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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PU1U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245184**

2. STATE VENDOR OR MEDICAID NO. (L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER EAST**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

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) **05/12/2006**

6. DATE OF SURVEY **9/29/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **116** (L18)

13.Total Certified Beds **116** (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: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	116			
(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 : 10/03/2016
Kyla Einertson, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 10/04/2016
Kamala Fiske-Downing, Health Program Representative (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 **09/01/1972** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245184

October 4, 2016

Mr. Jon Richardson, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, MN 55904

Dear Mr. Richardson:

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 September 24, 2016 the above facility is certified for:

116 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 116 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
October 3, 2016

Mr. Jon Richardson, Administrator
Golden Livingcenter - Rochester East
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Number S5184028, H5184088 and H5184085, H5184090

Dear Mr. Richardson:

On September 8, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 24, 2016. (42 CFR 488.422)

This was based on the deficiencies cited by this Department for a standard survey completed on July 20, 2016, that included an investigation of complaint number H5184088, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on September 8, 2016. The most serious deficiencies at the time of the revisit were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On September 29, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on September 8, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 8, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on September 8, 2016, as of September 24, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 24, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of September 19, 2016. 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 October 20, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 20, 2016, is to be rescinded. They will also notify the State

Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 20, 2016, is to be rescinded.

In our letter of September 19, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 20, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on September 24, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
245184		9/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0280 Reg. # 483.20(d)(3), 483.10(k)(2) LSC	Correction Completed 09/23/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 09/24/2016	ID Prefix F0329 Reg. # 483.25(l) LSC	Correction Completed 09/24/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** GPN/kfd	**DATE** 10/4/2016	**SIGNATURE OF SURVEYOR** 31221	**DATE** 9/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 7/20/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**			

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

October 13, 2016

Mr. Jon Richardson, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: Reinspection Results - Project Number S5184028, H5184088 and H5184085, H5184090

Dear Mr. Richardson:

On September 29, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 29, 2016, that included an investigation of complaint numbers H5184088 and H5184085, H5184090. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT
00953 Y1	Y2	9/29/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20570 Reg. # MN Rule 4658.0405 Subp. 4 LSC	Correction Completed 09/23/2016	ID Prefix 20830 Reg. # MN Rule 4658.0520 Subp. 1 LSC	Correction Completed 09/24/2016	ID Prefix 21540 Reg. # MN Rule 4658.1315 Subp. 2 LSC	Correction Completed 09/24/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) GPN/kfd	DATE 10/4/2016	SIGNATURE OF SURVEYOR 31221	DATE 9/29/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/20/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

 EVENT ID: PU1U13

STATE FORM: REVISIT REPORT (11/06)

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PU1U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245184**

2. STATE VENDOR OR MEDICAID NO. (L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER EAST**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

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) **05/12/2006**

6. DATE OF SURVEY **9/8/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **116** (L18)

13.Total Certified Beds **116** (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
	116			
(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 : 9/19/2016
Kyla Einertson, HFE NE II (L19)

18. STATE SURVEY AGENCY APPROVAL Date: 10/03/2016
Kamala Fiske-Downing, Health Program Representative (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 **09/01/1972** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

September 19, 2016

Mr. Jon Richardson, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Number S5184028 and Complaint Numbers H5184088 and H5184085, H5184090

Dear Mr. Richardson:

On August 9, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 20, 2016 that included an investigation of complaint numbers H5184088 and H5184085, H5184090. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 8, 2016, the Minnesota Department of Health and on August 29, 2016, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 20, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 29, 2016. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on July 20, 2016. The deficiencies not corrected are as follows:

F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs

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

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

• State Monitoring effective September 24, 2016. (42 CFR 488.422)

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

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 20, 2016. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 20, 2016. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 20, 2016. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Golden Livingcenter - Rochester East is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 20, 2016. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those

circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

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

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

DEPARTMENT CONTACT

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial

compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 20, 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.

Feel free to contact me if you have questions.

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
85 East Seventh Place, Suite 220
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 9/8/16. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Complaint H5184088 was substantiated during the survey exited 7/20/16 and was found to be in compliance during this PCR.	F 000		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in	{F 280}		9/23/16

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

Electronically Signed | 09/22/2016

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

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{F 280}	Continued From page 1 disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to revise 1 of 1 resident (R30) care plan to include interventions for diagnosis of atopic dermatitis and ongoing treatment per the facility plan of correction (POC) as cited on the survey exited 7/2/16. Findings include: R30 admitted to the facility on 5/30/13 according to the facility face sheet. The facility face sheet included diagnoses of diabetes and atopic dermatitis. R30's current electric care plan lacked a plan of care for diagnosis of atopic dermatitis and ongoing preventative treatment for skin infections. On 9/07/2016, at 2:42 p.m. registered nurse (RN)-D stated she looked through the care plan history and the current clan plan and was unable to locate a care plan for atopic dermatitis and interventions for ongoing treatment. RN-D stated a care plan should have been completed per the plan of correction for chronic dermatitis. On 9/08/2016, at 10:09 a.m. the director of nursing (DON) stated she expected the nurse	{F 280}	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed n this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19F2813/1F281F281programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	

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{F 280}	Continued From page 2 manager to have completed and implemented the care plan interventions as a part of the plan of correction for R30's atopic dermatitis.	{F 280}	F280 R30's care plan has been updated to include a plan of care for diagnosis of atopic dermatitis and ongoing interventions. All residents have the potential to be affected. Staff responsible for completing and updating care plans will be educated on the requirement to include residents in planning of care and treatments or updating care plans when changes of care or treatments are necessary. Random audits of care plans and care guides will be conducted weekly. Results of audits will be reported to QAPI. QAPI will determine if additional access is necessary. DNS or designee is responsible for monitoring for compliance. Corrective action will be completed by 9/24/2016.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review facility failed to ensure a neurological assessment was	F 309	F309 Neuro checks post fall:	9/24/16

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F 309	Continued From page 3 completed according to facility policy for 1 of 1 resident (R52) following a fall with injury and failed to ensure monitoring of bruises occurred for 1 of 3 residents (R55) reviewed for non-pressure related skin conditions. Findings include: R52's Incident Report dated 9/1/16, at 6:10 a.m. identifies R52's, "alarm sounded, resident found up walking by self, before NA (nursing assistant) could reach her, resident lost balance and fell on to the floor falling on right side." R52 was noted to have a "pink area" on right side of face. R52 's Neurological Assessment Flow sheet was started on 9/1/16, at 6:15 a.m. With neurological assessments occurring again at 7:00 a.m., 7:30 a.m., 8:30 a.m., 10:00 a.m., 1:00 p.m., 2:00 p.m., 3:00 p.m., 4:00 p.m., 8:00 p.m., and 11:00 p.m. Neurological assessment completed on 9/2/16, at 10:00 a.m. and 4:00 p.m. On 9/3/16, assessment was completed at 8:00 a.m. only. Interview on 9/7/16, at 9:27 a.m. with licensed nurse (LPN)-A stated neurological assessments are completed on residents who have hit their heads either during a fall or other type of accident. When asked about neurological assessment times of completion, LPN-A stated, "when I have time I try to get to them." LPN-A stated she thought neurological assessments were supposed to be completed every 15 minutes for an hour, every half an hour for an hour and every hour for two hours. LPN-A stated she wasn't sure the exact times. LPN-A attempted to find the exact times neurological assessments should be completed following a head injury but was unable to locate the information. Interview on 9/7/16, at 9:34 a.m. with registered nurse (RN)-B when asked how often neurological assessments should be completed stated, "I'm just learning my job, so I'll check."	F 309	All residents have the potential to be affected. R52 has shown no signs of neurological injury from her fall on 9/1/16. R52 has been evaluated by her primary physician. A new Process was developed by the QAPI committee and approved by the Medical Director for completing neurological assessments after a resident falls or otherwise suffers a head injury. Nursing staff will be trained on the new Golden Living Center Rochester East Process; and the Golden Living Neurological Checks Policy number CL800. Monitoring of bruises: R55□s bruises on the top of her left forearm were noted and monitoring was begun on 9/7/16. Monitoring will continue until they are resolved. All residents have the potential to be affected. A new Process was developed by the QAPI committee and approved by the medical director for bruise monitoring. Nursing staff will be trained on the Golden Living Center Rochester East bruise reporting and monitoring process. Random audits will be conducted weekly. Results of audits will be reported to QAPI. QAPI will determine if additional action is necessary. DNS or designee will be responsible. Corrective action will be completed by September 24, 2016.	

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F 309	Continued From page 4	F 309		

Interview on 9/7/16, at 9:38 a.m. with RN-A stated she was unsure of how often neurological assessments should be completed. RN-A attempted to locate the information but was unable to provide it to surveyor.
Interview on 9/7/16, at 2:02 p.m. with director of nursing (DON) stated the facility has a protocol for neurological assessments to be completed for any resident who has fallen, has a head injury, if someone states they have hit their head or for any unwitnessed fall. DON stated there are specific guidelines with specific time ranges for neurological assessments to be completed. DON stated the staff should be following the facility policy.
Policy titled, "Neurological Checks", dated 12/18/14, identifies, "Neurological checks shall be performed per physician order. Conduct neurological checks as follows: every 15 minutes for the first hour; every 30 minutes X 4; every 60 minutes times 2; then every shift for 72 hours."
LACK OF MONITORING OF BRUISES FOR NON-PRESSURE RELATED SKIN CONDITIONS:
R55 was observed on 9/6/16, at 11:22 a.m. R55 was wearing a short sleeved shirt and was noted to have large bruises on the top of her left forearm.
R55 had a weekly skin review on 9/4/16. Review indicated skin was intact. No bruises.
Interview on 9/7/16, at 3:08 p.m. with nursing assistant (NA)-A stated when a bruise is found during cares it should be immediately reported to the nurse working.
Interview on 9/7/16, at 3:26 p.m. RN-D stated when a bruise has been found it is documented on once a week during weekly skin reviews.
RN-D stated a found bruise is then monitored on a "Bruise Monitoring Worksheet" which is kept in

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F 309	Continued From page 5 a binder. This worksheet identifies the location of the bruise including measurements. RN-D verified there was not a bruise monitoring worksheet for R55. RN-D assessed R55's left forearm and verified two bruises present with a skin tear. RN-D stated the bruises must have occurred between the weekly skin review on 9/4/16 and when observed during the survey process on 9/6/16. RN-D stated the aides assisting R55 in the morning and evening with cares would have been aware of the bruises and should have notified the nurse immediately. Bruise monitoring worksheets completed on 9/7/16 by RN-D included a purple bruises on left forearm that measures 1.5 cm (centimeters) by 1.5 cm and 4 cm by 4.2 cm. Skin tear measurements found on a Wound Evaluation Floor Sheet dated 9/7/16 identify 1.3 cm by 0.1 cm. Interview on 9/8/16, at 10:22 a.m. with executive director stated the bruises should have been reported immediately upon finding. Facility provided documentation that is to be used when finding a bruise. Documents identify, "anytime you see a new bruise, even on admission, measure and document in bruise book, complete a progress note, measure and document in bruise book and progress notes weekly until resolved."	F 309		
{F 329} SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	{F 329}		9/24/16

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{F 329}	Continued From page 6 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify specific target behaviors for prescribed a medication for anxiety, to attempt a gradual dose reduction/titration of psychotropic and psychoactive medication or provide physician justification as to why a gradual dose reduction/titration is contraindicated at this time for 1 of 5 residents (R59). In addition the facility failed to ensure that non pharmacological interventions were offered and documented, symptom indicators had been consistently documented for the administration of as needed (PRN) medications, administering more than one PRN medication for the same diagnosis at the same time and administering PRN medication at the incorrect ordered time for 1 of 3 residents (R32) reviewed for unnecessary medications.	{F 329}	F329 Gradual dose reductions: R59□s Seroquel was discontinued by her physician All residents have the potential to be affected. The consultant pharmacist reviews all of the residents□ medications for unnecessary medications monthly and makes recommendations for dose reductions. His recommendations are acted upon with either a dose reduction or clinical justification for the continuance of the medication(s). Target behaviors: In collaboration with her hospice provider,	

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{F 329}	Continued From page 7 Findings Include: The facility plan of correction (POC) included, " R59 targeted behaviors monitoring has been clarified to identify which medications are being monitored for effectiveness. Facility will attempt a GDR [gradual dose reduction] for R59 or obtain a justification for continued use." The POC indicated corrective action would be completed by August 29, 2016. R59's admission record, dated 3/31/2011, indicated that the resident had diagnoses of dementia with Lewy bodies, insomnia and Parkinson's disease. R59's order summary report, start date 8/7/2013 for Seroquel a psychotropic medication which is currently in use. R59 was to take 12.5 mg (milligrams) by mouth at bedtime related to bipolar disorder. It identified the following target behaviors: repeat verbalizations, hitting at furniture for attention, calling out, anger toward family/staff. On 5/12/2014, R59 was prescribed Trazodone (an antidepressant) for insomnia. She was to take 50 mg by mouth at bedtime. On 7/23/2015, R59 was prescribed depakote sprinkles for anxiety and currently in use. She was to take 600 mg by mouth in the evening. The order summary report, dated 2/13/2014, indicated that R59 had been admitted to St. Croix hospice with a terminal illness of progressive supranuclear palsy. R59's care plan, dated 4/8/2011, stated that the resident was at risk for alteration in her behaviors and the potential for altercations with others which were related to yelling out at night, refusing	{F 329}	R59□s target behaviors have been identified, her medication regimen has been reviewed, and her medications are being monitored for effectiveness. All residents who receive psychoactive medications could be affected. All residents who receive psychoactive medications have been reviewed to ensure that target behaviors have been identified, care planned and medications are being monitored for effectiveness. Non-pharmacological interventions before as needed medication administration: In collaboration with her hospice provider, R32□s target behaviors have been identified, her medication regimen has been reviewed, and her medications are being monitored for effectiveness. All residents who receive as-needed medications and/or psychoactive medications could be affected. Licensed nursing staff will be educated on the need for exact target behaviors for all psychoactive medications, the need for non-pharmacological interventions prior to as-needed medications, the need for exact indications for all medications, proper clinical justification, and the process to follow for gradual dose reductions, the need for sleep assessments prior to initiating hypnotic medications. All nursing staff will be educated on the requirement of completing assigned documentation including, but not limited to, behaviors. Random audits will be conducted weekly. Results of audits will be reported to QAPI.	

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{F 329}	Continued From page 8 cares, being verbally abusive, becoming anxious when waiting for staff assistance, self-transferring, frequent use of the call light, being rude. The care plan further stated that R59 was at risk for alteration in her mood related to diagnoses of bipolar disorder, Parkinson's syndrome and episodic delirium. With the stated goal of safety in mind, it recommended notifying the doctor if her behaviors interfered with her functioning or symptoms were not improving to see if a change in medication was warranted. It advised to give medications as ordered. The facility was requested to provide all documentation which related to monitoring R59's behaviors since 8/29/16. R59's behavior monthly flow sheets, reviewed from August 29, 2016 through September 7, 2016 indicated that the facility had been monitoring the resident for the following behaviors: insomnia, anxiety, and striking out/hitting. From the documentation, R59 appeared to not have a single episode of anxiety, striking/hitting or insomnia. The progress notes requested from 8/29/2016 through 9/7/2016 were not provided. R59's pharmacy recommendation with a print date of 7/18/16 included a gradual dose reduction for the use of the Seroquel. The provider responded on 8/5/16, " Decline recommendations- she has failed DRT in the past. " The provider justification did not address the clinical rationale or reason(s) why an attempted dose reduction would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. On 9/7/16, at 2:05 p.m. registered nurse (RN)-D	{F 329}	QAPI will determine if additional action is necessary. DNS or designee will be responsible. Corrective action will be completed by September 24, 2016.	

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{F 329}	Continued From page 9 was asked about the lack of monitoring specific target behaviors for Seroquel. It was pointed out that the facility lacked documentation that they were monitoring for identified target behaviors. RN-D stated there should be specific targeted behaviors identified for the use of antipsychotic medications. It was pointed out that the facility was monitoring R59's "anxiety" but not monitoring specific, individualized symptoms of anxiety that R59 exhibited in order to justify the use of the Depakote Sprinkles. RN-D stated there should be specific identified symptoms to monitor for anxiety. It was pointed out that the facility lacked physician justification to continue the use of Seroquel and Trazodone medications without an annual attempt to reduce or titration the medications. RN-D stated a gradual does reduction (GDR) should be attempted on annual basis and stated if a GDR was not appropriate for a resident specific documentation needed to be completed as to why. RN-D confirmed the plan of correction had not been implemented to address the concerns identified with R59's medications cited in the original survey. On 9/08/2016, at 10:14 a.m. the director of nursing (DON) stated she was not sure how this was missed, stated specific targeted behaviors should be monitored for the use of antipsychotic medications, specific symptoms should be monitored for the use of antianxiety medications and stated annual GDR should be attempted or a clinical justification of why a GDR should not be completed should be documented. Review of the facility document titled, Mood/Behavior Management (3/31/2016), it stated that the behavior committee would monitor behaviors to assist in determining symptoms,	{F 329}		

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{F 329}	Continued From page 10	{F 329}		

cause, patterns and the severity of behavior. The social services staff should be trained on how to use the monitoring system and regularly review the system for proper use. It stated that a system to evaluate and document a behavior management plan would be established in order to document specific behavior problems. It stated that the behavior management plan would be evaluated for effectiveness at least monthly.

Review of the facility document titled, antipsychotic medication review (3/31/2016), it advised that the physician has reviewed a resident's medication program at least quarterly and has documented the reason for the continuance or change in the medication.
R32 diagnosis found on the Admission Record include Anxiety disorder, chronic obstructive pulmonary disease, unspecified open wound of right forearm.
R32 has an order for Ativan 0.5 mg every four hours as needed for muscle spasms/anxiety related to anxiety disorder effective 6/28/16; Cyclobenzaprine HCL 10 mg every eight hours as needed for muscle spasms effective 6/17/16; Morphine Sulfate 15 mg every 2 hours as needed for pain until 8/21/16 and 15 mg every four hours as needed for pain or shortness of breath effective 8/21/16; Trazodone 100 mg as needed at bedtime for sleep effective 6/17/16.
Medication administration record (MAR) indicates PRN Ativan was administered on 9/4/16 at 8:52 p.m., on 9/5/16, at 3:30 a.m. and 6:07 p.m., 9/6/16 at 4:51 p.m. and on 9/7/16 at 5:09 a.m. PRN Cyclobenzaprine was administered on 9/4/16 at 10:23 p.m., 9/5/16 at 5:25 a.m. and 6:06 p.m. and 9/7/16, at 5:09 a.m. PRN Morphine was administered on 9/1/16 at 3:44 a.m. and 10:37 a.m., 9/2/16 at 11:20 p.m., 9/3/16 at 1:22 p.m.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

(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 329}	Continued From page 11 9/4/16, at 4:31 a.m., 2:59 p.m. and 10:20 p.m., on 9/5/16 at 3:31 a.m. and 6:08 p.m., 9/6/16, at 2:05 p.m., and 9/7/17 at 5:10 a.m. Progress note dated 9/4/16, administration of PRN Morphine identifies indication for administration as, "unknown." No non-pharmacological interventions identified as attempted. PRN Ativan indication identified as, "anxiety", no non-pharmacological interventions identified. Progress note dated 9/5/16, administration of PRN Morphine however, does not identify symptom indication for administration or if non-pharmacological interventions had been tried. Progress note dated 9/5/16, at 3:30 a.m. identifies administration of PRN Ativan and Morphine again with no indications for administration and no non-pharmacological interventions. PRN Neurontin administered at 4:30 a.m. for pain, no non pharmacological interventions attempted. 9/5/16 at 5:25 a.m. administration of PRN Cyclobenzaprine with no symptom indicated for administration and no non-pharmacological interventions attempted. Progress note dated 9/6/16, identifies PRN Morphine administered again with no indication or non-pharmacological interventions. PRN Ativan administered for "anxiety and pain." PRN Ativan order indicates diagnosis of muscle spasms/anxiety. No non-pharmacological interventions identified. Progress note dated 9/7/16, at 5:09 a.m. indicates PRN Ativan, PRN Cyclobenzaprine, PRN Morphine and PRN Trazodone were administered at the same time. PRN Ativan and Cyclobenzaprine have the same diagnosis indicator to be given for muscle spasms. PRN Trazodone is to be given at bedtime for sleep. No	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

(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 329}	Continued From page 12	{F 329}		

symptoms indicators for administration of medication identified and no non-pharmacological interventions identified.
Interview on 9/7/16, at 9:27 a.m. with licensed practical nurse (LPN)-A stated non-pharmacological interventions should be attempted prior to medication administration, interventions should be documented in the MAR and in a progress note. LPN-A stated the symptoms for why medications are being administered should also be documented in the MAR and in the progress note.
Interview on 9/7/16, at 9:38 a.m. with registered nurse (RN)-A stated PRN medications should be documented in the MAR, also non-pharmacological interventions should be documented in a progress note along with specific symptoms for why medication was administered.
Interview on 9/7/16, at 2:02 p.m. with director of nursing (DON) stated non pharmacological interventions need to be documented, staff should not be administering more than one PRN medication with the same indicator at the same time and should not be administering PRN Trazodone at 5:00 a.m. in the morning when it is indicated for sleep. DON verified documentation of non-pharmacological interventions and specific symptoms for administration of PRN medications were not present. DON stated, "I have to make sure they are following our processes."
In-service education provided to nursing staff on 8/18/16, identifies, "All psychotropic medications need to have target behaviors, if the nurse/TMA[trained medication aide] thinks a resident may need a PRN psychotropic medication, the nurse/TMA must attempt a non-pharmacological intervention first, this non-pharmacological intervention must be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

(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 329}	Continued From page 13 documented in the progress notes, the behavior the resident is displaying must be included in the progress note, psychotropics are to be given as ordered, we cannot give a PRN psychotropic for a reason other than that which is listed in the order." Facility policy titled Medication Administration-General Guidelines dated August 2014, identifies when PRN medication are administered the following documentation is provided: complaints of symptoms for which the medication was given. Policy does not address non-pharmacological interventions as part of medication management.	{F 329}		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245184 Y1	A. Building B. Wing Y2	9/8/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0155	Correction	ID Prefix F0221	Correction	ID Prefix F0225	Correction
Reg. # 483.10(b)(4)	Completed	Reg. # 483.13(a)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed
LSC	08/29/2016	LSC	08/29/2016	LSC	08/29/2016
ID Prefix F0226	Correction	ID Prefix F0241	Correction	ID Prefix F0242	Correction
Reg. # 483.13(c)	Completed	Reg. # 483.15(a)	Completed	Reg. # 483.15(b)	Completed
LSC	08/29/2016	LSC	08/29/2016	LSC	08/29/2016
ID Prefix F0246	Correction	ID Prefix F0279	Correction	ID Prefix F0282	Correction
Reg. # 483.15(e)(1)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	08/29/2016	LSC	08/29/2016	LSC	08/29/2016
ID Prefix F0312	Correction	ID Prefix F0318	Correction	ID Prefix F0323	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(e)(2)	Completed	Reg. # 483.25(h)	Completed
LSC	08/29/2016	LSC	08/29/2016	LSC	08/29/2016
ID Prefix F0328	Correction	ID Prefix F0411	Correction	ID Prefix F0441	Correction
Reg. # 483.25(k)	Completed	Reg. # 483.55(a)	Completed	Reg. # 483.65	Completed
LSC	08/29/2016	LSC	08/29/2016	LSC	08/29/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	9/19/2016	31221	9/8/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/20/2016

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245184	A. Building 01 - MAIN BUILDING 01 B. Wing	8/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 08/15/2016	ID Prefix Reg. # NFPA 101 LSC K0147	Correction Completed 08/04/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** TL/kfd	**DATE** 9/19/2016	**SIGNATURE OF SURVEYOR** 37008	**DATE** 8/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 7/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on

September 19, 2016

Mr. Jon Richardson, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: Project # Project Number S5184028, H5184088 and H5184085, H5184090

Dear Mr. Richardson:

On September 8, 2016, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 20, 2016.

State licensing orders issued pursuant to the last survey completed on July 20, 2016 and found corrected at the time of this September 8, 2016 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on July 20, 2016, found not corrected at the time of this September 8, 2016 revisit and subject to penalty assessment are as follows:

F0570 MN Rule 4658.0405 Subp. 4 -- Comprehensive Plan Of Care; Revision	**$300.00**
F0830 MN Rule 4658.0520 Subp. 1 -- Adequate and Proper Nursing Care; General	**$350.00**
F1540 MN Rule 4658.1315 Subp. 2 -- Unnecessary DrugUsuage; Monitoring	**$300.00**

The details of the violations noted at the time of this revisit completed on September 8, 2016 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $950.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to:

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

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Kamala Fiske-Downing

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

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00953 Y1	A. Building B. Wing Y2	9/8/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20510	Correction	ID Prefix	20555	Correction	ID Prefix	20565	Correction
Reg. #	MN Rule 4658.0300 Subp. 2	Completed	Reg. #	MN Rule 4658.0405 Subp. 1	Completed	Reg. #	MN Rule 4658.0405 Subp. 3	Completed
LSC		08/29/2016	LSC		08/29/2016	LSC		08/29/2016
ID Prefix	20895	Correction	ID Prefix	20920	Correction	ID Prefix	21330	Correction
Reg. #	MN Rule 4658.0525 Subp. 2.B	Completed	Reg. #	MN Rule 4658.0525 Subp. 6 B	Completed	Reg. #	MN Rule 4658.0725 Subp. 2 A&B	Completed
LSC		08/29/2016	LSC		08/29/2016	LSC		08/29/2016
ID Prefix	21375	Correction	ID Prefix	21665	Correction	ID Prefix	21805	Correction
Reg. #	MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN Rule 4658.1400	Completed	Reg. #	MN St. Statute 144.651 Subd. 5	Completed
LSC		08/29/2016	LSC		08/29/2016	LSC		08/29/2016
ID Prefix	21810	Correction	ID Prefix	21830	Correction	ID Prefix	21840	Correction
Reg. #	MN St. Statute 144.651 Subd. 6	Completed	Reg. #	MN St. Statute 144.651 Subd. 10	Completed	Reg. #	MN St. Statute 144.651 Subd. 12	Completed
LSC		08/29/2016	LSC		08/29/2016	LSC		08/29/2016
ID Prefix	21980	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	MN St. Statute 626.557 Subd. 3	Completed	Reg. #		Completed	Reg. #		Completed
LSC		08/29/2016	LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/20/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 09/08/16. During this onsite visit it was determined that the following corrections orders/s # 570, 830, and 1540 were NOT corrected. These three uncorrected orders will remain in effect and will be reviewed at the next onsite visit. Also uncorrected orders will be reviewed for possible	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 penalty assessment/s. In addition, complaint investigation H5184088 at MN Rule 4658.0520 Subp. 1 (0830) was issued during the licensing survey exited 7/20/16. This licensing order is being reissued.	2 000		
{2 570}	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on interview and document review the facility failed to revise 1 of 1 resident (R30) care plan to include interventions for diagnosis of atopic dermatitis and ongoing treatment per the facility plan of correction (POC) as cited on the survey exited 7/2/16. Findings include: R30 admitted to the facility on 5/30/13 according to the facility face sheet. The facility face sheet included diagnoses of diabetes and atopic dermatitis.	{2 570}	R30's care plan has been updated to include a plan of care for diagnosis of atopic dermatitis and ongoing interventions. All residents have the potential to be affected. Staff responsible for completing and updating care plans will be educated on the requirement to include residents in planning of care and treatments or updating care plans when changes of care or treatments are necessary. Random audits of care plans and care guides will be conducted weekly. Results	9/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 570}	Continued From page 2 R30's current electric care plan lacked a plan of care for diagnosis of atopic dermatitis and ongoing preventative treatment for skin infections. On 9/07/2016, at 2:42 p.m. registered nurse (RN)-D stated she looked through the care plan history and the current clan plan and was unable to locate a care plan for atopic dermatitis and interventions for ongoing treatment. RN-D stated a care plan should have been completed per the plan of correction for chronic dermatitis. On 9/08/2016, at 10:09 a.m. the director of nursing (DON) stated she expected the nurse manager to have completed and implemented the care plan interventions as a part of the plan of correction for R30's atopic dermatitis. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	{2 570}	of audits will be reported to QAPI. QAPI will determine if additional access is necessary. DNS or designee is responsible for monitoring for compliance. Corrective action will be completed by 9/24/2016.	
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		9/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	R 09/08/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 3 This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on interview and record review facility failed to ensure a neurological assessment was completed according to facility policy for 1 of 1 resident (R52) following a fall with injury and failed to ensure monitoring of bruises occurred for 1 of 3 residents (R55) reviewed for non-pressure related skin conditions. Findings include: R52's Incident Report dated 9/1/16, at 6:10 a.m. identifies R52's, "alarm sounded, resident found up walking by self, before NA (nursing assistant) could reach her, resident lost balance and fell on to the floor falling on right side." R52 was noted to have a "pink area" on right side of face. R52 's Neurological Assessment Flow sheet was started on 9/1/16, at 6:15 a.m. With neurological assessments occurring again at 7:00 a.m., 7:30 a.m., 8:30 a.m., 10:00 a.m., 1:00 p.m., 2:00 p.m., 3:00 p.m., 4:00 p.m., 8:00 p.m., and 11:00 p.m. Neurological assessment completed on 9/2/16, at 10:00 a.m. and 4:00 p.m. On 9/3/16, assessment was completed at 8:00 a.m. only. Interview on 9/7/16, at 9:27 a.m. with licensed nurse (LPN)-A stated neurological assessments are completed on residents who have hit their heads either during a fall or other type of accident. When asked about neurological assessment times of completion, LPN-A stated, "when I have time I try to get to them." LPN-A stated she thought neurological assessments were supposed to be completed every 15 minutes for an hour, every half an hour for an hour and every hour for two hours. LPN-A stated she wasn't sure the exact times. LPN-A attempted to find the exact times neurological assessments	2 830	Neuro checks post fall: All residents have the potential to be affected. R52 has shown no signs of neurological injury from her fall on 9/1/16. R52 has been evaluated by her primary physician. A new Process was developed by the QAPI committee and approved by the Medical Director for completing neurological assessments after a resident falls or otherwise suffers a head injury. Nursing staff will be trained on the new Golden Living Center Rochester East Process; and the Golden Living Neurological Checks Policy number CL800. Monitoring of bruises: R55's bruises on the top of her left forearm were noted and monitoring was begun on 9/7/16. Monitoring will continue until they are resolved. All residents have the potential to be affected. A new Process was developed by the QAPI committee and approved by the medical director for bruise monitoring. Nursing staff will be trained on the Golden Living Center Rochester East bruise reporting and monitoring process. Random audits will be conducted weekly. Results of audits will be reported to QAPI. QAPI will determine if additional action is necessary. DNS or designee will be responsible. Corrective action will be completed by August 24, 2016.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00953	A. BUILDING: _____ B. WING _____	R 09/08/2016

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GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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2 830	Continued From page 4 should be completed following a head injury but was unable to locate the information. Interview on 9/7/16, at 9:34 a.m. with registered nurse (RN)-B when asked how often neurological assessments should be completed stated, "I'm just learning my job, so I'll check." Interview on 9/7/16, at 9:38 a.m. with RN-A stated she was unsure of how often neurological assessments should be completed. RN-A attempted to locate the information but was unable to provide it to surveyor. Interview on 9/7/16, at 2:02 p.m. with director of nursing (DON) stated the facility has a protocol for neurological assessments to be completed for any resident who has fallen, has a head injury, if someone states they have hit their head or for any unwitnessed fall. DON stated there are specific guidelines with specific time ranges for neurological assessments to be completed. DON stated the staff should be following the facility policy. Policy titled, "Neurological Checks", dated 12/18/14, identifies, "Neurological checks shall be performed per physician order. Conduct neurological checks as follows: every 15 minutes for the first hour; every 30 minutes X 4; every 60 minutes times 2; then every shift for 72 hours." LACK OF MONITORING OF BRUISES FOR NON-PRESSURE RELATED SKIN CONDITIONS: R55 was observed on 9/6/16, at 11:22 a.m. R55 was wearing a short sleeved shirt and was noted to have large bruises on the top of her left forearm. R55 had a weekly skin review on 9/4/16. Review indicated skin was intact. No bruises. Interview on 9/7/16, at 3:08 p.m. with nursing assistant (NA)-A stated when a bruise is found during cares it should be immediately reported to the nurse working.	2 830		

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2 830	Continued From page 5 Interview on 9/7/16, at 3:26 p.m. RN-D stated when a bruise has been found it is documented on once a week during weekly skin reviews. RN-D stated a found bruise is then monitored on a "Bruise Monitoring Worksheet" which is kept in a binder. This worksheet identifies the location of the bruise including measurements. RN-D verified there was not a bruise monitoring worksheet for R55. RN-D assessed R55's left forearm and verified two bruises present with a skin tear. RN-D stated the bruises must have occurred between the weekly skin review on 9/4/16 and when observed during the survey process on 9/6/16. RN-D stated the aides assisting R55 in the morning and evening with cares would have been aware of the bruises and should have notified the nurse immediately. Bruise monitoring worksheets completed on 9/7/16 by RN-D included a purple bruises on left forearm that measures 1.5 cm (centimeters) by 1.5 cm and 4 cm by 4.2 cm. Skin tear measurements found on a Wound Evaluation Floor Sheet dated 9/7/16 identify 1.3 cm by 0.1 cm. Interview on 9/8/16, at 10:22 a.m. with executive director stated the bruises should have been reported immediately upon finding. Facility provided documentation that is to be used when finding a bruise. Documents identify, "anytime you see a new bruise, even on admission, measure and document in bruise book, complete a progress note, measure and document in bruise book and progress notes weekly until resolved." Also uncorrected order/s will be reviewed for possible penalty assessment/s.	2 830		

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21540	Continued From page 6	21540		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: This licensing order was not corrected due to: Based on interview and document review the facility failed to identify specific target behaviors for prescribed a medication for anxiety, to attempt a gradual dose reduction/titration of psychotropic and psychoactive medication or provide physician justification as to why a gradual dose reduction/titration is contraindicated at this time for 1 of 5 residents (R59). In addition the facility failed to ensure that non pharmacological	21540	Gradual dose reductions: R59's Seroquel was discontinued by her physician All residents have the potential to be affected. The consultant pharmacist reviews all of the residents' medications for unnecessary medications monthly and makes recommendations for dose reductions. His recommendations are acted upon with either a dose reduction or	9/23/16

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21540	Continued From page 7 interventions were offered and documented, symptom indicators had been consistently documented for the administration of as needed (PRN) medications, administering more than one PRN medication for the same diagnosis at the same time and administering PRN medication at the incorrect ordered time for 1 of 3 residents (R32) reviewed for unnecessary medications. Findings Include: The facility plan of correction (POC) included, " R59 targeted behaviors monitoring has been clarified to identify which medications are being monitored for effectiveness. Facility will attempt a GDR [gradual dose reduction] for R59 or obtain a justification for continued use." The POC indicated corrective action would be completed by August 29, 2016. R59's admission record, dated 3/31/2011, indicated that the resident had diagnoses of dementia with Lewy bodies, insomnia and Parkinson's disease. R59's order summary report, start date 8/7/2013 for Seroquel a psychotropic medication which is currently in use. R59 was to take 12.5 mg (milligrams) by mouth at bedtime related to bipolar disorder. It identified the following target behaviors: repeat verbalizations, hitting at furniture for attention, calling out, anger toward family/staff. On 5/12/2014, R59 was prescribed Trazodone (an antidepressant) for insomnia. She was to take 50 mg by mouth at bedtime. On 7/23/2015, R59 was prescribed depakote sprinkles for anxiety and currently in use. She was to take 600 mg by mouth in the evening. The order summary report, dated 2/13/2014, indicated that R59 had been admitted to St. Croix hospice	21540	clinical justification for the continuance of the medication(s). Target behaviors: In collaboration with her hospice provider, R59's target behaviors have been identified, her medication regimen has been reviewed, and her medications are being monitored for effectiveness. All residents who receive psychoactive medications could be affected. All residents who receive psychoactive medications have been reviewed to ensure that target behaviors have been identified, care planned and medications are being monitored for effectiveness. Non-pharmacological interventions before as needed medication administration: In collaboration with her hospice provider, R32's target behaviors have been identified, her medication regimen has been reviewed, and her medications are being monitored for effectiveness. All residents who receive as-needed medications and/or psychoactive medications could be affected. Licensed nursing staff will be educated on the need for exact target behaviors for all psychoactive medications, the need for non-pharmacological interventions prior to as-needed medications, the need for exact indications for all medications, proper clinical justification, and the process to follow for gradual dose reductions, the need for sleep assessments prior to initiating hypnotic medications.. All nursing staff will be educated on the requirement of	

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21540	Continued From page 8 with a terminal illness of progressive supranuclear palsy. R59's care plan, dated 4/8/2011, stated that the resident was at risk for alteration in her behaviors and the potential for altercations with others which were related to yelling out at night, refusing cares, being verbally abusive, becoming anxious when waiting for staff assistance, self-transferring, frequent use of the call light, being rude. The care plan further stated that R59 was at risk for alteration in her mood related to diagnoses of bipolar disorder, Parkinson's syndrome and episodic delirium. With the stated goal of safety in mind, it recommended notifying the doctor if her behaviors interfered with her functioning or symptoms were not improving to see if a change in medication was warranted. It advised to give medications as ordered. The facility was requested to provide all documentation which related to monitoring R59's behaviors since 8/29/16. R59's behavior monthly flow sheets, reviewed from August 29, 2016 through September 7, 2016 indicated that the facility had been monitoring the resident for the following behaviors: insomnia, anxiety, and striking out/hitting. From the documentation, R59 appeared to not have a single episode of anxiety, striking/hitting or insomnia. The progress notes requested from 8/29/2016 through 9/7/2016 were not provided. R59's pharmacy recommendation with a print date of 7/18/16 included a gradual dose reduction for the use of the Seroquel. The provider responded on 8/5/16, " Decline recommendations- she has failed DRT in the past. " The provider justification did not address the clinical rationale or reason(s) why an	21540	completing assigned documentation including, but not limited to, behaviors. Random audits will be conducted weekly. Results of audits will be reported to QAPI. QAPI will determine if additional action is necessary. DNS or designee will be responsible. Corrective action will be completed by August 24, 2016	

