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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q3PC

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00775

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245361**

2.STATE VENDOR OR MEDICAID NO.
(L2) **134543500**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEEKER MANOR REHABILITATION CENTER, LLC**
(L4) **600 SOUTH DAVIS AVENUE**
(L5) **LITCHFIELD, MN** (L6) **55355**

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) **07/14/2016**

6. DATE OF SURVEY **09/27/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **90** (L18)
13.Total Certified Beds **90** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(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:
Brenda Fischer, Unit Supervisor 10/02/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist 10/02/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/19/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered October 2, 2018

CMS Certification Number (CCN): 245361

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

Dear Administrator:

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 10, 2018 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 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,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

Electronically delivered
October 2, 2018

Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: Project Number S5361027

Dear Administrator:

On August 13, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective August 18, 2018. (42 CFR 488.422)

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

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 27, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on July 27, 2018. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On September 27, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 17, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on July 27, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 10, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on July 27, 2018, as of September 10, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 10, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter dated August 13, 2018:

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

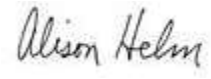
- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 27, 2018 be rescinded as of September 10, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure(s)

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: Q3PC

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(L3) **MEEKER MANOR REHABILITATION CENTER, LLC**
(L4) **600 SOUTH DAVIS AVENUE**
(L5) **LITCHFIELD, MN** (L6) **55355**

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) **07/14/2016**

6. DATE OF SURVEY **07/27/2018** (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)
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To (b) :

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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
	90			
(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:
Bruce Melchert, HFE NE II — 08/31/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Alison Helm, Enforcement Specialist — 09/18/2018 (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
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3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
10/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
August 13, 2018

Ms. Lynn Hogendorn, Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

RE: Project Number S5361027

Dear Ms. Hogendorn:

On July 27, 2018, an extended survey was completed at your facility by the Minnesota Department 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.

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

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

> Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;
>
> No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);
>
> Substandard Quality of Care means one or more deficiencies related to participation requirements under 42 CFR 483.12, Freedom from Abuse, Neglect, and Exploitation, 42 CFR 483.24, Quality of Life, or 42 CFR 483.25, Quality of Care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on July 26, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151
Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - REMEDIES

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

- State Monitoring effective August 18, 2018. (42 CFR 488.422)

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

- Civil money penalty. (42 CFR 488.430 through 488.444)

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 27, 2018. (42 CFR 488.417 (b))

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.24, Quality of Life, and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(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 an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Meeker Manor Rehabilitation Center, LLC is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 27, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. 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.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its

NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

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

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 PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your 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 plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved 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.

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 27, 2018 (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 27, 2019 (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.

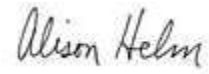
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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,



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

(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
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 7/23/18 thru 7/27/18, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group	E 039		9/10/18

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

Electronically Signed | 08/23/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

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E 039	Continued From page 1 discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure full scale and table top exercises to test their emergency plan. This had the potential to affect all 56 residents currently residing in the facility. Findings include: The Emergency Disaster Preparedness plan dated 11/2017, was reviewed. The facility's	E 039	Meeker Manor Rehab Center POC E039 □ EP Testing Requirements * The facility will complete 2 table top exercises to test the emergency plan * Staff will be re-educated on ensuring full scale and/or table top exercises to test their emergency plan are completed annually * An audit of full scale and/or table top exercises will be completed to ensure	

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E 039	Continued From page 2 current emergency preparedness plan lacked documentation or other evidence the plan was tested, addressed by: --Participation in a full-scale, community-based exercise, or if the community-based is not available, an individual, facility-based exercise that utilizes planned emergency procedures; and --Conduct an additional exercise that may be a second, full-scale, either community or individual, facility drill, or a table-top exercise, led by a facilitator, using a clinically-relevant emergency scenario to test the emergency plan; and --Analyzing the facility's response to the exercises and experiences and maintain the documentation from the review. When interviewed on 7/27/18, at 3:17 p.m. the regional director of operation (RDO) stated, "we have not completed" any table top exercise or other full scale drill to test the emergency plan. The RDO stated facility staff participated in routine fire and weather drills, but stated neither a full scale drill or table top exercise had not been done. The RDO stated there was no documentation that the full EP testing had been completed. The RDO stated completing a full-scale drill along with table top exercises would be an additional component the facility would have to address.	E 039	completion annually * Maintenance Director or designee will be responsible party * QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process * Completion Date: 9/10/2018	
E 041 SS=C	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in	E 041		9/10/18

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E 041	Continued From page 3 paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e) (e) Emergency and standby power systems. The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and maintenance requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g),	E 041		

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E 041	Continued From page 4 and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22,	E 041		

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E 041	Continued From page 5 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility did not provide an essential electrical system in accordance with NFPA 99 (2012) Health Care Facilities Code and NFPA 110 (2010) Standard for Emergency and Standby Power Systems and failed to ensure they had implemented emergency generator inspection/testing in accordance with the requirements. This had the potential to affect all 56 current residents, as well as staff and visitors, if the generator failed to operate during a power outage. Findings include: Observations were completed during the facilty tour between 9:00 AM to 1:00 PM on 07/23/2018. Record review and interview with the environmental services director (ESD) revealed: 1) The monthly generator log was not completed for 7/18, 6/18, 5/18 and 2/18. 2) Annual load bank test was not performed. During interview on 7/27/18, at 1:42 p.m. the environmental services director (ESD) stated the generator logs were missing for a number of months. The ESD also stated the facility needed to have a contractor come in to perform an annual load bank test on the generator as evidence the generator meets the standard, but "we have not had this test yet."	E 041	E041 – Hospital CAH and LTC Emergency Power • The facility completed an annual emergency generator inspection/testing on 8/13 for the annual load bank test. The facility has completed their monthly generator log. • Staff will be re-educated on ensuring the annual emergency generator inspection/testing is completed for the annual load bank test & monthly generator logs. • An audit of the annual emergency generator inspection/testing will be completed annually; then as needed. An audit of the monthly generator log will be completed monthly x 4 months; then as needed. • Maintenance Director or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 000	INITIAL COMMENTS On 7/23/17 to 7/27/18, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) and substandard quality of care at F600 when the facility failed to ensure an allegation of sexual abuse was addressed including being accurately and comprehensively investigated, protection provided to the alleged victim, and interventions being implemented to prevent recurrence. The administrator, regional director of operations (RDO), interim director of nursing (DON) and regional consultant (RC) were notified of the IJ on 7/26/18 at 5:06 p.m. The IJ was removed on 7/27/18, at 3:50 p.m. when the facility implemented a removal plan which included comprehensively investigating the alleged abuse, providing protection for the alleged victim, and educating staff on interventions to ensure safety of the alleged victim. In addition, an extended survey was completed on 7/27/18, for substandard quality of care. 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	F 000		

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F 000	Continued From page 7 on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal	F 550		9/10/18

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F 550	Continued From page 8 from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dignity was maintained when bandages were conspicuously dated in large font for 2 of 2 residents (R47and R44) who needed face and leg dressings. Findings include: R47's admission Minimum Data Set (MDS) dated 6/22/18, indicated she was cognitively intact. On 7/23/18, at 7:09 a.m. R47 was observed being assisted into the dining room for breakfast. R47 had a skin colored bandage about 4" (inches) by 4 inches on her right cheek, which had a large date of 7/21/18 written in thick black marker which covered approximately 50% of the dressing and was easily readable across the width of the dining room (greater than 20 feet in distance). During observation on 7/25/18 at 8:00 p.m. R47 was seated in her recliner in her room. R47 had a 4" by 4" dressing was in place on her right cheek, dated, A skin-colored bandage, about 4" (inches) by 4" was intact on R47's face and was dated "7/25/18" in black ink which covered about half the dressing. Licensed practical nurse (LPN)-A entered R47's room with evening medications.	F 550	F550 – Resident Rights/Exercise of Rights • R44 and R47 were reviewed for dignified existence and self-determination. R44 and R47 treatments were reviewed, plan of care and interventions have been updated to reflect dignified existence. R47 has been discharged. • All current residents have been identified for Resident Rights and Exercise to Rights for dignified existence and self-determination. Resident's interventions and plan of care have reviewed and updated • Staff will be re-educated on ensuring resident rights and resident dignity are being met specific to labeling of dressings • Audits of 3 residents for resident rights and resident dignity related to labeling of dressings will be completed weekly x 4 weeks; then as needed • Director of Nursing or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 550	Continued From page 9 During interview on 7/25/18, at 8:00 p.m. LPN-A stated she thought the writing on R47's face bandage "should be less in size" and that the date could be written small and on the lower edge of the dressing. LPN-A stated the size of the date attracted more attention to the dressing. R47's treatment administration record dated July 2018, directed to change foam border dressing to right cheek every 2-3 days and as needed. During interview on 7/27/18, at 2:02 p.m. the interim director of nursing (DON) stated she heard about "the date" on R47's dressing on her face. The DON stated "that would be a dignity issue." R44's admission Minimum Data Set (MDS) dated 4/27/18, indicated R44 was cognitively intact. During observation on 7/25/18, at 5:04 p.m. R44 was seated in her wheel chair, dressed in shorts. On both R44's right and left shins was a tan-colored bandage, each approximately 4" (inches) by 4". The date "7/24" was written in a large, black font on each of the bandages, which was easily visible and seen by anyone nearby. R44's treatment administration record for July 2018, directed to apply border foam dressings to abrasions to shins and cleanse with wound cleanser and apply new dressing every 3 days. During interview on 7/25/18, at 5:04 p.m. R44 stated the bandages would come off when she got her bath tonight and added "I don't like the dates on my bandages." R44 stated she did not know why they had to do that and her knees	F 550		

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F 550	Continued From page 10 "would look better without the dates on them." R44 stated staff put the dates on them the day they change the bandages and added "they could just document the dates in my chart instead. In a subsequent interview on 7/26/18, at 10:39 a.m. R44 stated it was not the fact the date was written on the bandage, but that it was written "so big" that was upsetting. R44 stated she'd be "ok" with the dates on her bandages if the date was written smaller. During interview on 7/26/18, at 12:22 p.m. the director of nursing (DON) stated the date was written on the bandages so we know when it was changed last. The DON then stated she did not know why the nurses were writing the date so big and if it's that big, "that concerns me for dignity" and the dates should be written smaller. A policy regarding dignity was requested, but none was provide.	F 550		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.	F 561		9/10/18

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F 561	Continued From page 11 §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facilty failed to ensure residents were given a choice of their meal preference for 1 of 1 resident (R9) who spoke Spanish as her primary language. Additionally, the facility failed to ensure residents were allowed the choice of bathing frequency for 1 of 1 (R24) reviewed for choices. Findings include: R9's quarterly Minimum Data Set (MDS) dated 7/26/18, identified R9 had diagnosis of dementia and depression with severe cognitive impairment. During interview on 07/25/18 5:44 p.m. with dietary aide (DA)-C and DA-D; DA-C stated at each noon meal residents are given a ticket for the next day's meal to choose from. They can either choose the main entree or alternate and circle or mark what they want for these meals. If they are unable to do this, then we or the nursing assistants (NA) help the resident complete this. They have a few staff in the dietary department	F 561	F561 - Self Determination • R9 and R24 were reviewed for self-determination. Plan of care and interventions have been updated and reviewed to reflect resident's self-determination. R24 bathing preferences were reviewed, plan of care has been updated to reflect self-determination. R9 meal preferences have been reviewed and care plan updated to reflect self-determination. • All current residents have been identified for self-determination of bathing preferences, and choice of their meal preferences. Interventions and plan of care have been reviewed and updated. • Staff will be re-educated on self-determination specific to food preferences and bathing preferences • Audits of 3 residents for resident self-determination of meal preferences and bathing preferences will be completed weekly x 4 weeks; then as needed	

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F 561	Continued From page 12 that speak Spanish and they help R9 choose food item on the menu as well. If these dietary staff are not working, they point to the food item word, and ask her "see" yes in Spanish or "no" and she tells us, even though R9 is unable to read. DA-D stated nothing during this conversation. R9 was observed on 07/25/18 06:01 p.m. at the table, and had just finished with her evening meal. She ate 1/2 of sandwich, 100% pear sauce and sips of her soup. There was a pile of filled out menu choices, and R9 menu preference was highlighted with a green marker. DA-B stated she helped R9 fill the menu out, and used Google translator on an iPad. DA-B found the iPad and proceeded to show how she used the translator with R9. DA-B placed the word potato in the translator, and showed it to R9, and the translator stated "papas". R9 just looked at DA-B, and started to laugh looking puzzled and confused. DA-B repeated the word "papas", and R9 again seemed puzzled, and said "No." The 7/26/18 menu had potatoes highlighted as R9's menu choice. In an interview on 7/25/18 at 6:14 p.m. with R20, who was R9's table mate stated, I have been a table mate of R9's for two years now. I have never seen the facility use that computer or whatever that thing was. R9 never eats her bread or only a few bites, she always leaves it on her plate. They don't ask her what she wants for the next day, if they gave her a choice of food, she probably would eat more but they don't. On 7/26/18 11:55 a.m. a.m. registered nurse (RN)-A stated she has never seen dietary staff use the Google Translator app on the iPad for R9.	F 561	• Director of Nursing or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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R9 was observed on 07/26/18 at 12:21 p.m. in the dining room eating independently. She just finished her meal and ate 100% cake, 50% beef stroganoff, 50% bread, no broccoli and 100% of her juice,
and coffee.

During interview on 7/26/18 12:23 p.m. the culinary services director (CS)-A stated each resident get a list of food items for the noon and evening meal the day before. The resident chooses what they want as a main entree, starch, vegetable, bread and dessert for the next day. When a resident is first admitted they go through a food preference sheet with each of the residents/family. Since R9 has been in the facility for a few years, they have not completed the preference list for her. If R9 had a preference or choice this would be on her meal ticket. Review of R9's meal ticket with CS, identified no likes, dislikes or preferences regarding any meals. This area was left blank. Also, on the meal ticket, there was beef and cheese quesadilla for noon and evening meal as a choice for R9. CS also identified in the past they used an iPad with Google Translator app that converts English to Spanish so they could communicate with R9. They had just reviewed this process with staff this morning (7/26/18) and had not used this with R9 for several months. CS stated she believes R9's preferences and choices are honored but was unsure what these were.

R9's family member (FM)-A was contacted for an interview about R9's preferences and choices, but did not return the call.

Bathing Preferences:

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F 561	Continued From page 14 R24's annual MDS completed on 4/21/18, identified R24 had intact cognition and was able to communicate her needs and wishes. R24 was noted to have a catheter in place to manage urinary functions and was incontinent of bowel. R24 received extensive assist to complete tasks of daily living (ADL's) which included personal grooming and mobility. R24's diagnoses included diabetes, arthritis, a neurological disorder which affected mobility, generalized muscle weakness, and morbid obesity. R24's plan of care revised on 7/6/18, identified R24 received assistance to complete her ADL's related to R24's level of strength. The care plan indicated R24 required extensive assistance of turn and reposition in bed every two hours and as necessary. The care plan also directed staff to provide with assistance to complete personal hygiene, including skin cleansing, and completion incontinence cares every two hours. The care plan was revised on 7/10/18, to identify an alteration in skin integrity related to an abrasion on her right buttocks. The care plan identified staff were to monitor skin integrity during cares, with documentation weekly. On 7/23/18, at 8:46 a.m. R24 stated she would like to receive a bath more frequently than a weekly for both comfort and health concerns. R24 stated she requested a second bath from the staff on the floor, though was unable to recall whom, and was told they were unable to do anything. R24 also stated she had asked a nurse when receiving meds, again was unable to recall whom, and they stated they didn't schedule baths, however, did not relay the request or direct her to the most correct person to assist.	F 561		

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F 561	Continued From page 15 During observation of morning cares on 7/26/18, at 7:21 a.m. viewed skin condition with registered nurse (RN)-B and viewed cleansing of calmoseptine (a zinc based barrier cream) off of skin prior to measurements. RN-B stated the cream was removed with gentle cleansing, however, was most effective removed with a whirlpool bath. R24 stated she only received one bath weekly but felt she would benefit from more frequent whirlpool baths for comfort and cleanliness. During interview on 7/26/18, at approximately 7:30 a.m. RN-B stated she was unaware of R24's request for additional baths and would follow up with this. RN-B stated staff should have relayed any requests for additional baths to either the floor nurse or to RN-B. RN-B stated she would add a second bath for R24. On 7/27/18, at 11:49, R24 stated at this time she was unaware of any change in her bath schedule and to her knowledge was scheduled on Tuesdays. R24 had not received any additional assistance to bathe this week. On 7/27/18, at 1:18 p.m. the director of nursing (DON) stated, upon review of the bath schedule that had been updated on 7/27/18 at 5:42 a.m. and R24 had been scheduled for a second bath and would have received a whirlpool this morning. A facility policy was requested for resident choices and was not received.	F 561		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v)	F 582		9/10/18

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F 582	Continued From page 16 §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's	F 582		

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F 582	Continued From page 17 per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to timely provide the required liability and appeal rights notices prior to discharge from Medicare A services for 2 of 3 residents (R39, R42) reviewed for beneficiary protection notification. Findings include: R39's last day of covered Medicare Part A Skilled Services was 6/20/18, as identified on the form CMS-20052 (SNF [skilled nursing facility] Beneficiary Protection Notification Review). R39's Notice of Medicare Non-Coverage (form CMS-10123) was signed by the authorized representative on 6/20/18, with a notation the authorized representative was called on 6/19/18. R39's Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, form CMS-10055) lacked a signature and date from the resident or authorized representative. R39's census record identified R39 currently	F 582	F582 – Medicaid/Medicare Coverage/Liability Notice • R39 discharged from facility on 8/13/2018. R42 discharged from facility on 7/6/2018. • Residents will continue to be given the correct/appropriate notifications of Medicare coverage/liabilities. • Staff will be re-educated on ensuring timely Medicare notices are being given • Audits of 3 Medicare coverage/liability forms will be completed weekly x 4 weeks; then as needed. • Administrator or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 582	Continued From page 18 resided in the facility. R42's last day of covered Medicare Part A Skilled Services was 7/5/18, as identified on the form CMS-2005 R42's census record identified R42 was discharged from the facility on 7/6/18. R42's medical record lacked evidence R42 or a family representative was provided the Notice of Medicare Non-Coverage (form CMS-10123) prior to R42's discharge. When interviewed 7/24/18, at 10:49 a.m. the regional director of operations (RDO) stated R39's authorized representative should have been contacted on 6/18/18, regarding the end of skilled coverage on 6/20/18. Further the CMS-100055 should have been signed by the authorized representative. The RDO stated R42's CMS- 10123 could not be located, and should have been signed by the resident on 7/3/18, at the latest. A former staff person was previously responsible for providing resident the required Medicare notices and the facility was working on a new procedure. A policy regarding beneficiary protection notices was requested, but none was provided.	F 582		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This	F 600		9/10/18

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F 600	Continued From page 19 includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure allegations of abuse were identified timely; failed to ensure appropriate action was taken to immediately provide resident protection; and failed to thoroughly investigate the allegations for 1 of 1 residents (R44) who felt shamed and was unable to sleep following an incident with R36 who offered her money and touched her breasts when she did not want him to. In addition, the facility staff were unaware or knew why R44 was placed on 15 minute checks, and there were subsequent encounters between R44 and the perpetrator (R36). Furthermore, there was conflicting information in the investigation. These allegations of abuse, and lack of facility investigation and protections resulted in an immediate jeopardy (IJ) situation for R44. The IJ began on 7/14/18, at an unknown time, when R44 approached and self-reported to the facility staff that on that day R36 offered her money in exchange for touching her breasts, and she did not want him to. The facility failed to identify potential sexual abuse and immediately protect R44, or thoroughly investigate the circumstances to determine if actual abuse	F 600	Free from Abuse and Neglect • R44 and R36 remain in the facility free from abuse and neglect. All staff are aware of R44 and R36 specific needs for increased monitoring. R44 and R36 allegation of abuse has been thoroughly investigated • Residents will remain free from abuse and neglect within the facility including staff being aware of specific needs for increase monitoring and ensuring a thorough investigation is completed • Staff will be re-educated on the Abuse Prevention/Vulnerable Adult Plan • Audits of all OHFC reports and 6 grievances specific to allegations of abuse/neglect, specific to ensuring correct reporting, investigation, interventions and protection of residents(s) are implemented timely including increase monitoring and thorough investigation will be completed weekly x 4 weeks; then every other week x 8 weeks; then monthly x 6 months; then as needed • Administrator or designee will be responsible party • QAA will provide redirection or change	

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F 600	Continued From page 20 occurred. The facility administrator and director of nursing (DON) were notified on 7/26/18, at 5:00 p.m. of the IJ. The IJ was removed 7/27/18, at 3:50 p.m. however, non-compliance remained at the lower scope and severity of a D which is isolated with potential for more than minimal harm. Findings include: R44 was sexually abused when she was coerced into taking money in exchange for R36 (male resident) to touch and fondle her breasts. Once the incident occurred, R36 continued to enter R44's room, without her consent which caused R44 to become fearful, scared and afraid, resulting in making it difficult for her to sleep. Although R44 told the facility multiple times she did not want R36 in her room, the facility did not provide adequate protection for R44, after the sexual abuse occurred. R44's OBRA Admission Minimum Data Set (MDS) dated 4/27/18, indicated she was cognitively intact, required extensive assistance of one staff with activities of daily living (ADLs), and used a wheelchair for mobility. R44's care plan dated 5/02/18, indicated diagnoses including depression, adjustment disorder, dementia, and mild cognitive impairment. R44's Care Area Assessment (CAA) dated 4/27/18, indicated she required assistance with ADLs, was alert and oriented, had deficits in judgement, and was impulsive. R36's OBRA Admission MDS dated 6/13/18, indicated he was cognitively intact, and required extensive assistance of two staff with ADLs. R36's Initial Comprehensive Care Plan dated	F 600	when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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6/6/18, indicated he was alert and orientated, and had weakness. The care plan further indicated R36 had no behaviors. R36's CAA dated 6/13/18, indicted he was alert and orientated, and received therapy due to a fall at his previous living situation. The CAA indicated R36 planned to return home.

A Facility Investigation Report submitted to the Office Of Facility Health Complaints (OHFC) on 7/14/18, at 11:29 p.m. indicated R44 reported to the nurse on duty that another resident (R36) had gone into her (R44's) room, closed the door, and offered her money to allow him to touch her breast, which he did. The report indicated the victim (R44) asked him to stop, which he did, then he left the room. The report further indicated R44 did not want R36 to touch her breast. An Internal investigation was initiated. A Facility Investigation Five Day Report dated 7/23/18, at 6:19 p.m. indicated R44's care plan was reviewed, and the administrator met with R44 to discuss the incident. The investigation report originally indicated R44 did not accept the cash, she did not want R36 to touch her. After a conversation, R44 informed the facility she did in fact accept the $10 in cash. R44 stated she and the alleged perpetrator (R36) went into her room, and closed the door behind them. R44 said someone knocked on the door, and asked them to keep the door open. R36 then suggested they go down to his room. R44 stated she followed R36 to his room, they closed the door, and she allowed him to touch her breast. R44 stated she did not want another encounter with R36, and wished for him to stay away from her. The facility indicated on the report R44 was placed on 15 minute checks, R36 was informed of R44's wishes to not meet with him again, and R36

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agreed.

During interview on 7/25/18, at 1:54 p.m. the administrator stated there was an incident between R44 and R36 that occurred on Saturday, 7/14/18, and she was unsure what time it occurred. The administrator stated she was informed by the director of nursing (DON) about the incident, then reported the incident to the State Agency (SA) later that evening. The administrator stated she completed the investigation, and R44 informed her that R36 offered her $10 in exchange to touch her breasts. Further, the administrator stated R44 was placed on 15 minute checks, then the facility decided to also place R36 on 15 minute checks. The administrator stated she talked with R36, and he did admit to offering R44 money so he could touch her breasts. The administrator stated she informed R36 that R44 did not want this to happen again.

