separated with a 2 hour fire barrier. The main level is divided into 3 smoke zones. The building is protected by a complete automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system and in common areas that is monitored for automatic fire department notification. The facility has a capacity of 40 beds and had a census of 20 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 133 SS=F	NFPA 101 Multiple Occupancies - Construction Type Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent	K 133		6/21/17

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K 133	Continued From page 2 construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.1.3.3. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 10 of 20 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 05/17/2017, observations revealed that the fire rated wall separating the main care center from the attached physical therapy addition has a 2 inch square opening around the fire alarm wire that is passing through the wall to the manual fire alarm pull station. This deficient condition was verified by the Maintenance Supervisor.	K 133	K133 The hole in the wall in the physical therapy addition has been patched using 5/8 inch sheetrock and sealed with fire calk. This work was done by the maintenance director. A review has been done to ensure that there are no other holes in the walls. Any other holes found have been fixed. Maintenance will do a quarterly inspection of facility walls to ensure that there are no new holes. Where new holes are found, they will be fixed.	

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K 291	Continued From page 3	K 291		
K 291 SS=D	NFPA 101 Emergency Lighting Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This STANDARD is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested and maintained in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect the residents, as well as an undetermined number of staff, and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 05/17/2017, observation during a review of all available testing and maintenance documentation and an interview with the Maintenance Supervisor revealed that the facility has not been conducting a monthly 30 second test for 2 of 12 months and failed to conduct a 90 minute annual test of the battery operated emergency lighting. This deficient condition was verified by the Maintenance Supervisor.	K 291	K291 A 90-minute emergency light test was conducted on May 22, 2017. The Building Engines program is installed on the maintenance computer and it generates a reminder that schedules the date and time for the 90-Minute emergency light tests. That reminder flashes up on the screen of the computer. A secondary reminder has been created which involves the facility Administrator scheduling the 90-Minute emergency on his master calendar. The facility Administrator will remind the maintenance supervisor about this 90-Minute test the day before it is due.	6/21/17
K 324 SS=D	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless:	K 324		6/21/17

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K 324	Continued From page 4 * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, it was determined that the facility has failed to ensure that 1 of 2 semi-annual inspections of the kitchen hood ventilation and fire suppression system protecting the cooking appliances have been completed. NFPA 96 (11), states that for moderate-volume cooking operations, the hood system and components shall be inspected and maintained semiannually by a properly trained, qualified, and certified company or person. This deficient practice could affect the residents as well as an undetermined number of staff, and visitors to the facility. Findings Include:	K 324	K324 The kitchen hood ventilation and fire suppression system inspection was missed for (2) reasons: no maintenance supervisor on staff and not properly scheduling the inspection with Summit Fire Protection which is the company that usually performs the inspection. To correct this, the Maintenance Supervisor and the new Facility Administrator have contacted Summit Fire Protection to ensure that they have the semi-annual inspection scheduled. The facility Administrator will add these inspections to his master calendar and ensure that Summit follows through semi-annually.	

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K 324	Continued From page 5 On facility tour between 10:00 a.m. to 2:00 p.m. on 05/17/2017, during the review of all available documentation for the kitchen hood ventilation and fire suppression system inspection reports, and interview with the Maintenance Supervisor, the facility failed to provide 1 of 2 service reports showing that the kitchen hood ventilation and fire suppression system has been professionally inspected within the last 12 month time period. This deficient condition was verified by the Maintenance Supervisor.	K 324		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This **STANDARD** is not met as evidenced by: Based on observations and interview with staff, the facility has failed to properly inspect and	K 353	K353 The maintenance supervisor and facility	6/21/17

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K 353	Continued From page 6 maintain the automatic sprinkler system in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems 2010 edition, and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, 2011 edition. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect 20 of 20 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 05/17/2017, observation during a review of all available testing and maintenance documentation and an interview with the Maintenance revealed that at the time of the inspection the facility could not provide any documentation for the annual fire sprinkler test verifying that it has been completed. This deficient condition was verified by the Maintenance Supervisor.	K 353	Administrator have contacted Summit Fire Protection to have them add the their schedule for quarterly, annual, and 5-year inspections of the sprinkler system. The facility administrator will add these sprinkler inspections to his master calendar so that they coincide with the calendared inspection done by Summit Fire Protection.	
K 355 SS=D	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: Based on documentation review and staff	K 355	K355	6/21/17