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21540	Continued From page 9 attempted dose reduction would likely impair the resident's function or cause psychiatric instability by exacerbating an underlying medical or psychiatric disorder. On 9/7/16, at 2:05 p.m. registered nurse (RN)-D was asked about the lack of monitoring specific target behaviors for Seroquel. It was pointed out that the facility lacked documentation that they were monitoring for identified target behaviors. RN-D stated there should be specific targeted behaviors identified for the use of antipsychotic medications. It was pointed out that the facility was monitoring R59's "anxiety" but not monitoring specific, individualized symptoms of anxiety that R59 exhibited in order to justify the use of the Depakote Sprinkles. RN-D stated there should be specific identified symptoms to monitor for anxiety. It was pointed out that the facility lacked physician justification to continue the use of Seroquel and Trazodone medications without an annual attempt to reduce or titration the medications. RN-D stated a gradual does reduction (GDR) should be attempted on annual basis and stated if a GDR was not appropriate for a resident specific documentation needed to be completed as to why. RN-D confirmed the plan of correction had not been implemented to address the concerns identified with R59's medications cited in the original survey. On 9/08/2016, at 10:14 a.m. the director of nursing (DON) stated she was not sure how this was missed, stated specific targeted behaviors should be monitored for the use of antipsychotic medications, specific symptoms should be monitored for the use of antianxiety medications and stated annual GDR should be attempted or a clinical justification of why a GDR should not be completed should be documented.	21540		

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21540	Continued From page 10 Review of the facility document titled, Mood/Behavior Management (3/31/2016), it stated that the behavior committee would monitor behaviors to assist in determining symptoms, cause, patterns and the severity of behavior. The social services staff should be trained on how to use the monitoring system and regularly review the system for proper use. It stated that a system to evaluate and document a behavior management plan would be established in order to document specific behavior problems. It stated that the behavior management plan would be evaluated for effectiveness at least monthly. Review of the facility document titled, antipsychotic medication review (3/31/2016), it advised that the physician has reviewed a resident's medication program at least quarterly and has documented the reason for the continuance or change in the medication. R32 diagnosis found on the Admission Record include Anxiety disorder, chronic obstructive pulmonary disease, unspecified open wound of right forearm. R32 has an order for Ativan 0.5 mg every four hours as needed for muscle spasms/anxiety related to anxiety disorder effective 6/28/16; Cyclobenzaprine HCL 10 mg every eight hours as needed for muscle spasms effective 6/17/16; Morphine Sulfate 15 mg every 2 hours as needed for pain until 8/21/16 and 15 mg every four hours as needed for pain or shortness of breath effective 8/21/16; Trazodone 100 mg as needed at bedtime for sleep effective 6/17/16. Medication administration record (MAR) indicates PRN Ativan was administered on 9/4/16 at 8:52 p.m., on 9/5/16, at 3:30 a.m. and 6:07 p.m., 9/6/16 at 4:51 p.m. and on 9/7/16 at 5:09 a.m.	21540		

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21540	Continued From page 11 PRN Cyclobenzaprine was administered on 9/4/16 at 10:23 p.m., 9/5/16 at 5:25 a.m. and 6:06 p.m. and 9/7/16, at 5:09 a.m. PRN Morphine was administered on 9/1/16 at 3:44 a.m. and 10:37 a.m., 9/2/16 at 11:20 p.m., 9/3/16 at 1:22 p.m., 9/4/16, at 4:31 a.m., 2:59 p.m. and 10:20 p.m., on 9/5/16 at 3:31 a.m. and 6:08 p.m., 9/6/16, at 2:05 p.m., and 9/7/17 at 5:10 a.m. Progress note dated 9/4/16, administration of PRN Morphine identifies indication for administration as, "unknown." No non-pharmacological interventions identified as attempted. PRN Ativan indication identified as, "anxiety", no non-pharmacological interventions identified. Progress note dated 9/5/16, administration of PRN Morphine however, does not identify symptom indication for administration or if non-pharmacological interventions had been tried. Progress note dated 9/5/16, at 3:30 a.m. identifies administration of PRN Ativan and Morphine again with no indications for administration and no non-pharmacological interventions. PRN Neurontin administered at 4:30 a.m. for pain, no non pharmacological interventions attempted. 9/5/16 at 5:25 a.m. administration of PRN Cyclobenzaprine with no symptom indicated for administration and no non-pharmacological interventions attempted. Progress note dated 9/6/16, identifies PRN Morphine administered again with no indication or non-pharmacological interventions. PRN Ativan administered for "anxiety and pain." PRN Ativan order indicates diagnosis of muscle spasms/anxiety. No non-pharmacological interventions identified. Progress note dated 9/7/16, at 5:09 a.m. indicates PRN Ativan, PRN Cyclobenzaprine, PRN Morphine and PRN Trazodone were	21540		

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21540	Continued From page 12	21540		

administered at the same time. PRN Ativan and Cyclobenzaprine have the same diagnosis indicator to be given for muscle spasms. PRN Trazodone is to be given at bedtime for sleep. No symptoms indicators for administration of medication identified and no non-pharmacological interventions identified.
Interview on 9/7/16, at 9:27 a.m. with licensed practical nurse (LPN)-A stated non-pharmacological interventions should be attempted prior to medication administration, interventions should be documented in the MAR and in a progress note. LPN-A stated the symptoms for why medications are being administered should also be documented in the MAR and in the progress note.
Interview on 9/7/16, at 9:38 a.m. with registered nurse (RN)-A stated PRN medications should be documented in the MAR, also non-pharmacological interventions should be documented in a progress note along with specific symptoms for why medication was administered.
Interview on 9/7/16, at 2:02 p.m. with director of nursing (DON) stated non pharmacological interventions need to be documented, staff should not be administering more than one PRN medication with the same indicator at the same time and should not be administering PRN Trazodone at 5:00 a.m. in the morning when it is indicated for sleep. DON verified documentation of non-pharmacological interventions and specific symptoms for administration of PRN medications were not present. DON stated, "I have to make sure they are following our processes."
In-service education provided to nursing staff on 8/18/16, identifies, "All psychotropic medications need to have target behaviors, if the nurse/TMA[trained medication aide] thinks a resident may need a PRN psychotropic

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21540	Continued From page 13 medication, the nurse/TMA must attempt a non-pharmacological intervention first, this non-pharmacological intervention must be documented in the progress notes, the behavior the resident is displaying must be included in the progress note, psychotropics are to be given as ordered, we cannot give a PRN psychotropic for a reason other than that which is listed in the order." Facility policy titled Medication Administration-General Guidelines dated August 2014, identifies when PRN medication are administered the following documentation is provided: complaints of symptoms for which the medication was given. Policy does not address non-pharmacological interventions as part of medication management. Also uncorrected order/s will be reviewed for possible penalty assessment/s.	21540		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PU1U

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245184**

2. STATE VENDOR OR MEDICAID NO. (L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER EAST**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

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) **05/12/2006**

6. DATE OF SURVEY **07/20/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **116** (L18)

13.Total Certified Beds **116** (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
	116			
(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 : (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 8/31/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1972
(L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001
(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
August 9, 2016

Mr. Jon Richardson, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, MN 55904

RE: Project Number S5184028, H5184088 and H5184085, H5184090

Dear Mr. Richardson:

On July 20, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the July 20, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5184088. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 20, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5184085, H5184090 that were found to be unsubstantiated.

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

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

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

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

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

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 29, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by October 20, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the

identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 20, 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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	07/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. "A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaints H5184088 were completed during the certification/licensing survey. This complaint were substantiated and deficiencies were cited at F328. An investigation of complaint H5184085 & H5184090 was completed and found not to be substantiated.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and	F 155		8/29/16

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

Electronically Signed | 08/18/2016

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F 155	Continued From page 1 procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure risk and benefits for 3 of 3 residents (R123, R149 and R171) were explained related to care plan interventions not being followed for preventive measures. Findings include: R123's care plan, print date 7/20/16, indicated at risk for falls related to poor vision and chronic vertigo with interventions of gait belt with transfers, contact guard assistance to prevent injuries to staff and resident. Physical functioning deficit related to self-care impairment, mobility impairment with interventions t locomotion supervision of one staff with a forward wheeled walker and gait belt on hand, resident gets agitated and angry when help is offered as he wants to be independent, transfer assistance of one staff, walker and gait belt and walking assistance.	F 155	R123 and responsible party have been educated on the risk and benefits of his desire to be noncompliant with his plan of care. A Risk and Benefits agreement has been signed and placed in the resident□s chart. Care plan has also been updated to reflect the resident□s right to refuse cares. R149 has been educated on the risk and benefits of his desire to be noncompliant with his plan of care. A Risk and Benefits agreement has been signed and placed in the resident□s chart. Care plan has also been updated to reflect the resident□s right to refuse cares. R171 discharged from the facility on August 3, 2016. All resident who refuse cares can be affected if they are not educated on the risk and benefits of their refusal to follow their plan of care. Residents (or responsible party) who has a pattern of refusing cares will be	

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F 155	Continued From page 2 On 7/18/16, at 8:18 a.m., R123 was observed to walk off the elevator independently using his walker. On 7/19/16, at 10:10 a.m., R123 was observed walking in the hallway on the first floor independently using his walker. On 7/20/16, at 1:41 p.m., R123 was observed to be walking in the dining room independently using his walker. On 7/20/16, at 2:47 p.m., registered nurse (RN)-A stated R123's care plan read one assist with mobility. RN-A stated R123's care plan did not include one assist with walking if R123 allowed it, but if he allows should be included with walking assistance on R123's care plan due to times becomes upset with staff assistance. RN-A stated she had talked to R123's family extensively. On 7/20/16, at 4:41 p.m., the director of nursing (DON) stated she would expect risk and benefits to be done if R123 was refusing for staff to provide walking assist. R149's care plan, print date 7/20/16, indicated R149 had a physical functioning deficit related to mobility impairment, extremely tall and unsteady with interventions of assist of one for all transfers and toileting assistance of one. On 7/19/16, at 8:10 a.m., R149 was observed to be sitting on the edge of his bed. R149 placed his walker in front of him, stood and self-transferred into his wheelchair. On 7/20/16, at 8:15 a.m., nursing assistant (NA)-I stated R149 transfers himself and toilets himself.	F 155	educated on the risk of their refusal. This education will be documented. If the pattern of refusal persists, resident will again be educated and asked to sign a Risk and Benefit agreement, acknowledging the resident□s right to refuse treatment. Nursing staff were educated on the process to follow when a resident refuses to follow the care plan during in-services beginning the week of 8/15/16. Audits will be conducted weekly to ensure residents have been educated on risk and benefits of refusing cares. Results of audits will be reported to QAPI. QAPI will determine if additional action is necessary. Director of Nursing Services (DNS) or designee will be responsible for monitoring for compliance. Corrective action will be completed by August 29, 2016.	

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F 155	Continued From page 3 NA-A stated usually R149 does not ask for assist for transfers or toileting, unless he wants his urinal emptied. On 7/20/16, at 11:01 a.m., licensed practical nurse (LPN)-D stated R149 required assist of one for transfers and toileting. LPN-D stated she had not included on R149's care plan that he self-transfers and she had not completed a risk and benefits regarding self-transferring for R149. On 7/20/16, at 4:25 p.m., the DON stated if a resident chooses to be non-complaint staff should be explaining the risk and benefits of self-transferring to the resident. R171's care plan, print date of 7/20/16, indicated R171 had a physical functioning deficit related to mobility impairment and range of motion limitations with interventions of non-weight bear (NWB) through heels, weight bear as tolerated through balls of feet if can remain NWB through heels. Pressure ulcer actual or at risk due to pressure ulcer present on left heel with interventions of float heels. On 7/18/16, at 1:49 p.m., R171 was sitting in his wheelchair with shoes on both feet and R171's feet were flat on the floor. On 7/19/16, at 7:03 a.m., R171 was assisted to bed and had blue boots on both feet. R171's feet laid directly on the mattress. Observation with registered nurse (RN)-D revealed R171's left heel had a closed, dark colored area of skin. On 7/20/16, at 8:11 a.m., R171 was sitting in his wheelchair with shoes on both feet and R171's feet were flat on the floor.	F 155		

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F 155	Continued From page 4 On 7/20/16, at 1:28 p.m., nursing assistant (NA)-H stated R171 was not to be full weight bearing when standing to transfer. NA-H stated R171 had foot rests for his wheelchair in his closet for use, but R171 had not used the footrests for a long time. NA-H stated R171 wanted to be without the footrests, as he wanted to be more mobile. On 7/19/16, at 7:03 a.m., RN-D stated R171 was usually non-compliant with keeping heels floated. RN-D stated R171 was to be non-weight bearing to heels, but R171 used his heels to propel his wheelchair due to poor memory and he does not remember to not bear weight on his heels. RN-D stated the facility had tried using wheelchair leg rests a lot of times, but R171 puts his heels back on the ground even with footrests on the wheelchair. On 7/20/16, at 4:31 p.m., the DON stated risk and benefits should have been done regarding R171 refusing to have heels floated. Policy was requested but none provided.	F 155		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 221	R152□s care plan has been updated to	8/29/16

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F 221	Continued From page 5 review, the facility failed to perform a comprehensive assessment for the least restrictive device for mobility for 1 of 1 resident (R152) reviewed for restraints. Findings included: R152 was observed on 7/17/16, at 5:33 p.m. R152 sat in a Rock and Go wheelchair with the back of the chair in a reclining position. R152 attempted to stand up out of the chair multiple times, however was unable to move self forward due to chair being reclined. R152's efforts at getting out of the chair caused the safety alarm to sound; R152 became increasingly irritated at the failed efforts and threw his blanket on the floor. An unidentified staff member picked up the blanket and put it back on R152 and then instructed him it was time to eat and to put the blanket back on. R152 then threw the blanket back on the floor. During a subsequent observation on 7/20/16, at 1:42 p.m. R152 made repeated attempts to stand up from his Rock and Go wheelchair. He was not able to come to a complete standing position related to the recline degree of the chair, R152 did not appear to be physically capable to get to a standing position from the chair. The breaks on the chair were locked at the time and the safety alarm sounded with every failed attempt R152 made. Registered nurse (RN)-D moved R152's chair a few feet and informed him they were going to walk him soon. R152 admitted to the facility on 3/25/16 according to the facility face sheet. The face sheet included diagnoses of dementia with behavioral disturbance, anxiety disorders, restlessness and agitation, major depressive disorder, and sleep disorder.	F 221	include the use of the Rock and Go wheelchair as a comfort measure for trunk control. Rock and Go wheelchair was in need of repair as the reclining function was not working properly and would not allow chair to be set in the upright position. Midwest Medical was notified and the chair is now repaired. Staff has been educated on the need allow R152 to direct the positioning of his chair either by verbal instruction or by non verbal cues. Residents with adaptive devices have the potential to have their functioning restricted more than necessary by these devices. All residents in the facility with devices will be evaluated to ensure that no other residents have devices that will restrict their functioning more than necessary. Going forward, any orders for potentially restrictive devices will have an assessment completed to insure the device promotes the highest practical level of independence and will be reviewed by IDT to ensure the order is appropriate. The center will create a plan of care for the device and will evaluate quarterly to ensure the device meets the needs of the resident and determine the potential for reduction or elimination of this restrictive device. Residents will be monitored after the devices have been put into place to ensure resident□s functioning is not limited more than necessary. Any potentially restrictive device orders will be reported to QAPI Committee for review. Nursing staff were educated on restraints and the process to follow during	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING _____ B. WING _____	07/20/2016

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GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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F 221	Continued From page 6 R152's significant change Minimum Data Set (MDS) dated 5/30/16 indicated R152 had moderate cognitive impairment. The MDS identified R152 had verbal behavioral symptoms 1-3 days during the assessment period that that put the resident at risk for physical illness or injury, significantly interfered with resident's cares, significantly interfered with the resident's participation in activities or social interactions, and put others at significant risk for physical injury. The MDS also indicated behaviors of rejecting care and wondering 1-3 days during the assessment period, had balance impairments requiring staff for stabilization for transfers, and required extensive assist from two staff for walking, toileting, and locomotion on and off the unit. The MDS reported R152 used a wheelchair and walker for mobility. The MDS did not reflect the use of physical restraints. R152's current electronic care plan included and informed staff of the following: · Admitted to hospice on 5/16/16. · Resident has diagnosis of dementia with behavioral disturbances. Due to cognitive loss, diminished decision making capabilities and safely and security issues, placement in the secure Alzheimer's care unit with programs designed for this population as evidenced by; Moderate to serve cognitive loss, memory loss, confusion, and disorientation. · At risk for falls related to history of falls and legally blind. A fall intervention dated 4/4/16 directed staff to, "Keep resident 1:1 over next few days as much as possible to acclimate for noises and new environment. When 1:1 not possible keep resident near a staff member." A fall intervention dated 5/16/16, directed staff to,"walk with resident when he is wanting to walk, do not repetivily [sic] tell him to sit down." The care plan	F 221	in-services beginning the week of 8/15/16. Audits will be conducted weekly to ensure residents are provided with the least restrictive devices possible. Results of audits will be reported to QAPI. QAPI will determine if additional action is necessary. The Director of Nursing Services or designee will be responsible for monitoring for compliance. Corrective action will be completed by August 29, 2016.	

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	245184	A. BUILDING _____ B. WING _____	07/20/2016

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F 221	Continued From page 7 also directed staff to ensure the safety alarm was in place. · Potential and history of verbal and physical behaviors. R152's hospice care plan coincided with the facility care plan. Neither care plan identified the use or plan of care for the Rock and Go wheelchair. R152's nursing progress notes reviewed since time of hospice admission, progress notes do not indicate when R152 obtained the chair or for what reason. R152's Mobility Lift Status assessment dated 6/1/16 indicated the need for assistance with moving up in bed and one staff for bed mobility and transfers. The assessment also reflected R152 was frequently incontinent, had shuffling gait, and indicated no side rails or restraints used. During an interview on 7/19/16, occupational therapist (OT)-I explained R152 use to be on a maintenance program but was discharged when he was admitted to hospice. OT-I stated when R152 was using a regular wheelchair at the time of discharge from therapy; OT-I reported a wheelchair fit assessment was not performed by their department for the Rock and Go, and it would be nursing that would assess the resident for appropriateness for a chair. OT-I was asked under what circumstances would a Rock and Go chair be recommended, OT-I explained that type of chair was good for people that required more back support and when residents become dependent on staff for mobility. OT-I explained for a resident who still has mobility that type of chair makes it hard to get out of it without assistance. During an interview on 7/19/16, at 2:34 p.m. RN-E indicated R152 was given the Rock and Go chair three weeks ago because he was on hospice. RN-E stated the chair is much nicer and	F 221		

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makes it easier for staff to take him for walks. RN-E indicated R152 could get himself out of the chair, but we (staff) don't want him to stand up at all independently or attempt to get out of his chair. RN-E reported if R152 attempted to stand up he would fall down instantly. RN-E indicated the chair was not a restraint.

During an interview on 7/19/16, at 3:09 p.m. with the hospice branch director RN explained the hospice RN case managers make the determination on what type of wheelchair is used for their patients. Hospice RN indicated the case manager who ordered the chair for R152 had stopped employment with the company. Hospice RN reported, their records did not reflect a completed assessment or progress note for the use of the Rock and Go wheelchair. Hospice RN explained, "We use it [Rock and Go's] for people that don't have trunk control, it is soothing for patients and basically it's comfort measure because the back sits up so high it's more comfortable when people start to loose body control." Hospice RN stated the chairs are not meant for controlling behaviors or prevent residents from standing up for fall prevention.

During an interview on 7/20/16, at 8:53 a.m. RN-D stated R152 obtained the chair from hospice. RN-D explained R152 attempts self-transfers and attempts to get out of it frequently. RN-D explained, "I don't think the chair prevents him from standing up, I think it's only hard for him to get up when the breaks are not locked, he is not steady on his feet."

During an interview on 7/20/16, nursing assistant (NA)-L was asked, "Why is [R152] in a Rock and Go wheelchair?" NA-L stated, when he was first here he was self-transferring a lot. NA-L reported we tried a recliner but he would just climb out of it. NA-L stated, the chair makes it harder for him

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to stand up and attempt to self-transfer. NA-L indicated she thought R152 was more comfortable in the Rock and Go chair.
During an interview on 7/20/16, at 2:25 p.m. in response to the question, "When would you do an assessment for a physical restraint?" The director of nursing (DON) stated, "We don't use any form of restraints." DON was not aware of a facility assessment for a restraint. DON then explained R152 does really well in the chair.
Facility policy Restraint Evaluation and Utilization Guideline last reviewed 2/4/16 included:
If a restraint is utilized to treat a resident's medical symptoms, to prevent injury and/or promote highest practicable level of independence, care evaluation will precede this decision. A restraint will not be applied for purposes of discipline or convenience or when not required to treat the resident's medical symptoms. The least restrictive device will be used. Physical restraints include "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.
If upon completion of the evaluation the IDT reaches the conclusion a restraint is needed the least restrictive device appropriate for the resident specific situation will be implemented. Documentation present. The medical symptoms and diagnosis that supports the use of the restraint will be documented. The need for the use of the restraint will be discussed with resident and/or family. The risks and benefits explained to the resident and/or family. The center will obtain a signed consent for the use of the restraint. The consent form will then be placed in the medical record. The center will obtain a physician order

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F 221	Continued From page 10 for the least restrictive device. The physician order must include: the medical symptoms for which the device is to be used, type of device to be used, when the restraint is to be used, and how long it should be applied. A plan of care is developed. The restraint is to be checked as frequently as needed in accordance with the residents needs. This intervention is to be documented on the plan of care. Documentation of checks, release and repositioning may appear on any form used in the center. Residents who have physical restraints are to be reevaluated quarterly or more often as directed by the needs of the resident. This evaluation is to focus on the potential for reduction and elimination based upon the resident specific information and findings.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225		8/29/16

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F 225	Continued From page 11 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately notify the designated state agency (Office of Health Facility) upon learning of an unwitnessed large bruise before completing a comprehensive investigation to determine if it met the requirement of being abuse/neglect for 1 of 1 resident (R59) reviewed for unknown bruise. Findings include: R59 was observed on 7/18/16, at 9:24 a.m. to have a large bruise over the entire top of right hand, going onto the top of the right wrist. A separate bruise located on the right forearm approximately the size of a quarter was also noted. 7/18/16, at 2:56 p.m. R59 was resting in bed and making no attempt to move arms or hands. Both arms were bent at the elbows and resting on	F 225	The bruise on R59's right hand/arm has been reported to OHFC. Investigation has been completed and uploaded to OHFC SNF portal. Bruising on R59's has since resolved. All residents in facility have the potential to be effected. All staff will be educated on the requirement that any employee who suspects an alleged violation shall immediately notify the ED. The ED or designee shall also notify the Common Entry Point in accordance with state law. The ED or designee will conduct all investigations which will include interviews of staff, visitors, or residents who may have knowledge of alleged incident. Investigation findings will be submitted to	

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F 225	Continued From page 12 R59's chest. Both hands clenched into fists. Short sleeve shirt on, no arm sleeves present. Large bruise noted to right hand and wrist. 7/18/16, at 3:36 p.m. a hospice nurse working for St. Croix approached a facility nurse to ask about the large bruise on R59. Staff informed hospice nurse that she had notified the hospice service regarding the bruise but offered no additional information. 7/19/16 at 3:05 p.m. RN-E assessed R59's hand. RN-E reported the forearm bruise is older and [R59] had that prior to the hand/wrist bruise. RN-E measured the bruise and reported it was 16 cm (centimeters) X (by) seven cm. RN-E stated as far as she was aware R59 had never worn arm sleeves and was unaware the care plan listed these as an intervention. RN-E attempted to open R59's hands but was unable to. The weekly skin review document dated 7/9/16 identified R59 had no bruises present. R59's diagnosis found on the Admission Record indicate Dementia with Lewy Bodies (onset date of 7/3/12), Unspecified Osteoarthritis (onset date 5/3/11) and Parkinson's Disease (onset date 3/31/11). R59's care plan with an initiated date of 6/28/13 identifies R59 as having a potential for altered skin integrity non pressure related to: she has tendency to bump arms/hands on walls, objects, has frail thin skin. Goal was revised on 7/14/16 which identified the affected area will heal without complications. Weekly skin review dated 7/9/16 identifies R59 had no bruises. Weekly skin review dated 7/16/16 identified R59 has a bruise to the back of the right hand and is light purple.	F 225	OHFC SNF portal. Incident reports will be reviewed daily (during work week) by ED or designee to ensure that any potential occurrences of abuse or neglect have been reported in a time appropriate manner; that the incident has been reported to the appropriate state agency in a timely manner; and the incident has been thoroughly investigated with findings reported to the appropriate state agency. Incidents will be reviewed at QAPI meetings for oversight. QAPI will determine if additional action is necessary. ED or Designee will be responsible for monitoring for compliance. Corrective action will be completed by August 29, 2016.	

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F 225	Continued From page 13 7/16/16, at 6:21 a.m. states, "night CNA [certified nursing assistant] observed a 10 cm [centimeter] long 6 cm wide bruise on top of right hand that is purple/blue in color w [with]/swelling. Pressure bandage applied. It is unknown when or how bruise occurred. DQI (type of incident report) to follow." 7/16/16 at 1:53 p.m. states, "She did have wkly [weekly] bed bath this morning. Noted to have the light purple bruise on top of her R hand. Measured about 10 X 6 cm." "Also notified [executive director and name], at 1pm to determine if bruise was reportable." 7/19/16, at 9:04 a.m. interview with licensed practical nurse (LPN)-B reported she wasn't sure how the bruise happened but thought her hand had somehow been bumped. LPN-B stated once a bruise is found the process is to complete a DQI, SBAR (communication method identifying situation, background, assessment, response), complete a state incident report and write a progress note. Physician and family should be notified and a copy of the SBAR and DQI go to the director of nursing. 7/19/16, at 10:05 a.m. interview with the Executive Director (ED) stated a bruise is reportable based on the location. R59's bruise according to the ED was not in a suspicious part of the body. The ED stated he had not seen the bruise. Interview on 7/19/16, at 1:22 p.m. with RN-E stated the bruise happened on Sunday during the night shift and the night shift trained medication aid (TMA) had reported the bruise to the night nurse. I worked the evening before that shift and it wasn't reported on my shift but it probably	F 225		

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happened on my shift. R59 went on to say R59 doesn't move her arms and I believe she got trapped in the hoyer.
7/19/16, at 1:57 p.m. interview with the ED stated he couldn't find the incident report related to the the large bruise on R59's hand. ED stated the bruise happened during a transfer and that it had been witnessed. ED then stated the bruise had been observed by the aid who was working the night shift but that staff were unaware of the cause. ED stated the bruise had not been reported to the Office of Health Compliance (designated state agency for reporting abuse/neglect etc.)
7/20/16, at 2:00 p.m. interview with RN-B stated all staff are trained on hire and with in-services the policy for reporting unexplained injuries. RN-B stated a binder with the policy and all the reporting information is located on each floor of the facility. RN-B stated all aids are instructed during abuse and neglect training that they should be reporting anything out of the ordinary to the nurse. The nurse would then be expected to utilize the binder to determine reporting protocol. RN-B stated there is a decision tree that is used for injuries of unknown sources and the binder also has information on how to report to outside sources.
Interview on 7/20/16, at 3:05 p.m. DON stated anything that isn't witnessed needs to be reported. An incident report should be filled out and stated the floor staff is expected to report to the state agency (Office of Health Facilities) for unknown injuries. DON also stated if a floor nurse has questions about the process they would call her or the ED for further instruction.
Policy, Reporting Alleged Abuse Violation, 1/15/15 states, "It is the responsibility of all employees to immediately report any alleged violation of abuse,

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F 225	Continued From page 15 neglect, injuries of unknown source and misappropriation of resident property." Policy titled, Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property, dated 7/12/16, identifies, "Any employee who suspects an alleged violation shall immediately notify the ED. The ED shall also notify the appropriate state agency in accordance with state law."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their facility policy and procedure for immediately reporting to the state agency (Office of Health Facility-OHFC) upon learning of an unwitnessed and suspicious bruse for 1 of 1 resident (R59) reviewed for Abuse Prohibition. Findings include: R59 was observed on 7/18/16, at 9:24 a.m. to have a large bruise over the entire top of right hand, going onto the top of the right wrist. A separate bruise located on the right forearm approximately the size of a quarter was also noted. 7/18/16, at 2:56 p.m. R59 was resting in bed and	F 226	The bruise on R59's right hand/arm has been reported to OHFC. Investigation has been completed and uploaded to OHFC SNF portal. Bruising on R59's has since resolved. All residents in facility have the potential to be effected. All staff will be educated on the facilities policy (Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, and Misappropriation of Resident's Property) requirement that any employee who suspects an alleged violation shall	8/29/16

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F 226	Continued From page 16 making no attempt to move arms or hands. Both arms were bent at the elbows and resting on R59's chest. Both hands clenched into fists. Short sleeve shirt on, no arm sleeves present. Large bruise noted to right hand and wrist. 7/18/16, at 3:36 p.m. a hospice nurse working for St. Croix approached a facility nurse to ask about the large bruise on R59. Staff informed hospice nurse that she had notified the hospice service regarding the bruise but offered no additional information. 7/19/16 at 3:05 p.m. RN-E assessed R59's hand. RN-E reported the forearm bruise is older and [R59] had that prior to the hand/wrist bruise. RN-E measured the bruise and reported it was 16 cm (centimeters) X (by) seven cm. RN-E stated as far as she was aware R59 had never worn arm sleeves and was unaware the care plan listed these as an intervention. RN-E attempted to open R59's hands but was unable to. The weekly skin review document dated 7/9/16 identified R59 had no bruises present. R59's diagnosis found on the Admission Record indicate Dementia with Lewy Bodies (onset date of 7/3/12), Unspecified Osteoarthritis (onset date 5/3/11) and Parkinson's Disease (onset date 3/31/11). R59's care plan with an initiated date of 6/28/13 identifies R59 as having a potential for altered skin integrity non pressure related to: she has tendency to bump arms/hands on walls, objects, has frail thin skin. Goal was revised on 7/14/16 which identified the affected area will heal without complications. Weekly skin review dated 7/16/16 identified R59 has a bruise to the back of the right hand and is light purple. 7/16/16, at 6:21 a.m. states, "night CNA [certified	F 226	immediately notify the ED. The ED shall also notify the Common Entry Point in accordance with state law. The ED or designee will conduct all investigations which will include interviews of staff, visitors, or residents who may have knowledge of alleged incident. Investigation findings will be submitted to OHFC SNF portal. Incident reports will be reviewed daily (during work week) by ED or designee to ensure that any potential occurrences of abuse or neglect have been reported in a time appropriate manner; that the incident has been reported to the appropriate state agency in a timely manner; and the incident has been thoroughly investigated with findings reported to the appropriate state agency. Incidents will be reviewed at QAPI meetings for oversight. QAPI will determine if additional action is necessary. ED or Designee will be responsible for monitoring for compliance. Corrective action will be completed by August 29, 2016.	

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nursing assistant] observed a 10 cm [centimeter] long 6 cm wide bruise on top of right hand that is purple/blue in color w [with]/swelling. Pressure bandage applied. It is unknown when or how bruise occurred. DQI (type of incident report) to follow."

7/16/16 at 1:53 p.m. states, "She did have wkly [weekly] bed bath this morning. Noted to have the light purple bruise on top of her R hand. Measured about 10 X 6 cm." "Also notified [executive director and name], at 1pm to determine if bruise was reportable."

7/19/16, at 9:04 a.m. interview with licensed practical nurse (LPN)-B reported she wasn't sure how the bruise happened but thought her hand had somehow been bumped. LPN-B stated once a bruise is found the process is to complete a DQI, SBAR (communication method identifying situation, background, assessment, response), complete a state incident report and write a progress note. Physician and family should be notified and a copy of the SBAR and DQI go to the director of nursing.
7/19/16, at 10:05 a.m. interview with the Executive Director (ED) stated a bruise is reportable based on the location. R59's bruise according to the ED was not in a suspicious part of the body. The ED stated he had not seen the bruise.
Interview on 7/19/16, at 1:22 p.m. with RN-E stated the bruise happened on Sunday during the night shift and the night shift trained medication aid (TMA) had reported the bruise to the night nurse. I worked the evening before that shift and it wasn't reported on my shift but it probably happened on my shift. R59 went on to say R59 doesn't move her arms and I believe she got

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trapped in the hoyer.
7/19/16, at 1:57 p.m. interview with the ED stated he couldn't find the incident report related to the the large bruise on R59's hand. ED stated the bruise happened during a transfer and that it had been witnessed. ED then stated the bruise had been observed by the aid who was working the night shift but that staff were unaware of the cause. ED stated the bruise had not been reported to the Office of Health Compliance (designated state agency for reporting abuse/neglect etc.)
7/20/16, at 2:00 p.m. interview with RN-B stated all staff are trained on hire and with in-services the policy for reporting unexplained injuries. RN-B stated a binder with the policy and all the reporting information is located on each floor of the facility. RN-B stated all aids are instructed during abuse and neglect training that they should be reporting anything out of the ordinary to the nurse. The nurse would then be expected to utilize the binder to determine reporting protocol. RN-B stated there is a decision tree that is used for injuries of unknown sources and the binder also has information on how to report to outside sources.
Interview on 7/20/16, at 3:05 p.m. DON stated anything that isn't witnessed needs to be reported. An incident report should be filled out and stated the floor staff is expected to report to the state agency (Office of Health Facilities) for unknown injuries. DON also stated if a floor nurse has questions about the process they would call her or the ED for further instruction.
Policy, Reporting Alleged Abuse Violation, 1/15/15 states, "it is the responsibility of all employees to immediately report any alleged violation of abuse, neglect, injuries of unknown source and misappropriation of resident property." Policy

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F 226	Continued From page 19 titled, Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property, dated 7/12/16, identifies, "Any employee who suspects an alleged violation shall immediately notify the ED. The ED shall also notify the appropriate state agency in accordance with state law."	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote dignity by knocking or annoucing self before entering resident rooms for 3 of 3 residents (R30, R52, R59) reviewed for dignity. In addition, failed to provide care and services in a dignified manner for 2 of 2 residents (R59 and R52) who were reviewed for dignity. Findings included: R30 admitted to the facility on 5/30/13 according to the facility face sheet. R30's annual Minimum Data Set (MDS) dated 5/6/16 reported no cognitive impairment with a Brief Interview for Mental status score of fifteen. During an interview on 7/18/16, at 9:01 a.m. R30 was conversing with surveyor when nursing assistant (NA)-A entered the room without	F 241	R30, R52, and R59 are being cared for in a manner and in an environment that promotes dignity and respect. NA-A, RN-B, NA-G, NA-D and DON have been education on facility requirement related to promoting dignity, respect and courtesy to residents. All residents have the potential to be affected. All staff will be educated on the facilities requirement to provide care and services for our residents in a manner that promotes dignity and respect. This training will include the need to knock and wait for response before entering a resident's room; addressing residents when in their presence; explaining cares before they are performed; and	8/29/16

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F 241	Continued From page 20 knocking. NA-A then walked to the other side of the room and grabbed R30's roomate's breakfast tray and proceeding to exit the room. During an interview on 7/18/16, at 9:30 a.m. NA-A stated she should have knocked prior to entering and wait for an invite into the room. During an interview on 7/19/16, at 12:35 p.m. registered nurse (RN)-B stated staff are supposed to knock on the door and wait to be invited in, and if there was not an answer, then staff are supposed to briefly pause and crack the door to alert the resident they are entering the room. During an interview on 7/19/16, at 2:03 p.m. director of nursing (DON) indicated the facilities expectation is for all staff members to knock on the resident's doors and wait to be invited in prior to entering a room. R52 was observed on 7/17/16, at 2:39 p.m. R52 observed to be in bed when staff entered the room without knocking to remove the hoyer lift (a mechanical lift for use with dependent residents during transfers), from R52's room. On 7/18/16, at 3:37 p.m. staff assisted R52 to her bed. Staff were stepping on the floor mat next to R52's bed which caused the alarm to be constantly sounding. After assisting R52 into bed, staff left the room and did not turn off the light. On 7/19/16, at 7:07 a.m. licensed practical nurse (LPN)-B was assisting R52 with blood sugar checks. During this time registered nurse (RN)-B entered the room to speak with LPN-B and did not knock before entering and did not address R52.	F 241	maintaining environment to promote resident comfort. Dignity audits will be performed weekly, to ensure residents are being treated with dignity and respect. Findings will be reviewed at QAPI. ED/DNS or designee will be responsible to monitor for compliance. Corrective action will be completed by August 29, 2016.	

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On 7/19/16, at 7:23 a.m. RN-B entered R52's room without knocking to speak with LPN-B and did not address R52 during this time.

R59 was observed on 7/19/16, at 7:55 a.m. NA-G was assisting R59 with her morning cares. R59 was lying on her back in the bed with her eyes closed. NA-G was waiting for a clean brief to be brought into the room during which R59's pants were pulled down and R59 was lying exposed on the bed. Once the pad was brought in NA-G continued with cares which included rolling R59 from side to side to get clothing properly placed. During this time NA-G did not address R59 or explain to R59 what they were doing for R59.