Although the incident between R44 and R36 occurred on 7/14/18, there was no mention of the incident in the medical record for either resident.

Review of R44's progress notes identified the following:

On 7/16/18, at 10:40 a.m. R36 was observed in R44's room, and then left her room. R36 went outside shortly after R44 went outside, and stated, "I'm going outside but I'm using a different door." Staff redirected R44 to go outside in the courtyard near the south nursing station, so she could be supervised by staff. R44 stated she would knock on the door if R36 came around her.

On 7/25/18, at 12:30 p.m. at 11:00 a.m. that

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morning, R36 was observed by a staff member coming out of R44's room. R36 stated, "[R44's] busy." Staff asked R44 about R36 coming into her room, and R44 stated she was going to see her case worker and was leaving, and so R36 left her room. R44 also stated R36 did not touch her, or do anything else to her.

As a result of the 7/14/18, incident, the facility initiated monitoring of R44 and R36. Both residents had a Resident Check List (RCL), and staff were directed to monitor and document R44's and R36's where abouts every 15 minutes for their safety.

R44's 15 minute monitoring began on 7/18/18, at 10:30 a.m. (four days after the incident occurred). Review of R44's 15 minute checks did not identify that R36 was in R44's room on 7/25/18, at 11:00 a.m. but identified R44 was in the lobby during that time.

R36's RCL indicated monitoring began on 7/18/18, at 10:00 a.m. and was stopped on 7/23/18, at 11:15 a.m. Although the facility implemented RCL for each resident, they were not consistently monitored to ensure resident safety.

During an initial interview on 7/23/18, at 8:45 a.m. R44 stated she was in her room in her electric wheelchair when R36 came into her room and gave her $10. R44 stated she asked R36, "What for, I don't want your money." R36 told R44 he wanted her to show him her breasts, and he wanted to touch her breasts. R44 stated she tried giving R36 his $10 back, but he continued to touch her breasts. R44 stated she did not want him to do this. R44 stated she had reported this

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to a nurse who was working the night the incident occurred. R44 also stated the DON and the administrator were both aware of the incident, and they were both aware she wanted R36 to stay away from her.

During an additional interview with R44 on 7/25/18, at 5:00 p.m. R44 stated R36 came into her room, gave her $10.00, and stated he wanted to play with her breasts and she told him "no." R44 then stated R36 pulled on her shirt and rubbed her breast and continued to pull her shirt down and rubbed on her breast which made her feel "awful". She identified R36 came into her room again after the incident. R44 state, "[R36] just comes into my room without knocking on my door." R44 further stated she did not want R36 to come into her room.

During a subsequent interview on 7/26/18, at 10:07 a.m. regarding the incident on 7/14/18, R44 stated, "When he touched me, I wanted to hit him but I cant. After the incident I wanted to get away for awhile, go to town or do something. I cried after it happened. I didn't want to say anything but I knew I should, so I told the nurse and had her shut the door when I told her." R44 stated it made her feel "dirty" and feel "sexually harassed and abused." R44 added, "When he came into my room the last time [7/25/18] I was upset. My door was open and I told him he needed to move, which he did, and backed his wheel chair out of the room, and I closed the door in my room." R44 further indicated it made her feel humiliated and upset. While R44 was describing the incident her eyes became watery, and teary. R44 stated she was worried the incident would happen again, adding she had not been sleeping, and she was afraid. R44 reiterated she did not want R36 in

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	245361	A. BUILDING _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

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her room.

During interview 7/26/18, at 10:53 a.m. R36 stated he had been at the facility for several months, and the administrator talked with him shortly after the incident occurred on 7/14/18. R36 stated the administrator told him that R44 did not want him to come around her. After the administrator talked to him, R36 said he told the administrator, "OK." R36 did not disclose he went back into R44's room on 7/16/18, and 7/25/18, after he was told by the administrator not to go into her room, and he had agreed to say out of her room.

Review of the facility 15 minute monitoring for R44 and R36 identified the following:

During interview on 7/25/18, at 7:00 p.m. nursing assistant (NA)-H stated she worked with R44, and was not aware of any incident between R44 and another resident. NA-H further stated she was not aware R44 was on 15 minute checks or monitoring. In addition, NA-H checked her nursing assistant care sheet, and verified there was no direction for monitoring for R44.

During interview on 7/25/18, at 7:21 p.m. NA-I stated she has worked with R44, and R44 had no behaviors. NA-I stated she was supposed to keep an eye on R44 every 15 or 30 minutes. NA-I further stated she was aware of an incident between R44 and another resident last week, but was not certain of what happened.

During interview on 7/25/18, at 7:27 p.m. resident companion (RC)-A stated she was not aware of any behaviors with R36, or if there was any special monitoring for R44 or R36.

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During interview on 7/25/18, at 7:51 p.m. NA-J stated she was not aware of any monitoring for R44, and she was not aware of any incidents between R44 and any other resident.

During interview on 7/26/18, at 10:58 a.m. NA-F stated R36 was on 15 minute checks, and was not aware of the reason. NA-F stated nurses and nursing assistants are to document the 15 minute checks on a sheet at the nurses station.

During interview on 7/26/18, at 11:05 a.m. NA-G stated R36 was on 15 minute checks because of another resident, but was not sure which resident. NA-G stated she documents R36's location every 15 minutes.

During interview on 7/26/18, at 11:09 a.m. licensed social worker (LSW)-A stated on Monday, 7/23/18, she had heard bits and pieces of the incident between R44 and R36, but she was not involved. LSW-A further stated situations like this were discussed at morning meeting, but she had to step out during the meeting. LSW-A further stated she had not talked to R44 after the incident with R36, because LSW-A was on leave on 7/24/18.

During interview on 7/26/18, at 11:54 a.m. with the administrator and DON, the DON stated she was informed of the incident on 7/14/18, around 9:00 p.m. when RN-D informed her what occurred. The DON stated she informed the administrator of the incident, and the administrator filed a report to the SA. After she was informed of the incident, the DON stated she placed R44 on 15 minute checks, and a few days later decided R36 also needed to be placed on 15

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minute checks. The DON stated when she was told about the incident she told the two nurses who were working that day, licensed practical nurse (LPN)-D, and RN-B to keep an eye on both residents. The DON stated she did not tell the nurse who was caring for R36 what actually occurred, because she wanted to keep R44's incident confidential. In addition, although the administrator stated R44 was placed on 15 minute checks, and a few days later R36 was also placed on 15 minute checks, the reports indicated both were placed on 15 minute checks on 7/18/18.

During interview on 7/26/18, at 2:20 p.m. LPN-B stated they were doing 15 minute checks on R44 to monitor her location. LPN-B further stated she found out about the incident through a nursing report, and indicated R44 had issues with another resident, but was not sure why.

During interview on 7/26/18, at 2:35 p.m. R44 stated the incident happened so fast he (R36) gave her the money and she took it and said, "What is this for?" R36 told her he wanted to touch her breasts, and she told him, "I don't want your money" but he would not take the money back. R44 indicated he touched her breasts through her shirt, and then removed her shirt strap, put his hand down her shirt and touched her breast. R44 stated she felt assaulted, and felt R36 tried to bribe her with the money. After the first incident occurred, R44 stated R36 told her again that he would give her another $10 to touch her breasts. R44 stated she told R36, "I don't want you to do this!" R44 stated she did not go to his room, and confirmed the incident occurred in her room.

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During interview on 7/26/18, at 4:36 p.m. RN-B stated the facility stopped R36's 15 minute checks after their morning meeting on Monday, 7/23/18. RN-B stated no additional incidents occurred, and she was directed by the administrator to stop the 15 minute checks, even though R36 was in R44's room after the 15 minute checks were stopped.

During observation on 7/27/18, from 9:40 a.m. until 2:20 p.m. R44 was not observed to have contact with R36.

The facility's Abuse Prevention/Vulnerable Adult Plan undated, indicated abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain or mental aguish. The policy identified sexual abuse as non-consensual sexual contact of any type with a resident. The policy also directed to that immediately, upon learning of an incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. The facility policy directed to immediately report to the Minnesota Adult Reporting Center (MAARC). The facility policy also directed the facility's investigation team would review all incident reports regarding residents.

The IJ that began on 7/14/18, was removed on 7/27/18, at 3:50 p.m. when the facility conducted an investigation of the incident, and additional training was provided to the DON and administrator, R44 had been placed on 15 minute checks, R36 was placed on 1:1 for close monitoring to ensure other residents were free from abuse, all verbal residents were interviewed

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F 600	Continued From page 29 to ensure they were free from abuse, neglect, mistreatment and exploitation, the facility Abuse Prevention/Vulnerable Adult Plan was reviewed, all staff were educated on the Abuse Prevention/Vulnerable Adult Plan, staff were educated on the reason for resident monitoring, and the administrator and DON were educated on the Abuse Prevention/Vulnerable Adult Plan specific to reporting resident abuse and sexual abuse. On 7/27/18, from 3:15 p.m. to 3:45 p.m. front line staff and nurses were interviewed, and stated they were educated on the Abuse Prevention/Vulnerable Adult policy, and the rational for R44 and R36's increased monitoring. The noncompliance remained at the lower scope and severity level of D which is isolated with potential for more than minimal harm.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in	F 609		9/10/18

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F 609	Continued From page 30 accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure allegations of abuse were reported immediately, no later than 2 hour to the State Agency (SA) for 1 of 1 residents (R44) who alleged sexual abuse. Findings include: R44's admission Minnimum Data Set (MDS) dated 4/27/18, indicated she was cognitively intact, needed extensive assist of one with activities of daily living and used a wheelchair for mobility. R44's care plan dated 5/02/18, indicated she diagnoses including depression, adjustment disorder, dementia and mild cognitive impairment. R44's Care Area Assessment (CAA) dated 4/27/18, indicated she required assistance with activities of daily living (ADLs), was alert and oriented with deficits in judgement and being impulsive. R36's admission MDS dated 06/13/18, indicated he was cognitively intact and needed extensive assist of two with ADLs. R36's Initial Comprehensive Care Plan indicated he had weakness and was alert and orientated. The care plan further indicated R36 had no behaviors.	F 609	– Reporting of Alleged Violations • R44 remains in the facility free from abuse and neglect • Resident allegations of abuse and/or neglect will be reported timely per Abuse Prevention/Vulnerable Adult Plan • Staff will be re-educated on the Abuse Prevention/Vulnerable Adult Plan specific to timeliness of reporting • Audits of all OHFC reports and 6 grievances specific to allegations of abuse/neglect, specific to ensuring correct reporting, investigation, interventions and protection of residents(s) are implemented timely including increase monitoring and thorough investigation will be completed weekly x 4 weeks; then every other week x 8 weeks; then monthly x 6 months; then as needed • Administrator or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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R36's CAA dated 6/13/18, indicted he was alert and orientated and received therapy due to a fall at his previous living situation. The CAA indicated R36 planned to return back home.

During interview 7/25/18, at 1:54 p.m. the facility administrator stated an incident occurred on Saturday 7/14/18, between R44 and R36 but was not sure what time it occurred. The administrator then stated she was informed by the DON and she reported the incident to the state agency later that night due to an allegation of sexual abuse.

A facility report submitted to the Office Of Facility Health Complaints (OHFC) 7/14/18, at 23:29 (11:29 p.m.)indicated R44 reported to nurse on duty another resident had gone into her room, closed the door, and offered cash to allow him to touch her breast, which he did. Resident asked him to stop, which he did, then he left. The report further indicated resdient does not want him to touch her breast. An Internal investigation was initiated. A Facility Investigation Report dated 7/23/18, at 18:19:07 indicated R44's care plan was reviewed and administrator met with victim to discuss the incident. The investigation report originally indicated resident stated she did not accept the cash and did not want him to touch her. After a conversation, she informed the facility she did in fact accept the $10.00 in cash. The victim said she and the alleged perpetrator went into her room, closing the door behind them. The victim said someone knocked on the door and asked them to keep it open. The alleged perpetrator then suggested they go down to his room. Victim stated that she followed the perpetrator down to his room, they closed the door and she allowed him to touch her breast. Victim did state that she did not want another

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F 609	Continued From page 32 encounter and wished for him to stay away. The facility indicated on the report the victim was put on 15 minute checks and the perpetrator was informed of the victim's wishes to not meet again and he agreed. During interview on 7/26/18, at 11:54 a.m. with the DON and adminstrator present, the DON stated she was informed of the incident on 7/14/18, around 9:00 p.m. by a floor nurse, after the DON returned to the facility from the town parade. The DON informed the administrator of the incident and stated the administrator filed the report. Although the facility was made aware of the incident that occurred on 7/14/18, at unknown time. The facility became aware of the allegation at 9:00 p.m. and the incident was not reported to the state agency until 11:29 p.m., two half hours later. The facility Abuse Prevention/Vulnerable Adult Plan dated 7/18, indicated Abuse is the willfully infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain or mental aguish. The policy defined sexual abuse at non-consensual sexual contact of any type with a resident. The policy directed: Suspected Abuse shall be reported to OHFC (state agency) online reporting process not later than 2 hours after forming the suspicion of abuse.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility	F 610		9/10/18

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F 610	Continued From page 33 must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to thoroughly investigate allegations of sexual abuse for 1 of 1 residents (R44) who had an allegation of sexual abuse. Findings include: R44's Minnimum Data Set (MDS) dated 4/27/18, indicated she was cognitively intact and needed extensive assist of one with activities of daily living and used a wheelchair for mobility. R44's care plan dated 5/02/2018, indicated she had a diagnosis of depression and adjustment disorder. R44's care plan further indicated she had diagnosis of dementia and mild cognitive impairment. R44's Care Area Assessment (CAA) dated 4/27/18, indicated she needs assist with activity of daily living, was alert and oriented with deficits in judgement and being impulsive. R36's MDS dated 06/13/18, indicated he was	F 610	F610 – Investigate/Prevent/Correct Alleged Violation • R44 remains in the facility free from abuse and neglect • Resident allegations of abuse and/or neglect will be thoroughly investigated per Abuse Prevention/Vulnerable Adult Plan. • Staff will be re-educated on the Abuse Prevention/Vulnerable Adult Plan specific to thorough investigations. IDT will review and discuss all investigations to ensure correct reporting, investigation, interventions and protection for resident(s) are implemented timely. Final review will be completed and submitted by Administrator and/or facility consultant(s). • Audits of all OHFC reports and 6 grievances specific to allegations of abuse/neglect, specific to ensuring correct reporting, investigation, interventions and protection of residents(s) are	

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F 610	Continued From page 34 cognitively intact and needed extensive assist of two with activities of daily living. R36's Initial Comprehensive Care Plan indicated he had weakness and was alert and orientated. The care plan further indicated he had no behaviors. R36's CAA dated 6/13/18, indicted he was alert and orientated and received therapy due to a fall at his previous living situation. The CAA indicated he planned to return back home. During an initial interview on 7/23/18, at 8:45 a.m. R44 stated she was in her room in her electric wheelchair and R36 came into her room and gave her $10.00. She asked, "what for, I don't want your money." R36 told R44 he wanted her to show and touch her breasts. She tried giving him back his $10.00, but he was touching my breasts and I did not want him to do this. R44 stated she had told the nurse who was working the night the incident happened. R44 further stated the DON and administrator were both aware she wanted him to stay away from her. A facility report submitted to the Office Of Facility Health Complaints (OHFC) 7/14/18, at 11:29 p.m. indicated R44 reported to the nurse on duty another resident (R36) had gone into her room, closed the door, and offered her money to allow him to touch her breast, which he did. R44 asked him to stop, which he did, and then left. The report further indicated R44 does not want him to touch her breast. An Internal investigation was initiated. A Facility Investigation Report dated 7/23/18, at 6:30 p.m. indicated R44's care plan was reviewed and administrator met with victim (R44) to discuss the incident. The investigation report originally indicated resident (R44) stated she did	F 610	implemented timely including increase monitoring and thorough investigation will be completed weekly x 4 weeks; then every other week x 8 weeks; then monthly x 6 months; then as needed • Administrator or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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not accept the cash and did not want him (R36) to touch her. After a conversation, R44 then informed the facility she did in fact accept the $10.00 in cash. The victim (R44) stated she and the alleged perpetrator (R36) went into her room, closing the door behind them. The victim (R44) said someone knocked on the door and asked them to keep it open. The alleged perpetrator (R36) then suggested they go down to his room. Victim (R44) stated that she followed the perpetrator (R36) down to his (R33's) room, they closed the door and she (R44) allowed him (R36) to touch her breast. Victim (R44) did state that she did not want another encounter and wished for him (R36) to stay away. The facility indicated on the report the victim (R44) was put on 15 minute checks and the perpetrator (R36) was informed of the victim's (R44) wished to not meet again and he (R36) agreed.

During interview 7/25/18, at 1:54 p.m. the facility administrator stated the incident occurred on Saturday 7/14/18, and was not sure what time it occurred. She was informed by the DON about the 7/14/18 incident and reported this to the state agency later that evening. The administrator stated she completed the investigation and R44 informed her that R36 offered her $10.00 and touched her breasts. In addition the administrator stated she talked to R36 and he did admit to touching R44's breasts and she informed him that R44 doesn't want that to happen again.

Review of the facility progress notes did not identify the incident of sexual abuse that occurred between R44 and R36 on 7/14/18.

During interview 7/26/18, at 10:53 a.m. R36 stated he had been at the facility for several

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months and the administrator talked to him about the incident that occurred on 7/14/18. The administrator told me that R44 did not want me to come around her. I told the administrator "O.K."

During interview 7/26/18, at 11:09 a.m. licensed social worker (LSW)-A stated she had heard bites and pieces of the incident on Monday and she was not involved. LSW-A further stated situations like this are discussed at morning meeting but she had to step out during the meeting. LSW-A further stated she had not talked to R44 after the incident with R36.

During interview 7/26/18, at 11:54 a.m. with the DON and adminstrator. The DON stated she was informed of the incident 7/14/18, around 9:00 p.m. after she returned to the facility from the town parade. The DON stated she informed the administrator of the incident and the administrator filed the report. She was aware that R36 gave her $10.00 and touched her breasts in her room. The adminstrator stated, her understanding was this incident occurred in R36's (his) room, and not in R44's room.

R44 was interviewed on 7/26/18, at 2:35 p.m. about the incident that occurred on 7/14/18 between herself and R36. R44 stated the incident happened so fast he gave me the money and I took it and said "what is this for?" and R36 stated he wanted to touch my breasts and I told him "I don't want his money" and he would not take the money back. R44 indicated he touched her breasts thru her shirt and then removed her spaghetti strap and but his hand down her shirt and touched her breast. R44 then stated she felt assaulted and that he tried to bribe her and after the incident he offered her another $10.00 to

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F 610	Continued From page 37 touch her breasts again. In addition R44 stated the incident happened in her room. Although the facility identified an investigation was completed, there was no indication that a thorough investigation was completed to identify the differences between the DON's and administrator's investigation of where the incident occurred. Also, the facility's investigation was not clear if R44 accepted or declined the money that R36 gave her. Also, there was no indication the facility talked with other residents, or staff regarding the allegation. The facility Abuse Prevention/Vulnerable Adult Plan undated, directed staff to investigate (including but not including to the administrator, DON, nurse manager and Social worker) will review all Incident Reports and investigate.	F 610		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		9/10/18

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F 655	Continued From page 38 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a baseline care plan within 48 hours of admission for 1 of 1 residents (R250) who was a new admissions with complaints of pain. Findings include: R250's undated Admission Record identified R250 was admitted to the facility on 7/12/18. R250's admission orders signed 7/12/18,	F 655	F655 - Baseline Care Plan • R250 initial care plan and pain management plan was reviewed and completed. Plan of care and interventions have been updated and reviewed to reflect resident's pain management plan. • All current residents who have been identified for base line care plans and pain management have had their care plans and interventions reviewed and updated. • Staff will be re-educated on initial care	

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F 655	Continued From page 39 identified orders for tramadol (narcotic for pain management) 50 milligrams (mg) every 6 hours as needed (PRN) for severe pain and Tylenol 325 mg every 6 hours PRN for mild pain or fever. R250's undated, Initial/ Comprehensive Care Plan section for pain and comfort, was blank and did not identify R250's risk for pain, a goal or interventions to manage pain. R250's Pain Evaluation dated 7/21/18, identified R250 had frequent lower back pain, rated her pain at a 3 out of 10, and had been taking tramadol 50 mg as needed for pain. The evaluation indicated the pain did not interfere with R250's sleep, but did interfere with her activities of daily living. During interview on 7/25/18, at 6:50 p.m. registered nurse (RN)-A stated R250 had chronic back pain and was admitted with tramadol to manage her pain. RN-A further stated she was responsible for completing the baseline care plan, verified it had not been completed, but should have been, and verified it should have identified interventions to manage R250's pain. A facility policy on baseline care plans was requested, but was not received.	F 655	plans and pain management • Audits of 3 resident initial plan of care and pain management will be completed weekly x 4 weeks; then as needed. • Director of Nursing or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		9/10/18

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F 656	Continued From page 40 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review, the facility failed to develop a comprehensive care for 5 of 5 residents (R25,	F 656	F656 Develop/Implement Comprehensive Care Plan • R25, R38, R11, R24 and R36	

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F 656	Continued From page 41 R38, R11, R24 and R36) reviewed who lacked updated care plans. Findings include: R25's Diagnoses Report printed 7/26/18, identified diagnoses which included chronic respiratory failure, dysphasia and tracheotomy status, and also indicated severe, cognitive impairment. The MDS also identified R25's admission date as 5/10/18. R25's Care Area Assessment (CAA) Worksheet dated 5/21/18, identified the following areas to include and address as actual or potential problems in the comprehensive care plan, to direct R25's needs in the facility: cognitive loss/dementia; visual function; communication; urinary continence; falls; feeding tube; dehydration/fluid maintenance; pressure ulcer; psychotropic drug use; and pain. R25's physician's orders, as identified on the Order Summary Report, dated 7/11/18, directed: to document in progress noted after suctioning respiratory rate, 02 SATS (oxygen saturation), amount, color and consistency of secretions, appearance of stoma, frequency of suctioning, frequency of trach (tracheostomy) care and change; and Trach plugging regimen per family. During observation on 7/24/18, at 3:19 p.m. R25 tracheotomy (trach) was in place and was receiving oxygen via the trach tubing. R25 and presented with audible gurgling, and a small amount of clear secretion coming from his mouth, bubble-like. Licensed practical nurse (LP)-A entered the room and deteremiend she would intervene to clear his congestion, and	F 656	Comprehensive Care Plans have been reviewed and updated. • All current residents who have been identified for Comprehensive Care Plans, have had their care plans reviewed and updated. • Staff will be re-educated on comprehensive care plans • Audits of 3 resident comprehensive care plans will be completed weekly x 4 weeks; then as needed. • Director of Nursing or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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subsequently provided R25 with suctioning of the trach.

R25's Initial/Comprehensive Care Plan with a listed goal dated of 5/10/18, was a computer-generated document that identified numerous care and problem areas, and under each care area listed various, pre-written, scripted interventions, some of which were checked to include for R25's care. The document also included space to detail interventions not listed on the pre-printed form. R25's care plan included resident-specific interventions related to tracheostomy care.

R25's care plan, as presented in the electronic heath record, identified a target date of 5/10/18, or more than two and one-half months after the start of the re-certification survey on 7/23/18. R25's care plan lacked specific, measurable, target goals and future dates for each of the care areas included in the care plan. Further, R25's care plan lacked inclusion or instruction to include physician's orders that further directed R25's tracheostomy care.