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K 355	Continued From page 7 interview, it was determined that the facility failed to maintain portable fire extinguishers in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) Section 19.3.5.5. This deficient practice could affect the residents, as well as an undetermined number of staff, and visitors in the event of an emergency Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 05/17/2017, observations revealed that the fire extinguisher inspections located in the boiler room outside of the maintenance supervisor's office was set on the floor and not mounted. It appeared that the mounting hardware had pulled out of the wall. This deficient condition was verified by the Maintenance Supervisor.	K 355	The wall mount for the fire extinguisher outside the Maintenance supervisor's office has been repaired and the fire extinguisher remounted. The Maintenance supervisor has reviewed all fire extinguishers in the facility to ensure that they are all properly mounted and in good working order. Any problems have been fixed. In addition to the monthly fire extinguisher gauge inspection normally done, the maintenance supervisor will check to ensure that they are properly mounted and in good working order.	
K 372 SS=F	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system	K 372		6/21/17

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K 372	Continued From page 8 in REMARKS. This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain 2 of 3 several smoke barrier walls in accordance with the requirements of NFPA 101 "The Life Safety Code" 2012 edition sections 19-3.7.3 and 8.3. This deficient practice could affect 20 of 20 residents as well as an undetermined number of staff, and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 05/17/2017, observations revealed the following deficient condition affecting the facility's smoke barrier walls: 1) The smoke barrier double doors by resident rooms 114 and 117 swing in the same direction and one of the doors has an astragal attached to it and the doors are not equipped with a door sequencer. 2) The smoke barrier double doors by resident rooms 114 and 117 did not have a fire rating labels attached to the doors. 3) the smoke barrier wall has a 8 inch by 24 inch opening above the ceiling tile over the door to the storage room that is located in the resident and visitor's lounge. This deficient condition was verified by the Maintenance Supervisor.	K 372	K372 The hole in the smoke barrier wall in the visitor's lounge has been repair with 5/8 sheetrock and fire caulk. The maintenance supervisor has inspected all other smoke barrier walls to ensure that there are no other holes. If found, they have been repaired. Maintenance will do a quarterly inspection of facility walls to ensure that there are no new holes. Where new holes are found, they will be fixed. Local venders have been contacted for quotes on obtaining proper fire doors.	
K 511	NFPA 101 Utilities - Gas and Electric	K 511		6/21/17

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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 511 SS=D	Continued From page 9 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview with the staff the facility had a deficient condition affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.1.2 and the NFPA 70 "National Electrical Code" 2011 edition. This deficient practice could affect the residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 05/17/2017, observations revealed that there is combustible being stored around and against electrical panels that are located in the maintenance supervisor's office. This deficient condition was verified by the Maintenance Supervisor.	K 511	K511 The combustible was removed from the electrical panels. The maintenance supervisor did an inspection of the area to ensure that no other combustibles were improperly placed. The maintenance supervisor will paint a barrier line in front of the electrical panel to prevent any items from being placed between that barrier line and the electrical panel.	
K 712 SS=F	NFPA 101 Fire Drills	K 712		6/21/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/17/2017**

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K 712	Continued From page 10 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct 1 of 12 fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 20 of 20 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 05/17/2017, during the review of all available fire drill documentation and interview with the Maintenance Supervisor it was found that the facility did not transmit a fire alarm signal to the alarm monitoring company for 1 of 12 fire drills This deficient condition was verified by the Maintenance Supervisor.	K 712	K712 The maintenance supervisor has corrected the monthly fire drill form by adding to it "call center verification" which will prevent any failure of verification in the future as the form must be completed entirely after each fire drill. The facility ED also signs the form to ensure that it is completed entirely which will include ensuring that verification has been done.	

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	245323	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/17/2017**

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K 753	Continued From page 11	K 753		
K 753 SS=D	NFPA 101 Combustible Decorations Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: * Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. * Decorations meet NFPA 701. * Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. * Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6 or 19.7.5.6. * The decorations in existing occupancies are in such limited quantities that a hazard of fire is not present. 18.7.5.6, 19.7.5.6 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility failed to maintain combustible decorations in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.5.4. This deficient practice could affect 20 of 20 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 05/17/2017, observations revealed that in the activities room and outside of the administrator's office there are candles that have not had the wicks removed from them making them unable to be lit.	K 753	K753 The two candles with wicks were removed at the time of survey. The maintenance supervisor inspected the facility for any other candles with wicks. If found, they were removed. Facility staff will be in-serviced on 6-14-17 on not having candles in the facility with wicks on them. The Activities Director will perform a quarterly audit using a diagram of the facility, checking each room for the exitance of any candles with wicks in them. If found, she will remove them. Additional education will be done if candles with wicks appear.	6/21/17

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	245323	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/17/2017**

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K 753	Continued From page 12 This deficient condition was verified by the Maintenance Supervisor.	K 753		