On 7/19/16, at 8:00 a.m. NA-G placed R59 in the hoyer sling and attached the sling to the hoyer lift without explaining the process or addressing R59. R59 was then transferred to her wheelchair without explanation.

During observation on 7/19/16, at 1:09 p.m. nursing assistant (NA)-D placed the hoyer lift into R52 and R59's shared bedroom for storage. NA-D stated that R59 would be layed down soon so the lift was kept in the bedroom. Upon entering the shared room NA-D did not knock or address R52 who was lying in bed.

On 7/19/16, at 1:12 p.m. the door to R52 and R59's room was shut. A family member (FM)-A of R59's was bringing her back to her bedroom and stopped at the shut door. NA-D told FM-A, "Go ahead in there it's just [R52]." R52 was not informed of FM-A entering room.

On 7/20/16, at 11:59 a.m. director of nursing

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(DON) entered the shared bedroom without knocking to assess the cord on the fall mat next to R52's bed. R59 was in the room with FM-A. Fall mat alarm began sounding loudly which at that time the DON apologized to R59's family for the disruption.

During an interview on 7/20/16, at 1:35 p.m. NA-F stated she received dignity training which included knocking on doors prior to entering the room, introducing yourself and shutting the curtains when providing care.

Interview with NA-E on 7/20/16, at 1:36 p.m. stated staff should knock before entering the resident rooms, asking permission before assisting with cares, letting the residents know what cares are being provided and treating the residents like human beings.

On 7/20/16, at 1:37 p.m. LPN-A stated staff are provided training on dignity for the residents which included keeping the resident doors closed when providing cares, knock before entering the room, keep the residents covered when providing cares, provide privacy.

Interview with RN-B who is responsible for staff training, on 7/20/16, at 2:00 p.m. stated staff are trained informally on providing dignity to the residents. This training includes, knocking and asking for permission to enter, pausing and announcing self. RN-B stated staff should not walk straight into the rooms and stated these are the resident's homes.

Interview with DON on 7/20/16, at 3:05 p.m. stated her expectation of staff is to knock and announce entry, asking for permission in a

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F 241	Continued From page 23 respectful manner, introducing self. I don't expect them to just barge into rooms." Policy titled, Preservation of Residents' Rights which was undated, identified "The social services staff will take an active role in training employees and monitoring practice on issues regarding residents' personal privacy including: privacy during medical treatments and personal care and knocking on doors and requesting permission to enter resident rooms" Facility policy Dignity last reviewed 3/31/16, stated "All resident will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality." The policy also indicated staff would respect resident's private space and property.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R30) was given a choice on medication administration times in order to participate in activities of preference reviewed for choices.	F 242	R30's medication administration times have been changed to allow him to participate in activities of his choice. All of our residents have the potential to be affected.	8/29/16

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F 242	Continued From page 24 Findings include R30 was interviewed on 7/17/16, at 6:41 p.m. R30 stated he was not able to participate in the activities that he would like to because of daily nebulizer treatments that are scheduled during the same time as the activities. R30 stated on the days they have BINGO they always have 500 or another dice game. R30 further explained he was not aware if the treatments could be moved to a different time so he could attend the activity. R30 admitted to the facility on 5/30/13 according to the facility face sheet. Facility face sheet included diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation. R30's annual Minimum Data Set (MDS) dated 5/6/16 revealed no cognitive impairment with a Brief Interview for Mental Status score of fifteen. The MDS indicated R30 reported it was very important to be around animals such as pets, was very important to listen to music he liked, was very important to do things with people, was very important to keep up with the news, and was very important to do favorite activities. R30's care plan included, "My favorite activities include bingo, poker, 500, rummy, sports, game shows, radio, church, country music, socials, animals, outdoors, and/or time with family and/or friends, please provide necessary assistance to ensure I can participate at my highest ability." R30's Physician's orders included Duoneb solution 0.5-2.5 (3) milligrams (Mg)/3 Milliliters (ml); inhale 3 ml orally four times a day for exacerbation related to COPD. R30's June 2016 and July's medication administration records (MAR) reflect R30 was administered the Duoneb at the scheduled times	F 242	Staff will be educated to assure meds and treatments are scheduled, as able, so they do not interfere with leisure activities. Audits will be conducted weekly to ensure cares/treatments are not interfering with resident choice any more than necessary. Results of audits will be reported to QAPI. Resident council minutes will also be monitored to see if complaints of cares affecting activity participation are occurring. QAPI will determine if additional action is necessary. Director of Nursing Services or designee is responsible for monitoring compliance. Corrective action will be completed by August 29, 2016.	

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F 242	Continued From page 25 of 4:00 a.m., 10:00 a.m., 4:00 p.m., and at 10:00 p.m. June 2016 and July's activity calendars reflect bingo scheduled twice per week at 2:00 p.m. followed by dice/500-1 at 3:00 p.m. R30's activity attendance record indicated R30 attended all of the bingo activities; the record did not reflect R30's attendance to any dice/500-1 activities. During an interview on 7/18/16, at 3:20 p.m. licensed practical nurse (LPN)-A reported R30 would come back to his room when the nebulizer treatments are scheduled and the afternoon dose was around 3:00 p.m. During an interview on 7/18/16, at 3:43 p.m. registered nurse (RN)-A reported R30 probably did not have a choice when medications were scheduled and explained the computer system assigned our standard dosing times of medication. RN-A explained R30 has a choice to change those times and could certainly change them so he can do the things he wants to do. During an interview on 7/20/16, at 9:00 a.m. activities assistant (AA)-A indicated R30 routinely attended bingo, but not too many other activities. AA-A indicated R30 would probably like 500 club or dice. AA-A was not aware R30 had a scheduled medication at the same time as dice/500-1. During an interview 7/20/16, at 2:03 p.m. director of nursing (DON) explained she was not aware of how the medications were scheduled around resident preferences. DON stated many of the residents were not alert and orientated so medications are scheduled and the pharmacy recommends the medication times. DON indicated medication times could be worked out to accommodate resident preferences. Facility policy Medication Administration-General Guidelines last reviewed 6/15 did not indicate a	F 242		

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F 242	Continued From page 26 circumstance for resident preference or choice. The policy included, "11) A schedule of routine dose administration times is established by the facility and utilized on the administration record. 12) Medications are administered with 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on meal times. Unless otherwise specified by the prescriber, routine medications are administered according to established medication administration schedule for the facility."	F 242		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a wheelchair which was assessed to promote body alignment and comfort for 1 of 1 resident (R38) reviewed for body positioning. Findings include: R38's admission record, dated 3/10/2015, indicated that the resident had diagnoses of chronic pain, shoulder pain, and age-related osteoporosis.	F 246	R38 has ben measured and provided an appropriate wheelchair. All residents in need of wheelchair could be affected. Nursing staff were educated during in-services beginning the week of 8/15/16 on the need to ensure residents have the correct size wheelchair and the process to follow for obtaining the correct size. Facility will ensure proper fitment by observation and by resident communication. Facility will audit wheelchair fit weekly. Findings will be	8/29/16

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F 246	Continued From page 27 R38's care area assessment (CAA), dated 3/17/2016, stated that the resident needed assistance with activities of daily living (ADL). R38 used a wheelchair and a walker and was at risk for a further decline in ADLs and falls. It stated factors which could potentially contribute to this decline were poor vision, pain and a changing cognitive status. R38's order summary report, dated 5/25/2016, indicated that the resident was prescribed Oxycodone for pain on a scheduled as well as an as-needed basis. R38's medical record, reviewed on 7/20/2016, indicated that R38 received occupational therapy from 3/11/2015 through 4/6/2015. R38's care plan, dated 3/24/2015, indicated that the resident had a deficit in physical functioning related to mobility impairment. It advised that R38 was in need of locomotion assistance of 1 person and used a wheelchair. It advised to monitor and report changes in physical functioning ability. It recommended rehabilitative services as ordered. During an observation and interview on 7/18/2016 at 9:15 a.m., R38 said her wheelchair was too tight fitting. She stated that when her roommate moved about about a month ago she took her roommate's wheelchair because her previous one made her back hurt. She stated that her current one did not hurt her back but that it was too tight fitting and she needed more space in order to sit properly. R38 was observed to be seated in her current wheelchair. The siding on the wheelchair was bulging on the right side. There was a visible crack running on the right side of the wheelchair	F 246	reported to QAPI – appropriate action will be taken if necessary. DNS or designee will be responsible to ensure compliance. Corrective action will be completed by August 29, 2016.	

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F 246	Continued From page 28 where it was bulging out. During an observation on 7/18/2016 at 3:24 p.m., R38 was seated in her wheelchair in the dining area listening to music. The right side of the wheelchair was observed to be bowed out. The resident had no room to maneuver in her wheelchair and all sides of the wheelchair gave no space to the resident. The area that bowed out had a large crack that showed where it bowed. When interviewed on 7/19/2016 at 1:06 p.m., registered nurse (RN)-D stated when a resident first admitted to the facility they were screened for a properly fitting wheelchair that the resident was measured for. She stated if the wheelchair exhibited visible damage, the resident would be reassessed for another chair. She stated that if a resident had an improperly fitting wheelchair she would make a referral to occupational therapy for a properly fitted wheelchair. When interviewed on 7/20/2016 at 11:17 a.m., licensed practical nurse (LPN)-D stated that the facility assessed residents' wheelchair functionality on a quarterly basis. She stated that if a resident had an ill-fitting wheelchair should would refer to occupational therapy. When interviewed on 7/20/2016 at 3:37 p.m. the director of nursing (DON) stated that when a resident discharged from the facility all the belongings are removed from the room. She stated that if a resident had a tight fitting wheelchair then certainly therapy would get involved to measure the resident for a more properly fitting wheelchair. She stated that a resident with a tight fitting wheelchair would be susceptible to skin breakdown.	F 246		

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F 246	Continued From page 29 Review of the facilty policy titled, Use of Wheelchair (2/29/2016), it stated that a wheelchair should be the proper size.	F 246		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for the diagnosis of insomnia and non-pharmalogical interventions for pain for 1 of 5 residents (R52); for 1 of 9 residents (R152); 1 of 2 residents (R59) who was reviewed for range of motion (ROM).	F 279	R52's care plan has been updated to encourage an increase in the frequency of participation in organized facility activities in an effort to reduce anxiety and promote a normal sleep pattern. Music therapy (traditional music) has also been implemented to help with non	8/29/16

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F 279	Continued From page 30 Findings include: LACK OF INTERVENTIONS FOR NONPHARMACOLOGICAL PAIN CONTROL AND FOR SLEEP: R52's physician orders, print date 7/19/16, identified orders for melatonin 3 mg one hour prior to bedtime as needed for insomnia, Morphine Sulfate (narcotic) 0.25 ml (milliliters) every four hours as needed (PRN) for pain or dyspnea and Tylenol 500 mg one tablet three times a day PRN for pain. R52's pain assessment, dated 7/8/16, identified no pain, and strategies/factors that reduce pain rest and distraction. R52's sleep assessment, dated 6/8/16 through 6/10/16, indicated lighting, room temperature and noise level were conducive to sleep. R52's care plan, print date 7/20/16, included the following: needs pain management and monitoring related to general discomfort; limited range of motion to shoulder. Interventions included administer pain medication as ordered, evaluate and establish level of pain on numeric scale/evaluation tool, evaluate need for routinely scheduled medications rather than PRN pain med administration, evaluate need to provide medications prior to treatment or therapy and utilize pain monitoring tool to evaluate effectiveness of interventions. R52's care plan failed to address the diagnosis of insomnia and interventions to implement related to problems with sleeping and failed to address non-pharmalogical interventions to implement for pain before pain medication is used.	F 279	pharmacological pain control as it serves as an effective distraction and helps her sleep at times. R152's care plan has been updated to include ADLs in the areas of bed mobility, toilet use, personal hygiene, dressing, and assistance with eating. R59's care guide (care plan sheet for direct care staff) has been updated to include interventions for ROM for fingers, hands and shoulders. Nursing staff will be educated beginning the week of 8/15/16 on developing, updating, and following care plans and care guides, based on comprehensive assessments, per facility procedure. Audits of care plans and care guides will be conducted weekly . Results of audits will be reported to QAPI. QAPI will determine if additional access is necessary. DNS or designee is responsible for monitoring for compliance. Corrective action will be completed by August 29, 2016.	

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On 7/20/16, at 3:04 p.m., registered nurse (RN)-A confirmed R52's care plan failed to address insomnia and non-pharmalogical interventions for pain.

On 7/20/16, at 4:33 p.m., the director of nursing (DON) stated she would expect insomnia to be addressed on R52's care plan and non-pharmalogical interventions for pain that worked for R52 be included on the care plan.
LACK OF CARE PLAN INTERVENTIONS IN REGARDS TO ASSESSED NEEDS IDENTIFIED IN ACTIVITIES OF DAILY LIVING (ADL) ASSESSMENT:
R152's current electronic care plan lacked a comprehensive individualized care plan for ADL's in the area of bed mobility, toilet use, personal hygiene, dressing and assistance with eating. The care plan did directed staff to, "assist with transfers and ambulation as appropriate," and "Assist in ADL's and mobility as needed."
R152 admitted to the facility on 3/25/16 according to the facility face sheet. The facility face sheet included diagnoses of dementia with behavioral disturbance.
R152's significant change Minimum Data Set (MDS) dated 5/30/16 included R152 required extensive assistance from two staff members for bed mobility, transfers, ambulation, toilet use, and personal hygiene. The MDS also identified R152 required extensive assistance from two staff members for dressing and eating.
The Corresponding Care Area Assessment (CAA) for activities of daily living (ADLs) signed on 6/9/16, indicated the need for assistance for ADL's would be developed in the care plan. The CAA included, "CAA triggered due to coding for extensive assistance. Patient has diagnosis of

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being legally blind, dementia, and decreased mobility. Needs staff assist with ADL's transfers. Staff to anticipate needs. Risk for missed messages, falls, isolation. Will care plan to minimize risk, attempt to socialize."
During an interview on 7/20/16, at 12:37 p.m. registered nurse (RN)-F indicated being the MDS coordinator. RN-F indicated there should have been a care plan in place for ADL's. RN-F stated she normally does the care plans. RN-F stated clinical managers were also assisting with the MDS and care plans and she tries to catch anything that may be missing. RN-F stated the care plans are reviewed and updated quarterly and as needed.
LACK OF RANGE OF MOTION (ROM) INTERVENTIONS DEVELOPED FOR FINGERS, HANDS & SHOULDERS:
R59 had been admitted according to the face sheet on 5/3/11, include unspecified osteoarthritis, unspecified site, dementia with Lewy bodies and Parkinson's disease.
Comprehensive quarterly assessment summary dated 7/18/16, identifies R52 to have, "limited ROM in fingers of both hands and shoulders secondary to arthritis."
R59's current care plan with an initiated date of 7/8/11, identifies R59 to have a "physical functioning deficit related to: self care impairment, ROM impairment of fingers/hands and shoulders." The care plan goal which was revised on 7/8/11 and 7/14/16 identified, "I [R59]will maintain my current ROM." Interventions included monitor and report changes in physical functioning ability which was initiated on 7/8/11, monitor and report changes in ROM ability initiated on 7/8/11.
Three East Nursing List (condensed care plan sheet for direct care staff) has no mention of

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F 279	Continued From page 33 interventions for R59's ROM for fingers, hands or shoulders. On 7/19/16, at 9:02 a.m. NA-G reported the washcloths in R59's hands are not done on a daily basis. NA-G stated that usually the hospice service will place the washcloths in both of [R59] hands to keep them from contracting. NA-G stated she hadn't seen the washcloths in place for a long time and stated there isn't anything she is supposed to be doing for R59's contractures. On 7/19/16, at 9:04 a.m. licensed practical nurse (LPN)-B identified R59 had contractures to both hands and stated she should have washcloths in both hands and the nursing assistants should be changing the washcloths every shift. Interview on 7/19/16, at 1:22 p.m. with registered nurse (RN)-E stated R59 is unable to move her arms or hands. RN-E stated she makes sure there is always a washcloth in both hands. RN-E verified that R59 is unable to open her hands independently and requires assistance. RN-E stated that she can get R59's hands to open and attempted to show surveyor but at this time was unable to open either of R59's hands. RN-E went on to state that R59's hands often "smell gross" due to being contracted and verified R59 does not wear a splint and no daily exercises are being completed. Interview on 7/19/16, at 3:18 p.m. with (RN)-A stated the care plans are completed as a team in the morning meetings. Staff are verbally informed of changes and care sheets are updated. Care guides have basic information needed to perform daily cares and they should have the same information as the care plans. RN-A stated the floor staff does not have access to the care plan only the care guide sheets. A facility policy was requested for comprehensive care plan, but was not provided.	F 279		

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F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to revise the care plan with mobility status for 1 of 3 residents (R123) reviewed for accidents; failed to revise the care plan for change in transfer status for 1 of 3 residents (R149); failed to revise the care plan for current wound interventions for 1 of 4 residents (R171) reviewed for pressure ulcers; failed to revise the care plan to include care of chronic dermatitis requiring preventive treatment for 1 of 3 residents (R30) reviewed for non-pressure related skin concerns.	F 280	R123's care plan has been updated to reflect his being independent with walking with a walker, per his risk and benefit agreement – exercising his right to refuse care in this area. R149's care plan has been updated to reflect his being independent with self transfers and toileting, per his risk and benefit agreement – exercising his right to refuse care in these areas. R171 discharged from facility on August 3, 2016. R30's care plans have been updated to	8/29/16

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F 280	Continued From page 35 Findings include: R123's care plan, print date 7/20/16, indicated at risk for falls related to poor vision and chronic vertigo with interventions of gait belt with transfers contact guard assistance to prevent injuries to staff and resident. Physical functioning deficit related to self-care impairment, mobility impairment with interventions of locomotion supervision of one staff with a forward wheeled walker and gait belt on hand, resident gets agitated and angry when help is offered as he wants to be independent, transfer assistance of one staff, walker and gait belt and walking assistance. On 7/18/16, at 8:18 a.m., R123 was observed to walk off the elevator independently using his walker. On 7/19/16, at 10:10 a.m., R123 was observed walking in the hallway on the first floor independently using his walker. On 7/20/16, at 1:41 p.m., R123 was observed to be walking in the dining room independently using his walker. R123's care plan failed to include that R123 was independently walking with a walker. On 7/20/16, at 2:47 p.m., registered nurse (RN)-A stated R123's care plan read one assist with mobility. RN-A stated R123's care plan did not include one assist with walking if R123 allowed it, but if he allows should be included with walking assistance on R123's care plan due to, at times becomes upset with staff assistance.	F 280	include dental recommendations and instructions for facility staff. R30's care plans have also been updated to include a plan of care for diagnosis of atopic dermatitis and ongoing treatment. All residents have the potential to be affected. Nursing staff will be educated beginning the week of 8/15/16 on the requirement to include residents in planning of care and treatments or updating care plans when changes of care or treatments are necessary. Audits of care plans and care guides will be conducted weekly . Results of audits will be reported to QAPI. QAPI will determine if additional access is necessary. DNS or designee is responsible for monitoring for compliance. Corrective action will be completed by August 29, 2016.	

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On 7/20/16, at 4:41 p.m., the director of nursing (DON) stated she would expect R123's care plan to be revised to include if R123 was refusing staff to provide walking assist.

R149's care plan, print date 7/20/16, indicated R149 had a physical functioning deficit related to mobility impairment, extremely tall and unsteady with interventions of assist of one for all transfers and toileting assistance of one.

On 7/19/16, at 8:10 a.m., R149 was observed to be sitting on the edge of his bed. R149 placed his walker in front of him, stood and self-transferred into his wheelchair.

R149's care plan failed to include that R149 was independently transferring and toileting himself. On 7/20/16, at 8:15 a.m., nursing assistant (NA)-I stated R149 transfers himself and toilets himself. NA-A stated usually R149 does not ask for assist for transfers or toileting, unless he wants his urinal emptied.

On 7/20/16, at 11:01 a.m., licensed practical nurse (LPN)-D stated R149 required assist of one for transfers and toileting. LPN-D stated she had not included on R149's care plan that he self-transfers.

On 7/20/16, at 4:25 p.m., the DON stated R149 self-transferring should be included on R149's care plan.

R171's care plan, print date of 7/20/16, indicated R171 had a physical functioning deficit related to mobility impairment and range of motion limitations with interventions of non-weight bear (NWB) through heels, weight bear as tolerated

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through balls of feet if can remain NWB through heels. Pressure ulcer actual or at risk due to pressure ulcer present on left heel with interventions of float heels.

On 7/18/16, at 1:49 p.m., R171 was sitting in his wheelchair with shoes on both feet and R171's feet were flat on the floor.

On 7/19/16, at 7:03 a.m., R171 was laid in bed and had blue boots on both feet. R171's feet laid directly on the mattress. Observation with registered nurse (RN)-D revealed R171's left heel had a closed, dark colored area of skin.

On 7/20/16, at 8:11 a.m., R171 was sitting in his wheelchair with shoes on both feet and R171's feet were flat on the floor.

R171's care plan failed to include R171's refusal to have heels floated.

On 7/20/16, at 1:28 p.m., nursing assistant (NA)-H stated R171 was not to be full weight bearing when standing to transfer. NA-H stated R171 had foot rests for his wheelchair in his closet for use, but R171 had not used the footrests for a long time. NA-H stated R171 wanted to be without the footrests, as he wanted to be more mobile.

On 7/19/16, at 7:03 a.m., RN-D stated R171 was usually non-compliant with keeping heels floated. RN-D stated R171 was to be non-weight bearing to heels, but R171 used his heels to propel his wheelchair due to poor memory and he does not remember to not bear weight on his heels. RN-D stated the facility had tried using wheelchair leg rests a lot of times, but R171 puts his heels back

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F 280	Continued From page 38 on the ground even with footrests on the wheelchair. On 7/20/16, at 4:31 p.m., the DON stated R171 refusing to have heels floated should be included on R171's care plan. A facility policy for revision of care plan was requested, but not provided. LACK OF REVISION FOR DENTAL STATUS: R30 admitted to the facility on 5/13/13 according to the facility face sheet. The facility face sheet included diagnosis of glaucoma, malaise, and diabetes. R30's annual Minimum Data Set (MDS) dated 5/6/16 reported no cognitive impairment with a Brief Interview for Mental status score of fifteen, required one staff physical assist for grooming and hygiene, and indicated no dental concerns. R30's dental provider visit progress note dated 2/24/16 included, "Upper denture suctions but drops due to pressure from lips as bone has resorbed border are a little long. After adjustment to upper borders retention was improve. Upper arch has advanced bone loss with only about 5 mm [millimeters] of height remaining.", and "Heavy plaque and calculus on lower teeth, [R30] is dependent on others for oral cares. Moderate xerostomia [dryness in mouth]." Visit order indicated prophylactic cleaning treatment every three months due to need for assistance with oral cares and xerostomia. The dental visit note included the following recommendations, "[R30's] gums were inflamed today as a result of bacterial plaque buildup he will need some extra assistance with his oral cares. Please brush his teeth twice each day. After breakfast and before bed is most effective. Please focus on the gum line using a soft brush	F 280		

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gently message each tooth/gum junction. Follow up with a vigorous water rinse if he can manage. Otherwise, dip a tooth sponge in water and clear debris from the mouth. Expect bleeding until the gums return to a healthier state. [R30] was very agreeable to help with his oral cares." The note also included instructions for staff for denture care and insertion to maintain suction.
R30's current electronic care plan informed staff R30 required dentures, required one assistance from staff for personal hygiene, and provide dental exams as necessary. The care plan did not reflect the recommendations given by the dentist on 2/24/16.
During an interview on 7/18/16, at 3:18 p.m. registered nurse (RN)-A indicated the recommendations from the dentist should have been added to the dental care plan.
During an interview on 7/20/16, at 2:03 p.m., director of nursing (DON) explained the health unit coordinator (HUC) is responsible for coordinating outside appointments, when the resident returns, the nurse on the floor received the information and was responsible for updating the care plan. DON explained the information may have been missed.
Facility policy as requested and not received.
LACK OF CARE PLANNING INTERVENTIONS TO ADDRESS CHRONIC DERMATITIS:
R30 was observed on 7/17/16, at 6:58 p.m. both of R30's arms showed diffuse red rashy areas with scattered pin point scabs. R30 stated staff sometimes use Vani-cream. During an observation on 7/19/16, at 7:02 a.m. R30's arms continued to show red rashy areas with scattered pin point scabs from wrist to shoulder. R30 reported the areas do not itch.
R30 admitted to the facility on 5/30/13 according to the facility face sheet. The facility face sheet

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F 280	Continued From page 40 included diagnoses of diabetes and atopic dermatitis. R30's current physician orders signed on 6/28/16 included, Chlorhexidine Gluconate 4% apply to skin topically one time a day every seven days; apply for two minutes, dry and repeat to decrease skin infection. R30's Care Area Assessment dated 5/11/16 reported R30, "at risk for skin breakdown with current Braden score of 16. No referrals at this time. Will proceed to plan of care with goal of maintaining skin integrity." R30's current electric care plan lacked a plan of care for diagnosis of atopic demits and ongoing preventative treatment for skin infections. During an observation on 7/20/16, at 8:48 a.m. RN-A verified the presence of the impaired skin integrity on R30's arms. R30 was observed to be scratching at the areas during the evaluation by RN-A. During an interview on 7/20/16, at 2:25 p.m. director of nursing (DON) stated the history and treatment of impaired skin integrity should be in the care plan. DON explained licensed staff members performed the weekly skin evaluation and document their findings and communicate any new issues, skin impairments are then assessed and monitored by the wound nurse. DON indicated NA's are to report any skin concerns to their nurse. A facility policy pertaining to care plan revision was requested and not received.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		8/29/16

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F 282	Continued From page 41 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement interventions according to the comprehensive care plan for 1 of 3 residents (R54) reviewed for range of motion; report/monitor for healing of multiple bruises for 1 of 3 residents (R152); follow falls interventions for 1 of 1 residents (R52) who was observed for accidents related to 11 falls in two months; provide oral care for 1 of 1 resident (R59) who is dependent on staff to meet oral care needs. Findings include: LACK OF CONSISTENT USE OF INTERVENTIONS FOR ROM SERVICES: R54's care plan, print date 7/20/16, indicated pressure ulcer actual or at risk due to impaired mobility and self-care deficit with interventions of rolled washcloth in left hand to protect from skin breakdown. On 7/18/16, at 3:50 p.m., observation revealed R54 was in bed and there was no wash cloth in R54's left hand. On 7/20/16, at 2:15 p.m., registered nurse (RN)-A stated if R54's care plan reads rolled wash cloth in left hand than she would expect it to be done. On 7/20/16, at 4:30 p.m., the director of nursing stated she would expect R54 to have the wash cloth in her hand as per R54 care plan. LACK OF REPORTING AND ONGOING MONITORING BRUISES FOR R152: R152 was observed on 7/17/16, at 7:27 p.m. R152 had bruises on his left upper arm, left wrist,	F 282	R54's care guide has been updated to include need for rolled washcloth to be placed in left hand daily. R152's care guide has been updated to include instruction to direct care staff to report any new bruising. Existing bruises are being monitored and measured during weekly skin checks or as necessary and continue to be monitored until bruises are gone. R52's care guide (care plan sheet for direct care staff) has been updated to reflect current fall interventions. R59's care guide (care plan sheet for direct care staff) has been updated to include the instruction for NAs to preform oral cares. All residents have the potential to be affected. Nursing staff will be educated beginning the week of 8/15/16 on the requirement to include dissemination of care and treatments to direct care staff when care plans are created or updated. Facility will audit care plans and care guides weekly. Any discrepancies will be corrected and noted. Findings will be reported to QAP for review and recommendations. DNS or designee is responsible for monitoring for compliance. Corrective action will be completed by August 29, 2016.	

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right knee, right shin, and 3 bruises on his left knee. During a subsequent observation on 7/20/16, at 8:51 a.m. R152's arms were exposed to show multiple bruises on both arms that were circular in shape. R152's record did not reflect identification or monitoring of the bruises.
R152 admitted to the facility on 3/25/16 according to the facility face sheet. The facility face sheet included diagnoses of dementia with behavioral disturbance, anxiety disorder, and restlessness and agitation.
R152's significant change Minimum Data Set dated 5/20/16 triggered a Care Area Assessment (CAA) for skin that required a plan of care; the CAA was signed on 6/9/16. The CAA informed staff, "CAA triggered due to coding for extensive assist. Patient has a diagnoses of being legally blind, dementia, and decreased mobility. Needs staff assist with ADL's [activities of daily living], transfers. Staff to anticipate needs. Has had fall episodes."
R152's current electronic care plan did not address the bruising and directed staff to, "conduct weekly skin inspections," and "skin assessment to be completed per Living Center Policy," and "monitor patient for changes in condition."
R152's progress notes reviewed from 7/1/16 through 7/18/16 did not reflect identification or monitoring of any bruising on the upper or lower extremities.
R152's progress notes for 7/5/16 reflected a bruised toe and on 7/19/16, after bruises were brought to the attention of facility staff. This assessment indicated the bruises were pre-existing and located on both hands and arms (no description of bruises was included), and the assessment did not reflect the bruising to bilateral lower extremities. In addition, the record did not

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reflect ongoing monitoring of the toe bruise identified on the 7/5/16 assessment.
During an interview on 7/20/16, at 10:12 a.m., nursing assistant (NA)-L explained R152 always has bruises, he tries to get out of bed. NA-L reported NA's keep an eye out for bruises and we communicate to the nurse if we find one or if it is getting worse. NA-L stated the nurse would let us know if the bruises were already reported.
During an interview on 7/20/16, at 10:32 a.m. registered nurse (RN)-D explained the nurse who is made aware of the bruise does an assessment and documents the findings, if the bruise is of unknown origin then we initiate an investigation to rule out abuse. RN-D indicated the wound nurse was then notified. RN-D indicated bruise monitoring should be done until resolution. RN-D could not state what the actual facility protocol was for routine monitoring and assessing bruises after identification.
During an interview on 7/20/16, at 10:41 a.m. RN-A explained the process for bruise identification and routine monitoring and assessment. RN-A indicated the nurse that discovers the bruise fills out a DQI (type of incident report) for both known or unknown origins, the nurse then would make a progress note or do a skin assessment form. RN-A indicated the nurse would evaluate the areas weekly on the Weekly Skin Assessment because nurses do not track bruises.
During an interview on 7/20/16, at 2:25 p.m. director of nursing (DON) stated staff should be following the care plan and the history and treatment of impaired skin integrity should be in the care plan. DON explained licensed staff members performed the weekly skin evaluation and document their findings and communicate any new issues, skin impairments are then

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F 282	Continued From page 44 assessed and monitored by the wound nurse. DON indicated NA's are to report any skin concerns to their nurse. Facility policy Weekly Skin Review last reviewed 3/24/16 included, "A weekly skin review UDA (user defined assessments) will be completed weekly on all residents and patients to check for any new skin issues not previously identified.", "Prior to initiating the Weekly Skin Review UDA, the licensed nurse will review the previous week's UDA for any changes. The licensed nurse will complete a head to toe skin review.", and If an alteration is identified- Dryness, Rash, Redness, Skin Tear, Blisters, or Other- the nurse is to indicate the site(s) in the drop down boxes, utilizing the anatomically numbered indicators on the figures provided, describing the type of alteration and location. If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each area identified. MD/NP are to be notified of any skin alterations, as well as the resident/patient, and his/her responsible party. Care plans are to be updated with new interventions, and CNA care sheets updated as indicated. LACK OF FOLLOWING FALLS INTERVENTIONS: R52's diagnosis found on the admission record included hemiplegia, unspecified affecting right dominant side with onset date of 6/10/16 and Cerebral infarction due to unspecified occlusion or stenosis of left anterior cerebral artery onset date of 11/24/15. Review of R52's care plan dated 10/2/15, identifies R52 to be at risk for falls related to "fell in the past 30 days, history of falls, poor balance." Interventions include but not limited to: activity programming, add anti roll back to wheelchair,	F 282		

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F 282	Continued From page 45 assess for pain, assess that wheelchair is of appropriate size; assess need for foot rests, bed and chair alarms, sensored fall mat beside bed on floor, bed in low position when occupied, call light or personal items available and in easy reach or provide reacher [device], deluxe bed alarm that connects to call light system, dycem to her wheelchair, gait belt with transfers, footwear to prevent slipping, keep wheelchair next to bed. Care guide worksheet titled, (3 East Nursing List) (utilized by direct care staff to provide services to residents they are assigned for their work period) identifies R52 to be a fall risk, bed and wheelchair alarms. One assist with ambulation and transfers with walker. Speaks some English. Observation of R52 on 7/18/16, at 3:37 p.m. staff assisting R52 from wheelchair to bed. Floor mat next to bed, wheelchair not parked next to the bed. Floor mat cords lying on the floor between the mat and the wheelchair. On 7/19/16, at 7:02 a.m. R52 sitting on the edge of her bed with her feet on top of the floor mat. Floor mat alarm is not sounding. R52 was left alone in her room sitting on the side of the bed while staff went to get her something to drink. Licensed practical nurse (LPN)-B entered the room and stated, "I wonder why that's [mat alarm] not working." LPN-B found the cord to be unplugged and made no attempt to plug the floor mat in and then LPN-B left the room. On 7/19/16, at 7:07 a.m. registered nurse (RN)-B entered the room, saw R52 sitting on the edge of the bed and referenced that R52 was wanting to get up. RN-B then exited the room. At 7:10 a.m. on 7/19/16, LPN-B entered the room and plugged the floor mat in which caused the alarm to start sounding. R52 was trying to stand. RN-B entered the room and asked LPN-B for her care guide and stated that she wasn't sure how	F 282		

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F 282	Continued From page 46 R52 transferred but thought she was a one assist. R52 was transferred from bed to wheelchair by LPN-B and RN-B without the use of a gait belt. On 7/19/16, at 8:49 a.m. R52 was taken from the dining room to her bedroom by two nursing assistant students. R52 was attempting to stand from wheelchair. Wheelchair alarm began sounding. Nursing assistant (NA)-G entered the room after alarm started sounding. R52 was trying to lift her feet over the foot pedals on the wheelchair which made her stumble. R52 began walking backwards from her wheelchair to the bed with (NA)-G holding on to her, R52 fell back onto the bed and laid down. No gait belt was attempted or used during the transfer. Interview on 7/19/16, at 8:57 a.m. with LPN-B who stated R52 usually is not on a 1:1 staff assist. LPN-B stated she had not received training on how the floor mat alarm works. Interview on 7/19/16, at 3:08 p.m. with RN-E stated that she believes the location of the mats and cords are a falls risk. RN-E stated the wheelchair is supposed to be right next to the bed and wasn't sure when that had been changed. RN-E unplugged the floor mat alarm and placed the wheelchair by the bed. Interview with director of nursing (DON) on 7/20/16 at 11:20 a.m. stated R52 is impulsive and many interventions have been added to assist R52 which were included on R52's care plan. DON stated R52 should not be left in bed alone when awake and when R52 is in bed that all alarms should be on. DON stated staff had been provided training on the floor mats and the proper way to have them plugged in. DON stated this is a newer intervention to the facility and expected staff to ask if they did not know how to use something. Policy titled Falls Management Guideline dated	F 282		

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F 282	Continued From page 47 10/21/15, identifies, "residents are evaluated for fall risk, communication system to identify the residents at risk for falls and residents at risk for falls are care planned with individualized interventions." Policy did not include how interventions are communicated to direct care staff. LACK OF FOLLOWING ORAL CARE INTERVENTIONS FOR R59: R59 was observed during morning cares on 7/19/16, at 7:55 a.m. Oral care was not provided or offered to R59. R59's care plan dated 7/8/11, identifies R59 as having a "physical functioning deficit related to: self-care impairment, ROM impairment of fingers/hands and shoulders with interventions for staff to perform oral care, resident is not wearing dentures and dental exams as necessary." Review of the 3 East Nursing List care guide (partial list of resident care plan interventions for staff to follow in giving cares) doesn't mention oral/dental care. Interview with nursing assistant (NA)-G on 7/19/16 at 8:06 a.m. NA-G stated R59 needs no assistance with oral care which is why none was provided by her. 7/19/16, at 1:22 p.m. interview with registered nurse (RN)-E stated R59 has her own teeth, does not wear dentures and is a total assist with oral cares. Policy, "Oral Hygiene", dated 1/20/16, identifies procedure purpose to "cleanse the mouth, teeth and dentures, to moisten the mucous membrane". Policy does not identify when or how often oral care should be provided to residents.	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		8/29/16

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F 309	Continued From page 48 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure monitoring of the accurate amount of fluid intake for 1 of 1 residents (R35) reviewed for dialysis; failed to ensure blood sugars were reported to the physician as ordered for 1 of 5 residents (R52) reviewed for unnecessary medications; failed to ensure an proper position for 6 of 6 residents (R50, R24, R55, R69, R74 and R152) observed during mealtime; failed to do neurological assessment following a head injury for at least 72 hours post incident for 1 of 1 resident (R123) who sustained head injury following a fall; failed to identify, monitor and apply medication according to physician's orders to skin impairment for 1 of 3 residents (R30) reviewed for non-pressure related skin issues; and failed to identify and monitor bruising for 1 of 3 residents (R152) reviewed for non-pressure related skin concerns. Findings include: LACK OF MONITORING DAILY FLUID RESTRICTION: R35 was observed on 7/19/16, at 8:30 a.m., R35 was sitting in the dining room and was given by facility staff 120 cc (cubic centimeters) glass of juice, 240 cc glass of milk, 180 cc glass of juice, raisin toast, scrambled eggs and two slices bacon	F 309	Staff working with R35 has been educated on facility procedure for recording fluid intake. R52's physician is now being notified anytime her blood sugar is over a reading of 500. R50, R24, R55, R69, R74, and R152 are now being positioned in a manner to promote independence, chewing, swallowing and prevent chocking or coughing. R24 will be assessed by therapy to ensure proper positioning. R123 has been evaluated to ensure no further neuro checks are indicated following the injury resulting from the fall on 7/10/16. R30's care plan has been updated to include a plan of care for ongoing preventative treatment for skin infections. R152's care guide has been updated to include instruction to direct care staff to report any new bruising. Existing bruises are being monitored and measured during weekly skin checks or as necessary and continue to be monitored until bruises are gone. All residents could be affected.	