When interviewed on 7/26/18 at 10:41 a.m., registered nurse (RN)-B stated after reviewing R25's care plan in the computer, that R25 did not really have a current target, and R25's care plan "was not right." RN-C stated when a resident was admitted, assessments and data collection was done to complete our initial care plans, and stated "we can use that care plan for 92 days." RN-C stated she did not put together "the comprehensive care plans" for residents. RN-C acknowledged the care plan for R25 was listed as "Initial/comprehensive" but stated the care plan did not have goal dates in the future, and also did

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not include the physicians orders, "but it should."

During interview on 7/26/18, at 11:41 a.m., RN-C stated a resident's comprehensive care plan included the plan, the doctor's orders, and pertinent labs, the nursing assistant care sheets, and "really any information to direct one's care." RN-C stated the comprehensive care plan needed to be in place by day twenty-one.

R38's Diagnosis Report printed 7/26/18, identified diagnoses which included congestive heart failure, hypertension and end-stage renal disease. R38's admission Minimum Data Set (MDS) indicated R38 had intact cognition and was admitted to the facility on 6/22/18. R38's Care Area Assessment (CAA) Worksheet dated 7/2/18 identified Activities of Daily Living (ADL) as an actual problem/need to include on the care plan, related to need for supervision with be mobility, transfers and toileting.

R38's Treatment Administration Record printed 7/26/18 identified a nursing order dated 6/23/18 to obtain daily weight, and report changes of 3 lbs (pounds) overnight or 5 lbs in a week to nephrology. Additionally, the treatment record included additional direction regarding R38's dialysis care including: to check communication file for any new orders upon return from dialysis; to remember to send a snack or lunch with resident and communication form to dialysis; to obtain vital signs after dialysis; and to offer rest and snack in the afternoons post dialysis.

During interview on 7/24/18, at 3:00 p.m. R38 stated he gets the help and care he needs at the facility. R38 stated he was planning to go back

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home, and was in the facility for "rehab" following a heart attack, and that he felt much better now following the incident. R38 also stated he went out of the building to get dialysis.

During observation on 7/24/18, at 3:10 p.m. R38 exited his room, holding on the handles of a regular wheel chair, ambulated down the hallway toward the day room area. R38 was able to walk at a steady pace, maintain balance, and showed no signs of pain or discomfort, and exhibited no shortness of breath.

R38's Initial/comprehensive Care Plan, as presented in the electronic health record, identified a goal date of 6/22/18, or more than a month following start of the re-certification survey on 7/23/18, or 20 days following completion of the CAA. R38's care plan lacked specific, measurable, target goals and future dates for each of the care areas included in the care plan. Additionally, R38's care plan lacked inclusion or instruction to include physician's orders including treatments that further directed R38's dialysis care.

During interview on 7/26/18, at 10:41 a.m. RN-B stated R38's care plan in the electronic record was his original, initial care plan. RN-B stated the target date for R25's care plan goals was not current.

When interviewed on 7/27/18, at 11:44 a.m., the interim director of nursing (DON) stated there was some misunderstanding as to how long we can use the initial care plan document. The DON stated initial/comprehensive care plans were a good start, but that residents' comprehensive care plans were to be in place by day 21 after a

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F 656	Continued From page 45 resident admission. The DON stated and recognized some of the residents' care plan were not up to date and had goal target dates that were not in the future. R11's significant change MDS dated 4/30/18 indicated R11 exhibited severe cognitive impairment and received extensive assistance to complete her ADL's including mobility and personal cares. R11's medical diagnoses included anemia, chronic kidney disease, diabetes, dementia, and generalized weakness. R11's care plan revised on 7/23/18, identified R11 experienced alteration in comfort related to wounds on right foot and coccyx. R11's care plan directed staff to implement non-pharmacological interventions which included: reposition, watching television in her room, warm blanket, family/friends company, music. The care plan directed staff to monitor R11's level of pain with the use of a flow sheet or FLACC (Face, Legs, Activity, Cry, Consolability)/Dementia scale, with a pain assessment per protocol. The care plan stated resident was to receive medications as ordered by primary provider and staff were to monitor for the effectiveness of the medication, as well as potential side effects. Staff are to encourage resident to verbalize discomfort, and encourage rest periods. The care plan directed staff to turn and reposition resident every two to two and a half hours. Staff were directed to lift, not slide to decrease friction. Staff were also directed to encourage resident to lie on sides	F 656		

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while in bed and offload bottom.

On 7/23/18, at 7:15 a.m R11 was observed in the dining room and was vocalizing moaning sounds. Family member (FM)-A was heard responding to resident and inquired if she was hurting. As meal progressed, FM-A asked R11 at 7:23 a.m. if she was crying because she hurt. R11 continued to moan. At 7:27 a.m. was heard asking R11 if she was crying because she hurt, to which R11 responded "yes". FM-A was heard telling R11 she had received pain meds but they "Must not be working. Lets eat quick and then get you laid down." R11 was observed to be reclined back in her wheelchair as FM-A assisted her to eat. At 7:29 a.m. R11 was heard moaning out loud and FM-A was dabbing eyes with a tissue. R11 was wheeled out of the dining room by FM-A at 7:30 a.m.

On 7/23/18, at 8:35 a.m. R11 was observed in resting on bed which was in a low position with a mat at the bedside. R11 made moaning vocalizations, however did not verbalize response when asked if experiencing pain. R11 was resting with eyes squinted, brows furrowed, and lips pursed.

On 7/23/18, at 11:30 a.m. R11 was observed resting on her bed and displayed facial grimacing, with eyebrows and forehead furrowed, moisture was noted in the corner of her eyes. Resident was making rhythmic moaning noises, without discernible words.

A review of the electronic records indicated a pain assessment was completed on 7/23/18 by the registered nurse (RN)-B which indicated resident had pain in coccyx and right foot. The document

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indicated: "Resident states pain is occasionally and rated 4/10 at worst, and does interfere with sleep and daily activities." The assessment indicated R11 had scheduled methadone 10 mg at 8:00 a.m. and and 5 mg at 4:00 p.m. The assessment identified R11 had additional orders for Morphine 10 mg and Tylenol 650 mg as needed, however, it was indicated these medications were not used during the assessment period. The interventions identified included adminsitration of mediations as ordered, monitoring for effectiveness, monitor resident for signs and symptoms of pain and intervene as needed. The assessment also indicated that staff would update the care provider as needed. These interventions were not added to the care plan.

On 7/25/18, at 2:14 p.m. R11 was observed in her wheelchair with her legs elevated on foot rests. R11's eyes were closed, brows furrowed, and resident was moaning in a constant, rhythmic pattern. Hospice nurse (HN) present in room at this time. Nursing assistant (NA)-G entered room to provide cares, and placed R11's right leg on a pillow to provide full leg support. R11 continued to cry out with moaning sound. RN-B entered room to provide assist. NA-G and RN-B assisted to place the mechanical lift sling, while R11 continued to display a constant moan which intensified with physical movement. R11 was transferred to the bed and mechanical lift sling was removed. R11 was observed to have an open area present on her coccyx with no dressing noted to be in place. R11 was noted to have ceased moaning while lying still, however, resumed moaning/vocalizations which intensified with any increased movement. Once R11 was positioned, RN-B asked resident where the pain was. R11 continued with moaning vocalizations

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but did not identify where pain was located. RN-B offered to remove pillows and vocalizations intensified with this. HN provided prompts to shift pillow down and assure heel was floating. A blanket was placed to provide less support/pressure than a pillow to improve comfort level. R11 stated pain was in her whole leg when crying out/moaning. RN-B asked R11 to rate pain, however, R11 only amplified vocalizations with moaning. HN was observed to rub hand and arms, offering words of reassurance. HN inquired of RN-B of recent pain medication status and RN-B stated she would follow up and exited the room.

During interview following provision of cares at 7/25/18, at 2:46 p.m. NA-G stated when R11 was observed to be uncomfortable as evidenced by verbalizations/vocalizations, moving in chair, and facial expression, she would assist with repositioning, offer to lay down, and then advise nurse if this was not beneficial in providing comfort. NA-G was unaware of any additional interventions to be implemented to promote comfort for R11.

During continued observation on 7/25/18, at 2:46 p.m. R11 began to cry out loudly, tearing up, with facial grimaces, brows and forehead furrowed and emitting a continuous moaning sound.

On 7/25/18, at 2:47 p.m. licensed practical nurse (LPN)-A entered room to administer morphine liquid and stated R11 had not had not received PRN (as needed) morphine for several days. At 2:49 p.m. R11 continued to cry out with lips quivering and tears present in both eyes. LPN-A offered to provide R11 assist to contact family member (FM)-A. R11 continued to cry,

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responding "mmmhmmm", with lips quivering, and tears were present in corners of both eyes. LPN-A placed a call to FM-A at 2:51 p.m. LPN-A held the phone to R11's left ear and R11 was observed to have lips pursed, brows and forehead furrowed. R11's eyes were squinted closed and R11 was actively crying with vocalizations and tears present. R11 stated "Help me, help me, help me" crying out into the phone. At this time, the head of the bed was elevated, R11 was lying on her back, pillows were under her right leg, and HN and LPN-A were rubbing her shoulder and arm in comforting motion. At 2:55 p.m. R11 continued to call out. LPN-A commented with pain management R11 did not consistently take her methadone for pain management. At 2:58 a.m. while being comforted by staff, R11 spoke in to telephone "It hurts." LPN-A checked to see if FM-A remained on the phone and identified FM-A was no longer on the phone. R11 continued to call out, in an amplified tone, of pain, and continued to moan. LPN-A stated R11 also had Ativan for symptom control when asked what interventions have been effective. LPN-A was unaware of other interventions to be put it into place outside of medication administration. LPN-A stated R11 had a family friend (FF)-A who visited frequently, and indicated FF-A may be more aware of what provided R11 comfort. LPN-A stated the TV was put on as a distraction, however, was not helpful. LPN-A went on to state R11 had not received her morning dose of morphine because there was no supply available. LPN-A was unsure when last dose was given and stated she would follow up with previous shift to check when last dose was given.

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On 7/25/18, at 3:26 p.m. HN continued to massage hands and lower arms and resident vocalizations decreased in intensity and frequency. R11 responded "Both" when asked if she was sad or in pain. HN continued to massage hands and offered to pray with R11. R11 started the Hail Mary and continued to repeat this prayer, with facial expression becoming more relaxed, decreased furrowing of brows, and absence of tears.

On 7/25/18, at 3:30 p.m. LPN-A returned to the room and informed HN the last dosing of methadone was given the previous evening and the morning dose for methadone had not been given. LPN-A stated pharmacy had been contacted regarding need for refill and was awaiting a script. LPN-A stated the supply is monitored by the facility staff and also by the pharmacy.

A review of the medication administration sheet, in correspondence with the Narcotic count book, R11 had last received methadone on 7/24/18 at 4:48 p.m.. The documentation also reflected refusal of methadone dosing the morning of 7/24/18. The medication record for 7/25/18 indicated a refusal of morning dose of morphine, however, the individual narcotic record for R11 indicated a count of zero after dosing was given on 7/24/18 at 4:45 p.m. R11 was noted to receive Morphine 100 mg/ml, 0.5 ml (10 mg) at 3:00 p.m. and again at 4:50 p.m. for pain management.

On 7/26/18, at 7:00 a.m. FF-A was a resident's bedside and stated she had been with R11 since early morning. FF-A stated R11 was resting more comfortably at this time. stated she had been with R11 since early morning and stated R11 was

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resting more comfortably at this time. .upon entrance into room, resident was observed in bed in the low position, resting on her back with the head of her bed raised, and R11 looked to surveyor and stated "Good morning". FF-A

On 7/26/18, at 10:45 a.m. R11 was observed in bed, under covers and was noted to be awake. R11's facial expression was noted to be free from furrowed brows, squinted/tearful eyes, and pursed lips. Trained medical assistant (TMA)-A was in with resident and stated R11 had received routinely scheduled methadone and an additional dose of morphine for pain management and was doing well. R11 responded she was "Pretty good." when asked. .

On 7/26/18, at 11:24 a.m. during telephone conversation FM-A stated she been with R11 on 7/19/18 and again on 7/22/18. FM-A described R11's pain on 7/22/18 as "really bad". On 7/22/18 FM-A reported R11 was crying, and stated she was having pain in her buttocks, her legs, and her back. R11 stated it was from laying all day. FM-A stated R11 was observed to cry for about two and a half hours, starting at lunch. FM-A stated she contacted staff and requested transfer into bed. FM-A stated staff stopped by a few times, but added "Sometimes when I am there they just let us be." FM-A stated the nurse on Sunday had stated R11 had refused medications on occasion and they had discussed alternate routes, but was unaware of any changes made in plan. FM-A stated she was at the facility on 7/23/18 at 7:00 a.m. and R11 was was crying at the breakfast table. FM-A described R11 to be sitting there "Kind of moaning" and when asked was was wrong R11 stated her "Butt hurt" . FM-A stated if R11 was experiencing pain, she should have

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received meds. FM-A stated staff have not inquired of her regarding things R11 would find soothing. FM-A stated R11 previously had watched old time television like the Andy Griffith show. Stated R11 enjoyed country western music and has been out to music activites, but is not aware of music in her room. FM-A stated she was not aware R11 had not received her methadone on 7/25/18. FM-A stated methadone has been very effective for R11, and historically, R11 did not like to use morphine as needed as she didn't like the way it made her feel. FM-A stated she had contacted the administrator approximately the third week in June regarding transfer of R11 and the fact R11 would call out in pain with moment.

A review of the treatment administration record for pain management was reviewed and noted R11 was recorded as exhibiting no pain from the 15th to the 25th of July on the 6:00 a.m. to 2:30 p.m. shift. R11's pain levels from the 2:30-10:00 p.m. shift for the same period was rated with zero to one. R11's pain monitoring sheet from the 11:00 p.m. to 6:00 a.m. pain levels were all recorded at zero with the exception 7/26/18 at which time the pain level was recorded at one. The information recorded on the pain monitoring sheet was noted to be in conflict to observations and information provided by FM-A and HN.

On 7/27/18, at 1:37 p.m. the acting director of nursing (DON) stated if a resident was noted to experience pain with movement, the staff could try to medicate before going to reposition. Upon review of the pain assessment being completed on 7/23/18, the DON stated it would be her expectation Hospice would be contacted with R11's increased presence of pain to review current interventions and modify plan of care as

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indicated.

On 7/27/18, at 3:35 p.m. the adminstrator stated she had spoke to FM-A regarding R11's status. The administrator stated she had discussed FM-A's concerns regarding management of comfort for R11. The administrator stated at times it was difficult to determine underlying cause for vocalizations as R11 has made moaning vocalizations in a positive manner with pet visits. The administrator stated FM-A did express concerns with comfort interventions and with turning and repositioning of resident.

R24's annual MDS completed on 4/21/18 identified R24 had intact cognition and was able to communicate her needs and wishes. R24 was noted to have a catheter in place to manage urinary functions and was incontinent of bowel. R24 received extensive assist to complete tasks of daily living (ADL's) which included transfers, turning and repositioning, and personal cares. R24's diagnoses included diabetes, arthritis, a neurological disorder which affected mobility, generalized muscle weakness, and morbid obesity. The Care Area Assessment (CAA) worksheet completed on 5/4/18 indicated resident was at risk for pressure ulcers related to multiple risk factors, including obesity, diabetes, neurological diseases, chronic pain, and muscle spasms. The CAA indicated R24 would receive assist to turn and reposition every two hours, in addition to use of pressure relieving mattress, and cushion in wheelchair.

R24's plan of care revised on 7/6/18 identified R24 received assistance to complete her ADL's related to R24's level of strength. The care plan indicated R24 required extensive assistance of

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two staff to assist to turn and reposition in bed every two hours and as necessary, in additional to provide. The care plan also directed staff to provide with assistance to complete personal hygiene, including skin cleansing, and completion incontinence cares every two hours. The care plan identified R24 went to the WOC (Wound, Ostomy, Continence) nurse at Meeker Memorial Hospital for wound follow up and PRN. The care plan was revised on 7/10/18 to identify an alteration in skin integrity related to an abrasion on her right buttocks. The care plan identified staff were to monitor skin integrity during cares, with documentation weekly. The care plan did not identify weekly wound care services provided by Integrated Wound Care.

On 7/23/18 at 8:44 a.m. R24 stated she is generally in bed by 9:30 p.m. but is not assisted to turn and repositioned until she puts her call light on. R24 stated she had skin breakdown and it was painful to lay in the same position for an extended period of time.

The nursing assistant care sheet identified under the heading Offload Reposition "Assist of two." The care sheet did not provide a frequency indicator of every two hours repositioning, although other residents care directions did include the recommended time frame.

A review of the nursing assistant care documentation was completed for R24 for the months of June and July and documentation was unavailable for 14 days during this period of 56 days possible. On 12 occasions it was noted to be greater than four hours between checks or "repo" (repositioning).

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On 7/26/18 at 7:40 a.m. RN-B stated the care plan instructed the staff to turn and reposition at least every two hours and more often as requested. RN-B stated she was unaware R24 had not been turned and repositioned at this frequency as "R24 has never come to me", however, stated the care plan should be followed.

During interview on 7/27/18, at 1:18 p.m. the director of nursing stated the plan of care for R24 outlined turning and repositioning every two hours. The DON went on to state if a resident preferred not to be turned or repositioned then it was the facility responsibility to educate the client regarding benefits of repositiong and to review the risks and benefits. This discussion should be reflected in the care plan.

R36's Diagnosis Report printed 7/26/18, indicated he had weakness and chronic kidney disease.

R36's CAA dated 6/13/18, indicated he can make decisions and was able to communicate his needs. R36's CAA further indicated he had no mood or behaviors.

R36's Initial Comprehensive Care Plan dated 6/06/18, indicated he was alert and orientated, pleasant and cooperative. The care plan further indicated he was further encouraged to attend activities they offer in helping him with socialization and better pass time.

R44's Minimum Data Set (MDS) dated 4/27/18, indicated she was cognitively intact

A facility investigation report submitted to the Office Of Facility Health Complaints (OHFC) on

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F 656	Continued From page 56 7/14/18, at 23:29:00 indicated R44 reported to nurse on duty another resident (R36) had gone into her (R44) room, closed the door, and offered money to allow him to touch her breast, which he did. Victim (R44) asked him to stop, which he did, then he left the room. The report further indicated R44 does not want him to touch her breast. An Internal investigation was initiated. A Facility Investigation five day report dated 7/23/18, at 18:19:07 indicated R44's care plan was reviewed and administrator met with R44 to discuss the incident. The investigation report originally indicated R44 did not accept the cash and did not want him to touch her. After a conversation, R44 informed the facility she did in fact accept the $10.00 in cash. R44 stated she and the alleged perpetrator (R36) went into her room, closing the door behind them. The victim (R44) said someone knocked on the door and asked them to keep it open. The alleged perpetrator (R36) then suggested they go down to his room. Victim (R44) stated that she followed the perpetrator (R36) down to his room, they closed the door and she allowed him to touch her breast. Victim (R44) did state that she did not want another encounter and wished for him to stay away. The facility indicated on the report the victim (R44) was put on 15 minute checks and the perpetrator (R36) was informed of the victim's (R44) wishes to not meet again and he (R36) agreed. During interview 7/26/18, at 4:37 p.m. RN-B stated R36's care plan lacked to indicate he had behaviors and should have. RN-B further stated she thought she had 92 days to complete the comprehensive care plan. Although R36 exhibited behaviors of sexual	F 656		

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F 656	Continued From page 57 abuse to R44 the facilities care plan lacked to indicate this. R44's Admission Record printed 7/26/18, indicated she had major depression, muscle weakness and mild cognitive impairment. R44's CAA dated 5/05/18, indicated she triggered in ADL's due to needing extensive assist in dressing, bathing, grooming and transfers. In addition the CAA indicated she triggered in urinary incontinence due to having occasional incontinence of urine. R44's Initial Compressive Care Plan dated 4/22/18, indicated she needed assist in ADL's and was incontinent. R44's comprhensive care plan dated 5/02/18, lacked to address her assistance needed in ADL's and urinary incontinence. During interview 7/25/18, at 7:08 p.m. RN-A stated she was aware that R44's care plan was not completed. RN-A stated she was initially told the care plan must be completed in 21 days and then she was told she had 90 days. RN-A stated what triggers on the CAA should be included on the care plan. A policy regarding the development and completion of resident comprehensive care plans was requested, but none was provided.	F 656		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the	F 676		9/10/18

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F 676	Continued From page 58 resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document the facility failed to implement a therapy recommended walking program was not	F 676	F676 Activities Daily Living/ Maintain Abilities • R23 was reviewed for restorative	

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F 676	Continued From page 59 implemented consistently for 1 of 1 residents (R23) who needed staff assistance with walking. Findings include: R23's significant change Minimum Data Set (MDS) dated 4/17/18, identified R23 had moderate cognitive impairment, and had a functional limitation in range of motion to one lower extremity. R23 needed extensive assistance with mobility. The MDS identified a diagnosis of arthritis. R23's activities of daily living (ADL) Care Area Assessment (CAA) dated 4/30/18, identified R23 fractured her right hip on 4/9/18, and was surgically repaired. R23 was receiving physical and occupational therapy with a goal to utilize her walker again. On 7/23/18, at 8:10 a.m. R23 was seated in a wheelchair in her room. She had a seated four wheeled walker in the corner of her room. R23 stated she had broke her right hip a few months ago and was supposed to be walked twice a day by staff. Further, staff were not walking her as directed. R23's Therapy Recommendations dated 5/9/18, instructed staff to walk R23 with her four wheeled walker (FWW) with one staff member twice daily. R23's care plan revised on 7/21/18, identified R23 needed an assistance of one to walk. R23 has a nursing rehabilitation program, which directed staff to walk R23 twice a day to promote daily exercise and help maintain and improve her strength. R23's nursing rehabilitation program documentation included:	F 676	nursing ambulation. Plan of care and interventions have been updated and reviewed to reflect restorative nursing ambulation. • All current residents who have been identified for restorative nursing ambulation have had their plan of care and interventions reviewed and updated. • Staff will be re-educated on proper documentation of restorative nursing ambulation • Audits of 3 restorative nursing ambulation will be completed weekly x 4 weeks; then as needed • Director of Nursing or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 676	Continued From page 60 - May 2018, identified 16 out of 24 opportunities to walk were documented as not applicable. - June 2018, identified 12 out of 29 opportunities to walk were documented as not applicable. - July 2018, identified 19 out 37 opportunities to walk and were documented as not applicable. During interview on 7/26/18, physical therapy assistant (PTA)-A stated the physical therapy recommendations were given in writing to nursing staff and the nursing staff were to follow through with the therapy recommendations. On 7/26/18, at 10:46 a.m. nursing assistant (NA)-A stated the nursing assistants were supposed to walk R23 twice a day, once on the day shift and once on the evening shift. NA-A stated R23 "probably" did not get walked every day. The staff were to offer walking to her and only occasionally did she refuse. The aids then documented resident refusal and were to let the charge nurse know. During interview on 7/26/18, at 3:01 p.m. NA-B stated if the nursing assistants chart not applicable in the nursing rehab section it meant it was not offered and was not completed. When interviewed on 7/26/18, at 3:03 p.m. registered nurse (RN)-A stated R23 was on a therapy recommended walking program. The nursing assistants were to let her know if they were not able to walk R23 or if she refused so a nursing note could be put in the residents chart. RN-A was not aware R23 was not walking as recommended. Not applicable meant the task was not completed.	F 676		
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		9/10/18

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F 686 SS=G	Continued From page 61 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct a comprehensive assessment/reassessment related to pressure ulcers and implement pressure ulcer interventions to reduce the risk of development of multiple pressure ulcers for 2 of 2 residents (R24, R11) who were reviewed for pressure ulcers. This resulted in actual harm for R24 and R11 who developed multiple pressure ulcers as a result of friction and shear without adequate interventions. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly	F 686	F686 Treatment/Svcs to Prevent/heal Pressure Ulcer • R24 was reviewed and assessed for risk of pressure ulcers. R24 has been reviewed and plan of care and interventions have been updated to reflect pressure ulcer interventions. R11 has discharged. • All current residents who have been identified for pressure ulcers, interventions and plan of care have reviewed and updated to reflect pressure ulcer interventions. • The DON or designee will provide re-education to all appropriate staff on comprehensive assessments/reassessments and pressure ulcer interventions to reduce risk of skin breakdown. • The DON or designee will complete audits for 3 current residents with	

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F 686	Continued From page 62 pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed.	F 686	pressure ulcers for comprehensive skin assessment and proper pressure ulcer interventions in place, This will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation. • Completion Date: 9/10/2018	

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Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

R24's annual Minimum Data Set (MDS) dated 4/21/18, identified R24 had intact cognition and was able to communicate her needs and wishes. The MDS identified R24 was noted to have an indwelling urinary catheter in place to manage urinary functions, and was incontinent of bowel. The MDS indicated R24 received extensive assistance to complete tasks of daily living (ADLs) which included transfers, turning and repositioning, and personal cares. The MDS identified diagnoses of diabetes, a neurological disorder which affected mobility, generalized muscle weakness, and morbid obesity. The MDS identified R24 was at risk for the development of pressure ulcers, and identified pressure reduction devices for R24's chair and bed. R24 was also identified as receiving treatment/ointment other than for foot problems, however, the MDS did not identify R24 had any skin problems.

R24's Care Area Assessment (CAA) worksheet dated 5/4/18, indicated R24 was at risk for pressure ulcers related to multiple risk factors that included obesity, diabetes, neurological diseases, chronic pain, and muscle spasms. The CAA indicated R24 would receive staff assistance to turn and reposition every two hours, use of a pressure reduction mattress, and a cushion in the wheelchair.

R24's care plan revised on 7/6/18, identified R24 received assistance to complete her ADLs related to her level of strength. The care plan indicated R24 required extensive assistance of two staff to turn and reposition in bed every two hours, and

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as necessary. The care plan also directed staff to provide R24 with assistance to complete personal hygiene including skin cleansing, and completion of incontinence cares every two hours. The care plan identified R24 went to the Wound, Ostomy, Continence (WOC) nurse at the hospital for wound follow up, and as needed (PRN). The care plan was revised on 7/10/18, to identify an abrasion on R24's right buttocks. The care plan identified staff were to monitor skin integrity during cares, and to complete weekly documentation. The care plan lacked identification of weekly wound care services provided by Integrated Wound Care (wound care consultant).

The nursing assistant care sheet identified under the heading Offload Reposition "Assist of two." The care sheet lacked the frequency of every two hours repositioning as directed by the care plan.

During observation on 7/23/18, at 9:02 a.m. nursing assistant (NA)-K provided assistance to complete personal dressing and grooming for R24. NA-K completed peri cares, and proceeded to provide cleansing to abdominal folds. Upon turning onto the left side to complete cares, R24's coccyx, gluteal cleft, labia, rectal area, and skin extending down from buttocks to upper thighs were covered with white cream. NA-K proceeded to wash this area with soap and water and applied Calmoseptine. NA-K stated the nurses will come in to assess areas if there are concerns. NA-K stated at times the area is "So sore that it bleeds" adding the areas were bleeding last week.

During observation of personal care on 7/23/18, at 9:14 a.m. R24 right gluteal cleft and upper

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thigh had an area macerated with a slough-like appearance and measured approximately 18 centimeters (cms) by 23 cms in a triangular shape. R24's left buttocks had a smaller area measuring approximately 13 cms by 13 cms. R24 also had an area on her labia, which registered nurse (RN)-B described as, "Scabs." The area had approximately a 5 cm area with light yellow (serous) drainage. RN-B stated these areas were considered friction or sheering, adding a pressure area would not be blanchable.

During observation on 7/26/18, at 7:21 a.m. personal cares were provided with NA-F, NA-L, and RN-B. Upon removing the incontinence product, RN-B stated R24's areas had a build up of tissue or scabs. During provision of care, R24 commented the area was "Sore" and "It burns." RN-B completed measurement of the areas as follows:
Left buttocks area was 17 cm by 11.6 cm and was described by RN-B as oval in shape.
The alteration in skin integrity on the labia and perirectal area was measured by RN-B at 3.7 cm by 2.4 cm.
Right buttocks area measured at 9.9 cm by 9.5 cm.

During interview with RN-B (during provision of cares) RN-B stated R24 should be off loaded (shifting and removing pressure from affected areas) and repositioned every two to two and a half hours. R24 commented aloud that on 7/25/18, she was assisted to bed at approximately 9:10 p.m. and was not assisted to reposition until she put her call light on after 5:00 a.m. to request repositioning (over seven hours between being turned and repositioned).

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Immediately following the provision of cares and skin measurements on 7/26/18, at 7:21 a.m. RN-B reviewed the plan of care for R24 which directed staff to turn and reposition R24 at least every two hours and more often as requested. RN-B stated the presence of an incontinence pad would cause increased moisture sweat/body heat, which would "keep the wound moist, not letting it dry out," increasing effects of friction and pressure. RN-B stated she was unaware of R24 not being repositioned, adding R24 had not informed her of this concern.

A review of the Integrated Wound Care (Wound Care Consultant, WCC) progress note was completed with RN-B on 7/26/18, at approximately 7:45 a.m. which identified the following findings:

6/5/18:
R24 was identified to have a single partial thickness buttock wound with a listed duration of 1 week. The wound was a mixed disease which was not healed, and measured 9 centimeters (cm) length by (X) 7 cm width; with an area of 63 squared (sq) cm.

6/12/18:
A single partial thickness buttock wound was listed with measurements recorded of 2 cm length X 2 cm width; with an area of 4 sq cm. A scant amount of serous drainage (clear, thin, watery drainage) was noted, with the peri-wound skin being normal.

6/19/18:
A single partial thickness buttock wound was listed with measurements recorded of 0.5 cm length X 0.5 cm width; with an area of 0.25 sq

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cm. Again, scant serous drainage was observed and the surrounding skin was normal. The dictation identified, "The wound is improving."

6/26/18:
A single partial thickness buttock wound was listed with measurements recorded of 0.5 cm length X 0.5 cm width; with an area of 0.25 sq cm. Again, scant serous drainage was observed and the surrounding skin was normal. The dictation identified, "The wound is improving."

7/3/18 :
R24 was now identified to have two buttock wounds.
Right buttocks: Partial thickness mixed disease with a status of not healed. Measurement of 1 cm in length by 3 cm in width.
Left buttocks: Mixed pressure/ friction area, not healed. Measurements of 1 cm in length by 5 cm in width. Wound status: Deteriorating.

A wound care visit by WCC was not completed on the week of 7/10/18.

7/17/18:
Right buttocks: Measured 14 cm by 14 cm. Skin status denoted as improving.
Left buttocks: Mixed pressure and friction. Deteriorating. A measurement of the area was not documented by the wound care nurse.

7/24/18:
Right buttocks: Partial thickness mixed disease. Not healed. Measurement: 14 cm x 16 cm.
Left buttocks: Mixed pressure/friction. Deteriorating. Measurement: 14 cm by 16 cm.

After this review on 7/26/18, RN-B stated with a

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deterioration in skin condition, an assessment should have been done to address the potential causes of the deterioration.

A review of the facility documents titled, Weekly Pressure Wound Evaluation, were reviewed from 5/29/18, to 7/26/18, which identified the following:

5/29/18:
Coccyx: (site unspecified): Shearing with no recorded measurements. No staging was completed of the wound. A "Date wound identified" was recorded of 5/22/18. Further, "Coccyx sheering has improved and not as red and irritated this week."

6/5/18:
Coccyx (site unspecified): Shearing with no recorded measurements. No staging was completed of the wound. Further, "Sheering [sic] is looking less red and more pink, less painful for the resident."

6/12/18:
Coccyx (site unspecified): Shearing with no recorded measurements. No staging was completed of the wound. Further, "Sheering [sic] has decreased in size and now only over the center coccyx and not past the buttock."

6/19/18:
Coccyx (site unspecified): Shearing with no recorded measurements. No staging was completed of the wound. A "Date wound identified" was now recorded of 6/19/18. Further, "Sheering [sic] is only around the coccyx area and slightly pink. Almost healed."

7/3/18:

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Three wounds were now listed.
Coccyx (Site unspecified) : Sheering: 1 cm x 3 cm. Stage 2
Coccyx (Site unspecified) ; Sheering: 1 cm x 5 cm. Stage 2
Coccyx (Site unspecified) : Sheering: (no measurement) Stage 1
Narrative note indicates that coccyx is close to being healed, with the exception of two open areas on her left coccyx.

7/10/18:
No documentation to reflect areas on coccyx. Addressed skin concerns with legs.

7/17/18:
Coccyx (Site unspecified) : Sheering: 14 cm by 14 cm
Narrative note identified R24 received assist of two to transfer with a mechanical lift but did not identify frequency of turning, repositioning, or offloading.

7/20/18:
Buttocks (Site unspecified): Type: Pressure. No size or stage documented.

7/24/18:
Buttocks/Upper thigh: Pressure: Size 14 cm by 16 cm.

7/26/18:
Right buttocks: Pressure (No staging or size identified).
Left buttocks: Pressure: (No staging or size identified).
Narrative note indicated R24 was educated as to risk and benefits and reviewed with the director of nursing (DON), which included decreased healing

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F 686	Continued From page 70 time and increased pain. A review of the nursing assistant care documentation was completed for R24 for the months of June and July, 2018, and documentation was unavailable for 14 days during this period of 56 days possible. On 12 occasions it was noted to be greater than four hours between checks or "repo" (repositioning). The documentation had no record of resident refusing to be turned or repositioned. On 7/27/18, at 1:18 p.m. the DON indicated R24's open areas were noted in the documentation on 7/26/18, by RN-B as a pressure ulcer. The DON stated she was unaware R24 was not being turned and repositioned every two hours, however, stated she was aware R24 would refuse to do so at times. The DON stated refusals should be reflected in staff's documentation. The DON stated when a skin area is not improving, assessment for potential cause should be completed, and staff should monitor for consistent repositioning. The DON stated staff had reviewed the risks and benefits with R24 on 7/26/18, which included potential worsening of the skin condition, delay in healing, and alteration in comfort if not routinely repositioned. The benefits of routine repositioning would be prevention of further deterioration of skin breakdown, improved healing, and comfort. The DON stated she did have not have specific information or documentation of R24's refusal to turn or reposition, and stated this should have been documented if this had occurred. The DON stated review of risks and benefits of routine turning and positioning is a routine process for residents with skin care concerns, however, she was unable to provide any documentation to reflect this had	F 686		

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been completed, nor was it included on R24's care plan prior to 7/26/18.

The WCC was called on 7/27/18, at 2:46 p.m. regarding R24's skin condition. The WCC returned the phone call on 8/1/18, at 4:45 p.m. The WCC stated she does consultation for skin care, and received a consultation for R24 on 6/5/18. The WCC stated R24's skin condition was caused by a mix of things: pressure, friction, and shearing. The WCC stated the pressure ulcer had deteriorated as identified in the progress notes, and there were multiple areas that were involved for R24. This was related to lack of frequency of repositioning R24, the process of repositioning R24, and items underneath R24 while laying on her bed or up in her wheelchair.

R11's significant change MDS dated 4/30/18, indicated R11 exhibited severe cognitive impairment and received extensive assistance to complete her ADLs including mobility and personal cares. R11's diagnoses included anemia, chronic kidney disease, diabetes, dementia, and generalized weakness. The MDS identified R11 was identified as having a Stage 1 pressure ulcer or greater, was at risk for development of additional pressure ulcers, and R11 had an unhealed Stage 1 pressure ulcer. R11's most severe stage of pressure ulcer was noted to be eschar/unstageable. R11 was identified as having a pressure reduction chair and bed, and received pressure ulcer care.

Review of the Hospice Interdisciplinary note on 7/20/18, identified a wound on R11's buttocks had healed.

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R11's care plan revised on 7/24/18, identified R11 was at risk for alteration in skin integrity related to immobility, incontinence, weight loss, and diagnosis of hypertension. The care plan directed staff to turn and reposition R11 every two to two and a half hours. Staff were directed to lift, not slide to decrease friction. Staff were also directed to encourage R11 to lie on her side while in bed to offload the pressure on her bottom. The care plan identified that the care plan was updated regarding the pressure ulcer on the coccyx on 7/23/18, and turning and repositioning was changed on 7/24/18 (during survey) from every 2 hours to every 2 1/2 hours.

During observation on 7/23/18, at 8:33 a.m. R11 was resting on her bed on her back with a mat on the right side of the bed, with the bed in the low position.

Review of the facility progress note of 7/23/18, indicated R11 received a bed bath that morning and had, "Pressure ulcers on right heel and coccyx. Resident heel has no change, and coccyx is smaller and is light red in color." R11 was being repositioned every 2- 21/2 hours and as needed (PRN). The note indicated R11 was incontinent of bowel and bladder, and wore an incontinence pad to aide in keeping the skin dry. The documentation did not reflect a plan of treatment for the coccyx pressure ulcer.

During observation on 7/24/18, at 2:28 p.m. R11 was observed in her room resting on her her back, with two pillows under her right leg to support her foot off of the bed. There were no additional pillows in place to attempt to alleviate pressure from the coccyx.

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A review of the WCC wound note of 7/24/18, indicated R11 had a reddened area on her coccyx 1 cm x 1 cm as WCC had noted per the narrative assessment by the nurse manager on 7/17/18, however, the WCC did measure the wound at the visit. The narrative note directed staff to apply a Mepilex (soft silicone foam dressing minimizes trauma to the pressure ulcer) dressing border to R11's coccyx, and change every three days. Additional interventions outlined by the WCC included for staff to reposition R11 every two to two and a half hours, air mattress to bed, pressure reduction cushion in wheelchair per hospice recommendations, daily skin checks with cares, and weekly skin assessments by nurse. The WCC documentation indicated R11 preferred to lay down in bed.

During observation on 7/25/18, at 2:14 p.m. R11 was seated in her wheelchair with her legs elevated on foot rests. R11 was sitting with her eyes closed, brows furrowed, and moaning in a constant, rhythmic pattern. The hospice nurse was present in room. NA-G entered R11's room in response to R11 crying out. NA-G proceeded to reposition R11's right leg, however, R11 continued to cry out with a moaning noise. RN-B then entered the room to provide NA-G assistance to transfer R11 into bed. R11 continued with a constant moan while being assisted to transfer to the bed with the use of mechanical lift. An acidic odor was noted in the room and hospice registered nurse (HRN)-A was unsure if this was related to the pressure ulcer or bowel incontinence, and requested R11's incontinence brief be checked. R11 had not been incontinent of bowel, however, R11 had an open area present on her coccyx with no dressing in place. HRN-A stated this area was not present

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when she last saw R11. The coccyx had drainage on the incontinence brief which was described by HRN-A as circular, blood tinged drainage and measured 2.5 cm by 2 cm. The coccyx also had two areas on the left side which were moist and HRN-A stated it appeared, "as if it could slough." The area on the left measured 2.5 cm by 1 cm, and the second measured 1.8 by 0.6 cm. On the right side of the coccyx there was an open area 2.5 cm by 1.7 cm with a center bridge of slough present measuring 0.3 cm in width and 1.0 cm in length. RN-B stated the WCC had instructed them to leave the area open without placement of a dressing. The HRN-A placed an Allevyn sacral dressing (dressing that removes fluid) to the open areas on the coccyx. Once R11 was positioned, RN-B asked R11 where her pain was. RN-B offered to remove some of R11's pillows and R11's vocalizations of pain intensified. HRN-A offered suggestions to shift the pillow down and assure R11's heel was floating.

During interview following provision of cares at 7/25/18, at 2:46 p.m. NA-G stated R11 was uncomfortable as evidenced by verbalizations/vocalizations, moving in the chair, and facial expressions. NA-G stated she would assist to reposition, offer to lay down, and then would advise the nurse if this was not beneficial in providing comfort. NA-G stated the importance of positioning for areas identified on R11's right foot but did not indicate any specific interventions to alleviate pressure on R11's coccyx. NA-G stated she was unsure of specific interventions for this.

On 7/25/18, at 3:36 p.m. HRN-A met with RN-B and requested orders for wound care to R11's coccyx. RN-B stated the WCC followed the resident for skin care needs. HRN-A stated the

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area on R11's coccyx had been healed with most recent visit. A copy of the Hospice Interdisciplinary Team (IDT) note identified on 7/20/18, indicated a wound on R11's buttocks was healed at that time.

On 7/26/18, at 11:24 a.m. family member (FM)-A stated R11's pain level on 7/22/18, was "really bad." On that day, FM-A stated R11 was observed crying out, stating her back and coccyx hurt once she had been gotten up for lunch. FM-A stated R11 cried continuously for about two and a half hours on 7/22/18, and attempts at diversion by propelling her in the wheelchair and reclining the wheelchair were of little benefit. FM-A stated R11 ceased crying once assisted into bed per family request. This was a period of greater than three hours between repositioning. FM-A stated staff will usually not intervene or provide care to R11 when family is visiting. FM-A stated on 7/23/18, at 7:00 a.m. R11 was noted to be crying and moaning while up in her wheelchair, and she expressed pain in her coccyx. FM-A stated she had spoken to the facility about the frequency of repositioning for R11 towards the end of June, and had agreed upon a plan to turn and reposition her every one and a half hours. FM-A stated earlier in July, FM-A stated there was a period of one week between visits and upon her return visit, she observed R11 had developed a "bedsore."

On 7/27/18, at 1:37 p.m. the DON stated she was aware R11 had a reddened coccyx, but was unaware of any open areas on R11's coccyx. The DON stated with observation of the reddened open area of the coccyx, the medical provider should be contacted. The DON stated staff should re-evaluate the turning and repositioning

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program to assure completion, and determine if anything should be done differently. The DON noted on 3/29/18, a tissue tolerance (to determine the length of time pressure can be tolerated to an area of the body) assessment was completed for R11. The DON stated a subsequent tissue tolerance assessment should have been completed with the development of a pressure area, a significant change, and with enrollment into Hospice. The DON state R11 met all three identified triggers for evaluation. The DON stated she was unaware of any concerns addressed by R11's family.

On 7/27/18, at 3:35 p.m. the administrator stated she had spoken to FM-A regarding the family's concerns about R11 not being positioned timely, and R11's pain management. The administrator stated she had followed up with staff regarding the concerns related to turning and repositioning. The administrator stated it was difficult to determine the underlying cause of R11's vocalizations at times, because R11 made similar vocalization in a positive response to pet visits.

On 7/27/18, at 2:46 p.m. The WCC was called to review current skin conditions, and plan of treatment for R11. A phone call was returned form the WCC on 8/1/18, at 4:45 p.m. The WCC stated she had initiated wound care consultation most recently on 6/12/18. Initial measurements of R11's Stage 3 pressure ulcer on the coccyx were 2.5 cm by 2.5 cm. The narrative note of 7/24/18, by the WCC was based on the nurse manager's measurement of 7/17/18, which indicated wound measurement as a 1 cm x 1 cm reddened area on R11's coccyx. A review of measurements obtained with HRN-A on 7/25/18, at 2:14 p.m. identified R11 was observed to have had

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F 686	Continued From page 77 drainage on the incontinence brief which was described by HRN-A as circular, blood tinged drainage, and measured 2.5 cm by 2 cm. The coccyx also had two areas on the left side which were moist and HRN-A stated it appeared, "as if it could slough." The area on the left measured 2.5 cm by 1 cm, and the second measured 1.8 by 0.6 cm. On the right side of the coccyx there was an open area was 2.5 by 1.7 cm with a center bridge of slough present measuring 0.3 cm in width and 1.0 cm in length. The WCC stated the underlying cause of the pressure ulcers was from pressure, and stated it was important to reposition R11 every two hours. The WCC stated these areas were caused from sitting in wheelchair, and laying in bed on her back. The WCC stated it was important to reposition R11 every two hours, utilize the pressure reduction mattress on the bed, and the pressure reduction cushion in her wheelchair. A facility policy titled, Skin Assessment and Wound Management dated 7/20, directed updates with ongoing skin problems would be relayed to the providers as indicated. The policy did not identify specific interventions to be implemented if the skin condition was noted to be deteriorating.	F 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	F 688		9/10/18

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F 688	Continued From page 78 §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document the facility failed to ensure a range of motion program for upper and lower extremities was implemented for 1 of 2 residents (R35) who had limited range of motion. Findings include: R35's face sheet, undated, identified diagnoses of dementia, muscle weakness and muscle wasting. R35's annual Minimum Data Set (MDS) on 6/18/18 identified R35 had moderate cognitive impairment, limited range of motion of her upper extremities on one side, and no nursing rehabilitation program. R35's rehabilitation Care Area Assessment (CAA), 6/13/18, identified R35 had a daily range of motion program. R35 was observed on 07/23/18 at 11:39 a.m. with her right hand curled around and under the arm of her wheelchair. Her right hand was closed and her wrist was bent and pulled inward towards the resident. On 07/25/18 at 5:58 p.m. R35 was in her wheelchair at the dining room table with her right	F 688	F688 Increase/Prevent Decrease of ROM/Mobility • R35 was reviewed for range of motion treatment, plan of care and interventions have been updated and reviewed to reflect range of motion plan. • All Current residents who have been identified for range of motion treatments have had their interventions and plan of care have reviewed and updated. • The DON or designee will provide re-education to all appropriate staff on range of motion plan of care per Meeker Manor Procedures • The DON or designee will complete audits for 3 residents for their range of motion programs that will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendations. • Completion Date: 9/10/2018	

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hand closed and her wrist bent inward. There was no splints or supports on her right hand. She used her left hand to eat her evening meal, while her right hand laid on her lap.

R35 was observed during evening cares on 07/25/18 at 7:04 p.m. with nursing assistant (NA)-J. NA-J placed a sling under R35's arms and hooked it to a mechanical lift (EZ stand). NA-J instructed R35 to grasp the handles of the EZ stand so she could hold herself while being transferred with the mechanical lift. R35 tells NA-J my right hand does not do too much and she was unable to grasp the handle of the EZ stand, but was able to use her left hand to hold onto the stand. NA-J then transfers R35 to the bathroom for evening cares using the EZ stand. NA-J washes R35 under R35's arms, back and perineal care. After washing NA-J placed a clean gown on R35 and transferred R35 back to bed with the EZ stand. During this time NA-J made no attempts to provide any range of motion to R35's upper extremities.

During interview on 7/25/18 07:33 p.m. NA-J stated R35 had no behaviors and they provide all personal cares, and use the EZ stand so she stands for a few minutes during cares for strengthening. NA-J stated she does not complete range of motion for R35 and thought therapy provided this.

The quarterly restorative review dated 3/12/18, identified R35 had assisted range of motion (AROM), lower extremities (LE)/upper extremities (UE), with participation in AROM documented 4 of 7 days in assessment period with 3-5 reps for 10 minutes documented each shift. The review identified R35 attends exercises in activities when

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offered. Exercise was effective in maintaining movement and prevent further decline, will continue with plan. There were no other assessments identified since 3/12/18.

R35's care plan, 6/27/18 identified a problems with limited physical mobility related to dementia, and osteoarthritis. Staff were directed to implement active range of motion (AROM) lower and upper extremities twice a day and encourage to attend exercise in activities when scheduled. There was no mention of splints or supports for her right hand.