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F 309	Continued From page 49 for breakfast. A total fluid intake of 540 cc for breakfast. On 7/19/16, at 9:13 a.m., nursing assistant student (NAS)-N verified she had removed R35's dishes from the table after breakfast and R35 had eaten all of his food, and drank all of his milk and juice. SNA-N was asked it the food and fluid was record and she stated no to recording the intake of meals for the facility. We tell the nursing assistants if they ask, but we are not obligated to tell them the intake. SNA-N stated no facility nursing assistant had asked about the amount of intake R35 had for breakfast. NAS-O stated R35 had drank ¾ cup of his coffee. A total of 135 cc fluids. On 7/20/16, at 8:25 a.m., R35 was sitting in the dining room at a table waiting for breakfast to be served. Facility staff were present in the dining room and were passing fluids and food out to the residents. R35 received 240 cc glass of milk, 120 cc glass of juice, 180 cc cup of coffee, two sausage links, scrambled eggs, one piece of toast and jam. R35 drank all of his liquids and ate all of his food. A total of 540 cc fluid intake at breakfast. R35's dietary card sheet for breakfast indicated 1500 cc (1.5 liters) per 24 hour day fluid restriction, 120 cc (four ounce) drink - milk, 240 cc (eight ounce) drink - cranberry or apple juice or coffee, no cooked onions, regular diet and on dialysis. For a total of 360 cc fluid intake for breakfast vs. the observed breakfast intake on 7/19 of 675 cc and on 7/20 540 cc fluids. R35's medication administration record for 7/16,	F 309	Staff will be educated on developing, updating, and following care plans and care guides, based on comprehensive assessments, per facility procedure. Staff will also be educated on the need for 72 hours of Neuro monitoring after all unwitnessed falls or falls with possible head injury. Audits will be conducted on recording fluid intake, positioning at mealtime, care plans, skin monitoring and neuro checks will be monitored via incident reports.. Results of audits will be reported to QAPI for review and recommendations. DNS or designee will be responsible to ensure compliance. Corrective action will be completed by August 29, 2016.	

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indicated monitor fluid intake every shift and document. Patient is on a 1.5 liter (1500 cc) fluid restriction. Total amount every shift of fluid intake including meals. The total amount recorded for the day shift on 7/19/16 was 240 cc. However, R35 had consumed a total of 675 cc of fluids for breakfast on 7/19/16.

R35's current physician orders identified dialysis diet 1.5 liter fluid restriction and monitor fluid intake every shift and document.

R35's care plan, print date of 7/20/16, indicated alteration in kidney function due to end stage renal disease, evidenced by hemodialysis with interventions of diet and fluid restrictions as ordered by physician.

On 7/19/16, at 8:57 a.m., dietary aide (DA)-A stated R35's diet card shows how much fluid R35 was able to have for breakfast. DA-A showed surveyor the card and the card read 1500 cc fluid restriction, four ounces milk, eight ounce drink of cranberry or apple juice or coffee, no cooked onions, regular diet and on dialysis.

On 7/19/16, at 2:20 p.m., registered nurse (RN)-G stated in regards to fluid restriction, the kitchen is allowed a certain amount of cc's, I think they have the amount they can give on a card. It is in the computer how many cc's nursing is allowed to give. The nursing assistants keep track of fluid intake during their shift and report to so we know how much R35 has had. RN-G stated as far as she knows there is not total done at the end of the day.

On 7/20/16, at 10:43 a.m. nursing assistant (NA)-P confirmed she had recorded on R35's

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medication administration record the amount of 240 cc of fluid intake for 7/19/16, for R35 for the day shift. NA-P stated the amount she recorded was the amount of fluid she had given R35 during the day only. NA-P stated she was told the fluids he gets for meals were already recorded, so I just have to record the ones I give him.

On 7/20/16, at 11:05 a.m., LPN-D said staff were to record how much fluid R35 drinks each shift, which includes what R35 has drank at meal times and on the floor. LPN-D stated the dietician informs nursing how fluid intake for R35 is broken up. LPN-D stated a communication sheet was to be sent every time R35 goes to dialysis and it would be the responsibility of the nurse on duty when R35 returns from dialysis to ensure the communication sheet returned with R35. If R35 did not have the communication sheet I would expect the nurse to call the dialysis unit.

On 7/20/16, at 1:33 p.m., the dietary manager (DM)-K stated R35 was on a 1.5 liter fluid restriction. R35 was to receive for breakfast: four ounce drink and an eight ounce drink, lunch: two four ounce drinks and for supper: two four ounce drinks and nursing can give 220 cc (cubic centimeters) each shift. DM-K stated a coffee cup holds 180 cc, large glass holds 240 cc and a small glass holds 120 cc. DM-K stated she did not have access in the computer system to review meal intakes and she was not responsible for the nutrition assessments, the dietician completed the nutrition assessments.

On 7/20/16, at 4:02 p.m., licensed practical nurse (LPN)-D stated we have some work to do with R35's fluids, what he should get and what he should not get. We are going to talk to R35 about

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F 309	Continued From page 52 it. We realize we have a problem and need to communicate better. On 7/20/16, at 4:43 p.m., the director of nursing stated (regarding fluid restriction) R35 should receive what is ordered, the amount he receives should be documented each shift and I would not expect him to get more than what is ordered. The Don stated in regards to communication with dialysis, we should be getting updated records how R35 did when going to dialysis and when he comes back from dialysis. A policy for fluid restriction was requested, but not provided. LACK OF REPORTING BLOOD SUGARS OVER A READING OF 500: R52's current physician orders indicated orders for blood glucose before meals and at bedtime, Novolog (insulin) FlexPen solution Pen-injector 100 unit/ml (milliliters), inject per sliding scale if 180-219 = 1 unit, 220-259 = 2 units, 260-299 = 3 units, 300-339 =4 units, 340-379 = 5 units, 380-499 = 6 units, 500 plus = 6 units Call NP (nurse practitioner)/MD (medical doctor). R52's care plan, print date 7/20/16 indicated alteration in blood glucose due to insulin dependent diabetes mellitus with intervention of report abnormal results per physician parameters/guideline. R52's MAR dated 6/16 to 7/16 identified the following blood sugar readings: 6/12 - 6 p.m. - 581 6/13 - 7 a.m. - 533 6/16 - 11 a.m. - 579 6/16 - 5 p.m. - 600	F 309		

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F 309	Continued From page 53 6/21 - 5 p.m. - 600 6/21 - 9 p.m. - 600 7/5 - 11 a.m. - 500 7/14 - 11 a.m. - 598 7/14 - 5 p.m. - 600 R52's record lacked documentation the physician had been notified of blood sugar readings 500 plus as above, as per physician orders. On 7/20/16, at 3:04 p.m., registered nurse (RN)-A reviewed R52's record and confirmed the physician was not notified regarding the blood sugars. RN-A stated staff should be notifying the physician as ordered and document when the physician had been notified. On 7/20/16, at 4:33 p.m., the director of nursing stated she would expect the physician to be notified as ordered, I do not know how those were missed. A facility policy for notifying the physician as ordered was requested, but not provided. LACK OF BODY ALIGNMENT TO PROMOTE SELF EATING AND SWALLOWING/CHEWING CONCERNS IN THE THIRD FLOOR CLOSED UNIT: R50 on 7/17/16, at 5:57 p.m. was observed in the dining room for the supper meal to be seated in wheelchair and a tray table in front of R50. The tray table was in a slanted position pushed away from the resident at one end. R50 was not able to reach her food with the tray table in a slanted position. At 6:05 p.m. (eight minutes after having meal set in front of resident) a facility staff person positioned the tray straight across in front of R50 and R50 began eating her food. Facility staff	F 309		

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failed to properly position the tray table when R50's food was served.

R24 on 7/17/16, at 1:02 p.m. was observed in the dining room for the lunch meal to be seated in his wheelchair and a tray table was in front of R24. R24 was leaning to the right over the wheelchairs right side arm rest for the entire meal. On 7/17/16, at 6:06 p.m., R24 was observed in the dining room for the supper meal to be seated in his wheelchair and a tray table was in front of R24. R24 was leaning to the right over the wheelchairs right side arm rest for the entire meal. Facility staff failed to position R24 in an upright position to allow proper body alignment to promote eating comfort.

R55 on 7/17/16, at 5:22 p.m., was observed in the dining room for the supper meal to be seated in her wheelchair and the chair was reclined back. R55 had to extend her full arm to reach the plate of food. Also noted to hold the cup, plate, etc close to chest so she could take sip, bite of food while reclined back without dropping food for the entire meal. Facility staff failed to position R55 in an upright position to accommodate self eating and prevent spills.
R69 on 7/17/16, at 1:12 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at the table. R69's mouth was even with the top side of the table. The table was too high for R69 to comfortably reach the food. The table had fixed legs and was not adjustable to accommodate residents who need a lower table surface to eat comfortably. R69 did not receive staff assist with her lunch meal and R69 did not eat her lunch meal independently. Facility staff failed to ensure adequate table height for R69 during a meal. On 7/17/16, at 5:22 p.m., R69

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F 309	Continued From page 55 was observed in the dining room for the supper meal to be seated in her wheelchair tipped back and a tray table was in front of R69. The tray table height was high and out of reach of R69. A facility staff person was observed to fully assist R69 her entire meal. R69 was attempting to reach items on the tray table, but the items on the tray table were out of her reach. Facility staff failed to position R69 in an upright position and ensure the tray table was at a height where R69 could reach her food and eat independently. R74 on 7/17/2016, at 6:11 p.m., was observed in the dining room for the supper meal to be seated in her wheelchair tipped back away from the table and being assisted with her supper meal by staff person. The facility failed to ensure an upright position for eating during mealtime to accommodate chewing and swallowing of foods. R152 on 7/17/16, at 5:22 p.m., was observed in the dining room for the supper meal to be seated in his wheelchair tipped back away from the table being fed his supper by a staff person. Again the facility failed to ensure an upright position for eating during mealtime to promote independence, chewing and swallowing and prevent chocking/coughing. On 7/20/16, at 2:06 p.m., registered nurse (RN)-A stated she would expect all resident's wheelchairs to be in an upright position and for the residents to be positioned properly at the tables during mealtime. RN-A stated for R24 regarding leaning to the right, R24 should have had a pillow in place to straighten him out. RN-A stated she had not noticed that R24 was leaning to the right in his wheelchair and staff had not informed her that R24 was leaning to the right in his wheelchair.	F 309		

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F 309	Continued From page 56 On 7/20/16, at 4:23 p.m., the DON stated staff should assist to have the tray table's close and ensure residents are in an upright position for eating. The Don stated in regards to R24, if someone is leaning to one side, therapy should do an assessment and work with the resident on positioning. The DON stated that is something we should have identified and corrected, regarding R24 leaning to the right in his wheelchair. The facility Meal Time Standards, undated, was provided but did not address positioning at mealtime. LACK OF MONITORING NEUROLOGICAL SIGNS AND SYMPTOMS TO DETERMINE DECLINE IN NEUROLOGICAL STATUS: R123's Minnesota Incident Report, indicated date and time of incident was 7/10/16, at 1:39 a.m., resident had fall resulting in head injury to forehead. Resident evaluated at emergency room (ER) and developed a 5 X 6 cm (centimeter) contusion on forehead with laceration bleeding. LOC [level of consciousness] at baseline. R123's progress note dated 7/10/16, at 1:39 a.m. indicated situation: fall resulting in injury and assessment: unable to speak, unable to follow command for neuro checks, LOC at baseline, 5 cm X 6 cm bump in the middle of forehead with laceration oozing blood. Response: sent to ER for medical evaluation. Documented on 7/10/16, at 3:29 a.m., resident returned to the facility with diagnosis of a closed head injury, forehead hematoma. R123's record lacked any further neuro checks being completed after R123 returned from the ER. Information regarding to assessment of	F 309		

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cognition, neurological assessment following return from ER was requested and none provided.

On 7/20/16, at 2:47 p.m., registered nurse (RN)-A stated in regards to if neuro checks were completed for R123 after he fell and hit his head on 7/10/1, I do not know if neuro's were done. Usually when a resident is evaluated in the emergency room and they come back they are stable. I do not know if I have ever been told to do neuro's after they have been evaluated. RN-A stated the consult from R123's emergency room visit indicated follow up with primary care as needed and test performed was computed tomography (CT) scan. RN-A stated the results of the CT scan were not in R123's record. RN-A stated she could call the clinic and have the CT scan results faxed over. When queried what the facility protocol for neuro checks were, RN-A replied let me call RN-B. At 3:07 p.m., RN-B arrived and stated she would have to look up what the facility policy was for neuro checks. RN-B proceeded to show RN-A how to look up the policy and read from the policy neuro checks should be performed following an unwitnessed fall or known head injury.

On 7/20/16, at 4:41 p.m., the director of nursing stated neuro checks should be done for 72 hours with a head injury, making sure the resident was orientated.

The facility policy Neurological Checks, dated effective 12/1/15, indicated it is the policy of the facility to conduct neurological checks on residents as clinically appropriate (whenever there is a question of a head injury or a change in neurological status or level of consciousness. A

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change in level of consciousness is the most significant indication of a neurological change. Neurological checks shall be performed following an unwitnessed fall or known head injury.
LAKE OF MONITORING AND TREATMENT FOR CHRONIC DERMATITIS:
R30 was observed on 7/17/16, at 6:58 p.m. both of R30's arms showed diffuse red rash areas with scattered pin point scabs. R30 stated staff sometimes use Vani-cream. During an observation on 7/19/16, at 7:02 a.m. R30's arms continued to show red rash areas with scattered pin point scabs from wrist to shoulder. R30 reported the areas do not itch.
R30 admitted to the facility on 5/30/13 according to the facility face sheet. The facility face sheet included diagnoses of diabetes and atopic dermatitis.
R30's current physician orders signed on 6/28/16 included, Chlorhexidine Gluconate 4% apply to skin topically one time a day every seven days; apply for two minutes, dry and repeat to decrease skin infection.
R30's medication administration record for June 2016 and July indicated the Chlorhexidine skin wash was not performed as scheduled.
Corresponding nursing progress notes dated 6/3, 6/10, 6/17, 7/8, and 7/15 indicated the skin wash was not provided related to "bath not due today" and progress note on 7/1 indicated the skin wash was not performed because the medication was not found.
R30's progress notes reviewed from 7/1/16-7/18/16 did not reflect identification or monitoring of the dermatological lesions or rash or administration of Chlorhexidine skin wash.
R30's Care Area Assessment dated 5/11/16 reported R30, "at risk for skin breakdown with current Braden score of 16. No referrals at this

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time. Will proceed to plan of care with goal of maintaining skin integrity."
R30's current electric care plan directed staff to, "Inspect skin with care. Report reddened areas, rashes, bruises, or open areas to charge nurse.", and "assessment of skin and foot condition weekly by licensed nurse." The care plan advised of the impaired skin integrity on the left toes and was at risk for pressure ulcers. The care plan lacked a plan of care for ongoing preventative treatment for skin infections. The Care Guide used by staff to provide direct cares was last updated 6/17/16 included, "MUST [capitalized] bag and label linens/clothing prior to laundry as he uses special soap."
R30's weekly skin assessments reviewed from 6/9/16 through 7/14/16 did not reflect the presence dermatitis lesions/rashes/scabs.
During an interview on 7/18/16, at 3:20 p.m., licensed practical nurse (LPN)-A stated the Chlorhexidine was scheduled in the computer for the wrong day; it was supposed to be scheduled for Thursday's with his showers. LPN-A explained the skin wash had been applied, however she had not documented the applications and could not verify the treatment had been completed on a weekly basis. LPN-A stated nursing assistance (NA's) apply the skin wash. When asked NA's scope of practice for applying the skin wash, LPN-A did not directly answer the question. LPN-A stated, "I tell them you can put it all over his body except for his face." When LPN-A was asked how long the solution should stay according to physician's orders, LPN-A stated, "I don't know how long it's supposed to sit on the skin." LPN-A was then asked to reference the physician instructions; LPN-A read the physician's orders and indicated she had not instructed the NA's to let the skin wash set for 2 minutes and

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F 309	Continued From page 60 then reapply. During an interview on 7/18/16, at 3:39 p.m. registered nurse (RN)-A explained the skin wash needed to be performed by a licensed staff member and applied as prescribed. RN-A explained NA's are to report skin concerns to the nurse, the nurse is then to document their findings and communicate to the nurse manager, then the wound nurse would be informed. RN-A stated weekly skin inspections are performed by licensed staff, and impaired skin areas are monitored for healing. During an observation on 7/20/16, at 8:48 a.m. RN-A verified the presence of the impaired skin integrity on R30's arms. R30 was observed to be scratching at the areas during the evaluation by RN-A. During an interview on 7/20/16, at 2:25 p.m. director of nursing (DON) stated, nurses should be performing physician ordered treatments and should not be delegated to NAs. DON stated the history and treatment of impaired skin integrity should be in the care plan. DON explained licensed staff members performed the weekly skin evaluation and document their findings and communicate any new issues, skin impairments are then assessed and monitored by the wound nurse. DON indicated NA's are to report any skin concerns to their nurse. Facility policy Weekly Skin Review last reviewed 3/24/16 included, "A weekly skin review UDA (user defined assessments) will be completed weekly on all residents and patients to check for any new skin issues not previously identified.", "Prior to initiating the Weekly Skin Review UDA, the licensed nurse will review the previous week's UDA for any changes. The licensed nurse will complete a head to toe skin review.", and If an alteration is identified- Dryness, Rash, Redness,	F 309		

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F 309	Continued From page 61 Skin Tear, Blisters, or Other- the nurse is to indicate the site(s) in the drop down boxes, utilizing the anatomically numbered indicators on the figures provided, describing the type of alteration and location. If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each area identified. MD/NP are to be notified of any skin alterations, as well as the resident/patient, and his/her responsible party. Care plans are to be updated with new interventions, and CNA care sheets updated as indicated." Facility policy Medication Administration-General Guidelines last reviewed on 6/15 included; "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.", "Medications are prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to prepare and administer medications.", and "Medications are administered in accordance with written orders of the prescriber." LACK OF REPORTING AND ONGOING MONITORING OF MULTIPLE BRUISES: R152 was observed on 7/17/16, at 7:27 p.m. R152 had bruises on his left upper arm, left wrist, right knee, right shin, and 3 bruises on his left knee. During a subsequent observation on 7/20/16, at 8:51 a.m. R152's arms were exposed to show multiple bruises on both arms that were circular in shape. R152's record did not reflect identification or monitoring of the bruises. R152 admitted to the facility on 3/25/16 according to the facility face sheet. The facility face sheet included diagnoses of dementia with behavioral	F 309		

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disturbance, anxiety disorder, and restlessness and agitation.
R152's significant change Minimum Data Set dated 5/20/16 triggered a Care Area Assessment (CAA) for skin that required a plan of care; the CAA was signed on 6/9/16. The CAA informed staff, "CAA triggered due to coding for extensive assist. Patient has a diagnoses of being legally blind, dementia, and decreased mobility. Needs staff assist with ADL's [activities of daily living], transfers. Staff to anticipate needs. Has had fall episodes."
R152's current electronic care plan did not address the bruising and directed staff to, "conduct weekly skin inspections," and "skin assessment to be completed per Living Center Policy," and "monitor patient for changes in condition."
R152's progress notes reviewed from 7/1/16 through 7/18/16 did not reflect identification or monitoring of any bruising on the upper or lower extremities.
R152's record reflected one weekly skin assessment in June dated 6/7/16; the assessment indicated no impaired skin integrity. The next assessment completed on 7/5/16 reflected a bruised toe. The next weekly skin assessment was performed on 7/19/16, after bruises were brought to the attention of facility staff. This assessment indicated the bruises were pre-existing and located on both hands and arms (no description of bruises was included), and the assessment did not reflect the bruising to bilateral lower extremities. In addition, the record did not reflect ongoing monitoring of the toe bruise identified on the 7/5/16 assessment.
During an interview on 7/20/16, at 10:12 a.m., nursing assistant (NA)-L explained R152 always has bruises, he tries to get out of bed. NA-L

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reported NA's keep an eye out for bruises and we communicate to the nurse if we find one or if it is getting worse. NA-L stated the nurse would let us know if the bruises were already reported.
During an interview on 7/20/16, at 10:32 a.m. registered nurse (RN)-D explained the nurse who is made aware of the bruise does an assessment and documents the findings, if the bruise is of unknown origin then we initiate an investigation to rule out abuse. RN-D indicated the wound nurse was then notified. RN-D indicated bruise monitoring should be done until resolution. RN-D could not state what the actual facility protocol was for routine monitoring and assessing bruises after identification.
During an interview on 7/20/16, at 10:41 a.m. RN-A explained the process for bruise identification and routine monitoring and assessment. RN-A indicated the nurse that discovers the bruise fills out a DQI (type of incident report) for both known or unknown origins, the nurse then would make a progress note or do a skin assessment form. RN-A indicated the nurse would evaluate the areas weekly on the Weekly Skin Assessment because nurses do not track bruises.
During an interview on 7/20/16, at 2:25 p.m. director of nursing (DON) stated the history and treatment of impaired skin integrity should be in the care plan. DON explained licensed staff members performed the weekly skin evaluation and document their findings and communicate any new issues, skin impairments are then assessed and monitored by the wound nurse. DON indicated NA's are to report any skin concerns to their nurse.
Facility policy Weekly Skin Review last reviewed 3/24/16 included, "A weekly skin review UDA (user defined assessments) will be completed

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F 309	Continued From page 64 weekly on all residents and patients to check for any new skin issues not previously identified.", "Prior to initiating the Weekly Skin Review UDA, the licensed nurse will review the previous week's UDA for any changes. The licensed nurse will complete a head to toe skin review.", and If an alteration is identified- Dryness, Rash, Redness, Skin Tear, Blisters, or Other- the nurse is to indicate the site(s) in the drop down boxes, utilizing the anatomically numbered indicators on the figures provided, describing the type of alteration and location. If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each area identified. MD/NP [medical doctor/nurse practitioner] are to be notified of any skin alterations, as well as the resident/patient, and his/her responsible party. Care plans are to be updated with new interventions, and CNA [certified nursing assistants] care sheets updated as indicated."	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure all residents assessed to need set up assistance to needed full assistance to eat was provided to 6 of 6 residents (R55, R56, R69, R74, R119 and R128)	F 312	R55, R56, R69, R74, R119, and R128 have been assessed to ensure an appropriate level of assistance is indicated on care plan. They are provided the assistance they need for their ADLs.	8/29/16

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F 312	Continued From page 65 observed during mealtime in the secured unit. Findings include: R55 on 7/17/16, at 12:37 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at a table. R55 was served her food by the facility staff. R55 was observed to not eat any of her food and the facility staff failed to offer assist R55 to eat any of her meal. R55's care plan, print date 7/20/16, indicated physical functioning deficit related to self-care impairment and mobility impairment with intervention of eating assistance of set-up one, monitor and report changes in physical functioning ability. R56 on 7/17/16, at 1:07 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at a table. R56 was served her food by the facility staff. R56 was observed to be licking out of a cup during her meal and drank her milk. Facility staff failed to intervene and offer R56 assist to eat. On 7/17/16, at 6:11 p.m., R56 was observed in the dining room for the supper meal to be seated in her wheelchair at a table. R56 was served her food by the facility staff. R56 was observed to be licking out of an ice cream cup during her entire meal. Facility staff failed to intervene and offer R56 assist to eat the rest of her meal. R56's care plan, print date of 7/20/16, indicated physical functioning deficit related to self-care impairment as evidenced by need for staff assist with activities of daily living with interventions of eating assistance: able to feed herself after staff serve her with reminders and monitor and report changes in physical functioning ability.	F 312	All residents dependent with ADL cares could be affected. All staff were educated on proper dining assistance during is-services beginning week of 8/15/16. Audits will be conducted weekly on resident positioning at mealtime. Results of audits will be reported to QAPI. QAPI will determine if additional access is necessary. DNS or designee will be responsible to ensure compliance. Corrective action will be completed by August 29, 2016.	

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F 312	Continued From page 66 R69 on 7/17/16, at 1:12 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at the table. R69 did not receive any staff assist with her lunch meal and R69 did not eat any of her lunch independently. On 7/17/16, at 5:22 p.m., R69 was observed in the dining room for the supper meal to be seated in her wheelchair tipped back and a tray table was in front of R69. The tray table height was to high and the food was out of reach of R69. A facility staff person was observed to assist R69 her with the meal. R69 was observed to make several attempts to reach items on the tray table, but the items on the tray table were out of her reach. Facility staff failed to reposition/accommodate independence in allowing R69 to independently eat as R69 was assessed to have the ability to independency eat and care planned as such. R69's care plan, print date 7/20/19, indicated physical functioning deficit related to self-care impairment, range of motion limitations (right shoulder limitations) with interventions of eating assistance of independent after set up and monitor and report changes in physical functioning ability. R74 on 7/17/2016, at 6:11 p.m., was observed in the dining room for the supper meal to be seated in her wheelchair tipped back away from the table being assisted to eat her meal by a facility staff person. The meal was out of reach of the resident. The staff did not position R74 to accommodate self eating skills as assessed and care planned. R74's care plan, print date 7/20/16, indicated physical functioning deficit related to self-care impairment with interventions of eating: able to feed self after meal served.	F 312		

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F 312	Continued From page 67 R119 on 7/17/16, at 1:05 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at a table. Staff had served R119 her food. R119 was observed to wheel herself away for the table and had not finished eating her lunch. Facility staff failed to redirect R119 back to the table to eat her lunch. R119 did not eat any of her meal however, when seated by the table R119 played with food. R119's care plan, print date 7/20/16, indicated physical functioning deficit related to self-care impairment, mobility impairment with interventions of eating assistance of set up and supervision, monitor and report changes in physical functioning ability. R128 on 7/17/16, at 6:11 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at a table. R128 was observed to place her fork in a bun and place a paper news bulletin over her food on her plate. R128 did not eat her lunch nor did staff intervene, cue or assist R128 during the lunch mealtime. On 7/17/16, at 6:09 p.m., R128 was observed in the dining room for the supper meal to be seated in her wheelchair at a table. R128 was observed to place a juice glass on her plate in her food, spilled her juice, was eating with her finger and was pulling on the table cloth which pulled other residents plate of foods out of reach for the two residents. A facility staff person had approached R128 at 6:11 p.m. and had pulled R128's juice soaked shirt back up onto R128 shoulder and encouraged her to eat and then staff walked away from R128. No further assistance with eating from the facility staff was offered to R128 during the remainder of the super meal.	F 312		

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F 312	Continued From page 68 R128's care plan, print date 7/20/16, indicated physical functioning deficit related to self-care impairment, mobility impairment with interventions of eating assistance of one staff to cue and remind her to eat monitor and report changes in physical functioning ability. On 7/20/16, at 2:06 p.m., registered nurse (RN)-A stated she would expect staff to assist all the residents with eating during mealtime. On 7/20/16, at 4:23 p.m., the DON stated staff should be assisting all residents to eat. The facility Meal Time Standards, undated, indicated when a resident needs to be fed offer encouragement, all residents receive the necessary physical, verbal, and social assistance required.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess, identify and implement interventions to improve or prevent further decline in contractures for 2 of 3 residents (R54 & R59) who currently	F 318	R54 will be evaluated and treated for contracture in lower extremities. R54 and R59's care plans have been updated to identify contractures and interventions. All residents with limited range of motion	8/29/16

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F 318	Continued From page 69 have contractures. Findings include: R54's quarterly Minimum Data Set (MDS), dated 4/7/16, indicated R54 had severe cognitive impairment, required total assist of two for transfers, walking did not occur, functional limitations in range of motion upper extremity: impairment one side and lower extremity no impairment. On 7/17/16, at 5:06 p.m., R54 was observed seated in her wheelchair watching television. R54 had a contracture of left hand with a splint in place and had a left foot contracture. On 7/18/16, at 2:11 p.m., certified occupational therapy assistant (COTA)-G was in R54's room providing therapy to R54. COTA-G stated she was working with R54 for contractures of left hand, left elbow and left shoulder. COTA-G stated left foot contracture would be responsibility of physical therapy and she did not know if physical therapy was working with R54 currently. On 7/18/16, at 3:50 p.m., R54 laid in bed. R54's had blue cushioned boots on both lower extremities and R54's left foot was observed to be turned inward, in a dropped position with the blue cushioned boot in place. R54's care plan, print date 7/20/16, indicated physical functioning deficit related to self-care impairment with interventions of monitor and report changes in physical functioning ability, rehab therapy services as ordered and turning and positioning program (offload every two hours), transfer assistance of two and Marisa lift (mechanical lift). Pressure ulcer actual or at risk	F 318	could be affected. Nursing staff will be educated on developing, updating, and following care plans and care guides, based on comprehensive assessments, per facility procedure beginning the week of 8/15/16. Audits will be conducted weekly to ensure interventions are in place. Results of audits will be reported to QAPI. QAPI will determine if additional access is necessary. DNS or designee will be responsible to ensure compliance. Corrective action will be completed by August 29, 2016.	

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due to impaired mobility and self-care deficit with intervention of rolled washcloth in left hand to protect from skin breakdown and Prevalon boots [reduces pressure] to heels at all times.

R54's care plan failed to identify R54 had contractures and interventions to implement related to the contractures.

R54's Quarterly interdisciplinary Resident Review, dated 7/18/16, indicated limitations that interfered with daily functions or placed the resident at risk of injury: upper extremity, impairment on one side and lower extremity, no impairment.

On 7/19/16, at 9:54 a.m., nursing assistant (NA)-J stated the only thing nursing assistants were doing for R54 was applying the blue boot to R54's left foot. NA-J stated occupational therapy was currently working with R54's contractures and was responsible for applying the splint to R54's left hand.

On 7/20/16, at 2:15 p.m., registered nurse (RN)-A Stated she had noticed R54 had a "foot drop" and contracture of her left foot. RN-A stated R54 was not receiving physical therapy currently and had not recommended physical therapy to assess the foot drop and contracture of her left foot and see if therapy would be beneficial. RN-A stated R54 was receiving occupational therapy for her left hand contracture. RN-A stated R54 was not on a restorative nursing program for range of motion of any king.

On 7/20/16, at 4:30 p.m., the director of nursing (DON) stated if a resident had a change in condition or the resident's condition was how they were, we should have identified the condition and

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therapy and nursing should work on recommendations and update the residents care plan.
R59's admission record dated 5/3/11, include unspecified osteoarthritis, unspecified site, dementia with Lewy bodies and Parkinson's disease.
On 7/18/16, at 2:56 p.m. R59 was observed in bed with arms bent at the elbows, lying over her chest. R59 was not observed moving her arms or hands. A washcloth was present in her left hand and right hand had a wash cloth rolled and put between between fingers and palm of hand.
On 7/18/16, at 3:36 p.m. R59 was sitting in her wheelchair with a washcloth in her left hand. No observation of R59 moving her arms or hands.
On 7/19/16, at 7:34 a.m. R59 was lying in bed, washcloth in her left hand, elbows bent and arms lying over her chest. Both hands clenched in fists.
During observation of morning cares on 7/19/16, at 7:55 a.m. R59 was not observed to move her arms or hands. Both the right and left hands remained in a clenched fist. Washcloth was in the left hand. Nursing assistant (NA)-G was not observed to offer ROM or change the washcloth.
Observed R59 in the dining room from 8:07 a.m. until 8:49 a.m. on 7/19/16, during this time R59 made no attempt to move her arms or hands.
Observation on 7/20/16 at 8:04 a.m. R59 sitting in her wheelchair with washcloths in both hands. R59 making no attempts to move her arms or hands.
Quarterly Minimum Data Set (MDS) an assessment dated 7/18/16, identifies R52 to have, "limited ROM [range of motion] in fingers of both hands and shoulders secondary to arthritis."
R59's care plan with an initiated date of 7/8/11, identifies R59 to have a "physical functioning deficit related to: self care impairment, ROM

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impairment of fingers/hands and shoulders." The care plan goal which was revised on 7/8/11 and 7/14/16 identified, "I will maintain my current ROM." Interventions included monitor and report changes in physical functioning ability which was initiated on 7/8/11, monitor and report changes in ROM ability initiated on 7/8/11.
R59's Recreation Services Assessment dated 1/5/16, identifies limited fine motor abilities to both the left and right hands, limited gross motor abilities to right and left arm/shoulder.
3 East Nursing List (condensed care plan sheet for nursing staff) has no mention of interventions for R59's contractures located in right and left hands/fingers.
R59's resident screening form dated 6/26/14 identifies no reduction in ROM. A copy of this form was requested but not received.
On 7/19/16, at 9:02 a.m. NA-G reported the washcloths in R59's hands are not changed on a daily basis. NA-G stated that usually the hospice service will place the washcloths in both of R59's hands to keep them from contracting. NA-G stated she hadn't seen the washcloths in place for a long time and stated there isn't anything she is supposed to be doing for R59's contractures.
On 7/19/16, at 9:04 a.m. licensed practical nurse (LPN)-B identified R59 had contractures to both hands and stated she should have washcloths in both hands and the nursing assistants should be changing the washcloths every shift.
Interview on 7/19/16, at 1:22 p.m. with registered nurse (RN)-E stated R59 is unable to move her arms or hands. RN-E stated she makes sure there is always a washcloth in both hands. RN-E verified that R59 is unable to open her hands independently and requires assistance. RN-E stated that she can get R59's hands to open and attempted to show surveyor but at this time was

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F 318	Continued From page 73 unable to open either of R59's hands. RN-E went on to state that R59's hands often "smell gross" due to being contracted and verified R59 does not wear a splint and no daily exercises are being completed. Interview on 7/19/16, at 3:18 p.m. with (RN)-A stated the care plans are completed as a team in the morning meetings. Staff are verbally informed of changes and care sheets are updated. Care guides (used by direct care staff to provide needed cares/services) have basic information needed to perform daily cares and they should have the same information as the care plans. RN-A stated the floor staff does not have access to the care plan only the care guide sheets. RN-A stated R59 does not have contractures that she has arthritis. RN-A stated she believed R59 has had no reduction in ROM since the 6/24/16 resident screening form was completed. RN-A assessed R59's bilateral hands with surveyor and was unable to open either or R59's hands. A facility policy for range of motion was requested, but not provided.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		8/29/16

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F 323	Continued From page 74 Based on observation, interview and record review, the facility failed to promote a safe environment regarding plugged in and ready to use toasters located in dining rooms on the third floor only of the facility. The third floor has various levels of cognitively impaired residents and one of the wings on third floor was secured to prevent elopement. This could affect several residents on the third floor who were ambulatory or in wheel chairs who had free access to the toasters when not supervised by staff between meals. Also failed to ensure nursing assistant students were properly supervised when providing eating assistance for 2 of 2 residents (R107 and R59) who were reviewed for accidents. Findings include: During a tour of the third floor on 07/17/16 at 1:19 p.m. where cognitively impaired residents lived it was noted that there were two toasters one on east wing and one on the west wing which was a secured wing was plugged into the wall and ready be used. On 7/17/16, at 1:19 p.m., the west dementia unit (secured unit) on third floor was observed to have a two slice plugged in toaster sitting on the kitchen counter which was located in the dining room area and was accessible to residents that were ambulatory. Also staff were not always in the area to monitor residents movement. On 7/17/16, at 2:19 p.m., the director of Alzheimer's care (DAC)-H stated the toaster had been on the unit since she started working at the facility a year ago. DAC-H stated there had been no incidents of burns related to the toaster and two residents (R118 and R157) were ambulatory and if wanted were able to access the toaster, but she had never seen the residents go by the toaster. On 7/17/16, at 2:25 p.m., DAC-H was	F 323	Toasters have been placed beyond reach of residents on 3rd floor when not in use. Facility has clarified procedures to ensure that R107 and R59 are not assisted with eating or drinking by NA students when facility staff is not present. All residents with dysphagia or on 3rd floor of facility could be affected. Staff has been educated on resident safety in regards to heat sources on 7/21/16 and 8/17/16. Staff and NA instructors have been educated supervision requirements for NA students. Random audits will be conducted weekly to ensure toasters have been put away after use and licensed staff is present while residents at risk of aspiration are present. Results of audits will be reported to QAPI. QAPI will determine if additional access is necessary. ED or designee will be responsible for monitoring compliance. Corrective action will be completed by August 29, 2016.	

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encouraged to assess the safety of the residents with the interdisciplinary team in regards to access to the toaster. DAC-H removed the toaster at this time and informed administrator. .

On 7/17/16, at 3:10 p.m., the third floor east dining room was observed to have a plugged in toaster sitting on the kitchen counter which was accessible to wandering confused residents in a dining room that is not always monitored by staff.

On 7/17/16, at 3:11 p.m., licensed practical nurse (LPN)-F stated she had worked at the facility since January 2016 and the plugged in toaster had been in the third floor east dining room area since she had started. LPN-F stated there had been no incidents of burns related to the toaster that she was aware of. LPN-F stated R123 was one out six residents on the third floor that had dementia, was ambulatory and would be able to access the toaster. LPN-F stated the other five residents were in wheelchairs and not able to access the toaster. LPN-H was encouraged to notify the administrator to determine what course of action they should take in regards to the plugged in toaster. LPN-H removed the toaster and notified the administrator.

Scientific research tested how hot a toaster needed to be to brown bread. They found that no matter which toaster is used an electric toaster must get to at least 310 degrees Fahrenheit for the toast to turn brown and depending on the kind of heating elements they can reach 1000 degrees Ferenheiht or more to heat the bread quickly.
LACK OF FACILITY STAFF MONITORING NURSING ASSISTANTS IN TRAINING WHILE ASSISTING TWO RESIDENTS ASSESSED TO HAVE CHEWING/SWALLOWING DEFICITS:

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GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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F 323	Continued From page 76 R107's admission record indicates R107 has diagnosis including Alzheimer's disease (onset 6/28/16), Dysphagia, oral phase and unspecified dementia (onset 8/24/15). During an observation on 7/19/16 at 8:40 a.m. nursing assistant student (NAS)-E assisting R107 with breakfast. R107 began coughing after taking a bite of banana. NAS-E did not notify facility nursing staff at that time. NAS-E continued to assist R107 with eating despite his continued coughing. It was also noted that there was no facility staff or nursing assistant trainer in the dining room during the time the resident was being assisted to eat. R107 care plan identifies chewing/swallowing difficulty as related to: dementia, debility and weakness. 12/2/15 no concerns on mechanical soft diet. 3/9/16 continues with no difficulties. 6/1/16 recent choking and pocketing of food downgraded to nectar thick liquids. Speech Therapy (ST) Plan of Care dated 5/6/16 identifies R107 was referred for "difficulty with swallowing, specifically pocketing and difficulty in initiating swallow. Doctor orders a swallowing evaluation at this time secondary to family and doctor concerns of difficulty, choking, coughing, and possibly aspiration. Patient is at risk for choking, aspiration, malnutrition, among other things". Nutrition Assessment dated 7/4/16 identifies R107 has swallowing difficulty related to dementia as evidenced by recent swallowing difficulty and pocketing of food. 7/19/16, at 9:10 a.m. NAS-D and NAS-E and their instructor. The instructor stated the students had been signed off on 58 core competencies (this included assisting resident/s to eat) and can do anything they have been trained in and signed off on with staff in the room. Instructor after finding	F 323		

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out students were by themselves in the dining room stated, they absolutely do not need to have a staff with them.
Interview on 7/19/16, at 9:41 a.m. NAS-D, NAS-E and instructor were present. NAS-D and NAS-E stated they have had classroom training related to diet consistency as well as lecture and competencies. NAS-D and NAS-E stated they had received training on aspiration, dysphagia and swallowing difficulties. NAS-D and NAS-E verified they had not told nursing staff when R107 and R59 were coughing.
Interview with registered nurse (RN)-E on 7/19/16, at 1:31 p.m. stated she is always in the dining room for meals due to R107 having choking and swallowing difficulties. RN-E stated R107 has required more assistance lately. RN-E was aware of R107's diet but was unaware of precautions/instructions for R107 to assist with coughing and pocketing food. RN-E stated the nursing assistant students are always to be supervised when providing care to the residents. R59's diagnosis found on the Admission record indicate dementia with Lewy bodies (onset date 7/3/12), Parkinson's disease (onset 3/31/11).

During meal observation on 7/19/16, at 8:27 a.m. nursing assistant student (NAS)-D poured thickened milk and water for R59. At 8:35 a.m. R59 sitting in wheelchair in dining room with eyes closed. NAS-D began assisting R59 to eat eggs and oatmeal. R59 took a drink of thickened milk and began coughing. NAS-D offered another bite of food despite coughing. NAS-D made no attempts to notify staff of R59 coughing. It was also noted from 8:35 a.m. to 8:43 a.m. no facility staff in the dining room. At 8:45 a.m. R59 continues to sit in wheelchair with eyes closed and was assisted with a drink of milk by NAS-D

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and again began coughing. NAS-D made no attempts to notify staff of R59 coughing.
During an interview at 7/19/16, at 8:47 a.m. NAS-D stated when R59 is done with eating she will cough more. NAS-D then left the dining room and R59 remained sitting in her wheelchair. NAS-D did not notify facility staff of R59 coughing.
R59's care plan with date initiated of 10/13/15 identifies R59 has chewing/swallowing difficulty as related to: dementia, Abnormal Swallow Study. Goal which was revised on 7/14/16 is for R59 to tolerate food texture and fluid consistency without choking episodes. Interventions updated 10/13/15 include diet as ordered, mechanical soft with nectar thickened.
An Olmsted Medical Center physician (P)-A note written on 5/9/16 stated,"usually does not aspirate. As I was watching her today, I did witness an episode where she coughed and was able to dislodge bits of pancake she was eating that was momentarily stuck in her throat. She then kept on chewing and eating thereafter without any pause or obvious concerns. She drank without incident.
On 7/19/16, at 9:10 a.m. NAS-D and NAS-E along with their nursing assistant training instructor. Instructor stated the students had been signed off on 58 core competencies (included assisting residents to eat) and can do anything they have been trained in and signed off on with staff in the room. Instructor after finding out students were by themselves in the dining room stated, they absolutely do not need to have a staff with them.
Interview on 7/19/16, at 9:41 a.m. NAS-D, NAS-E and instructor were present. NAS-D and NAS-E stated they have had classroom training related to diet consistency as well as lecture and competencies. NAS-D and NAS-E stated they

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F 323	Continued From page 79 had received training on aspiration, dysphagia and swallowing difficulties. NAS-D and NAS-E verified they had not told nursing staff when R107 and R59 were coughing. Interview on 7/19/16, at 1:22 p.m. with RN-E stated R59 is a total assist with eating. RN-E stated R59 was not an aspiration risk and had no special swallowing precautions. RN-E did acknowledge R59 has had swallowing problems in the past. Interview on 7/19/16, at 2:16 p.m. with Nursing Assistant Registry registered nurse (RN)-Z stated it is inappropriate to have students assisting residents who are considered at risk without appropriate supervision. Interview on 7/20/16, at 3:05 p.m. with director of nursing (DON) stated the expectation is the instructor is with the students and guides them based on what is learned in the classroom. DON stated the students are able to assist residents if facility staff are present. DON stated students should not be working independently with our residents. Facility Training Site Agreement between the facility and the nursing assistant training entity dated June 1, 2015 included under Exhibit A, 5. c. each student shall be supervised by a duly licensed and or certified instructor employed by center who shall work with personnel to ensure the success of the program and appropriate supervision of students; center will retain responsibility for and control of supervision of resident care. Accordingly, center will determine which residents are appropriate for assignment to students and reserves the right to change assignments based on its reasonable judgment as to the resident's needs.	F 323		
F 328	483.25(k) TREATMENT/CARE FOR SPECIAL	F 328		8/29/16

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F 328 SS=D	Continued From page 80 NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure continuous oxygen is delivered as ordered by the physician for 2 of 2 residents (R1 & R129) who received continuous oxygen treatment. Findings include: R1's admission record, dated 6/17/2010, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease (COPD) [a disease which makes it harder to breathe]. R1's order summary report, dated 3/27/2015, indicated that the physician had ordered continuous oxygen to be administered via nasal cannula. It was to be set at 2 L (liters) per minute of oxygen. The order summary report also indicated that the physician wanted nursing staff to check R1's oxygen saturation, the placement of the nasal cannula tubing as well as the functioning of the machines. This was to be	F 328	R1 and R129 are now administered oxygen per physician orders and portable tanks are monitored every two hours. All residents with oxygen orders have to potential to be affected. Staff has been educated on proper monitoring and administration of oxygen beginning 7/21/16. Audits of oxygen tanks will be conducted weekly. Results of audits will be reported to QAPI. QAPI will determine if additional access is necessary. DNS or designee will be responsible to ensure compliance. Corrective action will be completed by August 29, 2016.	

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F 328	Continued From page 81 checked every shift. R1's care plan, dated 4/25/2011, indicated that the resident was at risk for an alteration in respiratory status due to COPD. For the desired goal of freedom from an exacerbation of COPD symptoms, the care plan stated that R1 would have adequate gas exchange as evidence by no adventitious breath sounds, absence of respiratory distress and an absence of shortness of breath. Interventions in place to achieve this goal recommended administering oxygen per the physician's order, monitoring R1's oxygen saturations as well as monitoring her oxygen flow rate and response. During an observation at the evening meal time on 7/17/2016 at 5:17 p.m. R1 was seated at the dining table. Her nasal cannula was place to give her flowing oxygen per nose. The oxygen tank was attached to the back of R1's wheelchair. It had a color coded meter that was of red for empty and green for oxygen in tank. There was a white dial marker that was pointed all the way on the left hand side of the meter in the red section. The oxygen setting is set at 2 L. Licensed practical nurse (LPN)-E was asked to check the oxygen level to see if there was any oxygen in the tank. LPN-E picked up the tank and the white dial marker did not move from its location at the extreme left hand side of the meter in the red color coded section. LPN-E stated that the oxygen tank was either malfunctioning or it was out of oxygen. LPN-E consulted with nursing assistant (NA)-K who stated that the tank was out of oxygen. NA-K stated that he would go fill the tank with liquid oxygen. He disconnected R1's tubing from the machine and took the machine with him. At 5:24 p.m., NA-K returned and	F 328		

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attached the oxygen tank to R1's oxygen tubing. It was set at 2 L. From the time it was discovered until the time the oxygen tank had been filled with oxygen, R1's oxygen saturation had not been checked to see if R1's oxygen level was satisfactory.

When interviewed on 7/20/2016 at 2:15 p.m. LPN-D stated that oxygen tanks should not be checked and filled with oxygen so they don't run out. She stated that the lifespan of an oxygen tank was approximately four hours and the staff should be monitoring the tanks at least every four hours.

R129's family (F)-L said during a family council interview on 7/20/16 at 11:40 a.m. that R129 had often been found when visiting the facility to be out of oxygen in the tank. F-L said R129 needed continuous oxygen otherwise became more agitated. F-B had reported this to the staff and for a time it had gotten better but F-L occasionally finds the oxygen tank empty when visiting.

R129 was admitted to the facility on 8/19/15 according to the most current Order Summary Report. Also it has diagnosis of airway disease due to other specific organic dusts and the doctor ordered oxygen at 1 to 2 liters per minute with a start date of 2/23/16 and keep oxygen saturation in blood at 90 percent or more.

On 7/20/16 at 11:40 a.m. R129 was observed to be seated in a wheel chair located in the dining room. On checking the gauge on the oxygen tank it read Zero. On asking nursing assistant (NA)-R to check the tank, NA-R reported that it was empty and would get it filled for R129. The NA-R was not sure how long it had been empty. But

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F 328	Continued From page 83 said the tanks should be checked before moving the resident to the dining room. When interviewed on 7/20/2016 at 3:37 p.m., the director of nursing (DON) stated that the staff should be checking residents' oxygen tanks to ensure they do not run out of oxygen. Review of the facility document titled, oxygen administration (6/20/2016), it stated at regular intervals to check the liter flow contents of the oxygen cylinder.	F 328		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		8/29/16

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F 329	Continued From page 84 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to clearly identify target behaviors and mood behaviors to determine effectiveness of antidepressant, antianxiety and antipsychotic medication for 2 of 5 residents (R83, R152); failed to provide non-pharmacological measures prior to administration of an as-needed antianxiety medication and document the reason for use for 1 of 5 residents (R83); failed to administer an as-needed antianxiety medication as indicated for 1 of 5 residents (R83) reviewed for unnecessary medications; failed to ensure physician justification for use of a prescribed medications for sleep and anxiety and failed to ensure non-pharmalogical interventions were implemented prior to administration of as needed (PRN) medication for 1 of 5 residents (R52) reviewed for unnecessary medications; failed to monitor all identified target behaviors for 1 of 5 residents (R59) who had been prescribed psychotropic medications; failed to identify specific target behaviors for 1 of 5 residents (R59) prescribed a medication for anxiety; and, the facility failed to attempt a gradual dose reduction/titration off of medication or provide physician justification for the continued use of an antipsychotic and an antidepressant medication for 1 of 5 residents (R59). Findings include: LACK OF IDENTIFYING TARGET BEHAVIORS AND MOOD SYMPTOMS TO DETERMINE EFFECTIVENESS OF PSYCHOACTIVE	F 329	R59, R83 and R152's targeted behaviors monitoring has been clarified to identify which medications are being monitored for effectiveness. R83's non pharmacological interventions and/or complaints or symptoms will be documented when administering PRN antianxiety medications. R52's care plan will be updated to address insomnia and interventions including non pharmacological interventions. Facility will obtain physician justification for sleep and anxiety medications administered. Facility will attempt a GDR for R59 or obtain a justification for continued use. All residents could be affected. Licensed nursing staff will be educated on the need for exact target behaviors for all psychoactive medications, the need for non-pharmacological interventions prior to administration as-needed medications, the need for exact indications for all medications, proper clinical justification, and the process to follow for gradual dose reductions, the need for sleep assessments prior to initiating hypnotic medications and on going monitoring, beginning the week of 8/15/16. All nursing staff will be educated on the requirement of completing assigned documentation including, but not limited to, behaviors. Audits of targeted behaviors, non-pharmacological interventions, and	

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F 329	Continued From page 85 MEDICATIONS: R83 admitted to the facility on 2/7/13 with diagnoses that included major depressive disorder and unspecified psychosis according to the facility face sheet. R83's quarterly Minimum Data Set (MDS) dated 4/6/16 included R83 had long and short term memory problems and severely impaired decision making skills for daily living. The MDS identified a mood score of 3 indicating minimal depressive symptoms. The MDS indicated R83 received anti-psychotic, anti-depressant and anti-anxiolytic (antianxiety) medications. R83's physician orders dated 6/2/16 included: Sertaline 25 milligrams (mg) by mouth two times a day for anxiety and agitation. Remeron 15 mg once daily in the evening for major depressive disorder. Lorazepam Intensol Concentrate 0.5 mg by mouth every 4 hours as needed (PRN) for anxiety. Seroquel 25 mg 1 tablet by mouth three times a day related to unspecified psychosis. R83's target behavior monitoring included depressed withdrawn, striking out/hitting, agitated, anxiety, suspiciousness, fighting and mood changes. The target behavior monitoring did not identify which specific medication(s) were being monitored for effectiveness. During an interview on 07/18/2016, at 2:37 p.m. social services (SS)-A stated there were no specific targeted behaviors identified and being monitored for the use of the Seroquel for R83 at this time. SS-A stated this was something we	F 329	sleep monitoring will be conducted weekly. Results of audits will be reported to QAPI. QAPI will determine if additional access is necessary. DNS or designee will be responsible to ensure compliance. Corrective action will be completed by August 29, 2016.	

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have been working on and trying to identify for the residents and this resident must have been missed. SS-A verified based off the behavior monitoring it could not be determined which medication was associated with the target behavior.

R152 admitted to the facility on 3/25/16 according to the facility face sheet. The face sheet included diagnoses of dementia with behavioral disturbance, anxiety disorders, restlessness and agitation, major depressive disorder, and sleep disorder.
R152's significant change Minimum Data Set (MDS) dated 5/30/16 indicated R152 had moderate cognitive impairment. The MDS identified R152 had verbal behavioral symptoms 1-3 days during the assessment period that put the resident at risk for physical illness or injury, significantly interfered with resident's cares, significantly interfered with the resident's participation in activities or social interactions, and put others at significant risk for physical injury. The MDS also indicated behaviors of rejecting care and wondering 1-3 days during the assessment period, and had a staff assessed mood score of nine indicating moderate depression.
R152's current electronic physician's (a printed copy of the orders was requested and not received) included:
Ativan-Give 0.5 milliliters (ml) by mouth three times a day for Anxiety
Zoloft 25 milligrams (mg)-Give 1 tablet by mouth one time a day for Depression
ABHR cream (is a combination of Ativan 0.5 mg, Benadryl 12.5 mg, Haldol 0.5 mg and Reglan 0.5 mg) four times a day for 1 ml of cream to inner wrist related to restlessness and agitation.

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F 329	Continued From page 87 Mirtazapine (remeron an antidepressant)-Give 15 mg by mouth at bedtime related to major depressive recurrent depressive disorder. Seroquel a psychotropic-Give 1 tablet by mouth one time a day for Agitation & aggression AND Give 2 tablet by mouth at bedtime for agitation & aggression R152's target behavior monitoring included agitation, hitting, yelling, grabbing others, rejection of cares and wandering. During an interview on 7/20/16, at 10:25 a.m. registered nurse (RN)-D indicated an unawareness of which medication was prescribed for which behavior. RN-D stated she charted the behaviors and interventions in the electronic medication and treatment administration records. RN-D stated hospice provided an algorithm for the as needed psychotropic medications, if the first one doesn't work then we move to the next one on the list. A policy was requested for identifying and monitoring specific targeted behaviors for the use of an antipsychotic medication was requested and not provided. DID NOT ATTEMPT NONPHARMACOLOGICAL INTERVENTIONS BEFORE GIVING ANTIANXIETY MEDICATION AND GAVE MEDICATION WITHOUT CLEAR AND RESIDENT SPECIFIC INDICATIONS FOR USE: R83 admitted to the facility on 2/7/13 with diagnoses that included major depressive disorder and unspecified psychosis according to the facility face sheet. R83's quarterly Minimum Data Set (MDS) dated 4/6/16 included R83 had long and short term	F 329		

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memory problems and severely impaired decision making skills for daily living. The MDS identified a mood score of 3 indicating minimal depressive symptoms. The MDS indicated R83 received anti-psychotic, anti-depressant and anti-anxiolytic (antianxiety) medications.

R83's physician orders dated 6/2/16 included: Lorazepam Intensol Concentrate 0.5 mg by mouth every 4 hours as needed (PRN) for anxiety.

Review of the May, June and July 2016 medication administration record (MAR) showed the following:

R83 received PRN lorazepam intensol concentrate four times in the month of May and the facility did not document the reason for use or if non-pharmacological interventions were attempted prior to the use one time the medication was administered. Three times it was administered prior to showering which was not identified as an indication for use. R83 received PRN lorazepam intensol concentrate seven times in the month of June and the facility did not document the reason for use or if non-pharmacological interventions were attempted prior to the use for fives time the medication was administered. R83 received lorazepam intensol concentrate two times in July 2016 with no concerns identified with documentation.

During an interview on 7/20/16, at 8:57 a.m. registered nurse (RN)-A stated that the nursing staff should have been providing and documenting non-pharmacological measures taken prior to the administration of an as-needed

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antianxiety medication and should document the reason the medication was being administered.

During an interview on 07/20/2016, at 9:13 a.m. social services (SS)-A stated R83 did not have an order to use PRN lorazepam intensol concentrate in May 2016 when it had been administered prior to showering.

The Medication Administration General Guidelines dated 6/15 included, when a PRN medications were administered, the following documentation is provided: complaints or symptoms for which the medication was given. LACK OF USING NON-PHARMACOLOGICAL INTERVENTIONS PRIOR TO GIVING AS NEEDED MEDICATIONS; LACK OF IDENTIFYING MELATONIN AS A SLEEP AIDE:

R52's quarterly MDS dated 4/8/16, identified R52 had severe cognitive impairment and no behaviors, had trouble falling asleep, staying a sleep or too much sleep, received scheduled pain medication, received non-pharmalogical interventions for pain and had no pain.

R52's care plan was reviewed and failed to address insomnia and interventions to implement related to problems with sleeping.

R52's physician orders, print date 7/19/16, identified orders for melatonin (supplement used for sleep) 3 mg (milligrams) one hour prior to bedtime as needed for insomnia and lorazepam (anti-anxiety) 1 mg three times a day for anxiety/agitation, crying, exit seeking and striking out.

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R52's physician progress note dated 6/10/16, indicated R52 had been hospitalized 6/1/16 through 6/6/16, and had several falls in interim since last fall seen 4/22/16. R52 continued to demonstrate impulsivity and fall risk during hospitalization and Seroquel (antipsychotic) 6.25 mg was started twice daily on as needed basis for agitation and weeping which they thought was helpful. The note also identified R52 was receiving citalopram (antidepressant) and mirtazapine (antidepressant) for depression and given frequent crying and agitation augmenting R52's depressive treatment with Seroquel would be appropriate for potential associated anxiety. The note also identified under the current medication orders the melatonin as above, however, the physician progress note lacked documentation of physician justification for the use of the melatonin.

In addition, a physician progress note, dated 6/23/16, identified listed under current medications was Lorazepam 0.5 mg every eight hours for anxiety. However, the note lacked documentation of physician justification for the use of the Lorazepam.

R52's physician orders, print date 7/19/16, identified orders for melatonin 3 mg one hour prior to bedtime as needed for insomnia, Morphine Sulfate (narcotic) 0.25 ml (milliliters) every four hours PRN for pain or dyspnea, Seroquel (anti-psychotic) 12.5 mg every 12 hours PRN for agitation and Tylenol 500 mg one tablet three times a day PRN for pain.

R52's pain assessment, dated 7/8/16, identified no pain, and strategies/factors that reduce pain rest and distraction. R52's sleep assessment,

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dated 6/8/16 through 6/10/16, indicated lighting, room temperature and noise level were conducive to sleep.

R52's medication administration record and nursing progress notes dated 6/1/16 through 7/20/16, identified R52 had received the as needed medications as follows:
Melatonin four times, Seroquel 23 times, Morphine four times and Tylenol six times. However, R52's record failed to include consistently documented non-pharmalogical interventions being offered prior to the administration of the PRN medications.

On 7/20/16, at 3:04 p.m., registered nurse (RN)-A verified R52's physician progress notes failed to include physician justification for the use of melatonin and Ativan. RN-A stated she would expect staff to offer non-pharmalogical interventions prior to the administration of PRN medications.

On 7/20/16, at 4:33 p.m., the director of nursing (DON) stated (regarding physician justification) if the resident's medication is new or changed the physician should document the reason started, reason changed and reason for use. The DON stated (in regards to non-pharmalogical interventions being offered prior to PRN medications being administered) we should be documenting non-pharmalogical interventions we tried and medication should be the last result.

A facility policy was requested for physician justification for use of psychotropic medication and for offering non-pharmalogical interventions for PRN medications, but was not provided.
LACK OF ATTEMPTING A GRADUAL DOSE

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F 329	Continued From page 92 REDUCTION FOR AN ANTIPSYCHOTIC AND AN ANTIDEPRESSANT USED FOR INSOMNIA YEARLY OR A PHYSICIAN'S JUSTIFICATION AS TO WHY THE GRADUAL DOSE REDUCTION WAS NOT REDUCED AT THIS TIME: R59's admission record, dated 3/31/2011, indicated that the resident had diagnoses of dementia with Lewy bodies, insomnia and Parkinson's disease. R59's order summary report, start date 8/7/2013 for Seroquel a psychotropic medication which is currently in use. R59 was to take 12.5 mg (milligrams) by mouth at bedtime related to bipolar disorder. It identified the following target behaviors: repeat verbalizations, hitting at furniture for attention, calling out, anger toward family/staff. On 5/12/2014, R59 was prescribed Trazodone (an antidepressant) for insomnia. She was to take 50 mg by mouth at bedtime. On 7/23/2015, R59 was prescribed depakote sprinkles for anxiety and currently in use. She was to take 600 mg by mouth in the evening. The order summary report, dated 2/13/2014, indicated that R59 had been admitted to St. Croix hospice with a terminal illness of progressive supranuclear palsy. R59's care plan, dated 4/8/2011, stated that the resident was at risk for alteration in her behaviors and the potential for altercations with others which were related to yelling out at night, refusing cares, being verbally abusive, becoming anxious when waiting for staff assistance, self transferring, frequent use of the call light, being rude. The care plan further stated that R59 was at risk for alteration in her mood related to	F 329		

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diagnoses of bipolar disorder, parkinsons syndrome and episodic delirium. With the stated goal of safety in mind, it recommended notifying the doctor if her behaviors interfered with her functioning or symptoms were not improving to see if a change in medication was warranted. It advised to give medications as ordered.

The facility was requested to provide all documentation which related to monitoring R59's behaviors. Documents titled monthly flow sheet as well as progress notes were provided. R59's behavior monthly flow sheets, reviewed from May 2016 through July 2016 indicated that the facility had been monitoring the resident for the following behaviors: insomnia, anxiety, and striking out/hitting. From the documentation, R59 appeared to not have a single episode of anxiety or striking/hitting. In May 2016, R59 had only one episode of insomnia where she was repositioned and the result was documented that she had the same amount of insomnia. Review of the progress notes from 4/2016 through 7/2016 indicated R59 had no behaviors other that a little sleepiness noted.

R59's pharmacy review notes, reviewed from September 2015 through July 2016 did not indicate whether any gradual dose reductions in psychotropic medications had been initiated. Each note from the pharmacist stated: "Gradual Dose Reduction: **hospice patient -- no GDR per MD for now."

When interviewed on 7/20/2016 at 4:01 p.m., registered nurse (RN)-A was asked about the lack of monitoring specific target behaviors for Seroquel. It was pointed out that the facility lacked documentation that they were monitoring

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for identified target behaviors. RN-A stated that she understood that the facility needed to monitor identified target behaviors for the use of an antipsychotic. It was pointed out that the facility was monitoring R59's "anxiety" but not monitoring specific, individualized symptoms of anxiety that R59 exhibited in order to justify the use of the Depakote Sprinkles. RN-A stated that she understood the need to monitor specific symptoms of anxiety and not a broad statement such as "anxiety." It was pointed out that the facility lacked physician justification to continue the use of Seroquel and Trazodone medications without an annual attempt to reduce or titration the medications. RN-A stated that it was her understanding that the facility should be attempting gradual dose reductions (GDR) in an attempt to decrease the use of psychotropic medications.

When interviewed on 7/20/2016 at 4:11 p.m., RN-B stated that she spoke with the pharmacist the facility contracts with. She stated that R59 received hospice services and, in the case, they never do GDR's when a resident was admitted to hospice services.

Review of the facility document titled, Mood/Behavior Management (3/31/2016), it stated that the behavior committee would monitor behaviors to assist in determining symptoms, cause, patterns and the severity of behavior. The social services staff should be trained on how to use the monitoring system and regularly review the system for proper use. It stated that a system to evaluate and document a behavior management plan would be established in order to document specific behavior problems. It stated that the behavior management plan would be

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F 329	Continued From page 95 evaluated for effectiveness at least monthly. Review of the facility document titled, antipsychotic medication review (3/31/2016), it advised that the physician has reviewed a resident's medication program at least quarterly and has documented the reason for the continuance or change in the medication.	F 329		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental appointments were obtained according to dentist's recommendations for 1 of 3 residents (R30) reviewed for dental care/services should have been seen by dentist in May 2016. Findings included:	F 411	R30's care plan and care guide have been updated to ensure R30 is provided with daily oral cares and is seen per dentist's recommendations. All residents could be affected. Nursing staff will be educated on the need to follow all dental recommendations, and the need to provide dental services during in-services beginning the week of 8/15/16.	8/29/16

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F 411	Continued From page 96 R30 was interview on 7/17/16, at 6:52 p.m. R30 stated, "I can't get my dentures to stay in." R30 indicated it had been several months since his last dental, and reported the dentist had been to the facility since his last dental visit. R30 commented the nursing assistants do not like to brush his teeth and he had reported several times his dentures do not stay in. R30 admitted to the facility on 5/13/13 according to the facility face sheet. The facility face sheet included diagnosis of glaucoma, malaise, and diabetes. R30's annual Minimum Data Set (MDS) dated 5/6/16 reported no cognitive impairment with a Brief Interview for Mental status score of fifteen, required one staff physical assist for grooming and hygiene, and indicated no dental concerns. R30's dental provider visit progress note dated 2/24/16 included, "Upper denture suctions but drops due to pressure from lips as bone has resorbed border are a little long. After adjustment to upper borders retention was improve. Upper arch has advanced bone loss with only about 5 mm [millimeters] of height remaining.", and "Heavy plaque and calculus on lower teeth, [R30] is dependent on others for oral cares. Moderate xerostomia [defined as dry mouth resulting from reduced or absent saliva flow]." Visit order indicated prophylactic cleaning treatment every three months due to need for assistance with oral cares and xerostomia. The dental visit note included the following recommendations, "[R30's] gums were inflamed today as a result of bacterial plaque buildup he will need some extra assistance with his oral cares. Please brush his teeth twice each day.	F 411	Audits of care plans will be preformed monthly to ensure dental recommendations are being followed. Results of audits will be reported to QAPI. DNS or designee will be responsible to ensure compliance. Corrective action will be completed by August 29, 2016.	

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F 411	Continued From page 97 After breakfast and before bed is most effective. Please focus on the gum line using a soft brush gently message each tooth/gum junction. Follow up with a vigorous water rinse if he can manage. Otherwise, dip a tooth sponge in water and clear debris from the mouth. Expect bleeding until the gums return to a healthier state. [R30] was very agreeable to help with his oral cares." The note also included instructions for staff for denture care and insertion to maintain suction. The facility provided the last facility dental schedule visit for 6/1/16. The dental schedule reflected R30 was listed as an "extra" on the schedule; extra indicated if time allowed those residents would be seen. R30's record did not reflect a dental visit since 2/24/16 During an interview on 7/18/16, at 3:18 p.m. registered nurse (RN)-A stated an unawareness R30 had problems with his dentures and R30 had not specifically mentioned anything to her. RN-A indicated the recommendations from the dentist should have been added to the dental care plan. During an interview on 7/20/16, at 2:03 p.m., director of nursing (DON) explained the health unit coordinator (HUC) is responsible for coordinating outside appointments, when the resident returns, the nurse on the floor received the information and is responsible for updating the care plan. DON explained the information may have been missed. Facility policy concerning oral care and dental visits was requested and not provided.	F 411		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		8/29/16

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F 441	Continued From page 98 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 99 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly clean and store nebulizer equipment to prevent infection between use for 4 of 4 residents (R991, R131, R992, R9) observed to have nebulizer treatments. Findings include: During an initial tour of the facility on 7/17/2016 at 11:35 a.m. on the 2nd floor, there were three residents (R991, R131, & R992) that contained nebulizer equipment not in use and stored in a manner to promote infections to develop. R991's admission record, dated 6/17/2016, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease and dyspnea (shortness of breath). R991's order summary report, dated 6/28/2016, indicated that the resident was prescribed a medication that was to be administered by a nebulizer machine to aid with shortness of breath. During the initial tour of the facility on 7/17/2016 at 11:35 a.m. in R991's room, the nebulizer equipment was in her room. Attached to the machine were the tubing along with the mask and reservoir cup (which was used to hold the medication). It was observed to be still attached and sitting on her bed side table. There was a clear liquid still in the reservoir cup. R131's admission record, dated 2/17/2016, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease with acute	F 441	R991, R131, R992, and R9's nebulizers are now cleaned per facility protocol. All residents receiving nebulizer treatments could be affected. Staff has received training on proper nebulizer cleaning on 7/21/16. Northwest Repertory will do additional in services on 8/29/16 to further educate staff. Audits of nebulizer equipment cleaning will be conducted weekly. Results of audits will be reported to QAPI. QAPI will determine if additional access is necessary. DNS or designee will be responsible to ensure compliance. Corrective action will be completed by August 29, 2016.	

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exacerbation.

R131's order summary report, dated 2/17/2016, indicated that the physician had prescribed a medication that required the use of a nebulizer machine to administer the medication.

During the initial tour of the facility on 7/17/2016 at 11:35 a.m. in R131's room, there was observed to be the nebulizer machine with the tubing, mask and medication reservoir attached. There was observed to be fluid in the medication reservoir.

R992's admission record, dated 5/17/2013, indicated that the resident had a diagnosis of heart failure.

R992's order summary report, dated 9/11/2015, indicated that the physician had prescribed a medication that was to be administered via a nebulizer machine.

During an initial tour of the facility on 7/17/2016 at 11:35 a.m., R992's nebulizer machine was located on the bedside table. It was connected to tubing with the mask and medication reservoir attached. There was observed to be a clear liquid in the medication reservoir.

R9's admission record, dated 3/17/2014, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease (COPD).

R9's order summary report, dated 5/3/2016, indicated that the physician had prescribed a medication that was to be administered using a nebulizer machine.

During an observation on 7/17/2016 at 3:00 p.m.

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F 441	Continued From page 101 the nebulizer equipment in R9's room was left sitting out and all tubes connected with observable moisture in the reservoir. When interviewed on 7/17/2016 at 6:47, licensed practical nurse (LPN)-C was shown the nebulizer's for R991, R131, R992. where all the nebulizer equipment appeared as it had been during the initial tour at 11:35 a.m. LPN-C stated that the equipment should have been cleaned and dried immediately after each use. When interviewed on 7/20/2016 at 3:37 p.m., the director of nursing (DON) stated that she would expect the nursing staff to clean the nebulizer equipment after each use and store it properly. She stated that the nebulizer equipment should not contain medication or condensation in the reservoir cup after use. Review of the document titled, Oral Inhalation Administration (6/2015), it stated when the nebulizer treatment was complete, staff were to rinse and disinfect the nebulizer equipment by washing the pieces (except tubing) with warm, soapy water, rinse with hot water and allow to air dry completely on a paper towel. When the equipment was dry, it was to be stored in a plastic bag with the resident's name and the date on it.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated July 19, 2016, Golden Livingcenter - Rochester East was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/18/2016

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Golden Livingcenter - Rochester East, is a 3-story building with a full basement. The facility was built in 1968 and was determined to be of Type II(222) construction.	K 000		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches	K 027	Defective automatic door closing device has been replaced. Maintenance Director will be responsible	8/15/16

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K 027	Continued From page 2 from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 On facility tour between 09:00 AM and 12:00 PM on July 19, 2016, observation and revealed that the 2nd floor smoke compartment door by room 216 did not close when tested.	K 027	to monitor for compliance.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 On facility tour between 09:00 AM and 12:00 PM on July 19, 2016, observation revealed that the 2nd floor bi-hazard room had electric outlet hanging lose by the wires.	K 147	Outlet in 2nd floor utility room has been repaired. Maintenance Director will be responsible to monitor for compliance.	8/4/16

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
August 9, 2016

Mr. Jon Richardson, Administrator
Golden LivingCenter - Rochester East
501 Eighth Avenue Southeast
Rochester, MN 55904

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5184028 and Complaint Numbers H5184088, H5184085, H5184090

Dear Mr. Richardson:

The above facility was surveyed on July 17, 2016 through July 20, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5184088 that was found to be substantiated and H5184085 and H5184090 that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 17, 18, 19 & 20, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. "A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey." An investigation of complaints H5184088 were completed during the licensing survey. This complaint were substantiated at MN Rule §4658.0520 Subp. 1 (0830). An investigation of complaint H5184085 & H5184090 was also completed and found not to be substantiated.	2 000		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by:	2 510		8/29/16

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2 510	Continued From page 2 Based on observation, interview, and document review, the facility failed to perform a comprehensive assessment for the least restrictive device for mobility for 1 of 1 resident (R152) reviewed for restraints. Findings included: R152 was observed on 7/17/16, at 5:33 p.m. R152 sat in a Rock and Go wheelchair with the back of the chair in a reclining position. R152 attempted to stand up out of the chair multiple times, however was unable to move self forward due to chair being reclined. R152's efforts at getting out of the chair caused the safety alarm to sound; R152 became increasingly irritated at the failed efforts and threw his blanket on the floor. An unidentified staff member picked up the blanket and put it back on R152 and then instructed him it was time to eat and to put the blanket back on. R152 then threw the blanket back on the floor. During a subsequent observation on 7/20/16, at 1:42 p.m. R152 made repeated attempts to stand up from his Rock and Go wheelchair. He was not able to come to a complete standing position related to the recline degree of the chair, R152 did not appear to be physically capable to get to a standing position from the chair. The breaks on the chair were locked at the time and the safety alarm sounded with every failed attempt R152 made. Registered nurse (RN)-D moved R152's chair a few feet and informed him they were going to walk him soon. R152 admitted to the facility on 3/25/16 according to the facility face sheet. The face sheet included diagnoses of dementia with behavioral disturbance, anxiety disorders, restlessness and agitation, major depressive disorder, and sleep disorder.	2 510	Corrected	

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2 510	Continued From page 3 R152's significant change Minimum Data Set (MDS) dated 5/30/16 indicated R152 had moderate cognitive impairment. The MDS identified R152 had verbal behavioral symptoms 1-3 days during the assessment period that that put the resident at risk for physical illness or injury, significantly interfered with resident's cares, significantly interfered with the resident's participation in activities or social interactions, and put others at significant risk for physical injury. The MDS also indicated behaviors of rejecting care and wondering 1-3 days during the assessment period, had balance impairments requiring staff for stabilization for transfers, and required extensive assist from two staff for walking, toileting, and locomotion on and off the unit. The MDS reported R152 used a wheelchair and walker for mobility. The MDS did not reflect the use of physical restraints. R152's current electronic care plan included and informed staff of the following: · Admitted to hospice on 5/16/16. · Resident has diagnosis of dementia with behavioral disturbances. Due to cognitive loss, diminished decision making capabilities and safely and security issues, placement in the secure Alzheimer's care unit with programs designed for this population as evidenced by; Moderate to serve cognitive loss, memory loss, confusion, and disorientation. · At risk for falls related to history of falls and legally blind. A fall intervention dated 4/4/16 directed staff to, "Keep resident 1:1 over next few days as much as possible to acclimate for noises and new environment. When 1:1 not possible keep resident near a staff member." A fall intervention dated 5/16/16, directed staff to,"walk with resident when he is wanting to walk, do not repetivily [sic] tell him to sit down." The care plan also directed staff to ensure the safety alarm was	2 510		

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2 510	Continued From page 4 in place. · Potential and history of verbal and physical behaviors. R152's hospice care plan coincided with the facility care plan. Neither care plan identified the use or plan of care for the Rock and Go wheelchair. R152's nursing progress notes reviewed since time of hospice admission, progress notes do not indicate when R152 obtained the chair or for what reason. R152's Mobility Lift Status assessment dated 6/1/16 indicated the need for assistance with moving up in bed and one staff for bed mobility and transfers. The assessment also reflected R152 was frequently incontinent, had shuffling gait, and indicated no side rails or restraints used. During an interview on 7/19/16, occupational therapist (OT)-I explained R152 use to be on a maintenance program but was discharged when he was admitted to hospice. OT-I stated when R152 was using a regular wheelchair at the time of discharge from therapy; OT-I reported a wheelchair fit assessment was not performed by their department for the Rock and Go, and it would be nursing that would assess the resident for appropriateness for a chair. OT-I was asked under what circumstances would a Rock and Go chair be recommended, OT-I explained that type of chair was good for people that required more back support and when residents become dependent on staff for mobility. OT-I explained for a resident who still has mobility that type of chair makes it hard to get out of it without assistance. During an interview on 7/19/16, at 2:34 p.m. RN-E indicated R152 was given the Rock and Go chair three weeks ago because he was on hospice. RN-E stated the chair is much nicer and makes it easier for staff to take him for walks. RN-E indicated R152 could get himself out of the	2 510		

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2 510	Continued From page 5	2 510		

chair, but we (staff) don't want him to stand up at all independently or attempt to get out of his chair. RN-E reported if R152 attempted to stand up he would fall down instantly. RN-E indicated the chair was not a restraint.
During an interview on 7/19/16, at 3:09 p.m. with the hospice branch director RN explained the hospice RN case managers make the determination on what type of wheelchair is used for their patients. Hospice RN indicated the case manager who ordered the chair for R152 had stopped employment with the company. Hospice RN reported, their records did not reflect a completed assessment or progress note for the use of the Rock and Go wheelchair. Hospice RN explained, "We use it [Rock and Go's] for people that don't have trunk control, it is soothing for patients and basically it's comfort measure because the back sits up so high it's more comfortable when people start to loose body control." Hospice RN stated the chairs are not meant for controlling behaviors or prevent residents from standing up for fall prevention.
During an interview on 7/20/16, at 8:53 a.m. RN-D stated R152 obtained the chair from hospice. RN-D explained R152 attempts self-transfers and attempts to get out of it frequently. RN-D explained, "I don't think the chair prevents him from standing up, I think it's only hard for him to get up when the breaks are not locked, he is not steady on his feet."
During an interview on 7/20/16, nursing assistant (NA)-L was asked, "Why is [R152] in a Rock and Go wheelchair?" NA-L stated, when he was first here he was self-transferring a lot. NA-L reported we tried a recliner but he would just climb out of it. NA-L stated, the chair makes it harder for him to stand up and attempt to self-transfer. NA-L indicated she thought R152 was more comfortable in the Rock and Go chair.