Review of the facility Follow Up Question Report identified AROM UE/LE daily up to 8 minutes. The May thru July 2018 reports identified the following:

May 2018 report identified R35 received AROM 30 times out of 62 opportunities, and ranged from 1-15 minutes of time for AROM. R35 refused AROM 10 times, and not applicable 10 times.

June 2018 report identified R35 received AROM 23 times out of 60 opportunities, and ranged from 2-20 minutes of time for AROM. R35 refused AROM 16 times, and was not applicable 12 times.

July 2018 to date (7/26/18) identified R35 received AROM 30 times out of 52 opportunities, and ranged from 2-15 minutes for AROM. R35 refused AROM 11 times, and was not applicable 4 times.

During interview on 7/26/18 09:00 a.m. physical therapist (PT)-A stated they don't have R35 on their case load, and any functional maintenance

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program would be completed by nursing.

On 07/26/18 09:03 a.m. occupational therapist registered (OTR)-A stated some residents go to the exercise group but this would not work for R35 because she can not follow the program and would not be effective.

During interview on 7/26/18 10:47 a.m. NA-D, who provided morning cares for R35, stated she completed AROM while she gets R35 dressed and ready for the day. She stretches and extends each arm and leg, doing 10 repetitions on each extremity. She does nothing with her hands or wrists, she only does AROM with her arms and legs.

On 07/26/18 11:14 a.m RN-A stated when NA's get R35 dressed they are expected to provide AROM, for R35's upper and lower extremities along with doing AROM of her elbow, wrist and hand. They should be completing at least 5-10 repetitions of each movement everyday. RN-A was unaware the NA's were not completing AROM to R35's hand or wrists and stated they should be doing this.

On 7/26/18 11:25 a.m. certified occupational therapy assistant (COTA)-A evaluated R35 right hand which was closed with her wrist bent, and curled in towards the residents. COTA-A opened R35's hand and was able to straighten her hand but it "was tight." R35 stated she was unable to open her right hand or move her right wrist herself. COTA-A stated we need to pick her up for therapy and do some strengthening, and maybe a splint to keep it straight. Her upper extremities are tight along with her shoulders, she was unable to determine if this is worse because they

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F 688	Continued From page 82 had not evaluated R35. The occupational therapist completed an assessment of R35 on 7/26/18, which identified decreased right wrist ROM and was at risk for further decline. Plan to fit resdient with appropriate splint to promote correct wrist positioning and establish a wearing schedule. Although R35 was to received AROM for UE/LE twice a day by NA's, this was not being implemented.	F 688		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to secure adequate pain medications to allow prescribed medication to be administered as ordered to prevent episodes of pain and discomfort for 2 of 2 residents (R11, R250) reviewed for pain management. This resulted in actual harm for R11 who demonstrated severe physical symptoms of pain on multiple occasions. Findings include: R11's significant change Minimum Data Set (MDS) dated 4/30/18, identified diagnoses that included anemia, chronic kidney disease,	F 697	F697 - Pain Management • R250 was reviewed for pain management. Plan of care and interventions have been updated and reviewed to reflect the pain management plan. R11 was discharged. • All Current residents who have been identified for pain management have had their interventions and plan of care have reviewed and updated. • The DON or designee will provide re-education to all appropriate staff on pain management and proper procedure on ordering and obtaining pain medication from pharmacy per Meeker Manor	9/10/18

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F 697	Continued From page 83 diabetes, dementia, and generalized weakness. The MDS also indicated R11 required extensive assistance to complete activities of daily living (ADLs) and was severely cognitively impaired. R11 was identified as enrolled in Hospice effective 4/25/18. A corresponding Care Area Assessment (CAA) completed on 5/14/18, identified R11's level of pain impacted her sleep, limited her day to day activities, was rated as severe, and was noted to occur frequently. The assessment indicated R11 experienced vascular pain in her right leg, and pain in her heel. R11 was also noted to have pain in her buttocks. The CAA identified pain had improved since R11 had enrolled in Hospice. The desired outcome for care was palliative with symptom relief. R11's care plan revised 7/23/18, indicated R11 experienced alteration in comfort related to pressure ulcers on her right foot and coccyx. R11's care plan indicated staff were to implement non-pharmacological interventions including repositioning, television in R11's room, warm blanket, family/friends company, and music. In addition, the care plan directed staff to monitor R11's level of pain with the use of a flow sheet or FLACC (Face, Legs, Activity, Cry, Consolability)/Dementia scale, with a pain assessment per protocol. The care plan indicated R11 received medications as ordered by the primary provider (physician), and staff were to monitor for the effectiveness of the medications as well as potential side effects. Staff were also to encourage R11 to verbalize discomfort, and use rest periods. The care plan directed staff to turn and reposition R11 every two to two and a half hours, and to lift, not slide her to decrease friction, and to encourage R11 to lie on her sides while in bed to offload her bottom.	F 697	Procedures. • The DON or designee will complete audits for 3 residents for proper pain management and 3 staff members will be interviewed on proper procedures for pain management and reordering/obtaining pain medications from pharmacy. This will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation. • Completion Date: 9/10/2018	

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R11's pain evaluation completed on 4/30/18, identified R11 had experienced pain frequently over the last five days. The evaluation indicated the pain had impacted her sleep, limited her day to day activities, and was rated by R11 as severe. At the time of the assessment, R11 was using Fentanyl and Norco (narcotic pain medications) to manage her pain. The assessment indicated staff were to administer medications as ordered and to monitor for effectiveness. The assessment also indicated staff were to monitor for increased signs and symptoms of pain and intervene as needed.

On 7/23/18, at 7:15 a.m. R11 was observed in the dining room vocalizing moaning sounds. Family member (FM)-A responded to R11 and inquired as to whether she was hurting. As the meal progressed FM-A asked R11 at 7:23 a.m. if she was "crying because she hurt." R11 continued to moan. At 7:27 a.m. FM-A was heard again asking R11 if she was crying because she hurt, to which R11 responded, "Yes." FM-A was heard telling R11 she had received pain medications, adding they, "must not be working. Let's eat quick and then get you laid down." R11 was reclined back in her wheelchair as FM-A assisted her to eat. At 7:29 a.m. R11 was heard moaning out loud, and FM-A was dabbing R11's eyes with a tissue. R11 was wheeled out of the dining room by FM-A at 7:30 a.m.

On 7/23/18, at 8:35 a.m. R11 was observed resting in bed. R11 made moaning vocalizations, however, did not verbalize a response when asked whether she was experiencing pain.

On 7/23/18, at 11:30 a.m. R11 was observed resting on her bed. R11 displayed facial

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grimacing, with her eyebrows and forehead furrowed with moisture in the corner of her eyes. R11 was making rhythmic moaning noises, without discernible words.

A review of the electronic records indicated a pain assessment was completed on 7/23/18, by registered nurse (RN)-B. The pain assessment indicated R11 experienced pain on her coccyx and right foot. The document indicated, "Resident states pain is occasional, and rated 4/10 at worst [10 being the worst], and does interfere with sleep and daily activities." The assessment further indicated R11 received scheduled Methadone (pain medication) 10 milligrams (mg) at 8:00 a.m., and 5 mg at 4:00 p.m. in addition to orders for morphine (narcotic) 10 mg and Tylenol 650 mg as needed. However, the assessment indicated the medications had not been used during the assessment period. Interventions identified for use of the pain medications included administration of medications as ordered, monitoring for effectiveness, monitor resident for signs and symptoms of pain, and intervene as needed. The assessment also indicated staff were to update the care provider as needed. The assessment did not indicate notification of Hospice regarding the pain assessment completion, or of concerns regarding effectiveness of the current pain regime.

On 7/23/18, at 4:03 p.m. a call was placed to the Hospice agency to inquire whether about any contact regarding pain management for R11. The Hospice director (HD) stated she had not received any calls in follow up, and there had been no notification or contact regarding R11's increased pain level. The hospice registered nurse (HRN)-A who was R11's case manager

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was currently out of the office, but the HD stated she would advise her of the call and follow up. The HD stated when a resident is enrolled in Hospice and has increased pain, it was the expectation of Hospice for the nursing facility to contact the 24-hour nurse call line to advise them of the pain, so evaluation and coordination of current interventions could be done, with subsequent development of an appropriate plan of care for R11.

On 7/24/18, at 2:28 p.m. R11 was observed in her room resting on her bed lying on her back. R11 was resting quietly with relaxed facial expressions.

On 7/25/18, at 2:14 p.m. R11 was observed in her wheelchair with her legs elevated on the foot rests. R11's eyes were closed, her brows were furrowed, and R11 was moaning in a constant, rhythmic pattern. HRN-A was present in the room. Nursing assistant (NA)-G entered the room to provide cares, and placed R11's right leg on a pillow to provide full leg support. R11 continued to cry out with a moaning sound. Registered nurse (RN)-B entered the room to provide assistance. NA-G and RN-B assisted with placing a mechanical lift sling under R11, while R11 continued to constantly moan which intensified with physical movement. R11 was transferred to her bed, and the mechanical lift sling was removed. An acidic odor was noted in R11's room and HRN-A was unsure whether it was related to R11's foot wound, or bowel incontinence, so HRN-A requested staff check her incontinence brief. Incontinence care was provided by NA-G and RN-B with no noted incontinence of bowel. R11 had an open area on her coccyx with no dressing in place. HRN-A

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stated this area was not present when she had last seen R11 for evaluation. RN-B stated their Wound Care Consultant (WCC) had instructed them to leave the area open without placement of a dressing. HRN-A placed an Allevyn Sacral Dressing (foam moisture absorbing dressing that breathes) to the affected areas on the coccyx. R11 had ceased moaning while measurements were obtained, but resumed moaning and vocalizations which intensified with any increased movement. R11 was observed to hold her upper body in a semi-fetal position. Once R11 was repositioned, RN-B asked R11 where the pain was located. R11 continued with moaning vocalizations and did not identify where her pain was located. RN-B removed the pillows, and R11's vocalizations intensified. HRN-A offered suggestions to shift the pillow down to assure R11's heel was floating. A blanket was placed to provide less support/pressure than a pillow in an attempt to improve R11's comfort level. R11 vocalized crying out and moaning when her entire leg was moved. RN-B asked R11 to rate her pain however, R11 only amplified vocalizations with moaning. HRN-A rubbed R11's hand and arms, offering words of reassurance. HRN-A also asked RN-B about R11's recent pain medication status. RN-B stated she would follow up and exited the room.

During interview with NA-G, following provision of cares on 7/25/18, at 2:46 p.m. NA-G stated when R11 was observed to be uncomfortable as evidenced by verbalizations, vocalizations, moving in chair, and facial expressions. NA-G stated she would assist with repositioning R11, offer to lay R11 down, and would advise the nurse if those measures were not beneficial in providing comfort. During the observation at that time, R11

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began to cry out loudly, tear up, and displayed facial grimaces of her brows and forehead being furrowed. R11 also emitted a continuous moaning sound.

On 7/25/18, at 2:47 p.m. licensed practical nurse (LPN)-A entered R11's room to administer morphine liquid. When asked when the resident had previously received dosing of morphine, LPN-A stated R11 had not received the morphine liquid for several days. At 2:49 p.m., R11 continued to cry out with her lips quivering and tears present in both of her eyes. LPN-A offered to provide R11 assistance to contact FM-A. R11 continued to cry responding, "Mmmmmm." R11's lips continued to quiver, and tears were observed in the corners of both eyes. LPN-A placed a call to FM-A at 2:51 p.m. LPN-A held the phone to R11's left ear and R11 was observed to purse her lips, and to furrow her brows and forehead. R11's eyes were squinted closed, and R11 was actively crying with vocalizations and tears present. R11 cried into the phone, "Help me, help me, help me." At this time, the head of the bed was elevated, R11 was lying on her back, pillows were under her right leg, and HRN-A and LPN-A were observed to rub R11's shoulder and arm in a comforting motion. At 2:55 p.m. R11 continued to call out. LPN-A stated R11 did not consistently take her methadone (pain medication) for pain management. The HRN-A stated she had not been informed of R11's increased pain and added the methadone dosing had been increased two weeks ago, but the Hospice agency had not been informed of R11's refusals to take her medication. At 2:58 p.m. while being comforted by staff, R11 spoke into the telephone to FM-A, "It hurts." R11 continued to call out in an amplified tone of pain, and continued to moan. During this interaction,

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LPN-A stated R11 had Ativan (anti-anxiety) for symptom control when asked what interventions have been effective. LPN-A stated R11 had a family friend (FF)-A who visited frequently, and indicated FF-A may be more aware of what provided R11 comfort. LPN-A stated the television was put on as a distraction, but was not helpful. LPN-A was not aware of other non-pharmacological interventions implemented to provide R11 comfort. LPN-A stated R11 had not received her morning dose of morphine because there had been no supply available. LPN-A was unsure when the last dose of morphine had been administered, and stated she would follow up with the previous shift to check.

During a visit with R11 on 7/25/18, at 3:04 p.m. HRN-A stated this was the worse pain she had observed R11 experience. HRN-A stated she had not been notified by staff of the increased pain observed. HRN-A stated they had worked with FM-A, R11's primary medical provider, and the facility on R11's pain management. HRN-A said R11's methadone had been increased two weeks ago, and stated she had intended to consult with the hospice pharmacy and evaluate for a possible need to increase R11's methadone dosing. However, HRN-A stated Hospice had not been informed R11 had refused her medications, or that the facility was out of R11's methadone supply. HRN-A stated she would have expected the facility to advise Hospice of R11's refusal to take the medication, of any symptoms of R11 exhibiting increased pain, and of any lack of supply of methadone. HRN-A stated when she had increased the dosing two weeks ago she had verified with FM-A to assure an adequate supply was available. HRN-A stated the hospice medical director could have facilitated a refill of

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medications if needed, and if alerted. HRN-A stated the facility not having methadone available for administration was "concerning."

On 7/25/18, at 3:26 p.m. HRN-A continued to massage R11's hands and lower arms, and R11 was observed to decrease both the intensity and frequency of her vocalizations. R11 responded, "Both" when asked if she was sad or in pain. HRN-A continued to massage R11's hands and offered to pray with R11. R11 started verbalizing a prayer out loud and continued to repeat this prayer, with her facial expression becoming more relaxed as evidenced by decreased furrowing of her brows, and absence of tears.

On 7/25/18, at 3:30 p.m. LPN-A returned to the room and informed HRN-A the last dose of methadone had been given the previous evening, and verified no morning dose of methadone had been given. LPN-A stated the pharmacy had been contacted to refill the medication and was awaiting a prescription. LPN-A stated the methadone supply was monitored by facility staff and also by the pharmacy, and stated R11's medical doctor (MD)-A had been in the facility that day conducting rounds, but staff had not obtained a written prescription for the methadone refill during rounds.

On 7/25/18, at 3:38 p.m. HRN-A stated the facility was responsible for ordering the methadone. HRN-A said the lack of methadone for dosing was of concern to her, and stated it was "irresponsible" of the facility.

A review of the medication administration sheet, in correspondence with the narcotic count book, R11 had last received methadone on 7/24/18 at

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4:48 p.m. The documentation also reflected refusal of methadone dosing the morning of 7/24/18.

A review of the medication sheet for 7/25/18, indicated a refusal of morning dose of morphine, however, the individual narcotic record for R11 indicated a count of zero following the 4:45 p.m. 7/24/18, dose.

A review of the Medication Administration Record for 7/25/18, identified R11 received morphine 100 mg/ml, 0.5 ml (10 mg) at 3:00 p.m. and again at 4:50 p.m. for pain management.

On 7/25/18, at 5:46 p.m. LPN-A stated R11 had received a second dose of morphine for pain management. LPN-A stated the methadone should be delivered in time for the evening dose.

On 7/26/18, at 7:00 a.m. FM-A was at the resident's bedside. R11 was observed in bed, resting on her back with the head of her bed raised. R11 stated, "Good morning." FM-A stated she had been with R11 since early morning, and stated R11 was resting more comfortably at this time.

On 7/26/18, at 10:45 a.m. R11 was observed in bed, and was noted to be awake. R11's facial expression was noted to be free from furrowed brows, squinted/tearful eyes, and pursed lips. Trained medication assistant (TMA)-A was in with R11, and stated R11 had received her routinely scheduled methadone, and an additional dose of morphine for pain management and was doing well. When asked, R11 responded she was, "Pretty good."

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During conversation on 7/26/18, at 10:58 a.m. HRN-A stated she had been contacted by the the facility the prior evening after R11 had received the second PRN dose of morphine, and was notified R11 was actively dying. A Hospice visit was offered to the facility and the facility declined. HRN-A stated R11 was demonstrating increased shallow breathing following the second dose of morphine. HRN-A stated R11's lethargy and shallow breathing may have been related to the dosing of morphine. HRN-A stated historically, R11 had taken only one dose of morphine as needed throughout the course of a day. HRN-A stated R11 being out of methadone made a huge difference for her for pain, and receiving two doses of morphine impacted her response. HRN-A stated she used a dementia scale for pain with FLACC and would have classified R11 as a score of eight to nine on a scale of one to ten, indicating severe pain.

On 7/26/18, at 11:24 a.m. a call was received from FM-A. FM-A stated she had seen R11 on 7/19/18, and again on 7/22/18. FM-A described R11's pain on 7/22/18, as "really bad." FM-A reported on 7/22/18, R11 had been crying, and had stated she was having pain in her buttocks, legs and back, and had been laying all day. FM-A stated R11 had been observed on 7/22/18, to cry for about two and a half hours. FM-A said she contacted staff and requested they transfer R11 into bed. FM-A stated staff stopped by a few times, but added, "sometimes when I am there they just let us be." FM-A stated, "The nurse on Sunday told me [R11] had refused medications on occasion and they had discussed alternate routes." FM-A stated she was at the facility on 7/23/18, at 7:00 a.m. and R11 was crying at the breakfast table. FM-A stated R11 had been just

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sitting there "kind of moaning." FM-A stated when R11 was asked what was wrong, R11 stated her "butt hurt" and was crying. FM-A stated if R11 was experiencing pain, she should have received pain medication, and stated staff had not asked her what types of things R11 might find soothing. FM-A stated R11 previously had watched old time television like the Andy Griffith show, and stated R11 enjoyed country western music. Although FM-A said R11 had been out to music activities, FM-A was unaware of whether R11 had music provided in her room. FM-A stated she was not aware R11 had not received her methadone on 7/25/18, and stated the methadone had been very effective for R11 historically. FM-A further stated R11 did not like to use morphine as needed because she did not like the way the medication made her feel. FM-A stated she had contacted the administrator approximately the third week in June regarding transferring R11, because R11 would call out in pain with moment. FM-A stated they had since been much better about trying to keep her comfortable.

A review of the treatment administration record for pain management was reviewed and noted R11 was recorded as exhibiting no pain from the 15th to the 25th of July during the 6:00 a.m. to 2:30 p.m. shift. R11's pain levels from the 2:30-10:00 p.m. for the same period was rated with zero to one. R11's pain monitoring sheets for the 11:00 p.m. to 6:00 a.m. shift, indicated R11's pain levels were all recorded at zero with the exception of 7/26/18, at which time the pain level was recorded at one.

On 7/27/18, at 1:37 p.m. the director of nursing (DON) stated if a resident was noted to experience pain with movement, staff could try to

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medicate before assisting the resident to reposition. When the pain assessment completed 7/23/18, was reviewed with the DON, the DON stated she would expect Hospice to be contacted regarding R11's increased presence of pain, to review current interventions and modify her plan of care as necessary. A review was completed with the level of pain recorded on the treatment administration record in comparison to the narrative notes and medications administered. The DON stated the level of pain recorded should correspond with the interventions in place. The DON stated she was unaware R11 had not received her morning dose of methadone until she was informed she was out of methadone in the afternoon. The DON stated controlled substances are ordered from the pharmacy through a routine refill process. The DON stated if staff note the supply is down to a one day supply, they were supposed to fax and call the pharmacy to advise them of this. The DON stated at the time they were out of medication, the pharmacy was to be called and a plan of action coordinated. The DON further confirmed she was unaware of the need for a prescription form from MD-A until he had left the facility following rounds.

On 7/27/18, at 3:35 p.m. the administrator stated she had spoken to FM-A regarding R11's status. The administrator stated she had discussed FM-A's concerns regarding management of comfort for R11. The administrator stated at times it was difficult to determine the underlying causes for vocalizations as R11 had made moaning vocalizations in a positive manner with pet visits. The administrator also stated FM-A had expressed concerns with R11's comfort interventions, especially when turning and repositioning the resident.

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R250's undated Admission Record identified R250 was admitted to the facility on 7/12/18. R250's admission orders signed 7/12/18, identified orders for Tramadol (narcotic for pain management) 50 mg every 6 hours PRN for severe pain, and Tylenol 325 mg every 6 hours PRN, for mild pain or fever.

R250's undated, Initial/ Comprehensive Care Plan section for pain and comfort was blank and did not identify R250's risk for pain, any goals, or interventions to manage pain.

R250's Pain Evaluation dated 7/21/18, indicated R250 had frequent lower back pain,and rated her pain a 3 out of 10. The evaluation indicated R250 had been taking Tramadol 50 mg as needed for pain, and indicated the pain did not interfere with her sleep but did interfere with her activities of daily living.

On 7/23/18, at 11:21 a.m. R250 was observed lying in her bed. At that time, R250 stated she had chronic lower back pain, and rated her pain a 6 out of 10. R250 described the pain as throbbing, and stated she had been prescribed Tramadol and it helped relieve her pain, but stated it had been 4-5 days since she received any Tramadol because she had been told by facility staff she was out of the medication. R250 stated other medications did not help, so she had stopped asking for medication.

On 7/25/18, at 2:28 p.m. R250 was lying in her bed. She sat up to the edge of her bed and placed her right hand on her lower back and grimaced. Once seated at the edge of her bed, she removed her hand from her back and was no

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longer grimacing. She stated she had not heard what was going on with her pain medication and was now rating her pain at a 7 out of 10. She stated her pain was better with movement, and lying in bed most of the day did not help relieve her pain.

R250's MAR for July 2018, identified R250 received 15 doses of Tramadol 50 mg from 7/12/18, until 7/17/18. No further doses of Tramadol 50 mg were administered.

During interview on 7/25/18, at 2:36 p.m. NA-B stated R250 was very independent and had little interaction with her, but if she was having pain she would let the trained medication aid or nurse know.

During interview on 7/25/18, at 2:42 p.m. TMA-A stated R250 had not complained of any pain.

On 7/25/18, at 5:16 p.m. the medication cart was reviewed with LPN-A. LPN-A stated R250 did not have any Tramadol on the medication cart, and no longer had an order for Tramadol. LPN-A stated R250 had chronic lower back pain. LPN-A was unaware of what non-pharmacological interventions were supposed to be attempted with R250. LP:N-A stated R250 had not been asking for pain medications for about the last week, and added staff should be asking R250 to rate her pain when they gave her pain medications.

During interview on 7/25/18, at 6:50 p.m. RN-A stated R250 had chronic back pain, and had been admitted with Tramadol to manage her pain. RN-A stated she was responsible for completing the baseline care plan, and verified it was not completed. RN-A said a baseline care plan

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F 697	Continued From page 97 should have been developed to include interventions for pain control. RN-A was not aware until that afternoon that R250 had been complaining of back pain, had requested pain medications, or that R250 was out of Tramadol. RN-A stated she left a message with the on-call physician and called the pharmacy to get her pain medication. RN-A stated the TMA or nurse on the cart should have re-ordered R250's pain medication when there were 5 doses left. RN-A stated if there were only 2 doses left and additional pain meds had not been received, the pharmacy should have been called. RN-A stated the facility could have definitely done more to manage R250's pain. A facility policy for pain management was requested, but was not received.	F 697		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure they were knowledgeable about providing care and emergency services to dialysis patients with a central line access for 1 of 1 resident (R100) who had a central line access for dialysis services. Findings include:	F 698	F698 – Dialysis • R100 has been discharged. • No current residents receive Dialysis at Meeker Manor. • The DON or designee will provide re-education to all appropriate staff on Dialysis Emergency Services per Meeker Manor Procedures. • The DON or designee will complete	9/10/18

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F 698	Continued From page 98 R100's face sheet undated, identified he was admitted to the agency on 7/18/18, with diagnosis of stage 4 chronic kidney disease, and had a central line access (artificial tube surgically inserted in the subclavian artery through the chest) for dialysis services. R100's initial comprehensive care plan, 7/18/18, identified Chronic Kidney disease, and received dialysis on Tuesday, Thursday and Saturday. The interventions identified check dressing daily, if bleeding occurs apply pressure and call dialysis unit. If case of cap disconnection to central catheter, clamp tube, cover with sterile dressing and send to emergency room, call physician if elevated temperature and dialysis per schedule. There was no other information identified in the care plan about R100's central line access. Review of the Dialysis Communication Records, identified the nursing home nurses would fill the top form, and the dialysis nurse would complete the bottom of the form. Review of the communication form identified on 7/19, 7/21/18 and 7/24/18, the facility nurse identified "yes" that R100 had an access site (joining of a vein and artery with a soft tube in the forearm), and a thrill (presence of blood flow heard or felt through the dialysis access graft in the forearm) to monitor blood flow to ensure dialysis access in the area. During interview on 07/26/18 10:30 a.m. licensed practical nurse (LPN)-C stated she checks R100's central line daily for bleeding. In an emergency situation, she would contact RN-A or the dialysis center for direction. She was unsure of what the policy was for resident who had a central line dialysis access and was not familiar with a central lines. These residents were	F 698	audits for 3 residents for Dialysis Emergency Services (if applicable) and 3 staff members will be interviewed on proper procedures for Dialysis Emergency Services, this will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation. • Completion Date: 9/10/2018	

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F 698	Continued From page 99 typically on the south end of the nursing home. She stated there was a reference book at the nursing station of what to do. LPN-C looked at the nursing station for a three ring binder, and dialysis protocols. There was no protocols for dialysis patients in the reference book and LPN-C was unable to find any other dialysis protocols. The above information was discussed with registered nurse (RN)-A on 7/26/18 at 11:30 a.m., who stated the protocol should be in the book and they needed to add that information for a reference. Review of the facility Hemodialysis Emergency Protocols, undated, identified Central Venous Catheter Care, to keep site clean and dry, notify MD and dialysis nurse if infection and any swelling in the residents hand, arm, neck breast or chest. Do not pinch, poke, bend or pull at catheter, do not use sharp objects around the catheter. If dressing become soiled, saturate or falls off, cleanse site with betadine, and apply sterile dressing, note the catheter appears in place, and contact dialysis staff of any unusual findings. The policy also identified what to do if there was blood leaking around catheter, symptoms of air embolism, or if catheter dislodges.	F 698		
F 730 SS=F	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the	F 730		9/10/18

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F 730	Continued From page 100 requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance reviews were completed on an annual basis for 3 of 3 nursing assistants (NA-C, NA-D, NA-E) whose files were reviewed. This had potential to affect all 56 residents who resided in the nursing home and who could receive care from these staff. Findings include: A facility provided, unnamed listing dated 7/23/18, identified the following nursing assistant (NA) staff with their start dates: - NA-C was hired on 5/24/17, and worked on a full time basis; - NA-D was hired on 6/30/16, and worked on a full time basis; and, - NA-E was hired on 6/29/16, and worked on a full time basis. During the recertification survey, from 7/23/18, to 7/27/18, evidence was requested from their respective employee files to demonstrate a performance review had been completed for NA-C, NA-D, and NA-E. No evidence was provided. When interviewed on 7/27/18, at 2:02 p.m. the regional director of operations (RDO) stated when the facility transitioned to the current management company (over two years prior) the annual evaluations stopped being completed. The facility identified this a "couple months ago" and were planning to just complete employees'	F 730	F730 – Nurse Aide Perform Review 12 hr/yr In-Service • NA-C, NA-D, NA-E will receive an annual performance review. • All employees who have completed a year or more of employment will receive an evaluation and then annually thereafter. All employees will receive an evaluation annually going forward • Staff will be re-educated on ensuring employee annual evaluations are completed. • Audits of 3 employee evaluations will be completed weekly x 4 weeks; then as needed. • Human Resources Director or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 730	Continued From page 101 review going forward when their yearly anniversary came up. RDO clarified their were no other plans in place to catch the past due evaluations up more timely being implemented. A facility policy on NA performance reviews was not provided.	F 730		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data	F 732		9/10/18

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F 732	Continued From page 102 available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently include the facility census on the daily nurse staff posting. In addition, the nurse staff posting was not displayed in a prominent location and accessible for all resident to read. This had the potential to affect all 56 current residents, their families and visitors. Findings include: During observation on 7/23/18, at 7:31 a.m. the facility nurse staff posting was posted on the North side of the building at approximately 4-5 feet from the floor, which was unable to be viewed from someone seated in a wheelchair. The posting included the date, census; and direct care nursing staff shifts, numbers and total hours worked. During observation on 7/24/18, at 9:14 a.m. the posting was missing the daily census. The facility nurse staff posting was reviewed from 7/1/18, through 7/25/18, 20 out of 25 postings did not include the facility census. During interview on 7/26/18, at 11:02 a.m. the staffing coordinator (SC) stated she was	F 732	F732 – Posted Nurse Staff Information • The facility has moved the daily nursing staffing post to a centralized location and to appropriate wheelchair height. The facility has added the facilities daily census. • Staff will be re-educated on ensuring the daily nursing staffing post is completed timely and accurately specific to the facilities daily census • Audits of the facilities daily nursing hours posting to be completed weekly x 4 weeks; then as needed. • Administrator or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 732	Continued From page 103 responsible for updating and posting the nurse staff posting. She completes the nurse staff posting in advance of her days off and to her knowledge no one else in the facility adds the census or makes staffing changes if there were changes needed. Further, when she returned from time off she tried to update the postings after the fact. SC-C stated the posting was displayed on one unit and not the other and was not centrally located. Further it was posted at a height where a person in a wheelchair could not read it. During interview on 7/26/18, at 2:41 p.m. the regional director operations (RDO) stated the nurse staff posting was required to have the census information posted daily. The posting was not in a prominent locations and at a height that could be viewed by a person in a wheelchair. The facility did not have a policy on the nurse staff posting.	F 732		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		9/10/18

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F 756	Continued From page 104 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pharmacist recommendations were acted upon timely, and appropriate rationale was recorded for not implementing recommendations for 1 of 5 residents (R29) reviewed for unnecessary medication use. Findings include: NOT ACTED UPON: R29's quarterly Minimum Data Set (MDS) dated 5/25/18, identified R29 had dementia with a	F 756	F756 Drug Regimen Review, Report Irregular • R29 was reviewed for pharmacist recommendations, rational was recorded and recommendations have been implemented timely. Plan of care and interventions have been updated and reviewed to reflect pharmacist recommendations. • All current residents who have been identified for pharmacist recommendations, recommendations rationale was recorded timely. Residents interventions and plan of care have	

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F 756	Continued From page 105 severe cognitive impairment. In addition, R29's Diagnosis Report printed 7/27/18, identified R29 had numerous medical diagnoses including anxiety disorder, high blood pressure, and major depressive disorder. R29's Order Summary Report signed 7/19/18, identified R29 had current physician orders for several psychotropic medications including: - Celexa (an antidepressant) 10 milligrams (mg) everyday, - Lorazepam (an antianxiety medication) 0.5 mg orally, "... as needed for anxiety give twice daily [BID]." R29's Consultant Pharmacist's Medication Review dated 5/14/18, identified the consulting pharmacist (CP) dictated an irregularity as, " ... Non-antipsychotic PRN psychotropics such as this [R29's lorazepam] are limited to 14-day duration, unless the prescriber chooses to extend treatment by providing clinical rationale and documenting intended duration." CP requested the physician to re-evaluate R29's current lorazepam therapy and document their clinical evaluation/rationale of the resident if treatment was going to be continued. A listed section labeled, "Follow-Up or Action Taken," directed the physician to circle if they accepted or rejected the recommendation with a time frame to be completed in, "... ASAP but no later than 60 days." However, neither of these were circled nor did the report have any signature from the physician to demonstrate it had been reviewed and/or addressed. R29's subsequent Pharmacist's Medication Review dated 6/28/18, identified CP again	F 756	reviewed and updated. • Staff will be re-educated on proper review of pharmacist recommendations are completed timely • Audits of 3 pharmacy recommendations will be completed weekly x 4 weeks; then as needed • Director of Nursing or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 756	Continued From page 106	F 756		

identified the same irregularity with R29's lorazepam use, and requested the physician re-evaluate R29's current lorazepam therapy and document their clinical evaluation/rationale of the resident if treatment was going to be continued. As prior, a section labeled, "Follow-Up or Action Taken," directed the physician to circle if they accepted or rejected the recommendation with a time frame to be completed in, "... ASAP but no later than 60 days." However, neither of these were circled nor did the report have any signature from the physician to demonstrate it had been reviewed and/or addressed.

R29's additional, subsequent Pharmacist's Medication Review dated 7/11/18, identified CP again identified the same irregularity with R29's lorazepam use, and requested the physician re-evaluate R29's current lorazepam therapy and document their clinical evaluation/rationale of the resident if treatment was going to be continued. As prior, a section labeled, "Follow-Up or Action Taken," directed the physician to circle if they accepted or rejected the recommendation with a time frame to be completed in, "... ASAP but no later than 60 days." However, neither of these were circled nor did the report have any signature from the physician to demonstrate it had been reviewed and/or addressed.

When interviewed on 7/27/18, at 10:28 a.m. registered nurse (RN)-B stated R29's lorazepam was originally ordered in April 2018, and she continued to use the as-needed lorazepam when looking at the Medication Administration Records (MAR). RN-B stated their had been no follow-up to CP's identified concerns with R29's lorazepam therapy despite several months of it being recommended. RN-B added, "We're not

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following through," and it was important to make sure these identified irregularities were acted upon timely to make sure the resident is kept safe.

During interview on 7/27/18, at 2:17 p.m. the interim director of nursing (DON) stated there had been a "lack of follow through" with making sure the pharmacy recommendations were addressed and it was "not appropriate." DON explained this should have occurred as it was "what's best for the resident."

During telephone interview on 7/27/18, at 2:32 p.m. CP stated the facility should be communicating with the physician to ensure the identified irregularities are addressed timely. CP expressed some "better communication" was needed, and their systems to ensure the reports are addressed "need to be worked on."

LACK OF DOCUMENTED RATIONALE:

R29's Order Summary Report signed 7/19/18, identified R29 had current physician orders for dual doses of Tylenol (an anti-inflammatory; which can cause liver damage in high doses). These orders directed:

1) "Tylenol Extra Strength Tablet 500 mg ... Give 2 tablet orally as needed for pain tid [three times a day," and,

2) "Tylenol Tablet 325 mg ... Give 325 mg orally as needed for Pain/Fever May give 650 mg [2 tabs] every 4 - 6 hours as needed for pain/fever. Not to exceed a total daily dose of 4 gm [grams] in 24 hours."

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R29's Consultant Pharmacist's Medication Review dated 3/16/18, identified the consulting pharmacist (CP) identified an irregularity with R29's dual Tylenol orders and listed a, "Suggested Course of Action" which directed, "Please consider discontinuing one of the [as needed] orders." A section labeled, "Follow-Up or Action Taken," instructed the physician to circle if they accepted or rejected the recommendation. This was circled as "Rejected" and signed by the physician. This was dated 5/17/18, by the health unit coordinator (HUC). The report lacked any explanation or dictation by the physician as to why this recommendation was rejected despite having potential to expose R29 to potentially high doses of Tylenol. Further, the bottom of the report identified a statement, "*(1) Per regulatory guidelines, a brief explanation of why the recommendation is rejected is required."

R29's medical record was reviewed and lacked any other documentation or dictation from R29's physician regarding the dual Tylenol orders, despite being identified by the consulting pharmacist as a potential irregularity in March 2018.

When interviewed on 7/27/18, at 10:28 a.m. RN-B stated she reviewed R29's medical record and was unable to locate any documentation to demonstrate or support why the physician rejected CP's recommendation to discontinue one of the as-needed Tylenol orders. RN-B stated the facility was not "following through" and staff needed education.

During interview on 7/27/18, at 2:17 p.m. the DON stated the lack of rationale was a result of a "lack of follow through" and staff should have

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F 756	Continued From page 109 faxed it back to the physician asking for the rationale. A facility policy on pharmacy recommendations was requested, however, none was received.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a physician's order was followed and obtain daily weights to monitor diuretic medication use for 1 of 1 resident (R44) reviewed for unnecessary medication.	F 757	F757 Drug Regimen is Free from Unnecessary Drugs • R 44 Drug Regimen and Unnecessary Drugs was reviewed for physician orders for daily weights to monitor diuretic medications. R44's plan of care and	9/10/18

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F 757	Continued From page 110 Findings include: R44's admission Minimum Data Set (MDS) dated 4/27/18, included diagnoses of congestive heart failure, hypertension and renal insufficiency. The MDS also indicated R44 was cognitively intact. R44's current physician's orders dated 6/17/18, were reviewed and directed to obtain daily weight and to notify the doctor wight increases 3 lbs (pounds) in 24 hours. R44's orders also included two diuretic medications for congestive heart failure and high blood pressure: Bumetanide tablet 2 mg (milligrams) orally two times a day; and Spironolactone tablet 50 mg by mouth once a day. During observation on 7/25/18, at 3:00 p.m., R44 was seated in her wheel chair, in her room. R44 presented a calm demeanor, and exhibited no sign of pain or distress. R44 had two bandages on her lower extremities, one on each leg, and there was no observed swelling or edema of the lower legs or ankles. During interview on 7/25/18 at 3:11 p.m., R44 talked about her stay in the nursing home and her medications, including how often she got medication, and that she had to frequently get blood work. R44 stated they are supposed to weigh me everyday, "but they don't." R44's weights from 6/1/18 to 7/26/18 were reviewed. The electronic medical record identified R44's weights were not obtained or documented per the MD order on the following dates: 6/1/18, 6/5/18, 6/7/18, 6/8/18, 6/15/18, 6/16/18, 6/17/18, 6/18/18, 6/28/18, 6/30/18, 7/1/18, 7/2/18, 7/6/18, 7/7/18, 7/10/18, 7/11/18, 7/14/18, 7/20/18, and 7/22/18 for a total of 19	F 757	interventions have been updated and reviewed to reflect daily weights. • All current residents have been identified for daily weights related to diuretic use have had their interventions and plan of care have reviewed and updated. • Staff will be re-educated on proper documentation of daily weights related to diuretic use • Audits of 3 resident daily weights related to diuretic use will be completed weekly x 4 weeks; then as needed • Director of Nursing or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 757	Continued From page 111 times out of 56 opportunities. During July 2018, R44's documented weights have ranged from 190 lbs (pounds) to 193 lbs. During interview on 7/26/18 at 8:03 a.m., licensed practical nurse (LPN)-D stated R44's received medication to control blood pressure. LPN-D stated they monitored R44's blood pressure by checking for any swelling or edema in her legs, checking blood pressures, following the fluid restrictions, "and we also do a daily weight." LPN-D stated if R44's weight was 3 pounds or more over from the previous weight, the doctor was to be notified. LPN-D stated R44 had not recently had any serious weight gains. During interview on 7/26/18, at 3:39 p.m. registered nurse (RN)-A stated R44 was on a diuretic medication, and had current order for daily weights. RN-A stated R44 had symptoms of fluid overload and shortness of breath, and at one point in the hospital had 18 pounds of fluid removed. RN-A stated R44's monitoring included checking for edema, lungs, respiration rates and also included daily weights. RN-A stated it is the responsibility for the floor nurse and charge to make sure it is completed, and "I can't explain why" the weights are missing. When interviewed on 7/27/18, at 2:07 p.m. the interim director of nursing (DON) stated is a resident had doctor-ordered daily weights, she expected "they be completed daily." A policy regarding clinical monitoring of weights and vital signs was requested, but none was provided.	F 757		
F 842	Resident Records - Identifiable Information	F 842		9/10/18

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F 842 SS=E	Continued From page 112 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842		

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F 842	Continued From page 113 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure verification the consulting pharmacist reviewed resident medications and medical record on a monthly basis was readily accessible for 4 of 5 residents (R21, R37, R29, R7) reviewed for medication management. Findings include: R21's quarterly Minimum Data Set (MDS) dated	F 842	F842 Resident Records • R21, R37, R29, and R7 charts were reviewed to ensure documentation of monthly consulting pharmacist reviews is in their medical record. • All current residents have had their medical record reviewed to ensure documentation of monthly consulting pharmacist reviews are present in the medical record.	

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F 842	Continued From page 114 5/22/18, identified R21 was taking antianxiety, antidepressant and diuretic medications. Diagnoses included anemia, high blood pressure, anxiety disorder and depression. R21's medical record lacked evidence the consulting pharmacist had reviewed R21's medications and medical record on a monthly basis. R37's quarterly MDS dated 6/28/18, identified R37 was taking antipsychotic, antidepressant, and anticoagulant medications. The MDS included diagnoses of anemia, high blood pressure and high cholesterol. R37's medical record lacked evidence the consulting pharmacist had reviewed R37's medications and medical record on a monthly basis. R29's quarterly MDS dated 5/25/18, identified R29 was taking antianxiety and antidepressant medications. The MDS identified diagnoses of anxiety disorder and depression. R29's medical record lacked evidence the consulting pharmacist had reviewed R29's medications and medical record on a monthly basis. R7's quarterly MDS dated 4/20/18, identified R7 was taking insulin, antidepressant, anticoagulant, diuretic and opioid medications. The MDS included diagnoses of high blood pressure, diabetes, anxiety disorder and depression. R7's medical record lacked evidence the consulting pharmacist had reviewed R7's medications and medical record on a monthly basis. During interview on 7/26/18, at 4:01 p.m. the interim director of nursing (DON) stated she would need to contact the consulting pharmacist to receive the verification the monthly medication	F 842	• Staff will be re-educated on proper documentation of monthly consulting pharmacist reviews • Audits of 3 residents proper documentation specific to pharmacist reviews will be completed weekly x 4 weeks; then as needed • Director of Nursing or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 842	Continued From page 115 and record review were completed. At 4:46 p.m. the interim DON stated it was important to have the consulting pharmacists monthly documentation that each resident medications and record was reviewed to ensure adequate follow up and to meet the regulation. A policy on consulting pharmacist monthly medication review was requested and not received.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		9/10/18

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F 880	Continued From page 116 but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 117 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow contact and enteric precautions for 2 of 2 residents (R100 and R3) who were place on transmission based precautions. Findings include: R100's face sheet undated, identified he was admitted to the agency on 7/18/18, with urinary retention and an indwelling urinary catheter. R110 hospital discharge summary on 7/18/18 identified, he was admitted to the hospital for acute kidney injury, and urinary tract infection with Methicillin-resistant Staphylococcus aureus (MRSA) organism in his urine. MRSA is an infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections, and is classified as a multi drug resistant organism. R100's Initial/Comprehensive Careplan, 7/18/18, identified infection. R100 had a current infection of MRSA, with interventions of antibiotic medication per physician order, all staff to follow isolation precautions, isolation precautions per protocol and sign on resident's door. During interview on 7/23/18 08:37 a.m. registered nurse (RN)-A stated R100 had MRSA in his urine, and has an indwelling catheter for urinary retention. During observation on 7/22/18 at 8:40 a.m. R100's room had an isolation bag on his door that contained gloves, gowns and sani cloths with	F 880	F880 Infection Control • R100 has been discharged from the facility. R3 has had her contact enteric precautions discontinued. • No residents are currently on transmission-based precautions at this time. • The DON or designee will provide re-education to all appropriate staff on contact and enteric precautions per Meeker Manor Procedures. • The DON or designee will complete audits for 3 residents for contact and enteric precautions (if applicable) and 3 staff members will be interviewed on proper procedures for contact and enteric precautions, this will be conducted weekly X 4, and then monthly X 2. Audit results will be reviewed by QAPI Committee for further recommendation. • Completion Date: 9/10/2018	

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F 880	Continued From page 118	F 880		

bleach. There was sign on the door that read, Contact Precautions, in addition to Standard Precautions. Everyone must, clean hands when entering and leaving room. Doctors and Staff Must: gown and glove at the door, use patient dedicated or disposable equipment. Clean and disinfect shared equipment. The back of the sign identified contact precautions and listed common conditions of MDRO's, which included MRSA. Equipment and supplies, use dedicated or disposable equipment when available. Clean and disinfect reusable equipment including IV pumps, cell pone or pages, and other electronic, supplies and equipment prior to removing from residents room. Transport, assure resident is in clean clothes, clean and disinfect assistive devices.

During an interview on 07/23/18 01:06 p.m. R100 was in the room with a vinyl bag that covered his indwelling catheter bag which was hanging from the back of his wheelchair under his seat. R100 stated staff come in his room, with "stuff on" usually a gown and gloves. If they don't I tell them they need to do this and they are good about it.

During observation on 07/25/18 02:27 p.m. physical therapist (PT)-A entered R100's room with no gloves or gown on. He unhooked R100's urinary catheter bag from the wheelchair and hooks it onto his walker handling the catheter tubing and bag. PT-A then touches the handles of R100's walker and places a transfer belts around the resident without first washing his soiled hands. PT-A assists R100 to stand up, and places his clip board on the residents wheelchair cushion, where the resident was sitting. PT-A then assisted R100 to stand with his walker while holding onto the back of R100's

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transfer belt. PT-A walks with R100 holding onto his transfer belt, and ambulate with resident. PT-A does not wash his hands after touching the catheter tubing and catheter bag. Before leaving the room, PT-A picks up his clip board, and holds it while walking with R100 to the therapy room down the hallway.

At 07/25/18 03:20 p.m. PT-A and R100 were in the physical therapy room exercising. The soiled clip board which was in R100 room, was lying on an overbed table in therapy department. At 3:22 p.m. PT-A leaves R100's room and has a gait belt rolled up and under his arm touching his clothing while he cleansed his hands with a gel sanitizer. PT-A stated the gait belt, under his arm, was from R100. He was told yesterday by physical therapy assistant (PTA)-A that he did not need to use dedicated equipment for R100. PT-A was unsure what to do with R100's equipment or other items since he was on contact precautions. PT-A reviewed the instructions on R100's door, that identified using dedicated patient care equipment. He stated there was a transfer belt in R100's room, and he should use that equipment and will sanitize the gait/transfer belt he had in his hands. PT-A also stated he will clean the clipboard and the bedside stand that it was sitting on in the therapy room. He will ask the nurses and double check in the future what he needs to do when precautions are implemented.

During interview on 7/26/18 at 9:00 a.m. LPN-C stated all staff need to wear glove and gown, when working with R100. R100 has been emptying his own indwelling catheter bag, and we are unsure of his techniques so it is important to wear gloves, gown and wash hands. If someone is using a gait/transfer belt they need a clean one

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each time, or use the one in R100's room since he is on contact precautions.

During interview on 7/26/18 at 2:00 p.m. the PT-A observation was discussed with RN-A who stated all staff need to follow the precautions on R100's door and use the dedicated equipment.

Facility policy, titled, Contact Precautions, undated, identified use gown and gloves when you anticipate direct contact with body fluids.

R3's quarterly minimum data set (MDS) dated 4/03/18, indicated diagnoses including anxiety, depression and malnutrition.

R3's care plan dated 7/23/18, indicated she was on contact isolation for c-Diff (Clostridium difficile bacterial infection) The care plan further indicated all staff were to follow contact precautions.