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2 510	Continued From page 6 During an interview on 7/20/16, at 2:25 p.m. in response to the question, "When would you do an assessment for a physical restraint?" The director of nursing (DON) stated, "We don't use any form of restraints." DON was not aware of a facility assessment for a restraint. DON then explained R152 does really well in the chair. Facility policy Restraint Evaluation and Utilization Guideline last reviewed 2/4/16 included: If a restraint is utilized to treat a resident's medical symptoms, to prevent injury and/or promote highest practicable level of independence, care evaluation will precede this decision. A restraint will not be applied for purposes of discipline or convenience or when not required to treat the resident's medical symptoms. The least restrictive device will be used. Physical restraints include "any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. If upon completion of the evaluation the IDT reaches the conclusion a restraint is needed the least restrictive device appropriate for the resident specific situation will be implemented. Documentation present. The medical symptoms and diagnosis that supports the use of the restraint will be documented. The need for the use of the restraint will be discussed with resident and/or family. The risks and benefits explained to the resident and/or family. The center will obtain a signed consent for the use of the restraint. The consent form will then be placed in the medical record. The center will obtain a physician order for the least restrictive device. The physician order must include: the medical symptoms for which the device is to be used, type of device to be used, when the restraint is to be used, and	2 510		

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2 510	Continued From page 7 how long it should be applied. A plan of care is developed. The restraint is to be checked as frequently as needed in accordance with the residents needs. This intervention is to be documented on the plan of care. Documentation of checks, release and repositioning may appear on any form used in the center. Residents who have physical restraints are to be reevaluated quarterly or more often as directed by the needs of the resident. This evaluation is to focus on the potential for reduction and elimination based upon the resident specific information and findings. SUGGESTED METHOD OF CORRECTION: The director of nursing/administrator could in-service all staff responsible for assessing if a device is a restraint and if so then educate what the comprehensive assessment components are needed to justify the use of a restraint. Also monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 510		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by	2 555		8/29/16

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2 555	Continued From page 8 the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for the diagnosis of insomnia and non-pharmalogical interventions for pain for 1 of 5 residents (R52); for 1 of 9 residents (R152); 1 of 2 residents (R59) who was reviewed for range of motion (ROM). Findings include: LACK OF INTERVENTIONS FOR NONPHARMACOLOGICAL PAIN CONTROL AND FOR SLEEP: R52's physician orders, print date 7/19/16, identified orders for melatonin 3 mg one hour prior to bedtime as needed for insomnia, Morphine Sulfate (narcotic) 0.25 ml (milliliters) every four hours as needed (PRN) for pain or dyspnea and Tylenol 500 mg one tablet three times a day PRN for pain. R52's pain assessment, dated 7/8/16, identified no pain, and strategies/factors that reduce pain rest and distraction. R52's sleep assessment, dated 6/8/16 through 6/10/16, indicated lighting, room temperature and noise level were conducive to sleep. R52's care plan, print date 7/20/16, included the following: needs pain management and monitoring related to general discomfort; limited range of motion to shoulder. Interventions included administer pain medication as ordered,	2 555	Corrected	

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2 555	Continued From page 9 evaluate and establish level of pain on numeric scale/evaluation tool, evaluate need for routinely scheduled medications rather than PRN pain med administration, evaluate need to provide medications prior to treatment or therapy and utilize pain monitoring tool to evaluate effectiveness of interventions. R52's care plan failed to address the diagnosis of insomnia and interventions to implement related to problems with sleeping and failed to address non-pharmalogical interventions to implement for pain before pain medication is used. On 7/20/16, at 3:04 p.m., registered nurse (RN)-A confirmed R52's care plan failed to address insomnia and non-pharmalogical interventions for pain. On 7/20/16, at 4:33 p.m., the director of nursing (DON) stated she would expect insomnia to be addressed on R52's care plan and non-pharmalogical interventions for pain that worked for R52 be included on the care plan. LACK OF CARE PLAN INTERVENTIONS IN REGARDS TO ASSESSED NEEDS IDENTIFIED IN ACTIVITIES OF DAILY LIVING (ADL) ASSESSMENT: R152's current electronic care plan lacked a comprehensive individualized care plan for ADL's in the area of bed mobility, toilet use, personal hygiene, dressing and assistance with eating. The care plan did directed staff to, "assist with transfers and ambulation as appropriate," and "Assist in ADL's and mobility as needed." R152 admitted to the facility on 3/25/16 according to the facility face sheet. The facility face sheet included diagnoses of dementia with behavioral disturbance.	2 555		

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2 555	Continued From page 10 R152's significant change Minimum Data Set (MDS) dated 5/30/16 included R152 required extensive assistance from two staff members for bed mobility, transfers, ambulation, toilet use, and personal hygiene. The MDS also identified R152 required extensive assistance from two staff members for dressing and eating. The Corresponding Care Area Assessment (CAA) for activities of daily living (ADLs) signed on 6/9/16, indicated the need for assistance for ADL's would be developed in the care plan. The CAA included, "CAA triggered due to coding for extensive assistance. Patient has diagnosis of being legally blind, dementia, and decreased mobility. Needs staff assist with ADL's transfers. Staff to anticipate needs. Risk for missed messages, falls, isolation. Will care plan to minimize risk, attempt to socialize." During an interview on 7/20/16, at 12:37 p.m. registered nurse (RN)-F indicated being the MDS coordinator. RN-F indicated there should have been a care plan in place for ADL's. RN-F stated she normally does the care plans. RN-F stated clinical managers were also assisting with the MDS and care plans and she tries to catch anything that may be missing. RN-F stated the care plans are reviewed and updated quarterly and as needed. LACK OF RANGE OF MOTION (ROM) INTERVENTIONS DEVELOPED FOR FINGERS, HANDS & SHOULDERS: R59 had been admitted according to the face sheet on 5/3/11, include unspecified osteoarthritis, unspecified site, dementia with Lewy bodies and Parkinson's disease. Comprehensive quarterly assessment summary dated 7/18/16, identifies R52 to have, "limited ROM in fingers of both hands and shoulders secondary to arthritis." R59's current care plan with an initiated date of	2 555		

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2 555	Continued From page 11 7/8/11, identifies R59 to have a "physical functioning deficit related to: self care impairment, ROM impairment of fingers/hands and shoulders." The care plan goal which was revised on 7/8/11 and 7/14/16 identified, "I [R59]will maintain my current ROM." Interventions included monitor and report changes in physical functioning ability which was initiated on 7/8/11, monitor and report changes in ROM ability initiated on 7/8/11. Three East Nursing List (condensed care plan sheet for direct care staff) has no mention of interventions for R59's ROM for fingers, hands or shoulders. On 7/19/16, at 9:02 a.m. NA-G reported the washcloths in R59's hands are not done on a daily basis. NA-G stated that usually the hospice service will place the washcloths in both of [R59] hands to keep them from contracting. NA-G stated she hadn't seen the washcloths in place for a long time and stated there isn't anything she is supposed to be doing for R59's contractures. On 7/19/16, at 9:04 a.m. licensed practical nurse (LPN)-B identified R59 had contractures to both hands and stated she should have washcloths in both hands and the nursing assistants should be changing the washcloths every shift. Interview on 7/19/16, at 1:22 p.m. with registered nurse (RN)-E stated R59 is unable to move her arms or hands. RN-E stated she makes sure there is always a washcloth in both hands. RN-E verified that R59 is unable to open her hands independently and requires assistance. RN-E stated that she can get R59's hands to open and attempted to show surveyor but at this time was unable to open either of R59's hands. RN-E went on to state that R59's hands often "smell gross" due to being contracted and verified R59 does not wear a splint and no daily exercises are being completed.	2 555		

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2 555	Continued From page 12 Interview on 7/19/16, at 3:18 p.m. with (RN)-A stated the care plans are completed as a team in the morning meetings. Staff are verbally informed of changes and care sheets are updated. Care guides have basic information needed to perform daily cares and they should have the same information as the care plans. RN-A stated the floor staff does not have access to the care plan only the care guide sheets. A facility policy was requested for comprehensive care plan, but was not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is fully developed after the comprehensive assessment. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff develop a comprehensive care plan based on the comprehensive assessments. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and record	2 565	Corrected	8/29/16

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2 565	Continued From page 13	2 565		

review, the facility failed to implement interventions according to the comprehensive care plan for 1 of 3 residents (R54) reviewed for range of motion; report/monitor for healing of multiple bruises for 1 of 3 residents (R152); follow falls interventions for 1 of 1 residents (R52) who was observed for accidents related to 11 falls in two months; provide oral care for 1 of 1 resident (R59) who is dependent on staff to meet oral care needs.
Findings include:
LACK OF CONSISTENT USE OF INTERVENTIONS FOR ROM SERVICES:
R54's care plan, print date 7/20/16, indicated pressure ulcer actual or at risk due to impaired mobility and self-care deficit with interventions of rolled washcloth in left hand to protect from skin breakdown.
On 7/18/16, at 3:50 p.m., observation revealed R54 was in bed and there was no wash cloth in R54's left hand.

On 7/20/16, at 2:15 p.m., registered nurse (RN)-A stated if R54's care plan reads rolled wash cloth in left hand than she would expect it to be done.

On 7/20/16, at 4:30 p.m., the director of nursing stated she would expect R54 to have the wash cloth in her hand as per R54 care plan.
LACK OF REPORTING AND ONGOING MONITORING BRUISES FOR R152:
R152 was observed on 7/17/16, at 7:27 p.m. R152 had bruises on his left upper arm, left wrist, right knee, right shin, and 3 bruises on his left knee. During a subsequent observation on 7/20/16, at 8:51 a.m. R152's arms were exposed to show multiple bruises on both arms that were circular in shape. R152's record did not reflect identification or monitoring of the bruises.
R152 admitted to the facility on 3/25/16 according

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2 565	Continued From page 14 to the facility face sheet. The facility face sheet included diagnoses of dementia with behavioral disturbance, anxiety disorder, and restlessness and agitation. R152's significant change Minimum Data Set dated 5/20/16 triggered a Care Area Assessment (CAA) for skin that required a plan of care; the CAA was signed on 6/9/16. The CAA informed staff, "CAA triggered due to coding for extensive assist. Patient has a diagnoses of being legally blind, dementia, and decreased mobility. Needs staff assist with ADL's [activities of daily living], transfers. Staff to anticipate needs. Has had fall episodes." R152's current electronic care plan did not address the bruising and directed staff to, "conduct weekly skin inspections," and "skin assessment to be completed per Living Center Policy," and "monitor patient for changes in condition." R152's progress notes reviewed from 7/1/16 through 7/18/16 did not reflect identification or monitoring of any bruising on the upper or lower extremities. R152's progress notes for 7/5/16 reflected a bruised toe and on 7/19/16, after bruises were brought to the attention of facility staff. This assessment indicated the bruises were pre-existing and located on both hands and arms (no description of bruises was included), and the assessment did not reflect the bruising to bilateral lower extremities. In addition, the record did not reflect ongoing monitoring of the toe bruise identified on the 7/5/16 assessment. During an interview on 7/20/16, at 10:12 a.m., nursing assistant (NA)-L explained R152 always has bruises, he tries to get out of bed. NA-L reported NA's keep an eye out for bruises and we communicate to the nurse if we find one or if it is getting worse. NA-L stated the nurse would let us	2 565		

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2 565	Continued From page 15 know if the bruises were already reported. During an interview on 7/20/16, at 10:32 a.m. registered nurse (RN)-D explained the nurse who is made aware of the bruise does an assessment and documents the findings, if the bruise is of unknown origin then we initiate an investigation to rule out abuse. RN-D indicated the wound nurse was then notified. RN-D indicated bruise monitoring should be done until resolution. RN-D could not state what the actual facility protocol was for routine monitoring and assessing bruises after identification. During an interview on 7/20/16, at 10:41 a.m. RN-A explained the process for bruise identification and routine monitoring and assessment. RN-A indicated the nurse that discovers the bruise fills out a DQI (type of incident report) for both known or unknown origins, the nurse then would make a progress note or do a skin assessment form. RN-A indicated the nurse would evaluate the areas weekly on the Weekly Skin Assessment because nurses do not track bruises. During an interview on 7/20/16, at 2:25 p.m. director of nursing (DON) stated staff should be following the care plan and the history and treatment of impaired skin integrity should be in the care plan. DON explained licensed staff members performed the weekly skin evaluation and document their findings and communicate any new issues, skin impairments are then assessed and monitored by the wound nurse. DON indicated NA's are to report any skin concerns to their nurse. Facility policy Weekly Skin Review last reviewed 3/24/16 included, "A weekly skin review UDA (user defined assessments) will be completed weekly on all residents and patients to check for any new skin issues not previously identified.", "Prior to initiating the Weekly Skin Review UDA,	2 565		

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2 565	Continued From page 16 the licensed nurse will review the previous week's UDA for any changes. The licensed nurse will complete a head to toe skin review.", and If an alteration is identified- Dryness, Rash, Redness, Skin Tear, Blisters, or Other- the nurse is to indicate the site(s) in the drop down boxes, utilizing the anatomically numbered indicators on the figures provided, describing the type of alteration and location. If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each area identified. MD/NP are to be notified of any skin alterations, as well as the resident/patient, and his/her responsible party. Care plans are to be updated with new interventions, and CNA care sheets updated as indicated. LACK OF FOLLOWING FALLS INTERVENTIONS: R52's diagnosis found on the admission record included hemiplegia, unspecified affecting right dominant side with onset date of 6/10/16 and Cerebral infarction due to unspecified occlusion or stenosis of left anterior cerebral artery onset date of 11/24/15. Review of R52's care plan dated 10/2/15, identifies R52 to be at risk for falls related to "fell in the past 30 days, history of falls, poor balance." Interventions include but not limited to: activity programming, add anti roll back to wheelchair, assess for pain, assess that wheelchair is of appropriate size; assess need for foot rests, bed and chair alarms, sensor fall mat beside bed on floor, bed in low position when occupied, call light or personal items available and in easy reach or provide reacher [device], deluxe bed alarm that connects to call light system, dycem to her wheelchair, gait belt with transfers, footwear to prevent slipping, keep wheelchair next to bed. Care guide worksheet titled, (3 East Nursing List)	2 565		

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2 565	Continued From page 17 (utilized by direct care staff to provide services to residents they are assigned for their work period) identifies R52 to be a fall risk, bed and wheelchair alarms. One assist with ambulation and transfers with walker. Speaks some English. Observation of R52 on 7/18/16, at 3:37 p.m. staff assisting R52 from wheelchair to bed. Floor mat next to bed, wheelchair not parked next to the bed. Floor mat cords lying on the floor between the mat and the wheelchair. On 7/19/16, at 7:02 a.m. R52 sitting on the edge of her bed with her feet on top of the floor mat. Floor mat alarm is not sounding. R52 was left alone in her room sitting on the side of the bed while staff went to get her something to drink. Licensed practical nurse (LPN)-B entered the room and stated, "I wonder why that's [mat alarm] not working." LPN-B found the cord to be unplugged and made no attempt to plug the floor mat in and then LPN-B left the room. On 7/19/16, at 7:07 a.m. registered nurse (RN)-B entered the room, saw R52 sitting on the edge of the bed and referenced that R52 was wanting to get up. RN-B then exited the room. At 7:10 a.m. on 7/19/16, LPN-B entered the room and plugged the floor mat in which caused the alarm to start sounding. R52 was trying to stand. RN-B entered the room and asked LPN-B for her care guide and stated that she wasn't sure how R52 transferred but thought she was a one assist. R52 was transferred from bed to wheelchair by LPN-B and RN-B without the use of a gait belt. On 7/19/16, at 8:49 a.m. R52 was taken from the dining room to her bedroom by two nursing assistant students. R52 was attempting to stand from wheelchair. Wheelchair alarm began sounding. Nursing assistant (NA)-G entered the room after alarm started sounding. R52 was trying to lift her feet over the foot pedals on the wheelchair which made her stumble. R52 began	2 565		

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2 565	Continued From page 18 walking backwards from her wheelchair to the bed with (NA)-G holding on to her, R52 fell back onto the bed and laid down. No gait belt was attempted or used during the transfer. Interview on 7/19/16, at 8:57 a.m. with LPN-B who stated R52 usually is not on a 1:1 staff assist. LPN-B stated she had not received training on how the floor mat alarm works. Interview on 7/19/16, at 3:08 p.m. with RN-E stated that she believes the location of the mats and cords are a falls risk. RN-E stated the wheelchair is supposed to be right next to the bed and wasn't sure when that had been changed. RN-E unplugged the floor mat alarm and placed the wheelchair by the bed. Interview with director of nursing (DON) on 7/20/16 at 11:20 a.m. stated R52 is impulsive and many interventions have been added to assist R52 which were included on R52's care plan. DON stated R52 should not be left in bed alone when awake and when R52 is in bed that all alarms should be on. DON stated staff had been provided training on the floor mats and the proper way to have them plugged in. DON stated this is a newer intervention to the facility and expected staff to ask if they did not know how to use something. Policy titled Falls Management Guideline dated 10/21/15, identifies, "residents are evaluated for fall risk, communication system to identify the residents at risk for falls and residents at risk for falls are care planned with individualized interventions." Policy did not include how interventions are communicated to direct care staff. LACK OF FOLLOWING ORAL CARE INTERVENTIONS FOR R59: R59 was observed during morning cares on 7/19/16, at 7:55 a.m. Oral care was not provided or offered to R59.	2 565		

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2 565	Continued From page 19 R59's care plan dated 7/8/11, identifies R59 as having a "physical functioning deficit related to: self-care impairment, ROM impairment of fingers/hands and shoulders with interventions for staff to perform oral care, resident is not wearing dentures and dental exams as necessary." Review of the 3 East Nursing List care guide (partial list of resident care plan interventions for staff to follow in giving cares) doesn't mention oral/dental care. Interview with nursing assistant (NA)-G on 7/19/16 at 8:06 a.m. NA-G stated R59 needs no assistance with oral care which is why none was provided by her. 7/19/16, at 1:22 p.m. interview with registered nurse (RN)-E stated R59 has her own teeth, does not wear dentures and is a total assist with oral cares. Policy, "Oral Hygiene", dated 1/20/16, identifies procedure purpose to "cleanse the mouth, teeth and dentures, to moisten the mucous membrane". Policy does not identify when or how often oral care should be provided to residents. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending	2 570		8/29/16

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2 570	Continued From page 20 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to revise the care plan with mobility status for 1 of 3 residents (R123) reviewed for accidents; failed to revise the care plan for change in transfer status for 1 of 3 residents (R149); failed to revise the care plan for current wound interventions for 1 of 4 residents (R171) reviewed for pressure ulcers; failed to revise the care plan to include care of chronic dermatitis requiring preventive treatment for 1 of 3 residents (R30) reviewed for non-pressure related skin concerns. Findings include: R123's care plan, print date 7/20/16, indicated at risk for falls related to poor vision and chronic vertigo with interventions of gait belt with transfers contact guard assistance to prevent injuries to staff and resident. Physical functioning deficit related to self-care impairment, mobility impairment with interventions of locomotion supervision of one staff with a forward wheeled walker and gait belt on hand, resident gets agitated and angry when help is offered as he wants to be independent, transfer assistance of one staff, walker and gait belt and walking	2 570	Corrected	

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2 570	Continued From page 21 assistance. On 7/18/16, at 8:18 a.m., R123 was observed to walk off the elevator independently using his walker. On 7/19/16, at 10:10 a.m., R123 was observed walking in the hallway on the first floor independently using his walker. On 7/20/16, at 1:41 p.m., R123 was observed to be walking in the dining room independently using his walker. R123's care plan failed to include that R123 was independently walking with a walker. On 7/20/16, at 2:47 p.m., registered nurse (RN)-A stated R123's care plan read one assist with mobility. RN-A stated R123's care plan did not include one assist with walking if R123 allowed it, but if he allows should be included with walking assistance on R123's care plan due to, at times becomes upset with staff assistance. On 7/20/16, at 4:41 p.m., the director of nursing (DON) stated she would expect R123's care plan to be revised to include if R123 was refusing staff to provide walking assist. R149's care plan, print date 7/20/16, indicated R149 had a physical functioning deficit related to mobility impairment, extremely tall and unsteady with interventions of assist of one for all transfers and toileting assistance of one. On 7/19/16, at 8:10 a.m., R149 was observed to be sitting on the edge of his bed. R149 placed his walker in front of him, stood and self-transferred into his wheelchair.	2 570		

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2 570	Continued From page 22 R149's care plan failed to include that R149 was independently transferring and toileting himself. On 7/20/16, at 8:15 a.m., nursing assistant (NA)-I stated R149 transfers himself and toilets himself. NA-A stated usually R149 does not ask for assist for transfers or toileting, unless he wants his urinal emptied. On 7/20/16, at 11:01 a.m., licensed practical nurse (LPN)-D stated R149 required assist of one for transfers and toileting. LPN-D stated she had not included on R149's care plan that he self-transfers. On 7/20/16, at 4:25 p.m., the DON stated R149 self-transferring should be included on R149's care plan. R171's care plan, print date of 7/20/16, indicated R171 had a physical functioning deficit related to mobility impairment and range of motion limitations with interventions of non-weight bear (NWB) through heels, weight bear as tolerated through balls of feet if can remain NWB through heels. Pressure ulcer actual or at risk due to pressure ulcer present on left heel with interventions of float heels. On 7/18/16, at 1:49 p.m., R171 was sitting in his wheelchair with shoes on both feet and R171's feet were flat on the floor. On 7/19/16, at 7:03 a.m., R171 was laid in bed and had blue boots on both feet. R171's feet laid directly on the mattress. Observation with registered nurse (RN)-D revealed R171's left heel had a closed, dark colored area of skin. On 7/20/16, at 8:11 a.m., R171 was sitting in his	2 570		

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2 570	Continued From page 23 wheelchair with shoes on both feet and R171's feet were flat on the floor. R171's care plan failed to include R171's refusal to have heels floated. On 7/20/16, at 1:28 p.m., nursing assistant (NA)-H stated R171 was not to be full weight bearing when standing to transfer. NA-H stated R171 had foot rests for his wheelchair in his closet for use, but R171 had not used the footrests for a long time. NA-H stated R171 wanted to be without the footrests, as he wanted to be more mobile. On 7/19/16, at 7:03 a.m., RN-D stated R171 was usually non-compliant with keeping heels floated. RN-D stated R171 was to be non-weight bearing to heels, but R171 used his heels to propel his wheelchair due to poor memory and he does not remember to not bear weight on his heels. RN-D stated the facility had tried using wheelchair leg rests a lot of times, but R171 puts his heels back on the ground even with footrests on the wheelchair. On 7/20/16, at 4:31 p.m., the DON stated R171 refusing to have heels floated should be included on R171's care plan. A facility policy for revision of care plan was requested, but not provided. LACK OF REVISION FOR DENTAL STATUS: R30 admitted to the facility on 5/13/13 according to the facility face sheet. The facility face sheet included diagnosis of glaucoma, malaise, and diabetes. R30's annual Minimum Data Set (MDS) dated 5/6/16 reported no cognitive impairment with a Brief Interview for Mental status score of fifteen,	2 570		

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2 570	Continued From page 24 required one staff physical assist for grooming and hygiene, and indicated no dental concerns. R30's dental provider visit progress note dated 2/24/16 included, "Upper denture suctions but drops due to pressure from lips as bone has resorbed border are a little long. After adjustment to upper borders retention was improve. Upper arch has advanced bone loss with only about 5 mm [millimeters] of height remaining.", and "Heavy plaque and calculus on lower teeth, [R30] is dependent on others for oral cares. Moderate xerostomia [dryness in mouth]." Visit order indicated prophylactic cleaning treatment every three months due to need for assistance with oral cares and xerostomia. The dental visit note included the following recommendations, "[R30's] gums were inflamed today as a result of bacterial plaque buildup he will need some extra assistance with his oral cares. Please brush his teeth twice each day. After breakfast and before bed is most effective. Please focus on the gum line using a soft brush gently message each tooth/gum junction. Follow up with a vigorous water rinse if he can manage. Otherwise, dip a tooth sponge in water and clear debris from the mouth. Expect bleeding until the gums return to a healthier state. [R30] was very agreeable to help with his oral cares." The note also included instructions for staff for denture care and insertion to maintain suction. R30's current electronic care plan informed staff R30 required dentures, required one assistance from staff for personal hygiene, and provide dental exams as necessary. The care plan did not reflect the recommendations given by the dentist on 2/24/16. During an interview on 7/18/16, at 3:18 p.m. registered nurse (RN)-A indicated the recommendations from the dentist should have been added to the dental care plan.	2 570		

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2 570	Continued From page 25 During an interview on 7/20/16, at 2:03 p.m., director of nursing (DON) explained the health unit coordinator (HUC) is responsible for coordinating outside appointments, when the resident returns, the nurse on the floor received the information and was responsible for updating the care plan. DON explained the information may have been missed. Facility policy as requested and not received. LACK OF CARE PLANNING INTERVENTIONS TO ADDRESS CHRONIC DERMATITIS: R30 was observed on 7/17/16, at 6:58 p.m. both of R30's arms showed diffuse red rashy areas with scattered pin point scabs. R30 stated staff sometimes use Vani-cream. During an observation on 7/19/16, at 7:02 a.m. R30's arms continued to show red rashy areas with scattered pin point scabs from wrist to shoulder. R30 reported the areas do not itch. R30 admitted to the facility on 5/30/13 according to the facility face sheet. The facility face sheet included diagnoses of diabetes and atopic dermatitis. R30's current physician orders signed on 6/28/16 included, Chlorhexidine Gluconate 4% apply to skin topically one time a day every seven days; apply for two minutes, dry and repeat to decrease skin infection. R30's Care Area Assessment dated 5/11/16 reported R30, "at risk for skin breakdown with current Braden score of 16. No referrals at this time. Will proceed to plan of care with goal of maintaining skin integrity." R30's current electric care plan lacked a plan of care for diagnosis of atopic demits and ongoing preventative treatment for skin infections. During an observation on 7/20/16, at 8:48 a.m. RN-A verified the presence of the impaired skin integrity on R30's arms. R30 was observed to be scratching at the areas during the evaluation by	2 570		

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2 570	Continued From page 26 RN-A. During an interview on 7/20/16, at 2:25 p.m. director of nursing (DON) stated the history and treatment of impaired skin integrity should be in the care plan. DON explained licensed staff members performed the weekly skin evaluation and document their findings and communicate any new issues, skin impairments are then assessed and monitored by the wound nurse. DON indicated NA's are to report any skin concerns to their nurse. A facility policy pertaining to care plan revision was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the	2 830		8/29/16

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2 830	Continued From page 27 resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure monitoring of the accurate amount of fluid intake for 1 of 1 residents (R35) reviewed for dialysis; failed to ensure blood sugars were reported to the physician as ordered for 1 of 5 residents (R52) reviewed for unnecessary medications; failed to ensure an proper position for 6 of 6 residents (R50, R24, R55, R69, R74 and R152) observed during mealtime; failed to do neurological assessment following a head injury for at least 72 hours post incident for 1 of 1 resident (R123) who sustained head injury following a fall; failed to identify, monitor and apply medication according to physician's orders to skin impairment for 1 of 3 residents (R30) reviewed for non-pressure related skin issues; and failed to identify and monitor bruising for 1 of 3 residents (R152) reviewed for non-pressure related skin concerns. Findings include: LACK OF MONITORING DAILY FLUID RESTRICTION: R35 was observed on 7/19/16, at 8:30 a.m., R35 was sitting in the dining room and was given by facility staff 120 cc (cubic centimeters) glass of juice, 240 cc glass of milk, 180 cc glass of juice, raisin toast, scrambled eggs and two slices bacon for breakfast. A total fluid intake of 540 cc for breakfast. On 7/19/16, at 9:13 a.m., nursing assistant	2 830	Corrected	

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2 830	Continued From page 28 student (NAS)-N verified she had removed R35's dishes from the table after breakfast and R35 had eaten all of his food, and drank all of his milk and juice. SNA-N was asked it the food and fluid was record and she stated no to recording the intake of meals for the facility. We tell the nursing assistants if they ask, but we are not obligated to tell them the intake. SNA-N stated no facility nursing assistant had asked about the amount of intake R35 had for breakfast. NAS-O stated R35 had drank ¾ cup of his coffee. A total of 135 cc fluids. On 7/20/16, at 8:25 a.m., R35 was sitting in the dining room at a table waiting for breakfast to be served. Facility staff were present in the dining room and were passing fluids and food out to the residents. R35 received 240 cc glass of milk, 120 cc glass of juice, 180 cc cup of coffee, two sausage links, scrambled eggs, one piece of toast and jam. R35 drank all of his liquids and ate all of his food. A total of 540 cc fluid intake at breakfast. R35's dietary card sheet for breakfast indicated 1500 cc (1.5 liters) per 24 hour day fluid restriction, 120 cc (four ounce) drink - milk, 240 cc (eight ounce) drink - cranberry or apple juice or coffee, no cooked onions, regular diet and on dialysis. For a total of 360 cc fluid intake for breakfast vs. the observed breakfast intake on 7/19 of 675 cc and on 7/20 540 cc fluids. R35's medication administration record for 7/16, indicated monitor fluid intake every shift and document. Patient is on a 1.5 liter (1500 cc) fluid restriction. Total amount every shift of fluid intake including meals. The total amount recorded for the day shift on 7/19/16 was 240 cc. However,	2 830		

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2 830	Continued From page 29 R35 had consumed a total of 675 cc of fluids for breakfast on 7/19/16. R35's current physician orders identified dialysis diet 1.5 liter fluid restriction and monitor fluid intake every shift and document. R35's care plan, print date of 7/20/16, indicated alteration in kidney function due to end stage renal disease, evidenced by hemodialysis with interventions of diet and fluid restrictions as ordered by physician. On 7/19/16, at 8:57 a.m., dietary aide (DA)-A stated R35's diet card shows how much fluid R35 was able to have for breakfast. DA-A showed surveyor the card and the card read 1500 cc fluid restriction, four ounces milk, eight ounce drink of cranberry or apple juice or coffee, no cooked onions, regular diet and on dialysis. On 7/19/16, at 2:20 p.m., registered nurse (RN)-G stated in regards to fluid restriction, the kitchen is allowed a certain amount of cc's, I think they have the amount they can give on a card. It is in the computer how many cc's nursing is allowed to give. The nursing assistants keep track of fluid intake during their shift and report to so we know how much R35 has had. RN-G stated as far as she knows there is not total done at the end of the day. On 7/20/16, at 10:43 a.m. nursing assistant (NA)-P confirmed she had recorded on R35's medication administration record the amount of 240 cc of fluid intake for 7/19/16, for R35 for the day shift. NA-P stated the amount she recorded was the amount of fluid she had given R35 during the day only. NA-P stated she was told the fluids he gets for meals were already recorded, so I just	2 830		

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2 830	Continued From page 30 have to record the ones I give him. On 7/20/16, at 11:05 a.m., LPN-D said staff were to record how much fluid R35 drinks each shift, which includes what R35 has drank at meal times and on the floor. LPN-D stated the dietician informs nursing how fluid intake for R35 is broken up. LPN-D stated a communication sheet was to be sent every time R35 goes to dialysis and it would be the responsibility of the nurse on duty when R35 returns from dialysis to ensure the communication sheet returned with R35. If R35 did not have the communication sheet I would expect the nurse to call the dialysis unit. On 7/20/16, at 1:33 p.m., the dietary manager (DM)-K stated R35 was on a 1.5 liter fluid restriction. R35 was to receive for breakfast: four ounce drink and an eight ounce drink, lunch: two four ounce drinks and for supper: two four ounce drinks and nursing can give 220 cc (cubic centimeters) each shift. DM-K stated a coffee cup holds 180 cc, large glass holds 240 cc and a small glass holds 120 cc. DM-K stated she did not have access in the computer system to review meal intakes and she was not responsible for the nutrition assessments, the dietician completed the nutrition assessments. On 7/20/16, at 4:02 p.m., licensed practical nurse (LPN)-D stated we have some work to do with R35's fluids, what he should get and what he should not get. We are going to talk to R35 about it. We realize we have a problem and need to communicate better. On 7/20/16, at 4:43 p.m., the director of nursing stated (regarding fluid restriction) R35 should receive what is ordered, the amount he receives should be documented each shift and I would not	2 830		

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2 830	Continued From page 31 expect him to get more than what is ordered. The Don stated in regards to communication with dialysis, we should be getting updated records how R35 did when going to dialysis and when he comes back from dialysis. A policy for fluid restriction was requested, but not provided. LACK OF REPORTING BLOOD SUGARS OVER A READING OF 500: R52's current physician orders indicated orders for blood glucose before meals and at bedtime, Novolog (insulin) FlexPen solution Pen-injector 100 unit/ml (milliliters), inject per sliding scale if 180-219 = 1 unit, 220-259 = 2 units, 260-299 = 3 units, 300-339 =4 units, 340-379 = 5 units, 380-499 = 6 units, 500 plus = 6 units Call NP (nurse practitioner)/MD (medical doctor). R52's care plan, print date 7/20/16 indicated alteration in blood glucose due to insulin dependent diabetes mellitus with intervention of report abnormal results per physician parameters/guideline. R52's MAR dated 6/16 to 7/16 identified the following blood sugar readings: 6/12 - 6 p.m. - 581 6/13 - 7 a.m. - 533 6/16 - 11 a.m. - 579 6/16 - 5 p.m. - 600 6/21 - 5 p.m. - 600 6/21 - 9 p.m. - 600 7/5 - 11 a.m. - 500 7/14 - 11 a.m. - 598 7/14 - 5 p.m. - 600 R52's record lacked documentation the physician had been notified of blood sugar readings 500	2 830		

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2 830	Continued From page 32 plus as above, as per physician orders. On 7/20/16, at 3:04 p.m., registered nurse (RN)-A reviewed R52's record and confirmed the physician was not notified regarding the blood sugars. RN-A stated staff should be notifying the physician as ordered and document when the physician had been notified. On 7/20/16, at 4:33 p.m., the director of nursing stated she would expect the physician to be notified as ordered, I do not know how those were missed. A facility policy for notifying the physician as ordered was requested, but not provided. LACK OF BODY ALIGNMENT TO PROMOTE SELF EATING AND SWALLOWING/CHEWING CONCERNS IN THE THIRD FLOOR CLOSED UNIT: R50 on 7/17/16, at 5:57 p.m. was observed in the dining room for the supper meal to be seated in wheelchair and a tray table in front of R50. The tray table was in a slanted position pushed away from the resident at one end. R50 was not able to reach her food with the tray table in a slanted position. At 6:05 p.m. (eight minutes after having meal set in front of resident) a facility staff person positioned the tray straight across in front of R50 and R50 began eating her food. Facility staff failed to properly position the tray table when R50's food was served. R24 on 7/17/16, at 1:02 p.m. was observed in the dining room for the lunch meal to be seated in his wheelchair and a tray table was in front of R24. R24 was leaning to the right over the wheelchairs right side arm rest for the entire meal. On 7/17/16, at 6:06 p.m., R24 was observed in the	2 830		

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2 830	Continued From page 33 dining room for the supper meal to be seated in his wheelchair and a tray table was in front of R24. R24 was leaning to the right over the wheelchairs right side arm rest for the entire meal. Facility staff failed to position R24 in an upright position to allow proper body alignment to promote eating comfort. R55 on 7/17/16, at 5:22 p.m., was observed in the dining room for the supper meal to be seated in her wheelchair and the chair was reclined back. R55 had to extend her full arm to reach the plate of food. Also noted to hold the cup, plate, etc close to chest so she could take sip, bite of food while reclined back without dropping food for the entire meal. Facility staff failed to position R55 in an upright position to accommodate self eating and prevent spills. R69 on 7/17/16, at 1:12 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at the table. R69's mouth was even with the top side of the table. The table was too high for R69 to comfortably reach the food. The table had fixed legs and was not adjustable to accommodate residents who need a lower table surface to eat comfortably. R69 did not receive staff assist with her lunch meal and R69 did not eat her lunch meal independently. Facility staff failed to ensure adequate table height for R69 during a meal. On 7/17/16, at 5:22 p.m., R69 was observed in the dining room for the supper meal to be seated in her wheelchair tipped back and a tray table was in front of R69. The tray table height was high and out of reach of R69. A facility staff person was observed to fully assist R69 her entire meal. R69 was attempting to reach items on the tray table, but the items on the tray table were out of her reach. Facility staff failed to position R69 in an upright position and ensure the tray table was at a height where R69 could reach	2 830		

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2 830	Continued From page 34 her food and eat independently. R74 on 7/17/2016, at 6:11 p.m., was observed in the dining room for the supper meal to be seated in her wheelchair tipped back away from the table and being assisted with her supper meal by staff person. The facility failed to ensure an upright position for eating during mealtime to accommodate chewing and swallowing of foods. R152 on 7/17/16, at 5:22 p.m., was observed in the dining room for the supper meal to be seated in his wheelchair tipped back away from the table being fed his supper by a staff person. Again the facility failed to ensure an upright position for eating during mealtime to promote independence, chewing and swallowing and prevent chocking/coughing. On 7/20/16, at 2:06 p.m., registered nurse (RN)-A stated she would expect all resident's wheelchairs to be in an upright position and for the residents to be positioned properly at the tables during mealtime. RN-A stated for R24 regarding leaning to the right, R24 should have had a pillow in place to straighten him out. RN-A stated she had not noticed that R24 was leaning to the right in his wheelchair and staff had not informed her that R24 was leaning to the right in his wheelchair. On 7/20/16, at 4:23 p.m., the DON stated staff should assist to have the tray table's close and ensure residents are in an upright position for eating. The Don stated in regards to R24, if someone is leaning to one side, therapy should do an assessment and work with the resident on positioning. The DON stated that is something we should have identified and corrected, regarding R24 leaning to the right in his wheelchair. The facility Meal Time Standards, undated, was	2 830		

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2 830	Continued From page 35 provided but did not address positioning at mealtime. LACK OF MONITORING NEUROLOGICAL SIGNS AND SYMPTOMS TO DETERMINE DECLINE IN NEUROLOGICAL STATUS: R123's Minnesota Incident Report, indicated date and time of incident was 7/10/16, at 1:39 a.m., resident had fall resulting in head injury to forehead. Resident evaluated at emergency room (ER) and developed a 5 X 6 cm (centimeter) contusion on forehead with laceration bleeding. LOC [level of consciousness] at baseline. R123's progress note dated 7/10/16, at 1:39 a.m. indicated situation: fall resulting in injury and assessment: unable to speak, unable to follow command for neuro checks, LOC at baseline, 5 cm X 6 cm bump in the middle of forehead with laceration oozing blood. Response: sent to ER for medical evaluation. Documented on 7/10/16, at 3:29 a.m., resident returned to the facility with diagnosis of a closed head injury, forehead hematoma. R123's record lacked any further neuro checks being completed after R123 returned from the ER. Information regarding to assessment of cognition, neurological assessment following return from ER was requested and none provided. On 7/20/16, at 2:47 p.m., registered nurse (RN)-A stated in regards to if neuro checks were completed for R123 after he fell and hit his head on 7/10/1, I do not know if neuro's were done. Usually when a resident is evaluated in the emergency room and they come back they are stable. I do not know if I have ever been told to do neuro's after they have been evaluated. RN-A	2 830		

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2 830	Continued From page 36 stated the consult from R123's emergency room visit indicated follow up with primary care as needed and test performed was computed tomography (CT) scan. RN-A stated the results of the CT scan were not in R123's record. RN-A stated she could call the clinic and have the CT scan results faxed over. When queried what the facility protocol for neuro checks were, RN-A replied let me call RN-B. At 3:07 p.m., RN-B arrived and stated she would have to look up what the facility policy was for neuro checks. RN-B proceeded to show RN-A how to look up the policy and read from the policy neuro checks should be performed following an unwitnessed fall or known head injury. On 7/20/16, at 4:41 p.m., the director of nursing stated neuro checks should be done for 72 hours with a head injury, making sure the resident was orientated. The facility policy Neurological Checks, dated effective 12/1/15, indicated it is the policy of the facility to conduct neurological checks on residents as clinically appropriate (whenever there is a question of a head injury or a change in neurological status or level of consciousness. A change in level of consciousness is the most significant indication of a neurological change. Neurological checks shall be performed following an unwitnessed fall or known head injury. LAKE OF MONITORING AND TREATMENT FOR CHRONIC DERMATITIS: R30 was observed on 7/17/16, at 6:58 p.m. both of R30's arms showed diffuse red rash areas with scattered pin point scabs. R30 stated staff sometimes use Vani-cream. During an observation on 7/19/16, at 7:02 a.m. R30's arms continued to show red rash areas with scattered	2 830		

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2 830	Continued From page 37 pin point scabs from wrist to shoulder. R30 reported the areas do not itch. R30 admitted to the facility on 5/30/13 according to the facility face sheet. The facility face sheet included diagnoses of diabetes and atopic dermatitis. R30's current physician orders signed on 6/28/16 included, Chlorhexidine Gluconate 4% apply to skin topically one time a day every seven days; apply for two minutes, dry and repeat to decrease skin infection. R30's medication administration record for June 2016 and July indicated the Chlorhexidine skin wash was not performed as scheduled. Corresponding nursing progress notes dated 6/3, 6/10, 6/17, 7/8, and 7/15 indicated the skin wash was not provided related to "bath not due today" and progress note on 7/1 indicated the skin wash was not performed because the medication was not found. R30's progress notes reviewed from 7/1/16-7/18/16 did not reflect identification or monitoring of the dermatological lesions or rash or administration of Chlorhexidine skin wash. R30's Care Area Assessment dated 5/11/16 reported R30, "at risk for skin breakdown with current Braden score of 16. No referrals at this time. Will proceed to plan of care with goal of maintaining skin integrity." R30's current electric care plan directed staff to, "Inspect skin with care. Report reddened areas, rashes, bruises, or open areas to charge nurse.", and "assessment of skin and foot condition weekly by licensed nurse." The care plan advised of the impaired skin integrity on the left toes and was at risk for pressure ulcers. The care plan lacked a plan of care for ongoing preventative treatment for skin infections. The Care Guide used by staff to provide direct cares was last updated 6/17/16 included, "MUST [capitalized]	2 830		

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2 830	Continued From page 38 bag and label linens/clothing prior to laundry as he uses special soap." R30's weekly skin assessments reviewed from 6/9/16 through 7/14/16 did not reflect the presence dermatitis lesions/rashes/scabs. During an interview on 7/18/16, at 3:20 p.m., licensed practical nurse (LPN)-A stated the Chlorhexidine was scheduled in the computer for the wrong day; it was supposed to be scheduled for Thursday's with his showers. LPN-A explained the skin wash had been applied, however she had not documented the applications and could not verify the treatment had been completed on a weekly basis. LPN-A stated nursing assistance (NA's) apply the skin wash. When asked NA's scope of practice for applying the skin wash, LPN-A did not directly answer the question. LPN-A stated, "I tell them you can put it all over his body except for his face." When LPN-A was asked how long the solution should stay according to physician's orders, LPN-A stated, "I don't know how long it's supposed to sit on the skin." LPN-A was then asked to reference the physician instructions; LPN-A read the physician's orders and indicated she had not instructed the NA's to let the skin wash set for 2 minutes and then reapply. During an interview on 7/18/16, at 3:39 p.m. registered nurse (RN)-A explained the skin wash needed to be performed by a licensed staff member and applied as prescribed. RN-A explained NA's are to report skin concerns to the nurse, the nurse is then to document their findings and communicate to the nurse manager, then the wound nurse would be informed. RN-A stated weekly skin inspections are performed by licensed staff, and impaired skin areas are monitored for healing. During an observation on 7/20/16, at 8:48 a.m. RN-A verified the presence of the impaired skin	2 830		

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2 830	Continued From page 39 integrity on R30's arms. R30 was observed to be scratching at the areas during the evaluation by RN-A. During an interview on 7/20/16, at 2:25 p.m. director of nursing (DON) stated, nurses should be performing physician ordered treatments and should not be delegated to NAs. DON stated the history and treatment of impaired skin integrity should be in the care plan. DON explained licensed staff members performed the weekly skin evaluation and document their findings and communicate any new issues, skin impairments are then assessed and monitored by the wound nurse. DON indicated NA's are to report any skin concerns to their nurse. Facility policy Weekly Skin Review last reviewed 3/24/16 included, "A weekly skin review UDA (user defined assessments) will be completed weekly on all residents and patients to check for any new skin issues not previously identified.", "Prior to initiating the Weekly Skin Review UDA, the licensed nurse will review the previous week's UDA for any changes. The licensed nurse will complete a head to toe skin review.", and If an alteration is identified- Dryness, Rash, Redness, Skin Tear, Blisters, or Other- the nurse is to indicate the site(s) in the drop down boxes, utilizing the anatomically numbered indicators on the figures provided, describing the type of alteration and location. If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each area identified. MD/NP are to be notified of any skin alterations, as well as the resident/patient, and his/her responsible party. Care plans are to be updated with new interventions, and CNA care sheets updated as indicated." Facility policy Medication Administration-General Guidelines last reviewed on 6/15 included;	2 830		

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2 830	Continued From page 40 "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.", "Medications are prepared only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to prepare and administer medications.", and "Medications are administered in accordance with written orders of the prescriber." LACK OF REPORTING AND ONGOING MONITORING OF MULTIPLE BRUISES: R152 was observed on 7/17/16, at 7:27 p.m. R152 had bruises on his left upper arm, left wrist, right knee, right shin, and 3 bruises on his left knee. During a subsequent observation on 7/20/16, at 8:51 a.m. R152's arms were exposed to show multiple bruises on both arms that were circular in shape. R152's record did not reflect identification or monitoring of the bruises. R152 admitted to the facility on 3/25/16 according to the facility face sheet. The facility face sheet included diagnoses of dementia with behavioral disturbance, anxiety disorder, and restlessness and agitation. R152's significant change Minimum Data Set dated 5/20/16 triggered a Care Area Assessment (CAA) for skin that required a plan of care; the CAA was signed on 6/9/16. The CAA informed staff, "CAA triggered due to coding for extensive assist. Patient has a diagnoses of being legally blind, dementia, and decreased mobility. Needs staff assist with ADL's [activities of daily living], transfers. Staff to anticipate needs. Has had fall episodes." R152's current electronic care plan did not address the bruising and directed staff to, "conduct weekly skin inspections," and "skin assessment to be completed per Living Center	2 830		

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2 830	Continued From page 41 Policy," and "monitor patient for changes in condition." R152's progress notes reviewed from 7/1/16 through 7/18/16 did not reflect identification or monitoring of any bruising on the upper or lower extremities. R152's record reflected one weekly skin assessment in June dated 6/7/16; the assessment indicated no impaired skin integrity. The next assessment completed on 7/5/16 reflected a bruised toe. The next weekly skin assessment was performed on 7/19/16, after bruises were brought to the attention of facility staff. This assessment indicated the bruises were pre-existing and located on both hands and arms (no description of bruises was included), and the assessment did not reflect the bruising to bilateral lower extremities. In addition, the record did not reflect ongoing monitoring of the toe bruise identified on the 7/5/16 assessment. During an interview on 7/20/16, at 10:12 a.m., nursing assistant (NA)-L explained R152 always has bruises, he tries to get out of bed. NA-L reported NA's keep an eye out for bruises and we communicate to the nurse if we find one or if it is getting worse. NA-L stated the nurse would let us know if the bruises were already reported. During an interview on 7/20/16, at 10:32 a.m. registered nurse (RN)-D explained the nurse who is made aware of the bruise does an assessment and documents the findings, if the bruise is of unknown origin then we initiate an investigation to rule out abuse. RN-D indicated the wound nurse was then notified. RN-D indicated bruise monitoring should be done until resolution. RN-D could not state what the actual facility protocol was for routine monitoring and assessing bruises after identification. During an interview on 7/20/16, at 10:41 a.m. RN-A explained the process for bruise	2 830		

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2 830	Continued From page 42 identification and routine monitoring and assessment. RN-A indicated the nurse that discovers the bruise fills out a DQI (type of incident report) for both known or unknown origins, the nurse then would make a progress note or do a skin assessment form. RN-A indicated the nurse would evaluate the areas weekly on the Weekly Skin Assessment because nurses do not track bruises. During an interview on 7/20/16, at 2:25 p.m. director of nursing (DON) stated the history and treatment of impaired skin integrity should be in the care plan. DON explained licensed staff members performed the weekly skin evaluation and document their findings and communicate any new issues, skin impairments are then assessed and monitored by the wound nurse. DON indicated NA's are to report any skin concerns to their nurse. Facility policy Weekly Skin Review last reviewed 3/24/16 included, "A weekly skin review UDA (user defined assessments) will be completed weekly on all residents and patients to check for any new skin issues not previously identified.", "Prior to initiating the Weekly Skin Review UDA, the licensed nurse will review the previous week's UDA for any changes. The licensed nurse will complete a head to toe skin review.", and If an alteration is identified- Dryness, Rash, Redness, Skin Tear, Blisters, or Other- the nurse is to indicate the site(s) in the drop down boxes, utilizing the anatomically numbered indicators on the figures provided, describing the type of alteration and location. If a skin alteration is identified the licensed nurse is to initiate/update the Wound Evaluation Flow UDA, one UDA for each area identified. MD/NP [medical doctor/nurse practitioner] are to be notified of any skin alterations, as well as the resident/patient, and his/her responsible party. Care plans are to	2 830		

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2 830	Continued From page 43 be updated with new interventions, and CNA [certified nursing assistants] care sheets updated as indicated." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible to meet the assessed needs of each resident. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. Based on observation, interview and document review the facility failed to ensure continuous oxygen is delivered as ordered by the physician for 2 of 2 residents (R1 & R129) who received continuous oxygen treatment. Findings include: R1's admission record, dated 6/17/2010, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease (COPD) [a disease which makes it harder to breathe]. R1's order summary report, dated 3/27/2015, indicated that the physician had ordered continuous oxygen to be administered via nasal cannula. It was to be set at 2 L (liters) per minute of oxygen. The order summary report also indicated that the physician wanted nursing staff to check R1's oxygen saturation, the placement of the nasal cannula tubing as well as the functioning of the machines. This was to be checked every shift. R1's care plan, dated 4/25/2011, indicated that the resident was at risk for an alteration in respiratory status due to COPD. For the desired goal of freedom from an exacerbation of COPD symptoms, the care plan stated that R1 would	2 830		

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2 830	Continued From page 44 have adequate gas exchange as evidence by no adventitious breath sounds, absence of respiratory distress and an absence of shortness of breath. Interventions in place to achieve this goal recommended administering oxygen per the physician's order, monitoring R1's oxygen saturations as well as monitoring her oxygen flow rate and response. During an observation at the evening meal time on 7/17/2016 at 5:17 p.m. R1 was seated at the dining table. Her nasal cannula was place to give her flowing oxygen per nose. The oxygen tank was attached to the back of R1's wheelchair. It had a color coded meter that was of red for empty and green for oxygen in tank. There was a white dial marker that was pointed all the way on the left hand side of the meter in the red section. The oxygen setting is set at 2 L. Licensed practical nurse (LPN)-E was asked to check the oxygen level to see if there was any oxygen in the tank. LPN-E picked up the tank and the white dial marker did not move from its location at the extreme left hand side of the meter in the red color coded section. LPN-E stated that the oxygen tank was either malfunctioning or it was out of oxygen. LPN-E consulted with nursing assistant (NA)-K who stated that the tank was out of oxygen. NA-K stated that he would go fill the tank with liquid oxygen. He disconnected R1's tubing from the machine and took the machine with him. At 5:24 p.m., NA-K returned and attached the oxygen tank to R1's oxygen tubing. It was set at 2 L. From the time it was discovered until the time the oxygen tank had been filled with oxygen, R1's oxygen saturation had not been checked to see if R1's oxygen level was satisfactory. When interviewed on 7/20/2016 at 2:15 p.m.	2 830		

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2 830	Continued From page 45 LPN-D stated that oxygen tanks should not be checked and filled with oxygen so they don't run out. She stated that the lifespan of an oxygen tank was approximately four hours and the staff should be monitoring the tanks at least every four hours. R129's family (F)-L said during a family council interview on 7/20/16 at 11:40 a.m. that R129 had often been found when visiting the facility to be out of oxygen in the tank. F-L said R129 needed continuous oxygen otherwise became more agitated. F-B had reported this to the staff and for a time it had gotten better but F-L occasionally finds the oxygen tank empty when visiting. R129 was admitted to the facility on 8/19/15 according to the most current Order Summary Report. Also it has diagnosis of airway disease due to other specific organic dusts and the doctor ordered oxygen at 1 to 2 liters per minute with a start date of 2/23/16 and keep oxygen saturation in blood at 90 percent or more. On 7/20/16 at 11:40 a.m. R129 was observed to be seated in a wheel chair located in the dining room. On checking the gauge on the oxygen tank it read Zero. On asking nursing assistant (NA)-R to check the tank, NA-R reported that it was empty and would get it filled for R129. The NA-R was not sure how long it had been empty. But said the tanks should be checked before moving the resident to the dining room. When interviewed on 7/20/2016 at 3:37 p.m., the director of nursing (DON) stated that the staff should be checking residents' oxygen tanks to ensure they do not run out of oxygen. Review of the facility document titled, oxygen	2 830		

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2 830	Continued From page 46 administration (6/20/2016), it stated at regular intervals to check the liter flow contents of the oxygen cylinder. SUGGESTED METHOD OF CORRECTION: The administrator/director of nursing could in-service all staff responsible to maintain resident oxygen tanks filled with oxygen the need to check them often so they don't run out of oxygen. Also monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to comprehensively assess, identify and implement interventions to improve or prevent further decline in contractures for 2 of 3 residents (R54 & R59) who currently	2 895	Corrected	8/29/16

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2 895	Continued From page 47 have contractures. Findings include: R54's quarterly Minimum Data Set (MDS), dated 4/7/16, indicated R54 had severe cognitive impairment, required total assist of two for transfers, walking did not occur, functional limitations in range of motion upper extremity: impairment one side and lower extremity no impairment. On 7/17/16, at 5:06 p.m., R54 was observed seated in her wheelchair watching television. R54 had a contracture of left hand with a splint in place and had a left foot contracture. On 7/18/16, at 2:11 p.m., certified occupational therapy assistant (COTA)-G was in R54's room providing therapy to R54. COTA-G stated she was working with R54 for contractures of left hand, left elbow and left shoulder. COTA-G stated left foot contracture would be responsibility of physical therapy and she did not know if physical therapy was working with R54 currently. On 7/18/16, at 3:50 p.m., R54 laid in bed. R54's had blue cushioned boots on both lower extremities and R54's left foot was observed to be turned inward, in a dropped position with the blue cushioned boot in place. R54's care plan, print date 7/20/16, indicated physical functioning deficit related to self-care impairment with interventions of monitor and report changes in physical functioning ability, rehab therapy services as ordered and turning and positioning program (offload every two hours), transfer assistance of two and Marisa lift (mechanical lift). Pressure ulcer actual or at risk due to impaired mobility and self-care deficit with	2 895		

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2 895	Continued From page 48 intervention of rolled washcloth in left hand to protect from skin breakdown and Prevalon boots [reduces pressure] to heels at all times. R54's care plan failed to identify R54 had contractures and interventions to implement related to the contractures. R54's Quarterly interdisciplinary Resident Review, dated 7/18/16, indicated limitations that interfered with daily functions or placed the resident at risk of injury: upper extremity, impairment on one side and lower extremity, no impairment. On 7/19/16, at 9:54 a.m., nursing assistant (NA)-J stated the only thing nursing assistants were doing for R54 was applying the blue boot to R54's left foot. NA-J stated occupational therapy was currently working with R54's contractures and was responsible for applying the splint to R54's left hand. On 7/20/16, at 2:15 p.m., registered nurse (RN)-A Stated she had noticed R54 had a "foot drop" and contracture of her left foot. RN-A stated R54 was not receiving physical therapy currently and had not recommended physical therapy to assess the foot drop and contracture of her left foot and see if therapy would be beneficial. RN-A stated R54 was receiving occupational therapy for her left hand contracture. RN-A stated R54 was not on a restorative nursing program for range of motion of any king. On 7/20/16, at 4:30 p.m., the director of nursing (DON) stated if a resident had a change in condition or the resident's condition was how they were, we should have identified the condition and therapy and nursing should work on recommendations and update the residents care	2 895		

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2 895	Continued From page 49 plan. R59's admission record dated 5/3/11, include unspecified osteoarthritis, unspecified site, dementia with Lewy bodies and Parkinson's disease. On 7/18/16, at 2:56 p.m. R59 was observed in bed with arms bent at the elbows, lying over her chest. R59 was not observed moving her arms or hands. A washcloth was present in her left hand and right hand had a wash cloth rolled and put between between fingers and palm of hand. On 7/18/16, at 3:36 p.m. R59 was sitting in her wheelchair with a washcloth in her left hand. No observation of R59 moving her arms or hands. On 7/19/16, at 7:34 a.m. R59 was lying in bed, washcloth in her left hand, elbows bent and arms lying over her chest. Both hands clenched in fists. During observation of morning cares on 7/19/16, at 7:55 a.m. R59 was not observed to move her arms or hands. Both the right and left hands remained in a clenched fist. Washcloth was in the left hand. Nursing assistant (NA)-G was not observed to offer ROM or change the washcloth. Observed R59 in the dining room from 8:07 a.m. until 8:49 a.m. on 7/19/16, during this time R59 made no attempt to move her arms or hands. Observation on 7/20/16 at 8:04 a.m. R59 sitting in her wheelchair with washcloths in both hands. R59 making no attempts to move her arms or hands. Quarterly Minimum Data Set (MDS) an assessment dated 7/18/16, identifies R52 to have, "limited ROM [range of motion] in fingers of both hands and shoulders secondary to arthritis." R59's care plan with an initiated date of 7/8/11, identifies R59 to have a "physical functioning deficit related to: self care impairment, ROM impairment of fingers/hands and shoulders." The care plan goal which was revised on 7/8/11 and 7/14/16 identified, "I will maintain my current	2 895		

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2 895	Continued From page 50	2 895		

ROM." Interventions included monitor and report changes in physical functioning ability which was initiated on 7/8/11, monitor and report changes in ROM ability initiated on 7/8/11.
R59's Recreation Services Assessment dated 1/5/16, identifies limited fine motor abilities to both the left and right hands, limited gross motor abilities to right and left arm/shoulder.
3 East Nursing List (condensed care plan sheet for nursing staff) has no mention of interventions for R59's contractures located in right and left hands/fingers.
R59's resident screening form dated 6/26/14 identifies no reduction in ROM. A copy of this form was requested but not received.
On 7/19/16, at 9:02 a.m. NA-G reported the washcloths in R59's hands are not changed on a daily basis. NA-G stated that usually the hospice service will place the washcloths in both of R59's hands to keep them from contracting. NA-G stated she hadn't seen the washcloths in place for a long time and stated there isn't anything she is supposed to be doing for R59's contractures.
On 7/19/16, at 9:04 a.m. licensed practical nurse (LPN)-B identified R59 had contractures to both hands and stated she should have washcloths in both hands and the nursing assistants should be changing the washcloths every shift.
Interview on 7/19/16, at 1:22 p.m. with registered nurse (RN)-E stated R59 is unable to move her arms or hands. RN-E stated she makes sure there is always a washcloth in both hands. RN-E verified that R59 is unable to open her hands independently and requires assistance. RN-E stated that she can get R59's hands to open and attempted to show surveyor but at this time was unable to open either of R59's hands. RN-E went on to state that R59's hands often "smell gross" due to being contracted and verified R59 does not wear a splint and no daily exercises are being

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2 895	Continued From page 51 completed. Interview on 7/19/16, at 3:18 p.m. with (RN)-A stated the care plans are completed as a team in the morning meetings. Staff are verbally informed of changes and care sheets are updated. Care guides (used by direct care staff to provide needed cares/services) have basic information needed to perform daily cares and they should have the same information as the care plans. RN-A stated the floor staff does not have access to the care plan only the care guide sheets. RN-A stated R59 does not have contractures that she has arthritis. RN-A stated she believed R59 has had no reduction in ROM since the 6/24/16 resident screening form was completed. RN-A assessed R59's bilateral hands with surveyor and was unable to open either or R59's hands. A facility policy for range of motion was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The DON, director of therapy or designee(s) could review and revise as necessary the policies and procedures regarding implementing and maintaining proper range of motion care. The DON, director of therapy or designee(s) could provide an in-service for all appropriate staff on providing treatment per each resident's plan of care. The DON, director of therapy or designee(s) could monitor to assure residents receive proper range of motion treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing	2 920		8/29/16

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2 920	Continued From page 52 home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure all residents assessed to need set up assistance to needed full assistance to eat was provided to 6 of 6 residents (R55, R56, R69, R74, R119 and R128) observed during mealtime in the secured unit. Findings include: R55 on 7/17/16, at 12:37 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at a table. R55 was served her food by the facility staff. R55 was observed to not eat any of her food and the facility staff failed to offer assist R55 to eat any of her meal. R55's care plan, print date 7/20/16, indicated physical functioning deficit related to self-care impairment and mobility impairment with intervention of eating assistance of set-up one, monitor and report changes in physical functioning ability. R56 on 7/17/16, at 1:07 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at a table. R56 was served her food by the facility staff. R56 was observed to be licking out of a cup during her meal and drank her milk. Facility staff failed to intervene and offer R56 assist to eat. On 7/17/16, at 6:11 p.m., R56 was observed in the dining room for the supper meal to be seated in her wheelchair at a table.	2 920	Corrected	

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2 920	Continued From page 53 R56 was served her food by the facility staff. R56 was observed to be licking out of an ice cream cup during her entire meal. Facility staff failed to intervene and offer R56 assist to eat the rest of her meal. R56's care plan, print date of 7/20/16, indicated physical functioning deficit related to self-care impairment as evidenced by need for staff assist with activities of daily living with interventions of eating assistance: able to feed herself after staff serve her with reminders and monitor and report changes in physical functioning ability. R69 on 7/17/16, at 1:12 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at the table. R69 did not receive any staff assist with her lunch meal and R69 did not eat any of her lunch independently. On 7/17/16, at 5:22 p.m., R69 was observed in the dining room for the supper meal to be seated in her wheelchair tipped back and a tray table was in front of R69. The tray table height was to high and the food was out of reach of R69. A facility staff person was observed to assist R69 her with the meal. R69 was observed to make several attempts to reach items on the tray table, but the items on the tray table were out of her reach. Facility staff failed to reposition/accommodate independence in allowing R69 to independently eat as R69 was assessed to have the ability to independency eat and care planned as such. R69's care plan, print date 7/20/19, indicated physical functioning deficit related to self-care impairment, range of motion limitations (right shoulder limitations) with interventions of eating assistance of independent after set up and monitor and report changes in physical functioning ability. R74 on 7/17/2016, at 6:11 p.m., was observed in	2 920		

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2 920	Continued From page 54 the dining room for the supper meal to be seated in her wheelchair tipped back away from the table being assisted to eat her meal by a facility staff person. The meal was out of reach of the resident. The staff did not position R74 to accommodate self eating skills as assessed and care planned. R74's care plan, print date 7/20/16, indicated physical functioning deficit related to self-care impairment with interventions of eating: able to feed self after meal served. R119 on 7/17/16, at 1:05 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at a table. Staff had served R119 her food. R119 was observed to wheel herself away for the table and had not finished eating her lunch. Facility staff failed to redirect R119 back to the table to eat her lunch. R119 did not eat any of her meal however, when seated by the table R119 played with food. R119's care plan, print date 7/20/16, indicated physical functioning deficit related to self-care impairment, mobility impairment with interventions of eating assistance of set up and supervision, monitor and report changes in physical functioning ability. R128 on 7/17/16, at 6:11 p.m., was observed in the dining room for the lunch meal to be seated in her wheelchair at a table. R128 was observed to place her fork in a bun and place a paper news bulletin over her food on her plate. R128 did not eat her lunch nor did staff intervene, cue or assist R128 during the lunch mealtime. On 7/17/16, at 6:09 p.m., R128 was observed in the dining room for the supper meal to be seated in her wheelchair at a table. R128 was observed to place a juice glass on her plate in her food,	2 920		

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2 920	Continued From page 55 spilled her juice, was eating with her finger and was pulling on the table cloth which pulled other residents plate of foods out of reach for the two residents. A facility staff person had approached R128 at 6:11 p.m. and had pulled R128's juice soaked shirt back up onto R128 shoulder and encouraged her to eat and then staff walked away from R128. No further assistance with eating from the facility staff was offered to R128 during the remainder of the super meal. R128's care plan, print date 7/20/16, indicated physical functioning deficit related to self-care impairment, mobility impairment with interventions of eating assistance of one staff to cue and remind her to eat monitor and report changes in physical functioning ability. On 7/20/16, at 2:06 p.m., registered nurse (RN)-A stated she would expect staff to assist all the residents with eating during mealtime. On 7/20/16, at 4:23 p.m., the DON stated staff should be assisting all residents to eat. The facility Meal Time Standards, undated, indicated when a resident needs to be fed offer encouragement, all residents receive the necessary physical, verbal, and social assistance required. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review ADL policies for providing assist with eating with direct care staff members and provide education as needed. The DON or designee could then develop and implement an auditing system as part of their quality assurance to ensure on-going compliance.	2 920		

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2 920	Continued From page 56 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21330	MN Rule 4658.0725 Subp. 2 A&B Providing Routine & Emergency Oral Health Ser Subp. 2. Annual dental visit. A. Within 90 days after admission, a resident must be referred for an initial dental examination unless the resident has received a dental examination within the six months before admission. B. After the initial dental examination, a nursing home must ask the resident if the resident wants to see a dentist and then provide any necessary help to make the appointment, on at least an annual basis. This opportunity for an annual dental checkup must be provided within one year from the date of the initial dental examination or within one year from the date of the examination done within the six months before admission. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dental appointments were obtained according to dentist's recommendations for 1 of 3 residents (R30) reviewed for dental care/services should have been seen by dentist in May 2016. Findings included: R30 was interview on 7/17/16, at 6:52 p.m. R30 stated, "I can't get my dentures to stay in." R30 indicated it had been several months since his	21330	Corrected	8/29/16

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21330	Continued From page 57	21330		

last dental, and reported the dentist had been to the facility since his last dental visit. R30 commented the nursing assistants do not like to brush his teeth and he had reported several times his dentures do not stay in.
R30 admitted to the facility on 5/13/13 according to the facility face sheet. The facility face sheet included diagnosis of glaucoma, malaise, and diabetes.

R30's annual Minimum Data Set (MDS) dated 5/6/16 reported no cognitive impairment with a Brief Interview for Mental status score of fifteen, required one staff physical assist for grooming and hygiene, and indicated no dental concerns.

R30's dental provider visit progress note dated 2/24/16 included, "Upper denture suctions but drops due to pressure from lips as bone has resorbed border are a little long. After adjustment to upper borders retention was improve. Upper arch has advanced bone loss with only about 5 mm [millimeters] of height remaining.", and "Heavy plaque and calculus on lower teeth, [R30] is dependent on others for oral cares. Moderate xerostomia [defined as dry mouth resulting from reduced or absent saliva flow]." Visit order indicated prophylactic cleaning treatment every three months due to need for assistance with oral cares and xerostomia.

The dental visit note included the following recommendations, "[R30's] gums were inflamed today as a result of bacterial plaque buildup he will need some extra assistance with his oral cares. Please brush his teeth twice each day. After breakfast and before bed is most effective. Please focus on the gum line using a soft brush gently message each tooth/gum junction. Follow up with a vigorous water rinse if he can manage.

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21330	Continued From page 58 Otherwise, dip a tooth sponge in water and clear debris from the mouth. Expect bleeding until the gums return to a healthier state. [R30] was very agreeable to help with his oral cares." The note also included instructions for staff for denture care and insertion to maintain suction. The facility provided the last facility dental schedule visit for 6/1/16. The dental schedule reflected R30 was listed as an "extra" on the schedule; extra indicated if time allowed those residents would be seen. R30's record did not reflect a dental visit since 2/24/16 During an interview on 7/18/16, at 3:18 p.m. registered nurse (RN)-A stated an unawareness R30 had problems with his dentures and R30 had not specifically mentioned anything to her. RN-A indicated the recommendations from the dentist should have been added to the dental care plan. During an interview on 7/20/16, at 2:03 p.m., director of nursing (DON) explained the health unit coordinator (HUC) is responsible for coordinating outside appointments, when the resident returns, the nurse on the floor received the information and is responsible for updating the care plan. DON explained the information may have been missed. Facility policy concerning oral care and dental visits was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff who are responsible to schedule dental visits how to get them in the system so they are not forgotten. Also monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21330		

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21330	Continued From page 59 (21) days.	21330		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly clean and store nebulizer equipment to prevent infection between use for 4 of 4 residents (R991, R131, R992, R9) observed to have nebulizer treatments. Findings include: During an initial tour of the facility on 7/17/2016 at 11:35 a.m. on the 2nd floor, there were three residents (R991, R131, & R992) that contained nebulizer equipment not in use and stored in a manner to promote infections to develop. R991's admission record, dated 6/17/2016, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease and dyspnea (shortness of breath). R991's order summary report, dated 6/28/2016, indicated that the resident was prescribed a medication that was to be administered by a nebulizer machine to aid with shortness of breath. During the initial tour of the facility on 7/17/2016	21375	Corrected	8/29/16

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21375	Continued From page 60	21375		

at 11:35 a.m. in R991's room, the nebulizer equipment was in her room. Attached to the machine were the tubing along with the mask and reservoir cup (which was used to hold the medication). It was observed to be still attached and sitting on her bed side table. There was a clear liquid still in the reservoir cup.

R131's admission record, dated 2/17/2016, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease with acute exacerbation.

R131's order summary report, dated 2/17/2016, indicated that the physician had prescribed a medication that required the use of a nebulizer machine to administer the medication.

During the initial tour of the facility on 7/17/2016 at 11:35 a.m. in R131's room, there was observed to be the nebulizer machine with the tubing, mask and medication reservoir attached. There was observed to be fluid in the medication reservoir.

R992's admission record, dated 5/17/2013, indicated that the resident had a diagnosis of heart failure.

R992's order summary report, dated 9/11/2015, indicated that the physician had prescribed a medication that was to be administered via a nebulizer machine.

During an initial tour of the facility on 7/17/2016 at 11:35 a.m., R992's nebulizer machine was located on the bedside table. It was connected to tubing with the mask and medication reservoir attached. There was observed to be a clear liquid in the medication reservoir.