R3's door to her room indicated she was on "Contact Enteric Precautions". The note also indicated "They must wear gloves and gown while in the room and remove them before leaving. They must also wear mask and goggles."

A facility policy indicated that Contact Enteric Precautions (CEP) meant it "will be used in the care of all residents known or suspected to be infected with organisms that are transmitted by contact with the patient or contaminated surfaces and are particular to infections pertaining to gastrointestinal organisms that are difficult to kill or are easily transmissible.

The Policy further indicated "Residents whom contact enteric precautions are clinically indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING _____ B. WING _____	07/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEEKER MANOR REHABILITATION CENTER, LLC	600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355

(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 880	Continued From page 121 to include some of the following common conditions." 1. Residents who have acute diarrhea of unknown etiology. 2. Residents who have Clostridium difficile (is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). 3. Residents with Norovirus or Rotavirus (stomach flu). During observation on 7/23/18, at 9:38 a.m. maintenance assistant (MA)-A entered R3's room and stated he was going to put a new footboard on R3's room. MA-A did not put on a gown or gloves and proceeded to touch R3's bed, bed linen while mounting the footboard on the frame of R3's bed. MA-A was in R3's room for approximately 10 minutes, and left the room without first washing his hands. During interview on 7/24/18, at 3:00 p.m. the interim director of nursing (DON) stated all staff who go into R3's room "should gown and glove" including dietary and maintenance staff.	F 880		
F 908 SS=F	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to ensure the freezer door in the main kitchen was in working condition to prevent condensation and ice build up in the freezer to	F 908	F908 – Essential Equipment, Safe Operating Condition • All repairs will be made to the walk-in freezer including putting a new insulated	9/10/18

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F 908	Continued From page 122 safely store food for 1 of 1 walk-in freezers reviewed. This had the potential to affect all 56 residents, visitors and staff who consumed food stored and subsequently served from this freezer. Findings include: On 7/23/18, at 7:02 a.m. a brief tour of the facility kitchen was completed, and the walk in cooler/freezer combination unit was inspected. When the cooler door was opened, hanging plastic strips (in place to help maintain temperature) were pushed to the side and tucked behind serving carts. The freezer had its own entry door, inside the cooler. On the floor, in front of the freezer door, there was a wet area, extending about 8" (inches) from the door, and as wide as the cooler, about 7' (feet). The ceiling in the cooler above the freezer door was dripping with condensation. The freezer door had ice/frost built up across its bottom, extending up from the floor to a height of approximately 4 inches in height and the ice build up was approximately 1" inch at the thickest point. Inside the freezer, hanging plastic strips had approximately 1/2" of frost build up on them, extending about 18" downward; and snowflake-like chunks fell off the strips when disturbed. The inside freezer door frame was encased with frost build up, some areas approximately 5" thick, and a pile of frost crystal was observed on the floor just inside the door. Expandable foam was in place around the door frame, some of which protruded from the frame and, in one section, forced the door approximately 1" away from the wall. An electrical box inside the freezer was labeled "caution" and was encased in frost build up. Various frozen meats and other foods were packaged on the shelving to the left and right of	F 908	door on to ensure the freezer is at a safe operating condition. • All residents have the potential to be effected if not provided appropriate operating equipment • Staff will be re-educated on using TELS for maintenance work orders for items/areas needing report or maintenance. • Audits of the facilities walk-in freezer to be completed weekly x 4 weeks; then as needed • Maintenance Director or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 908	Continued From page 123	F 908		

the door. On one upper shelf a bag of cubed chicken dated 7/22/18, had chunks of ice and ice crystals in the bag. On another top shelf, two pork tenderloin packages had ice chunks (about 2" by 4" in size) on each package.

During interview on 7/23/18, at 7:25 a.m. dining assistant (DA)-A stated it was "typical" for the ice/frost build up in the freezer, as well as the water on the floor and the humidity dripping from the ceiling. DA-A did not know how long this had been a problem.

On 7/25/18, at 6:39 p.m., the cooler/freezer unit was reviewed with the corporate dietician (CD) and culinary service staff (CSS)-A. Condensation was present and water dripped from the ceiling inside the cooler. The frost/ice build up on the outside of the freezer door had been removed. However, the frost/ice build up remained inside the door, the door frame and on the hanging plastic strips. The package of diced chicken was gone, but the packages of pork tenderloin with the ice chunks were still present and stored in the freezer.

When interviewed during the tour, the CD stated the frost on the outside of the door had been removed, as well as the package of chicken. The CD stated maintenance had the freezer door on a cleaning schedule, and was aware of the deficiency cited for the issue during the last survey. At 6:45 p.m. the environmental service director (ESD) joined the conversation and talked about the interventions in place to deal with the freezer door. The ESD stated he created a log to track when they came in to check the freezer function and also came into the cooler every other week "to knock the ice down." The ESD

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F 908	Continued From page 124 stated they updated the exhaust system in the past three months to help keep the moisture down. The ESD stated he was unaware when the expandable foam had been placed to try and seal the door. The ESD stated although he was aware of the condition of the freezer door, there were no formalized plans to correct it. During interview on 7/27/18, at 3:31 p.m. the administrator stated the freezer had a faulty seal, and a vendor had been contacted who would coordinate installation of a new freezer door to correct the problem. A facility policy regarding maintenance of refrigerators and freezers was requested, but none was provided.	F 908		
F 921 SS=B	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain carpet in a clean, sanitary manner in 1 of 1 hallways observed to have visibly stained carpeting. This had potential to affect 2 of 2 residents (R36, R24) who voiced concerns with the carpeting and 35 additional residents identified to use the area on a routine basis. Findings include: R36's 14-day Minimum Data Set (MDS) dated	F 921	F921 □ F921 – Safe/Functional/Sanitary/Comfortable Environment • All carpet areas of concern are being addressed to continue to remove any stains and maintain them in the best possible condition. R24 and R36 state the carpet has fewer stains on them over the past couple weeks. • All residents have the potential to be effected if not provided a clean environment.	9/10/18

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F 921	Continued From page 125 6/20/18, identified R36 had intact cognition. When interviewed on 7/24/18, at 2:27 p.m. R36 stated he would like to see some of the carpeting in the building replaced as it was unsightly. R36 expressed it made someone feel better if the furnishing and carpet were nice looking. R24's annual MDS dated 4/21/18, identified R24 had intact cognition. During interview on 7/24/18, at 2:28 p.m. R24 stated the building needed new carpeting as it was so stained and soiled. R24 added, "Please get clean carpet in here." On 7/27/18, at 1:19 p.m. the hallway outside the main dining room and chapel was observed. The floor was carpeted with a light gray center and dark maroon edging. The light gray area of the carpet had numerous, various sized dark brown colored stains which were present up and down the entire hallway. There were several tiles of the applied carpet which the perimeter of the individual tile(s) had visible edging of a dark black border. Further, several areas of the carpeting had visibly smashed substance(s) present on them which were dark black in color and sticky when touched with the bare hand. A facility provided Service Order List printed 7/27/18, identified 35 residents who routinely used the hallway when going to meals and/or chapel services. On 7/27/18, at 1:22 p.m. housekeeper (HK)-A observed the carpeting in the hallway with the surveyor and stated it had been in the same condition for approximately "three or four years." HK-A added the facility did shampoo it regularly and was "working on replacing this carpet" to her knowledge.	F 921	• Staff will be re-educated on ensuring a clean and well maintained environment • Audits of facility carpet cleanliness to be completed weekly x 4 weeks; then every other week x 8 weeks; then monthly x 6 months; then as needed. 3 resident interviews of facility environment specific to cleanliness of carpeting will be completed weekly x 4 weeks; then every other week x 8 weeks; then monthly x 6 months; then as needed • Maintenance Director or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 921	Continued From page 126 When interviewed on 7/27/18, at 1:24 p.m. the environmental services director (ESD) stated the maintenance team had been working on various repairs since taking over the building a few months prior. ESD explained the prior maintenance crews were not cleaning the carpets correctly, so moisture wasn't being wicked away properly which caused the edges of the carpet tiles to discolor and curl. ESD expressed their had been discussion on improving or replacing the carpet(s) in the nursing home, however, it had been "all talk" so far with no formal plans put into place. Further, ESD stated a tasking machine, like one used at some of their other managed sites, would help improve the carpet appearance. A facility policy on carpet repair and/or cleaning schedules was requested, however, none was provided.	F 921		
F 925 SS=C	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement effective and timely pest control measures to reduce and/or eliminate flies in the facility. This had potential to affect all 56 residents living in the facility. Findings include: During observation on 7/23/18, at 7:48 a.m.	F 925	F925 – Maintains Effective Pest Control Program • All appropriate pest control specific to flies has been resolved • The facility has a pest control contract with monthly site visits and as needed • Staff will be re-educated on the pest control policy to ensure the facility is free of pests • Audits of the facility will be completed	9/10/18

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F 925	Continued From page 127 during breakfast R13 was shooing flies away from his plate while eating. An adjacent resident, R6 had four flies on his plate. Dietary Aid (DA)-B offered to replace his meal, but R6 stated he was done. R13 stated it was like this "morning, noon, and night." DA-B stated there were flies present in the dining room during the summer months, and added staff were told they can't use flyswatters in the dining areas. On 7/23/18, at 8:11 a.m. in the south hallway day room area, a fly was buzzing about R33's face and upper body, and she crinkled her nose and blinked her eyes while the fly was near her face. During a subsequent observation at 8:16 a.m., R33 was in her room, seated in her wheelchair, and flies were present, circling her head and upper body. R33 closed her eyes and moaned out when flies landed on her. The flies circled her head, then rested on her nose, forehead and in the corner of her lips, which triggered R33 to awaken and make more moaning noises. On 7/23/18, at 8:18 a.m. R11 was lying on her bed with her eyes closed, glasses on, and two flies were circling resident's upper body and landing on her face. Flies were on R11's forehead, corner of her lips, and crease between lips. R11 furrowed her brow and pursed her lips as flies landed. During a subsequent observation at 11:26 a.m., flies continued to be present in the room and continued to fly about and land on R11's forehead and mouth. On 7/23/18, at 11:18 a.m. with flies buzzing about her room, R8 stated "'the flies are terrible this fall." As she watched a fly, R8 stated "They're pesty!"	F 925	weekly x 4 weeks; then every other week x 8 weeks; then monthly x 6 months; then as needed specific to fly and pest control throughout the facility specific to the dining room and resident rooms • Maintenance Director or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

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F 925	Continued From page 128 While in the dining room on 7/23/18, at 12:33 p.m. R20 stated the flies have been "bad all summer". As a fly landed on her face and shooed it away, R20 stated "I hate flies!" and "I wish they could get them before we eat. " R20 expressed she wished the facility would get someone in to manage flies. R20 stated the aides and nurses were aware of flies, but nothing has changed. On 7/24/18, at 2:36 p.m. R100 was in his room with a purple fly swatter in his hand. R100 stated he has been using it to kill flies in the facility. During interview on 7/24/18, at 2:47 p.m. the environmental services director (ESD) was questioned about a portable, hand-held sprayer seen next to the business office. The ESD stated the pest control company was here looking at the fly situation and the exterior of the main doors were sprayed today. Additionally, the ESD said a fly light was installed in the dining room the afternoon of 7/23/18. The ESD stated there had been a fly light installed in the dish room several months ago. The cardboard collector strip that was installed 24 hours 24 hours ago in the dining room was reviewed, and the ESD counted six-full size flies and several gnats. The fly light collector cardboard was also checked in the dish room and stated there were at least 15 flies counted. The ESD stated he was aware only of flies near the entryways, but was not aware of any flies in the dining or resident rooms. The ESD stated there was no formalized system in place for pest control and insect management. The ESD stated he placed 10-12 flyswatters out in the building to help with fly management. During interview a fly was observed buzzing around surveyor's computer.	F 925		

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F 925	Continued From page 129 During interview on 7/26/18, at 10:32 a.m. nursing assistant (NA)-G stated she was aware of the flies and everyone was provided a fly swatter. NA-G stated flies had been present all summer, but had become increasingly "persistent" and "bad" the past couple of weeks. NA-G said residents had complained and stated she even spent helping the residents to kill them. NA-G stated maintenance was aware of the problem them "as far as I know" but was unsure of what was being done. NA-G stated big problem was mainly the flies in the residents' rooms. When interviewed on 7/26/18, at 11:30 p.m. licensed practical nurse (LPN)-C stated the flies are 'terrible in general" but became worse when it was really hot. LPN-C stated the staff had fly swatters to use. During interview on 7/27/18, at 3:31 p.m. the administrator stated they have been having problems with flies in the building and had recently had the pest control agency out to treat. A facility policy regarding pest control was requested, but none was provided.	F 925		

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	245361	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2018**

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K 000	INITIAL COMMENTS	K 000		

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 CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT 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, on July 25, 2018. At the time of this survey, Meeker Manor was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

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

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/23/2018

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. Meeker Manor is a one-story building with partial basement. The original building was constructed in 1978, with building additions constructed in 1979 and 1988. The original building and both building additions are fully fire sprinkler protected, and were determined to be of Type V(000) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 75 beds and had a census of 56 at time of the survey. The requirement at 42 CFR Subpart 483.70(a) is **NOT MET** as evidenced by:	K 000		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353		9/10/18

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MEEKER MANOR REHABILITATION CENTER, LLC	**600 SOUTH DAVIS AVENUE LITCHFIELD, MN 55355**

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K 353	Continued From page 2 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 75 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:00 am to 1:00 pm on 07/25/2018 documentation review revealed in the last 12 months no quarterly sprinkler inspection reports were available and when interviewed the Environmental Service Director	K 353	K353 – Sprinkler System – Maintenance and Testing • Quarterly sprinkler system maintenance/testing completed on 731/2018 • Staff will be re-educated on the quarterly sprinkler system maintenance/testing • Audits of the facilities quarterly sprinkler system maintenance/testing will be completed quarterly x 4 quarters; then as needed • Maintenance Director of designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245361	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2018**

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K 353	Continued From page 3 stated they had not been completed. This deficient condition was confirmed by the Environmental Service Director.	K 353		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide documentation of fire drills at least quarterly on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would affect all residents and an undetermined amount of staff and visitors. Findings include: On facility tour between 9:00 AM and 1:00 PM on 07/25/2018, documentation reviewed revealed that Fire drills were not performed during these times:	K 712	K712 – Fire Drills • The facility will complete and document fire drills at least quarterly on each shift • Staff will be re-educated on fire drill documentation and schedule • Audits of the facilities fire drills will be completed monthly x 6 months; then as needed • Maintenance Director of designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/10/2018	9/10/18

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K 712	Continued From page 4 1) 1st quarter 1st shift of 2018. 2) 1st and 2nd shift fourth quarter 2017 This deficient practice was verified by the Environmental Service Director.	K 712		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents. Findings include: During documentation review between 9:00 AM and 1:00 PM on 07/25/2018, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey.	K 901	K901 – Fundamentals – Building System Categories • The facility will complete a facility risk assessment • Staff will be re-educated on the facility risk assessment • Audit of the facilities risk assessment will be completed upon completion of the risk assessment and annually x 1 year; then as needed • Maintenance Director of designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/12/2018	9/10/18

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K 901	Continued From page 5 This deficient condition was confirmed by the Environmental Service Director.	K 901		
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.	K 918		9/10/18

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K 918	Continued From page 6 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to provide test documentation in accordance with the 2012 edition of the Life Safety Code (NFPA 101) section 9.1.3.1 and the 2010 edition of NFPA 110 the Standard for Emergency and Standby Power Systems. This deficient practice could affect the safety of all 75 patients and an undetermined amount of staff and visitors if the generator failed to operate during a power outage. Findings include: On the facility tour between 9:00 AM to 1:00 PM on 07/23/2018 record review and staff interview revealed: 1) The monthly generator log was not completed for 7/18, 6/18, 5/18 and 2/18. 2) Annual load bank test was not performed. This deficient conditions was confirmed by the Environmental Services Director.	K 918	K918 – Electrical Systems – Essential Electric System • The facility completed an annual emergency generator inspection/testing on 8/13 for the annual load bank test. The facility has completed their monthly generator log. • Staff will be re-educated on ensuring the annual emergency generator inspection/testing is completed for the annual load bank test & monthly generator logs. • An audit of the annual emergency generator inspection/testing will be completed annually; then as needed. An audit of the monthly generator log will be completed monthly x 4 months; then as needed. • Maintenance Director or designee will be responsible party • QAA will provide redirection or change when necessary to ensure completion and/or continuation of monitoring process • Completion Date: 9/12/2018	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 13, 2018

Ms. Lynn Hogendorn, Administrator
Meeker Manor Rehabilitation Center, LLC
600 South Davis Avenue
Litchfield, MN 55355

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5361027

Dear Ms. Hogendorn:

The above facility was surveyed on July 23, 2018 through July 27, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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.

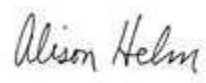
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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 immediately contact Teresa Ament, Unit Supervisor at teresa.ament@state.mn.us or (218) 302-6151.

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.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00775	A. BUILDING: _____ B. WING _____	07/27/2018

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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 23 - 27, 2018, 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. 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance reviews were completed on an annual basis for 3 of 3 nursing assistants (NA-C, NA-D, NA-E) whose files were reviewed. This had potential to affect all 56 residents who resided in the nursing home and who could receive care from these staff. Findings include: A facility provided, unnamed listing dated 7/23/18, identified the following nursing assistant (NA) staff with their start dates:	2 285	Corrected.	9/10/18

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2 285	Continued From page 3 - NA-C was hired on 5/24/17, and worked on a full time basis; - NA-D was hired on 6/30/16, and worked on a full time basis; and, - NA-E was hired on 6/29/16, and worked on a full time basis. During the recertification survey, from 7/23/18, to 7/27/18, evidence was requested from their respective employee files to demonstrate a performance review had been completed for NA-C, NA-D, and NA-E. No evidence was provided. When interviewed on 7/27/18, at 2:02 p.m. the regional director of operations (RDO) stated when the facility transitioned to the current management company (over two years prior) the annual evaluations stopped being completed. The facility identified this a "couple months ago" and were planning to just complete employees' review going forward when their yearly anniversary came up. RDO clarified their were no other plans in place to catch the past due evaluations up more timely being implemented. A facility policy on NA performance reviews was not provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing or designee could develop/revise and implement policies and procedures related to timely completion of nursing assistant performance reviews. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	2 285		

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2 285	Continued From page 4 (21) days.	2 285		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation interview and document review, the facility failed to develop a comprehensive care for 5 of 5 residents (R25, R38,R11, R24, R36 and R44) reviewed who lacked updated care plans. Findings include: R25's Diagnoses Report printed 7/26/18, identified diagnoses which included chronic respiratory failure, dysphasia and tracheotomy status, and also indicated severe, cognitive impairment. The MDS also identified R25's admission date as 5/10/18. R25's Care Area Assessment (CAA) Worksheet dated 5/21/18, identified the following areas to include and address as actual or potential problems in the comprehensive care plan, to direct R25's needs in the facility: cognitive loss/dementia; visual function; communication;	2 560	Corrected.	9/10/18

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2 560	Continued From page 5 urinary continence; falls; feeding tube; dehydration/fluid maintenance; pressure ulcer; psychotropic drug use; and pain. R25's physician's orders, as identified on the Order Summary Report, dated 7/11/18, directed: to document in progress noted after suctioning respiratory rate, 02 SATS (oxygen saturation), amount, color and consistency of secretions, appearance of stoma, frequency of suctioning, frequency of trach (tracheostomy) care and change; and Trach plugging regimen per family. During observation on 7/24/18, at 3:19 p.m. R25 tracheotomy (trach) was in place and was receiving oxygen via the trach tubing. R25 and presented with audible gurgling, and a small amount of clear secretion coming from his mouth, bubble-like. Licensed practical nurse (LP)-A entered the room and deteremiend she would intervene to clear his congestion, and subsequently provided R25 with suctioning of the trach. R25's Initial/Comprehensive Care Plan with a listed goal dated of 5/10/18, was a computer-generated document that identified numerous care and problem areas, and under each care area listed various, pre-written, scripted interventions, some of which were checked to include for R25's care. The document also included space to detail interventions not listed on the pre-printed form. R25's care plan included resident-specific interventions related to tracheostomy care. R25's care plan, as presented in the electronic heath record, identified a target date of 5/10/18, or more than two and one-half months after the start of the re-certification survey on 7/23/18.	2 560		

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2 560	Continued From page 6 R25's care plan lacked specific, measurable, target goals and future dates for each of the care areas included in the care plan. Further, R25's care plan lacked inclusion or instruction to include physician's orders that further directed R25's tracheostomy care. When interviewed on 7/26/18 at 10:41 a.m., registered nurse (RN)-B stated after reviewing R25's care plan in the computer, that R25 did not really have a current target, and R25's care plan "was not right." RN-C stated when a resident was admitted, assessments and data collection was done to complete our initial care plans, and stated "we can use that care plan for 92 days." RN-C stated she did not put together "the comprehensive care plans" for residents. RN-C acknowledged the care plan for R25 was listed as "Initial/comprehensive" but stated the care plan did not have goal dates in the future, and also did not include the physicians orders, "but it should." During interview on 7/26/18, at 11:41 a.m., RN-C stated a resident's comprehensive care plan included the plan, the doctor's orders, and pertinent labs, the nursing assistant care sheets, and "really any information to direct one's care." RN-C stated the comprehensive care plan needed to be in place by day twenty-one. R38's Diagnosis Report printed 7/26/18, identified diagnoses which included congestive heart failure, hypertension and end-stage renal disease. R38's admission Minimum Data Set (MDS) indicated R38 had intact cognition and was admitted to the facility on 6/22/18. R38's Care Area Assessment (CAA) Worksheet dated 7/2/18 identified Activities of Daily Living (ADL) as an actual problem/need to include on the care	2 560		

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plan, related to need for supervision with be mobility, transfers and toileting.

R38's Treatment Administration Record printed 7/26/18 identified a nursing order dated 6/23/18 to obtain daily weight, and report changes of 3 lbs (pounds) overnight or 5 lbs in a week to nephrology. Additionally, the treatment record included additional direction regarding R38's dialysis care including: to check communication file for any new orders upon return from dialysis; to remember to send a snack or lunch with resident and communication form to dialysis; to obtain vital signs after dialysis; and to offer rest and snack in the afternoons post dialysis.

During interview on 7/24/18, at 3:00 p.m. R38 stated he gets the help and care he needs at the facility. R38 stated he was planning to go back home, and was in the facility for "rehab" following a heart attack, and that he felt much better now following the incident. R38 also stated he went out of the building to get dialysis.

During observation on 7/24/18, at 3:10 p.m. R38 exited his room, holding on the handles of a regular wheel chair, ambulated down the hallway toward the day room area. R38 was able to walk at a steady pace, maintain balance, and showed no signs of pain or discomfort, and exhibited no shortness of breath.

R38's Initial/comprehensive Care Plan, as presented in the electronic health record, identified a goal date of 6/22/18, or more than a month following start of the re-certification survey on 7/23/18, or 20 days following completion of the CAA. R38's care plan lacked specific, measurable, target goals and future dates for each of the care areas included in the care plan.

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Additionally, R38's care plan lacked inclusion or instruction to include physician's orders including treatments that further directed R38's dialysis care.

During interview on 7/26/18, at 10:41 a.m. RN-B stated R38's care plan in the electronic record was his original, initial care plan. RN-B stated the target date for R25's care plan goals was not current.

When interviewed on 7/27/18, at 11:44 a.m., the interim director of nursing (DON) stated there was some misunderstanding as to how long we can use the initial care plan document. The DON stated initial/comprehensive care plans were a good start, but that residents' comprehensive care plans were to be in place by day 21 after a resident admission. The DON stated and recognized some of the residents' care plan were not up to date and had goal target dates that were not in the future.