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21375	Continued From page 61 R9's admission record, dated 3/17/2014, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease (COPD). R9's order summary report, dated 5/3/2016, indicated that the physician had prescribed a medication that was to be administered using a nebulizer machine. During an observation on 7/17/2016 at 3:00 p.m. the nebulizer equipment in R9's room was left sitting out and all tubes connected with observable moisture in the reservoir. When interviewed on 7/17/2016 at 6:47, licensed practical nurse (LPN)-C was shown the nebulizer's for R991, R131, R992. where all the nebulizer equipment appeared as it had been during the initial tour at 11:35 a.m. LPN-C stated that the equipment should have been cleaned and dried immediately after each use. When interviewed on 7/20/2016 at 3:37 p.m., the director of nursing (DON) stated that she would expect the nursing staff to clean the nebulizer equipment after each use and store it properly. She stated that the nebulizer equipment should not contain medication or condensation in the reservoir cup after use. Review of the document titled, Oral Inhalation Administration (6/2015), it stated when the nebulizer treatment was complete, staff were to rinse and disinfect the nebulizer equipment by washing the pieces (except tubing) with warm, soapy water, rinse with hot water and allow to air dry completely on a paper towel. When the equipment was dry, it was to be stored in a plastic bag with the resident's name and the date on it.	21375		

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21375	Continued From page 62 SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff responsible for inhalation therapy to follow the directions for cleaning and storing the equipment to prevent infections. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by:	21540		8/29/16

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21540	Continued From page 63 Based on document review and interview, the facility failed to clearly identify target behaviors and mood behaviors to determine effectiveness of antidepressant, antianxiety and antipsychotic medication for 2 of 5 residents (R83, R152); failed to provide non-pharmacological measures prior to administration of an as-needed antianxiety medication and document the reason for use for 1 of 5 residents (R83); failed to administer an as-needed antianxiety medication as indicated for 1 of 5 residents (R83) reviewed for unnecessary medications; failed to ensure physician justification for use of a prescribed medications for sleep and anxiety and failed to ensure non-pharmalogical interventions were implemented prior to administration of as needed (PRN) medication for 1 of 5 residents (R52) reviewed for unnecessary medications; failed to monitor all identified target behaviors for 1 of 5 residents (R59) who had been prescribed psychotropic medications; failed to identify specific target behaviors for 1 of 5 residents (R59) prescribed a medication for anxiety; and, the facility failed to attempt a gradual dose reduction/titration off of medication or provide physician justification for the continued use of an antipsychotic and an antidepressant medication for 1 of 5 residents (R59). Findings include: LACK OF IDENTIFYING TARGET BEHAVIORS AND MOOD SYMPTOMS TO DETERMINE EFFECTIVENESS OF PSYCHOACTIVE MEDICATIONS: R83 admitted to the facility on 2/7/13 with diagnoses that included major depressive disorder and unspecified psychosis according to the facility face sheet.	21540	Corrected	

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21540	Continued From page 64 R83's quarterly Minimum Data Set (MDS) dated 4/6/16 included R83 had long and short term memory problems and severely impaired decision making skills for daily living. The MDS identified a mood score of 3 indicating minimal depressive symptoms. The MDS indicated R83 received anti-psychotic, anti-depressant and anti-anxiolytic (antianxiety) medications. R83's physician orders dated 6/2/16 included: Sertaline 25 milligrams (mg) by mouth two times a day for anxiety and agitation. Remeron 15 mg once daily in the evening for major depressive disorder. Lorazepam Intensol Concentrate 0.5 mg by mouth every 4 hours as needed (PRN) for anxiety. Seroquel 25 mg 1 tablet by mouth three times a day related to unspecified psychosis. R83's target behavior monitoring included depressed withdrawn, striking out/hitting, agitated, anxiety, suspiciousness, fighting and mood changes. The target behavior monitoring did not identify which specific medication(s) were being monitored for effectiveness. During an interview on 07/18/2016, at 2:37 p.m. social services (SS)-A stated there were no specific targeted behaviors identified and being monitored for the use of the Seroquel for R83 at this time. SS-A stated this was something we have been working on and trying to identify for the residents and this resident must have been missed. SS-A verified based off the behavior monitoring it could not be determined which medication was associated with the target behavior.	21540		

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21540	Continued From page 65 R152 admitted to the facility on 3/25/16 according to the facility face sheet. The face sheet included diagnoses of dementia with behavioral disturbance, anxiety disorders, restlessness and agitation, major depressive disorder, and sleep disorder. R152's significant change Minimum Data Set (MDS) dated 5/30/16 indicated R152 had moderate cognitive impairment. The MDS identified R152 had verbal behavioral symptoms 1-3 days during the assessment period that put the resident at risk for physical illness or injury, significantly interfered with resident's cares, significantly interfered with the resident's participation in activities or social interactions, and put others at significant risk for physical injury. The MDS also indicated behaviors of rejecting care and wondering 1-3 days during the assessment period, and had a staff assessed mood score of nine indicating moderate depression. R152's current electronic physician's (a printed copy of the orders was requested and not received) included: Ativan-Give 0.5 milliliters (ml) by mouth three times a day for Anxiety Zoloft 25 milligrams (mg)-Give 1 tablet by mouth one time a day for Depression ABHR cream (is a combination of Ativan 0.5 mg, Benadryl 12.5 mg, Haldol 0.5 mg and Reglan 0.5 mg) four times a day for 1 ml of cream to inner wrist related to restlessness and agitation. Mirtazapine (remeron an antidepressant)-Give 15 mg by mouth at bedtime related to major depressive recurrent depressive disorder. Seroquel a psychotropic-Give 1 tablet by mouth one time a day for Agitation & aggression AND Give 2 tablet by mouth at bedtime for agitation & aggression R152's target behavior monitoring included	21540		

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21540	Continued From page 66	21540		

agitation, hitting, yelling, grabbing others, rejection of cares and wandering.
During an interview on 7/20/16, at 10:25 a.m. registered nurse (RN)-D indicated an unawareness of which medication was prescribed for which behavior. RN-D stated she charted the behaviors and interventions in the electronic medication and treatment administration records. RN-D stated hospice provided an algorithm for the as needed psychotropic medications, if the first one doesn't work then we move to the next one on the list.

A policy was requested for identifying and monitoring specific targeted behaviors for the use of an antipsychotic medication was requested and not provided.

DID NOT ATTEMPT NONPHARMACOLOGICAL INTERVENTIONS BEFORE GIVING ANTIANXIETY MEDICATION AND GAVE MEDICATION WITHOUT CLEAR AND RESIDENT SPECIFIC INDICATIONS FOR USE:

R83 admitted to the facility on 2/7/13 with diagnoses that included major depressive disorder and unspecified psychosis according to the facility face sheet.

R83's quarterly Minimum Data Set (MDS) dated 4/6/16 included R83 had long and short term memory problems and severely impaired decision making skills for daily living. The MDS identified a mood score of 3 indicating minimal depressive symptoms. The MDS indicated R83 received anti-psychotic, anti-depressant and anti-anxiolytic (antianxiety) medications.

R83's physician orders dated 6/2/16 included: Lorazepam Intensol Concentrate 0.5 mg by

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21540	Continued From page 67 mouth every 4 hours as needed (PRN) for anxiety. Review of the May, June and July 2016 medication administration record (MAR) showed the following: R83 received PRN lorazepam intensol concentrate four times in the month of May and the facility did not document the reason for use or if non-pharmacological interventions were attempted prior to the use one time the medication was administered. Three times it was administered prior to showering which was not identified as an indication for use. R83 received PRN lorazepam intensol concentrate seven times in the month of June and the facility did not document the reason for use or if non-pharmacological interventions were attempted prior to the use for fives time the medication was administered. R83 received lorazepam intensol concentrate two times in July 2016 with no concerns identified with documentation. During an interview on 7/20/16, at 8:57 a.m. registered nurse (RN)-A stated that the nursing staff should have been providing and documenting non-pharmacological measures taken prior to the administration of an as-needed antianxiety medication and should document the reason the medication was being administered. During an interview on 07/20/2016, at 9:13 a.m. social services (SS)-A stated R83 did not have an order to use PRN lorazepam intensol concentrate in May 2016 when it had been administered prior to showering. The Medication Administration General	21540		

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21540	Continued From page 68 Guidelines dated 6/15 included, when a PRN medications were administered, the following documentation is provided: complaints or symptoms for which the medication was given. LACK OF USING NON-PHARMACOLOGICAL INTERVENTIONS PRIOR TO GIVING AS NEEDED MEDICATIONS; LACK OF IDENTIFYING MELATONIN AS A SLEEP AIDE: R52's quarterly MDS dated 4/8/16, identified R52 had severe cognitive impairment and no behaviors, had trouble falling asleep, staying a sleep or too much sleep, received scheduled pain medication, received non-pharmalogical interventions for pain and had no pain. R52's care plan was reviewed and failed to address insomnia and interventions to implement related to problems with sleeping. R52's physician orders, print date 7/19/16, identified orders for melatonin (supplement used for sleep) 3 mg (milligrams) one hour prior to bedtime as needed for insomnia and lorazepam (anti-anxiety) 1 mg three times a day for anxiety/agitation, crying, exit seeking and striking out. R52's physician progress note dated 6/10/16, indicated R52 had been hospitalized 6/1/16 through 6/6/16, and had several falls in interim since last fall seen 4/22/16. R52 continued to demonstrate impulsivity and fall risk during hospitalization and Seroquel (antipsychotic) 6.25 mg was started twice daily on as needed basis for agitation and weeping which they thought was helpful. The note also identified R52 was receiving citalopram (antidepressant) and mirtazapine (antidepressant) for depression and	21540		

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given frequent crying and agitation augmenting R52's depressive treatment with Seroquel would be appropriate for potential associated anxiety. The note also identified under the current medication orders the melatonin as above, however, the physician progress note lacked documentation of physician justification for the use of the melatonin.

In addition, a physician progress note, dated 6/23/16, identified listed under current medications was Lorazepam 0.5 mg every eight hours for anxiety. However, the note lacked documentation of physician justification for the use of the Lorazepam.

R52's physician orders, print date 7/19/16, identified orders for melatonin 3 mg one hour prior to bedtime as needed for insomnia, Morphine Sulfate (narcotic) 0.25 ml (milliliters) every four hours PRN for pain or dyspnea, Seroquel (anti-psychotic) 12.5 mg every 12 hours PRN for agitation and Tylenol 500 mg one tablet three times a day PRN for pain.

R52's pain assessment, dated 7/8/16, identified no pain, and strategies/factors that reduce pain rest and distraction. R52's sleep assessment, dated 6/8/16 through 6/10/16, indicated lighting, room temperature and noise level were conducive to sleep.

R52's medication administration record and nursing progress notes dated 6/1/16 through 7/20/16, identified R52 had received the as needed medications as follows:
Melatonin four times, Seroquel 23 times, Morphine four times and Tylenol six times. However, R52's record failed to include consistently documented non-pharmalogical

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21540	Continued From page 70 interventions being offered prior to the administration of the PRN medications. On 7/20/16, at 3:04 p.m., registered nurse (RN)-A verified R52's physician progress notes failed to include physician justification for the use of melatonin and Ativan. RN-A stated she would expect staff to offer non-pharmalogical interventions prior to the administration of PRN medications. On 7/20/16, at 4:33 p.m., the director of nursing (DON) stated (regarding physician justification) if the resident's medication is new or changed the physician should document the reason started, reason changed and reason for use. The DON stated (in regards to non-pharmalogical interventions being offered prior to PRN medications being administered) we should be documenting non-pharmalogical interventions we tried and medication should be the last result. A facility policy was requested for physician justification for use of psychotropic medication and for offering non-pharmalogical interventions for PRN medications, but was not provided. LACK OF ATTEMPTING A GRADUAL DOSE REDUCTION FOR AN ANTIPSYCHOTIC AND AN ANTIDEPRESSANT USED FOR INSOMNIA YEARLY OR A PHYSICIAN'S JUSTIFICATION AS TO WHY THE GRADUAL DOSE REDUCTION WAS NOT REDUCED AT THIS TIME: R59's admission record, dated 3/31/2011, indicated that the resident had diagnoses of dementia with Lewy bodies, insomnia and Parkinson's disease. R59's order summary report, start date 8/7/2013	21540		

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for Seroquel a psychotropic medication which is currently in use. R59 was to take 12.5 mg (milligrams) by mouth at bedtime related to bipolar disorder. It identified the following target behaviors: repeat verbalizations, hitting at furniture for attention, calling out, anger toward family/staff. On 5/12/2014, R59 was prescribed Trazodone (an antidepressant) for insomnia. She was to take 50 mg by mouth at bedtime. On 7/23/2015, R59 was prescribed depakote sprinkles for anxiety and currently in use. She was to take 600 mg by mouth in the evening. The order summary report, dated 2/13/2014, indicated that R59 had been admitted to St. Croix hospice with a terminal illness of progressive supranuclear palsy.

R59's care plan, dated 4/8/2011, stated that the resident was at risk for alteration in her behaviors and the potential for altercations with others which were related to yelling out at night, refusing cares, being verbally abusive, becoming anxious when waiting for staff assistance, self transferring, frequent use of the call light, being rude. The care plan further stated that R59 was at risk for alteration in her mood related to diagnoses of bipolar disorder, parkinsons syndrome and episodic delirium. With the stated goal of safety in mind, it recommended notifying the doctor if her behaviors interfered with her functioning or symptoms were not improving to see if a change in medication was warranted. It advised to give medications as ordered.

The facility was requested to provide all documentation which related to monitoring R59's behaviors. Documents titled monthly flow sheet as well as progress notes were provided. R59's behavior monthly flow sheets, reviewed from May 2016 through July 2016 indicated that the facility

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had been monitoring the resident for the following behaviors: insomnia, anxiety, and striking out/hitting. From the documentation, R59 appeared to not have a single episode of anxiety or striking/hitting. In May 2016, R59 had only one episode of insomnia where she was repositioned and the result was documented that she had the same amount of insomnia. Review of the progress notes from 4/2016 through 7/2016 indicated R59 had no behaviors other that a little sleepiness noted.

R59's pharmacy review notes, reviewed from September 2015 through July 2016 did not indicate whether any gradual dose reductions in psychotropic medications had been initiated. Each note from the pharmacist stated: "Gradual Dose Reduction: **hospice patient -- no GDR per MD for now."

When interviewed on 7/20/2016 at 4:01 p.m., registered nurse (RN)-A was asked about the lack of monitoring specific target behaviors for Seroquel. It was pointed out that the facility lacked documentation that they were monitoring for identified target behaviors. RN-A stated that she understood that the facility needed to monitor identified target behaviors for the use of an antipsychotic. It was pointed out that the facility was monitoring R59's "anxiety" but not monitoring specific, individualized symptoms of anxiety that R59 exhibited in order to justify the use of the Depakote Sprinkles. RN-A stated that she understood the need to monitor specific symptoms of anxiety and not a broad statement such as "anxiety." It was pointed out that the facility lacked physician justification to continue the use of Seroquel and Trazodone medications without an annual attempt to reduce or titration the medications. RN-A stated that it was her

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understanding that the facility should be attempting gradual dose reductions (GDR) in an attempt to decrease the use of psychotropic medications.

When interviewed on 7/20/2016 at 4:11 p.m., RN-B stated that she spoke with the pharmacist the facility contracts with. She stated that R59 received hospice services and, in the case, they never do GDR's when a resident was admitted to hospice services.

Review of the facility document titled, Mood/Behavior Management (3/31/2016), it stated that the behavior committee would monitor behaviors to assist in determining symptoms, cause, patterns and the severity of behavior. The social services staff should be trained on how to use the monitoring system and regularly review the system for proper use. It stated that a system to evaluate and document a behavior management plan would be established in order to document specific behavior problems. It stated that the behavior management plan would be evaluated for effectiveness at least monthly.

Review of the facility document titled, antipsychotic medication review (3/31/2016), it advised that the physician has reviewed a resident's medication program at least quarterly and has documented the reason for the continuance or change in the medication.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee, could review all residents receiving psychotropic medications to ensure the clinical record contained justification for the medication, and adequate monitoring for continued use. The DON

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21540	Continued From page 74 or designee, could educate all appropriate staff. The DON or designee, could develop monitoring systems to ensure ongoing compliance. A report could be submitted to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to promote a safe environment regarding plugged in and ready to use toasters located in dining rooms on the third floor only of the facility. The third floor has various levels of cognitively impaired residents and one of the wings on third floor was secured to prevent elopement. This could affect several residents on the third floor who were ambulatory or in wheel chairs who had free access to the toasters when not supervised by staff between meals. Findings include: During a tour of the third floor on 07/17/16 at 1:19 p.m. where cognitively impaired residents lived it was noted that there were two toasters one on east wing and one on the west wing which was a secured wing was plugged into the wall and ready be used. On 7/17/16, at 1:19 p.m., the west dementia unit (secured unit) on third floor was observed to have	21665	Corrected	7/20/16

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a two slice plugged in toaster sitting on the kitchen counter which was located in the dining room area and was accessible to residents that were ambulatory. Also staff were not always in the area to monitor residents movement.

On 7/17/16, at 2:19 p.m., the director of Alzheimer's care (DAC)-H stated the toaster had been on the unit since she started working at the facility a year ago. DAC-H stated there had been no incidents of burns related to the toaster and two residents (R118 and R157) were ambulatory and if wanted were able to access the toaster, but she had never seen the residents go by the toaster. On 7/17/16, at 2:25 p.m., DAC-H was encouraged to assess the safety of the residents with the interdisciplinary team in regards to access to the toaster. DAC-H removed the toaster at this time and informed administrator. .

On 7/17/16, at 3:10 p.m., the third floor east dining room was observed to have a plugged in toaster sitting on the kitchen counter which was accessible to wandering confused residents in a dining room that is not always monitored by staff.

On 7/17/16, at 3:11 p.m., licensed practical nurse (LPN)-F stated she had worked at the facility since January 2016 and the plugged in toaster had been in the third floor east dining room area since she had started. LPN-F stated there had been no incidents of burns related to the toaster that she was aware of. LPN-F stated R123 was one out six residents on the third floor that had dementia, was ambulatory and would be able to access the toaster. LPN-F stated the other five residents were in wheelchairs and not able to access the toaster. LPN-H was encouraged to notify the administrator to determine what course of action they should take in regards to the

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21665	Continued From page 76 plugged in toaster. LPN-H removed the toaster and notified the administrator. Scientific research tested how hot a toaster needed to be to brown bread. They found that no matter which toaster is used an electric toaster must get to at least 310 degrees Fahrenheit for the toast to turn brown and depending on the kind of heating elements they can reach 1000 degrees Ferenheiht or more to heat the bread quickly. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of a safe environment. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure a safe, environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: One (1) day.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote dignity by knocking or announcing self before entering resident rooms for 3 of 3 residents (R30, R52, R59) reviewed for dignity. In addition, failed to	21805	Corrected	8/29/16

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21805	Continued From page 77 provide care and services in a dignified manner for 2 of 2 residents (R59 and R52) who were reviewed for dignity. Findings included: R30 admitted to the facility on 5/30/13 according to the facility face sheet. R30's annual Minimum Data Set (MDS) dated 5/6/16 reported no cognitive impairment with a Brief Interview for Mental status score of fifteen. During an interview on 7/18/16, at 9:01 a.m. R30 was conversing with surveyor when nursing assistant (NA)-A entered the room without knocking. NA-A then walked to the other side of the room and grabbed R30's roommate's breakfast tray and proceeding to exit the room. During an interview on 7/18/16, at 9:30 a.m. NA-A stated she should have knocked prior to entering and wait for an invite into the room. During an interview on 7/19/16, at 12:35 p.m. registered nurse (RN)-B stated staff are supposed to knock on the door and wait to be invited in, and if there was not an answer, then staff are supposed to briefly pause and crack the door to alert the resident they are entering the room. During an interview on 7/19/16, at 2:03 p.m. director of nursing (DON) indicated the facilities expectation is for all staff members to knock on the resident's doors and wait to be invited in prior to entering a room. R52 was observed on 7/17/16, at 2:39 p.m. R52 observed to be in bed when staff entered the room without knocking to remove the hoyer lift (a mechanical lift for use with dependent residents during transfers), from R52's room.	21805		

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21805	Continued From page 78 On 7/18/16, at 3:37 p.m. staff assisted R52 to her bed. Staff were stepping on the floor mat next to R52's bed which caused the alarm to be constantly sounding. After assisting R52 into bed, staff left the room and did not turn off the light. On 7/19/16, at 7:07 a.m. licensed practical nurse (LPN)-B was assisting R52 with blood sugar checks. During this time registered nurse (RN)-B entered the room to speak with LPN-B and did not knock before entering and did not address R52. On 7/19/16, at 7:23 a.m. RN-B entered R52's room without knocking to speak with LPN-B and did not address R52 during this time. R59 was observed on 7/19/16, at 7:55 a.m. NA-G was assisting R59 with her morning cares. R59 was lying on her back in the bed with her eyes closed. NA-G was waiting for a clean brief to be brought into the room during which R59's pants were pulled down and R59 was lying exposed on the bed. Once the pad was brought in NA-G continued with cares which included rolling R59 from side to side to get clothing properly placed. During this time NA-G did not address R59 or explain to R59 what they were doing for R59. On 7/19/16, at 8:00 a.m. NA-G placed R59 in the hoyer sling and attached the sling to the hoyer lift without explaining the process or addressing R59. R59 was then transferred to her wheelchair without explanation. During observation on 7/19/16, at 1:09 p.m. nursing assistant (NA)-D placed the hoyer lift into R52 and R59's shared bedroom for storage. NA-D stated that R59 would be lay down soon so the lift was kept in the bedroom. Upon entering	21805		

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the shared room NA-D did not knock or address R52 who was lying in bed.

On 7/19/16, at 1:12 p.m. the door to R52 and R59's room was shut. A family member (FM)-A of R59's was bringing her back to her bedroom and stopped at the shut door. NA-D told FM-A, "Go ahead in there it's just [R52]." R52 was not informed of FM-A entering room.

On 7/20/16, at 11:59 a.m. director of nursing (DON) entered the shared bedroom without knocking to assess the cord on the fall mat next to R52's bed. R59 was in the room with FM-A. Fall mat alarm began sounding loudly which at that time the DON apologized to R59's family for the disruption.

During an interview on 7/20/16, at 1:35 p.m. NA-F stated she received dignity training which included knocking on doors prior to entering the room, introducing yourself and shutting the curtains when providing care.

Interview with NA-E on 7/20/16, at 1:36 p.m. stated staff should knock before entering the resident rooms, asking permission before assisting with cares, letting the residents know what cares are being provided and treating the residents like human beings.

On 7/20/16, at 1:37 p.m. LPN-A stated staff are provided training on dignity for the residents which included keeping the resident doors closed when providing cares, knock before entering the room, keep the residents covered when providing cares, provide privacy.

Interview with RN-B who is responsible for staff training, on 7/20/16, at 2:00 p.m. stated staff are

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21805	Continued From page 80 trained informally on providing dignity to the residents. This training includes, knocking and asking for permission to enter, pausing and announcing self. RN-B stated staff should not walk straight into the rooms and stated these are the resident's homes. Interview with DON on 7/20/16, at 3:05 p.m. stated her expectation of staff is to knock and announce entry, asking for permission in a respectful manner, introducing self. I don't expect them to just barge into rooms." Policy titled, Preservation of Residents' Rights which was undated, identified "The social services staff will take an active role in training employees and monitoring practice on issues regarding residents' personal privacy including: privacy during medical treatments and personal care and knocking on doors and requesting permission to enter resident rooms" Facility policy Dignity last reviewed 3/31/16, stated "All resident will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality." The policy also indicated staff would respect resident's private space and property. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all employees on treating all resident with respect to promoting courtesy and dignity. Monitoring for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21810	Continued From page 81	21810		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a wheelchair which was assessed to promote body alignment and comfort for 1 of 1 resident (R38) reviewed for body positioning. Findings include: R38's admission record, dated 3/10/2015, indicated that the resident had diagnoses of chronic pain, shoulder pain, and age-related osteoporosis. R38's care area assessment (CAA), dated 3/17/2016, stated that the resident needed assistance with activities of daily living (ADL). R38 used a wheelchair and a walker and was at risk for a further decline in ADLs and falls. It stated factors which could potentially contribute to this decline were poor vision, pain and a changing cognitive status. R38's order summary report, dated 5/25/2016, indicated that the resident was prescribed	21810	Corrected	8/29/16

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	00953	A. BUILDING: _____ B. WING _____	07/20/2016

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21810	Continued From page 82 Oxycodone for pain on a scheduled as well as an as-needed basis. R38's medical record, reviewed on 7/20/2016, indicated that R38 received occupational therapy from 3/11/2015 through 4/6/2015. R38's care plan, dated 3/24/2015, indicated that the resident had a deficit in physical functioning related to mobility impairment. It advised that R38 was in need of locomotion assistance of 1 person and used a wheelchair. It advised to monitor and report changes in physical functioning ability. It recommended rehabilitative services as ordered. During an observation and interview on 7/18/2016 at 9:15 a.m., R38 said her wheelchair was too tight fitting. She stated that when her roommate moved about about a month ago she took her roommate's wheelchair because her previous one made her back hurt. She stated that her current one did not hurt her back but that it was too tight fitting and she needed more space in order to sit properly. R38 was observed to be seated in her current wheelchair. The siding on the wheelchair was bulging on the right side. There was a visible crack running on the right side of the wheelchair where it was bulging out. During an observation on 7/18/2016 at 3:24 p.m., R38 was seated in her wheelchair in the dining area listening to music. The right side of the wheelchair was observed to be bowed out. The resident had no room to maneuver in her wheelchair and all sides of the wheelchair gave no space to the resident. The area that bowed out had a large crack that showed where it bowed. When interviewed on 7/19/2016 at 1:06 p.m.,	21810		

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21810	Continued From page 83 registered nurse (RN)-D stated when a resident first admitted to the facility they were screened for a properly fitting wheelchair that the resident was measured for. She stated if the wheelchair exhibited visible damage, the resident would be reassessed for another chair. She stated that if a resident had an improperly fitting wheelchair she would make a referral to occupational therapy for a properly fitted wheelchair. When interviewed on 7/20/2016 at 11:17 a.m., licensed practical nurse (LPN)-D stated that the facility assessed residents' wheelchair functionality on a quarterly basis. She stated that if a resident had an ill-fitting wheelchair should would refer to occupational therapy. When interviewed on 7/20/2016 at 3:37 p.m. the director of nursing (DON) stated that when a resident discharged from the facility all the belongings are removed from the room. She stated that if a resident had a tight fitting wheelchair then certainly therapy would get involved to measure the resident for a more properly fitting wheelchair. She stated that a resident with a tight fitting wheelchair would be susceptible to skin breakdown. Review of the facilty policy titled, Use of Wheelchair (2/29/2016), it stated that a wheelchair should be the proper size. SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service employees responsible for a wheel chair assessed to be appropriate for the resident. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		

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21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the	21830		8/29/16

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21830	Continued From page 85	21830		

resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.

(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social

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21830	Continued From page 86 service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R30) was given a choice on medication administration times in order to participate in activities of preference reviewed for choices. Findings include R30 was interviewed on 7/17/16, at 6:41 p.m. R30 stated he was not able to participate in the activities that he would like to because of daily nebulizer treatments that are scheduled during the same time as the activities. R30 stated on the days they have BINGO they always have 500 or another dice game. R30 further explained he was not aware if the treatments could be moved to a different time so he could attend the activity. R30 admitted to the facility on 5/30/13 according to the facility face sheet. Facility face sheet included diagnoses of chronic obstructive pulmonary disease (COPD) with acute exacerbation. R30's annual Minimum Data Set (MDS) dated 5/6/16 revealed no cognitive impairment with a Brief Interview for Mental Status score of fifteen. The MDS indicated R30 reported it was very important to be around animals such as pets, was very important to listen to music he liked, was	21830	Corrected	

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21830	Continued From page 87 very important to do things with people, was very important to keep up with the news, and was very important to do favorite activities. R30's care plan included, "My favorite activities include bingo, poker, 500, rummy, sports, game shows, radio, church, country music, socials, animals, outdoors, and/or time with family and/or friends, please provide necessary assistance to ensure I can participate at my highest ability." R30's Physician's orders included Duoneb solution 0.5-2.5 (3) milligrams (Mg)/3 Milliliters (ml); inhale 3 ml orally four times a day for exacerbation related to COPD. R30's June 2016 and July's medication administration records (MAR) reflect R30 was administered the Duoneb at the scheduled times of 4:00 a.m., 10:00 a.m., 4:00 p.m., and at 10:00 p.m. June 2016 and July's activity calendars reflect bingo scheduled twice per week at 2:00 p.m. followed by dice/500-1 at 3:00 p.m. R30's activity attendance record indicated R30 attended all of the bingo activities; the record did not reflect R30's attendance to any dice/500-1 activities. During an interview on 7/18/16, at 3:20 p.m. licensed practical nurse (LPN)-A reported R30 would come back to his room when the nebulizer treatments are scheduled and the afternoon dose was around 3:00 p.m. During an interview on 7/18/16, at 3:43 p.m. registered nurse (RN)-A reported R30 probably did not have a choice when medications were scheduled and explained the computer system assigned our standard dosing times of medication. RN-A explained R30 has a choice to change those times and could certainly change them so he can do the things he wants to do. During an interview on 7/20/16, at 9:00 a.m. activities assistant (AA)-A indicated R30 routinely attended bingo, but not too many other activities.	21830		

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21830	Continued From page 88 AA-A indicated R30 would probably like 500 club or dice. AA-A was not aware R30 had a scheduled medication at the same time as dice/500-1. During an interview 7/20/16, at 2:03 p.m. director of nursing (DON) explained she was not aware of how the medications were scheduled around resident preferences. DON stated many of the residents were not alert and orientated so medications are scheduled and the pharmacy recommends the medication times. DON indicated medication times could be worked out to accommodate resident preferences. Facility policy Medication Administration-General Guidelines last reviewed 6/15 did not indicate a circumstance for resident preference or choice. The policy included, "11) A schedule of routine dose administration times is established by the facility and utilized on the administration record. 12) Medications are administered with 60 minutes of scheduled time, except before, with or after meal orders, which are administered based on meal times. Unless otherwise specified by the prescriber, routine medications are administered according to established medication administration schedule for the facility." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service staff responsible for assessing residents choice in attending activities is allowed to do so. Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights	21840		8/29/16

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21840	Continued From page 89 Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record. This MN Requirement is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure risk and benefits for 3 of 3 residents (R123, R149 and R171) were explained related to care plan interventions not being followed for preventive measures. Findings include: R123's care plan, print date 7/20/16, indicated at risk for falls related to poor vision and chronic vertigo with interventions of gait belt with transfers, contact guard assistance to prevent injuries to staff and resident. Physical functioning deficit related to self-care impairment, mobility impairment with interventions t locomotion supervision of one staff with a forward wheeled walker and gait belt on hand, resident gets agitated and angry when help is offered as he wants to be independent, transfer assistance of one staff, walker and gait belt and walking assistance.	21840	Corrected	

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21840	Continued From page 90 On 7/18/16, at 8:18 a.m., R123 was observed to walk off the elevator independently using his walker. On 7/19/16, at 10:10 a.m., R123 was observed walking in the hallway on the first floor independently using his walker. On 7/20/16, at 1:41 p.m., R123 was observed to be walking in the dining room independently using his walker. On 7/20/16, at 2:47 p.m., registered nurse (RN)-A stated R123's care plan read one assist with mobility. RN-A stated R123's care plan did not include one assist with walking if R123 allowed it, but if he allows should be included with walking assistance on R123's care plan due to times becomes upset with staff assistance. RN-A stated she had talked to R123's family extensively. On 7/20/16, at 4:41 p.m., the director of nursing (DON) stated she would expect risk and benefits to be done if R123 was refusing for staff to provide walking assist. R149's care plan, print date 7/20/16, indicated R149 had a physical functioning deficit related to mobility impairment, extremely tall and unsteady with interventions of assist of one for all transfers and toileting assistance of one. On 7/19/16, at 8:10 a.m., R149 was observed to be sitting on the edge of his bed. R149 placed his walker in front of him, stood and self-transferred into his wheelchair. On 7/20/16, at 8:15 a.m., nursing assistant (NA)-I stated R149 transfers himself and toilets himself.	21840		

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21840	Continued From page 91 NA-A stated usually R149 does not ask for assist for transfers or toileting, unless he wants his urinal emptied. On 7/20/16, at 11:01 a.m., licensed practical nurse (LPN)-D stated R149 required assist of one for transfers and toileting. LPN-D stated she had not included on R149's care plan that he self-transfers and she had not completed a risk and benefits regarding self-transferring for R149. On 7/20/16, at 4:25 p.m., the DON stated if a resident chooses to be non-complaint staff should be explaining the risk and benefits of self-transferring to the resident. R171's care plan, print date of 7/20/16, indicated R171 had a physical functioning deficit related to mobility impairment and range of motion limitations with interventions of non-weight bear (NWB) through heels, weight bear as tolerated through balls of feet if can remain NWB through heels. Pressure ulcer actual or at risk due to pressure ulcer present on left heel with interventions of float heels. On 7/18/16, at 1:49 p.m., R171 was sitting in his wheelchair with shoes on both feet and R171's feet were flat on the floor. On 7/19/16, at 7:03 a.m., R171 was assisted to bed and had blue boots on both feet. R171's feet laid directly on the mattress. Observation with registered nurse (RN)-D revealed R171's left heel had a closed, dark colored area of skin. On 7/20/16, at 8:11 a.m., R171 was sitting in his wheelchair with shoes on both feet and R171's feet were flat on the floor.	21840		

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21840	Continued From page 92 On 7/20/16, at 1:28 p.m., nursing assistant (NA)-H stated R171 was not to be full weight bearing when standing to transfer. NA-H stated R171 had foot rests for his wheelchair in his closet for use, but R171 had not used the footrests for a long time. NA-H stated R171 wanted to be without the footrests, as he wanted to be more mobile. On 7/19/16, at 7:03 a.m., RN-D stated R171 was usually non-compliant with keeping heels floated. RN-D stated R171 was to be non-weight bearing to heels, but R171 used his heels to propel his wheelchair due to poor memory and he does not remember to not bear weight on his heels. RN-D stated the facility had tried using wheelchair leg rests a lot of times, but R171 puts his heels back on the ground even with footrests on the wheelchair. On 7/20/16, at 4:31 p.m., the DON stated risk and benefits should have been done regarding R171 refusing to have heels floated. Policy was requested but none provided. A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to resident's rights to refuse treatment after having been educated to potential risks. The DON could develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21840		

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21980	Continued From page 93	21980		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead	21980		8/29/16

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21980	Continued From page 94 agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately notify the designated state agency (Office of Health Facility) upon learning of an unwitnessed large bruise before completing a comprehensive investigation to determine if it met the requirement of maltreatment for 1 of 1 resident (R59) reviewed for unknown bruise. Findings include: R59 was observed on 7/18/16, at 9:24 a.m. to have a large bruise over the entire top of right hand, going onto the top of the right wrist. A separate bruise located on the right forearm approximately the size of a quarter was also noted. 7/18/16, at 2:56 p.m. R59 was resting in bed and making no attempt to move arms or hands. Both arms were bent at the elbows and resting on R59's chest. Both hands clenched into fists. Short sleeve shirt on, no arm sleeves present. Large bruise noted to right hand and wrist. 7/18/16, at 3:36 p.m. a hospice nurse working for St. Croix approached a facility nurse to ask about the large bruise on R59. Staff informed hospice nurse that she had notified the hospice service	21980	Corrected	

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	00953	A. BUILDING: _____ B. WING _____	07/20/2016

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21980	Continued From page 95 regarding the bruise but offered no additional information. 7/19/16 at 3:05 p.m. RN-E assessed R59's hand. RN-E reported the forearm bruise is older and [R59] had that prior to the hand/wrist bruise. RN-E measured the bruise and reported it was 16 cm (centimeters) X (by) seven cm. RN-E stated as far as she was aware R59 had never worn arm sleeves and was unaware the care plan listed these as an intervention. RN-E attempted to open R59's hands but was unable to. The weekly skin review document dated 7/9/16 identified R59 had no bruises present. R59's diagnosis found on the Admission Record indicate Dementia with Lewy Bodies (onset date of 7/3/12), Unspecified Osteoarthritis (onset date 5/3/11) and Parkinson's Disease (onset date 3/31/11). R59's care plan with an initiated date of 6/28/13 identifies R59 as having a potential for altered skin integrity non pressure related to: she has tendency to bump arms/hands on walls, objects, has frail thin skin. Goal was revised on 7/14/16 which identified the affected area will heal without complications. Weekly skin review dated 7/9/16 identifies R59 had no bruises. Weekly skin review dated 7/16/16 identified R59 has a bruise to the back of the right hand and is light purple. 7/16/16, at 6:21 a.m. states, "night CNA [certified nursing assistant] observed a 10 cm [centimeter] long 6 cm wide bruise on top of right hand that is purple/blue in color w [with]/swelling. Pressure bandage applied. It is unknown when or how bruise occurred. DQI (type of incident report) to follow."	21980		

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21980	Continued From page 96 7/16/16 at 1:53 p.m. states, "She did have wkly [weekly] bed bath this morning. Noted to have the light purple bruise on top of her R hand. Measured about 10 X 6 cm." "Also notified [executive director and name], at 1pm to determine if bruise was reportable." 7/19/16, at 9:04 a.m. interview with licensed practical nurse (LPN)-B reported she wasn't sure how the bruise happened but thought her hand had somehow been bumped. LPN-B stated once a bruise is found the process is to complete a DQI, SBAR (communication method identifying situation, background, assessment, response), complete a state incident report and write a progress note. Physician and family should be notified and a copy of the SBAR and DQI go to the director of nursing. 7/19/16, at 10:05 a.m. interview with the Executive Director (ED) stated a bruise is reportable based on the location. R59's bruise according to the ED was not in a suspicious part of the body. The ED stated he had not seen the bruise. Interview on 7/19/16, at 1:22 p.m. with RN-E stated the bruise happened on Sunday during the night shift and the night shift trained medication aid (TMA) had reported the bruise to the night nurse. I worked the evening before that shift and it wasn't reported on my shift but it probably happened on my shift. R59 went on to say R59 doesn't move her arms and I believe she got trapped in the hoyer. 7/19/16, at 1:57 p.m. interview with the ED stated he couldn't find the incident report related to the the large bruise on R59's hand. ED stated the bruise happened during a transfer and that it had been witnessed. ED then stated the bruise had been observed by the aid who was working the	21980		

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21980	Continued From page 97	21980		

night shift but that staff were unaware of the cause. ED stated the bruise had not been reported to the Office of Health Compliance (designated state agency for reporting abuse/neglect etc.)
7/20/16, at 2:00 p.m. interview with RN-B stated all staff are trained on hire and with in-services the policy for reporting unexplained injuries. RN-B stated a binder with the policy and all the reporting information is located on each floor of the facility. RN-B stated all aids are instructed during abuse and neglect training that they should be reporting anything out of the ordinary to the nurse. The nurse would then be expected to utilize the binder to determine reporting protocol. RN-B stated there is a decision tree that is used for injuries of unknown sources and the binder also has information on how to report to outside sources.
Interview on 7/20/16, at 3:05 p.m. DON stated anything that isn't witnessed needs to be reported. An incident report should be filled out and stated the floor staff is expected to report to the state agency (Office of Health Facilities) for unknown injuries. DON also stated if a floor nurse has questions about the process they would call her or the ED for further instruction.
Policy, Reporting Alleged Abuse Violation, 1/15/15 states, "It is the responsibility of all employees to immediately report any alleged violation of abuse, neglect, injuries of unknown source and misappropriation of resident property." Policy titled, Reporting and Investigation of Alleged Violations of Federal and State Laws Involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source and Misappropriation of Resident's Property, dated 7/12/16, identifies, "Any employee who suspects an alleged violation shall immediately notify the ED. The ED shall also notify the appropriate state agency in accordance

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21980	Continued From page 98 with state law." SUGGESTED METHOD OF CORRECTION: The director of nursing could in-service all staff on the directions in the maltreatment statute to report a bruise of unknown origin immediately to the Common Entry Point (Office of Health Facility Complaints). Also to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		