R11's significant change MDS dated 4/30/18 indicated R11 exhibited severe cognitive impairment and received extensive assistance to complete her ADL's including mobility and personal cares. R11's medical diagnoses included anemia, chronic kidney disease, diabetes, dementia, and generalized weakness.

R11's care plan revised on 7/23/18, identified R11 experienced alteration in comfort related to wounds on right foot and coccyx. R11's care plan directed staff to implement non-pharmacological interventions which included: reposition, watching television in her room, warm blanket, family/friends company, music. The care plan directed staff to monitor R11's level of pain with the use of a flow sheet or FLACC (Face, Legs,

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2 560	Continued From page 9 Activity, Cry, Consolability)/Dementia scale, with a pain assessment per protocol. The care plan stated resident was to receive medications as ordered by primary provider and staff were to monitor for the effectiveness of the medication, as well as potential side effects. Staff are to encourage resident to verbalize discomfort, and encourage rest periods. The care plan directed staff to turn and reposition resident every two to two and a half hours. Staff were directed to lift, not slide to decrease friction. Staff were also directed to encourage resident to lie on sides while in bed and offload bottom. On 7/23/18, at 7:15 a.m R11 was observed in the dining room and was vocalizing moaning sounds. Family member (FM)-A was heard responding to resident and inquired if she was hurting. As meal progressed, FM-A asked R11 at 7:23 a.m. if she was crying because she hurt. R11 continued to moan. At 7:27 a.m. was heard asking R11 if she was crying because she hurt, to which R11 responded "yes". FM-A was heard telling R11 she had received pain meds but they "Must not be working. Lets eat quick and then get you laid down." R11 was observed to be reclined back in her wheelchair as FM-A assisted her to eat. At 7:29 a.m. R11 was heard moaning out loud and FM-A was dabbing eyes with a tissue. R11 was wheeled out of the dining room by FM-A at 7:30 a.m. On 7/23/18, at 8:35 a.m. R11 was observed in resting on bed which was in a low position with a mat at the bedside. R11 made moaning vocalizations, however did not verbalize response when asked if experiencing pain. R11 was resting with eyes squinted, brows furrowed, and lips pursed.	2 560		

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2 560	Continued From page 10 On 7/23/18, at 11:30 a.m. R11 was observed resting on her bed and displayed facial grimacing, with eyebrows and forehead furrowed, moisture was noted in the corner of her eyes. Resident was making rhythmic moaning noises, without discernible words. A review of the electronic records indicated a pain assessment was completed on 7/23/18 by the registered nurse (RN)-B which indicated resident had pain in coccyx and right foot. The document indicated: "Resident states pain is occasionally and rated 4/10 at worst, and does interfere with sleep and daily activities." The assessment indicated R11 had scheduled methadone 10 mg at 8:00 a.m. and and 5 mg at 4:00 p.m. The assessment identified R11 had additional orders for Morphine 10 mg and Tylenol 650 mg as needed, however, it was indicated these medications were not used during the assessment period. The interventions identified included adminsitration of mediations as ordered, monitoring for effectiveness, monitor resident for signs and symptoms of pain and intervene as needed. The assessment also indicated that staff would update the care provider as needed. These interventions were not added to the care plan. On 7/25/18, at 2:14 p.m. R11 was observed in her wheelchair with her legs elevated on foot rests. R11's eyes were closed, brows furrowed, and resident was moaning in a constant, rhythmic pattern. Hospice nurse (HN) present in room at this time. Nursing assistant (NA)-G entered room to provide cares, and placed R11's right leg on a pillow to provide full leg support. R11 continued to cry out with moaning sound. RN-B entered room to provide assist. NA-G and RN-B assisted to place the mechanical lift sling, while R11 continued to display a constant moan which	2 560		

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intensified with physical movement. R11 was transferred to the bed and mechanical lift sling was removed. R11 was observed to have an open area present on her coccyx with no dressing noted to be in place. R11 was noted to have ceased moaning while lying still, however, resumed moaning/vocalizations which intensified with any increased movement. Once R11 was positioned, RN-B asked resident where the pain was. R11 continued with moaning vocalizations but did not identify where pain was located. RN-B offered to remove pillows and vocalizations intensified with this. HN provided prompts to shift pillow down and assure heel was floating. A blanket was placed to provide less support/pressure than a pillow to improve comfort level. R11 stated pain was in her whole leg when crying out/moaning. RN-B asked R11 to rate pain, however, R11 only amplified vocalizations with moaning. HN was observed to rub hand and arms, offering words of reassurance. HN inquired of RN-B of recent pain medication status and RN-B stated she would follow up and exited the room.

During interview following provision of cares at 7/25/18, at 2:46 p.m. NA-G stated when R11 was observed to be uncomfortable as evidenced by verbalizations/vocalizations, moving in chair, and facial expression, she would assist with repositioning, offer to lay down, and then advise nurse if this was not beneficial in providing comfort. NA-G was unaware of any additional interventions to be implemented to promote comfort for R11.

During continued observation on 7/25/18, at 2:46 p.m. R11 began to cry out loudly, tearing up, with facial grimaces, brows and forehead furrowed and emitting a continuous moaning sound.

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2 560	Continued From page 12 On 7/25/18, at 2:47 p.m. licensed practical nurse (LPN)-A entered room to administer morphine liquid and stated R11 had not had not received PRN (as needed) morphine for several days. At 2:49 p.m. R11 continued to cry out with lips quivering and tears present in both eyes. LPN-A offered to provide R11 assist to contact family member (FM)-A. R11 continued to cry, responding "mmmhmmm", with lips quivering, and tears were present in corners of both eyes. LPN-A placed a call to FM-A at 2:51 p.m. LPN-A held the phone to R11's left ear and R11 was observed to have lips pursed, brows and forehead furrowed. R11's eyes were squinted closed and R11 was actively crying with vocalizations and tears present. R11 stated "Help me, help me, help me" crying out into the phone. At this time, the head of the bed was elevated, R11 was lying on her back, pillows were under her right leg, and HN and LPN-A were rubbing her shoulder and arm in comforting motion. At 2:55 p.m. R11 continued to call out. LPN-A commented with pain management R11 did not consistently take her methadone for pain management. At 2:58 a.m. while being comforted by staff, R11 spoke in to telephone "It hurts." LPN-A checked to see if FM-A remained on the phone and identified FM-A was no longer on the phone. R11 continued to call out, in an amplified tone, of pain, and continued to moan. LPN-A stated R11 also had Ativan for symptom control when asked what interventions have been effective. LPN-A was unaware of other interventions to be put it into place outside of medication administration. LPN-A stated R11 had a family friend (FF)-A who visited frequently, and indicated FF-A may be more aware of what provided R11 comfort. LPN-A stated the TV was put on as a distraction, however, was not helpful.	2 560		

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2 560	Continued From page 13 LPN-A went on to state R11 had not received her morning dose of morphine because there was no supply available. LPN-A was unsure when last dose was given and stated she would follow up with previous shift to check when last dose was given. On 7/25/18, at 3:26 p.m. HN continued to massage hands and lower arms and resident vocalizations decreased in intensity and frequency. R11 responded "Both" when asked if she was sad or in pain. HN continued to massage hands and offered to pray with R11. R11 started the Hail Mary and continued to repeat this prayer, with facial expression becoming more relaxed, decreased furrowing of brows, and absence of tears. On 7/25/18, at 3:30 p.m. LPN-A returned to the room and informed HN the last dosing of methadone was given the previous evening and the morning dose for methadone had not been given. LPN-A stated pharmacy had been contacted regarding need for refill and was awaiting a script. LPN-A stated the supply is monitored by the facility staff and also by the pharmacy. A review of the medication administration sheet, in correspondence with the Narcotic count book, R11 had last received methadone on 7/24/18 at 4:48 p.m.. The documentation also reflected refusal of methadone dosing the morning of 7/24/18. The medication record for 7/25/18 indicated a refusal of morning dose of morphine, however, the individual narcotic record for R11 indicated a count of zero after dosing was given on 7/24/18 at 4:45 p.m. R11 was noted to receive Morphine 100 mg/ml, 0.5 ml (10 mg) at 3:00 p.m.	2 560		

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2 560	Continued From page 14 and again at 4:50 p.m. for pain management. On 7/26/18, at 7:00 a.m. FF-A was a resident's bedside and stated she had been with R11 since early morning. FF-A stated R11 was resting more comfortably at this time. stated she had been with R11 since early morning and stated R11 was resting more comfortably at this time. .upon entrance into room, resident was observed in bed in the low position, resting on her back with the head of her bed raised, and R11 looked to surveyor and stated "Good morning". FF-A On 7/26/18, at 10:45 a.m. R11 was observed in bed, under covers and was noted to be awake. R11's facial expression was noted to be free from furrowed brows, squinted/tearful eyes, and pursed lips. Trained medical assistant (TMA)-A was in with resident and stated R11 had received routinely scheduled methadone and an additional dose of morphine for pain management and was doing well. R11 responded she was "Pretty good." when asked. . On 7/26/18, at 11:24 a.m. during telephone conversation FM-A stated she been with R11 on 7/19/18 and again on 7/22/18. FM-A described R11's pain on 7/22/18 as "really bad". On 7/22/18 FM-A reported R11 was crying, and stated she was having pain in her buttocks, her legs, and her back. R11 stated it was from laying all day. FM-A stated R11 was observed to cry for about two and a half hours, starting at lunch. FM-A stated she contacted staff and requested transfer into bed. FM-A stated staff stopped by a few times, but added "Sometimes when I am there they just let us be." FM-A stated the nurse on Sunday had stated R11 had refused medications on occasion and they had discussed alternate routes, but was unaware of any changes made in plan. FM-A	2 560		

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stated she was at the facility on 7/23/18 at 7:00 a.m. and R11 was was crying at the breakfast table. FM-A described R11 to be sitting there "Kind of moaning" and when asked was was wrong R11 stated her "Butt hurt" . FM-A stated if R11 was experiencing pain, she should have received meds. FM-A stated staff have not inquired of her regarding things R11 would find soothing. FM-A stated R11 previously had watched old time television like the Andy Griffith show. Stated R11 enjoyed country western music and has been out to music activites, but is not aware of music in her room. FM-A stated she was not aware R11 had not received her methadone on 7/25/18. FM-A stated methadone has been very effective for R11, and historically, R11 did not like to use morphine as needed as she didn't like the way it made her feel. FM-A stated she had contacted the administrator approximately the third week in June regarding transfer of R11 and the fact R11 would call out in pain with moment.

A review of the treatment administration record for pain management was reviewed and noted R11 was recorded as exhibiting no pain from the 15th to the 25th of July on the 6:00 a.m. to 2:30 p.m. shift. R11's pain levels from the 2:30-10:00 p.m. shift for the same period was rated with zero to one. R11's pain monitoring sheet from the 11:00 p.m. to 6:00 a.m. pain levels were all recorded at zero with the exception 7/26/18 at which time the pain level was recorded at one. The information recorded on the pain monitoring sheet was noted to be in conflict to observations and information provided by FM-A and HN.

On 7/27/18, at 1:37 p.m. the acting director of nursing (DON) stated if a resident was noted to experience pain with movement, the staff could try to medicate before going to reposition. Upon

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2 560	Continued From page 16 review of the pain assessment being completed on 7/23/18, the DON stated it would be her expectation Hospice would be contacted with R11's increased presence of pain to review current interventions and modify plan of care as indicated. On 7/27/18, at 3:35 p.m. the adminstrator stated she had spoke to FM-A regarding R11's status. The administrator stated she had discussed FM-A's concerns regarding management of comfort for R11. The administrator stated at times it was difficult to determine underlying cause for vocalizations as R11 has made moaning vocalizations in a positive manner with pet visits. The administrator stated FM-A did express concerns with comfort interventions and with turning and repositioning of resident. R24's annual MDS completed on 4/21/18 identified R24 had intact cognition and was able to communicate her needs and wishes. R24 was noted to have a catheter in place to manage urinary functions and was incontinent of bowel. R24 received extensive assist to complete tasks of daily living (ADL's) which included transfers, turning and repositioning, and personal cares. R24's diagnoses included diabetes, arthritis, a neurological disorder which affected mobility, generalized muscle weakness, and morbid obesity. The Care Area Assessment (CAA) worksheet completed on 5/4/18 indicated resident was at risk for pressure ulcers related to multiple risk factors, including obesity, diabetes, neurological diseases, chronic pain, and muscle spasms. The CAA indicated R24 would receive assist to turn and reposition every two hours, in addition to use of pressure relieving mattress, and cushion in wheelchair.	2 560		

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R24's plan of care revised on 7/6/18 identified R24 received assistance to complete her ADL's related to R24's level of strength. The care plan indicated R24 required extensive assistance of two staff to assist to turn and reposition in bed every two hours and as necessary, in additional to provide. The care plan also directed staff to provide with assistance to complete personal hygiene, including skin cleansing, and completion incontinence cares every two hours. The care plan identified R24 went to the WOC (Wound, Ostomy, Continence) nurse at Meeker Memorial Hospital for wound follow up and PRN. The care plan was revised on 7/10/18 to identify an alteration in skin integrity related to an abrasion on her right buttocks. The care plan identified staff were to monitor skin integrity during cares, with documentation weekly. The care plan did not identify weekly wound care services provided by Integrated Wound Care.

On 7/23/18 at 8:44 a.m. R24 stated she is generally in bed by 9:30 p.m. but is not assisted to turn and repositioned until she puts her call light on. R24 stated she had skin breakdown and it was painful to lay in the same position for an extended period of time.

The nursing assistant care sheet identified under the heading Offload Reposition "Assist of two." The care sheet did not provide a frequency indicator of every two hours repositioning, although other residents care directions did include the recommended time frame.

A review of the nursing assistant care documentation was completed for R24 for the months of June and July and documentation was unavailable for 14 days during this period of 56 days possible. On 12 occasions it was noted to

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2 560	Continued From page 18 be greater than four hours between checks or "repo" (repositioning). On 7/26/18 at 7:40 a.m. RN-B stated the care plan instructed the staff to turn and reposition at least every two hours and more often as requested. RN-B stated she was unaware R24 had not been turned and repositioned at this frequency as "R24 has never come to me", however, stated the care plan should be followed. During interview on 7/27/18, at 1:18 p.m. the director of nursing stated the plan of care for R24 outlined turning and repositioning every two hours. The DON went on to state if a resident preferred not to be turned or repositioned then it was the facility responsibility to educate the client regarding benefits of repositiong and to review the risks and benefits. This discussion should be reflected in the care plan. R36's Diagnosis Report printed 7/26/18, indicated he had weakness and chronic kidney disease. R36's CAA dated 6/13/18, indicated he can make decisions and was able to communicate his needs. R36's CAA further indicated he had no mood or behaviors. R36's Initial Comprehensive Care Plan dated 6/06/18, indicated he was alert and orientated, pleasant and cooperative. The care plan further indicated he was further encouraged to attend activities they offer in helping him with socialization and better pass time. R44's Minimum Data Set (MDS) dated 4/27/18, indicated she was cognitively intact	2 560		

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2 560	Continued From page 19 A facility investigation report submitted to the Office Of Facility Health Complaints (OHFC) on 7/14/18, at 23:29:00 indicated R44 reported to nurse on duty another resident (R36) had gone into her (R44) room, closed the door, and offered money to allow him to touch her breast, which he did. Victim (R44) asked him to stop, which he did, then he left the room. The report further indicated R44 does not want him to touch her breast. An Internal investigation was initiated. A Facility Investigation five day report dated 7/23/18, at 18:19:07 indicated R44's care plan was reviewed and administrator met with R44 to discuss the incident. The investigation report originally indicated R44 did not accept the cash and did not want him to touch her. After a conversation, R44 informed the facility she did in fact accept the $10.00 in cash. R44 stated she and the alleged perpetrator (R36) went into her room, closing the door behind them. The victim (R44) said someone knocked on the door and asked them to keep it open. The alleged perpetrator (R36) then suggested they go down to his room. Victim (R44) stated that she followed the perpetrator (R36) down to his room, they closed the door and she allowed him to touch her breast. Victim (R44) did state that she did not want another encounter and wished for him to stay away. The facility indicated on the report the victim (R44) was put on 15 minute checks and the perpetrator (R36) was informed of the victim's (R44) wishes to not meet again and he (R36) agreed. During interview 7/26/18, at 4:37 p.m. RN-B stated R36's care plan lacked to indicate he had behaviors and should have. RN-B further stated she thought she had 92 days to complete the comprehensive care plan.	2 560		

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2 560	Continued From page 20 Although R36 exhibited behaviors of sexual abuse to R44 the facilities care plan lacked to indicate this. R44's Admission Record printed 7/26/18, indicated she had major depression, muscle weakness and mild cognitive impairment. R44's CAA dated 5/05/18, indicated she triggered in ADL's due to needing extensive assist in dressing, bathing, grooming and transfers. In addition the CAA indicated she triggered in urinary incontinence due to having occasional incontinence of urine. R44's Initial Compressive Care Plan dated 4/22/18, indicated she needed assist in ADL's and was incontinent. R44's comprhensive care plan dated 5/02/18, lacked to address her assistance needed in ADL's and urinary incontinence. During interview 7/25/18, at 7:08 p.m. RN-A stated she was aware that R44's care plan was not completed. RN-A stated she was initially told the care plan must be completed in 21 days and then she was told she had 90 days. RN-A stated what triggers on the CAA should be included on the care plan. A policy regarding the development and completion of resident comprehensive care plans was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures with staff regarding the timely development of resident care plans. Further, the DON or designee could	2 560		

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2 560	Continued From page 21 perform audits to ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 575	MN Rule 4658.0430 Subp. 1 Health Information Management Service Subpart 1. Health information management. A nursing home must maintain health information management services, including clinical records, in accordance with accepted professional standards and practices, federal regulations, and state statutes pertaining to the content of the clinical record, health care data, computerization, confidentiality, retention, and retrieval. For purposes of this part, "health information management" means the collection, analysis, and dissemination of data to support decisions related to: disease prevention and resident care; effectiveness of care; reimbursement and payment; planning, research, and policy analysis; and regulations. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to complete a baseline care plan within 48 hours of admission for 1 of 1 residents (R280) who was new admissions and had complaints of pain. Findings include: R250's undated Admission Record identified R250 was admitted to the facility on 7/12/18. R250's admission orders signed 7/12/18, identified orders for tramadol (narcotic for pain management) 50 milligrams (mg) every 6 hours	2 575	Corrected.	9/10/18

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2 575	Continued From page 22 as needed (PRN) for severe pain and Tylenol 325 mg every 6 hours PRN for mild pain or fever. R250's undated, MHM Initial/ Comprehensive Care Plan section for pain and comfort was blank and did not identify R280's risk for pain, a goal or interventions to manage pain. R250's MHM Pain Evaluation dated 7/21/18, identified R250 had frequent lower back pain and rated her pain a 3 out of 10 and had been taking tramadol 50 mg as needed for pain. The pain did not interfere with her sleep but did interfere with her activities of daily living. During interview on 7/25/18, at 6:50 p.m. registered nurse (RN)-A stated R280 had chronic back pain and was admitted with tramadol to manage her pain. She was responsible for completing the baseline care plan, and it was not completed and should have included a care plan for pain. A facility policy on baseline care plans was requested and was not received. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review/revise polices related to ensure baseline care plans are developed upon admission and educate all appropriate staff. The DON could develop a monitoring system to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 575		

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2 625	Continued From page 23	2 625		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care;	2 625		9/10/18

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2 625	Continued From page 24 N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure verification the consulting pharmacist reviewed resident medications and medical record on a monthly basis was readily accessible for 4 of 5 residents (R21, R37, R29, R7) reviewed for medication management. Findings include: R21's quarterly Minimum Data Set (MDS) dated 5/22/18, identified R21 was taking antianxiety, antidepressant and diuretic medications. Diagnoses included anemia, high blood pressure, anxiety disorder and depression. R21's medical record lacked evidence the consulting pharmacist had reviewed R21's medications and medical record on a monthly basis. R37's quarterly MDS dated 6/28/18, identified R37 was taking antipsychotic, antidepressant, and anticoagulant medications. The MDS included diagnoses of anemia, high blood pressure and high cholesterol. R37's medical record lacked evidence the consulting pharmacist had reviewed R37's medications and medical record on a monthly basis.	2 625	Corrected.	

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2 625	Continued From page 25 R29's quarterly MDS dated 5/25/18, identified R29 was taking antianxiety and antidepressant medications. The MDS identified diagnoses of anxiety disorder and depression. R29's medical record lacked evidence the consulting pharmacist had reviewed R29's medications and medical record on a monthly basis. R7's quarterly MDS dated 4/20/18, identified R7 was taking insulin, antidepressant, anticoagulant, diuretic and opioid medications. The MDS included diagnoses of high blood pressure, diabetes, anxiety disorder and depression. R7's medical record lacked evidence the consulting pharmacist had reviewed R7's medications and medical record on a monthly basis. During interview on 7/26/18, at 4:01 p.m. the interim director of nursing (DON) stated she would need to contact the consulting pharmacist to receive the verification the monthly medication and record review were completed. At 4:46 p.m. the interim DON stated it was important to have the consulting pharmacists monthly documentation that each resident medications and record was reviewed to ensure adequate follow up and to meet the regulation. A policy on consulting pharmacist monthly medication review was requested and not received. SUGGESTED METHOD OF CORRECTION: The administrator and director of nursing could review policies and procedures regarding content of the medical record and provide staff education as needed. The DON or designee could perform chart audits to ensure requried documentation is contained in the records to maintain compliance.	2 625		

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2 625	Continued From page 26 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to secure adequate pain medications to allow prescribed medication to be administered as ordered to prevent episodes of pain and discomfort for 2 of 2 residents (R11, R250) reviewed for pain management. This resulted in actual harm for R11 who demonstrated severe physical symptoms of pain on multiple occasions. Findings include: R11's significant change Minimum Data Set (MDS) dated 4/30/18, identified diagnoses that included anemia, chronic kidney disease,	2 830	Corrected.	9/10/18

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2 830	Continued From page 27 diabetes, dementia, and generalized weakness. The MDS also indicated R11 required extensive assistance to complete activities of daily living (ADLs) and was severely cognitively impaired. R11 was identified as enrolled in Hospice effective 4/25/18. A corresponding Care Area Assessment (CAA) completed on 5/14/18, identified R11's level of pain impacted her sleep, limited her day to day activities, was rated as severe, and was noted to occur frequently. The assessment indicated R11 experienced vascular pain in her right leg, and pain in her heel. R11 was also noted to have pain in her buttocks. The CAA identified pain had improved since R11 had enrolled in Hospice. The desired outcome for care was palliative with symptom relief. R11's care plan revised 7/23/18, indicated R11 experienced alteration in comfort related to pressure ulcers on her right foot and coccyx. R11's care plan indicated staff were to implement non-pharmacological interventions including repositioning, television in R11's room, warm blanket, family/friends company, and music. In addition, the care plan directed staff to monitor R11's level of pain with the use of a flow sheet or FLACC (Face, Legs, Activity, Cry, Consolability)/Dementia scale, with a pain assessment per protocol. The care plan indicated R11 received medications as ordered by the primary provider (physician), and staff were to monitor for the effectiveness of the medications as well as potential side effects. Staff were also to encourage R11 to verbalize discomfort, and use rest periods. The care plan directed staff to turn and reposition R11 every two to two and a half hours, and to lift, not slide her to decrease friction, and to encourage R11 to lie on her sides while in bed to offload her bottom.	2 830		

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2 830	Continued From page 28 R11's pain evaluation completed on 4/30/18, identified R11 had experienced pain frequently over the last five days. The evaluation indicated the pain had impacted her sleep, limited her day to day activities, and was rated by R11 as severe. At the time of the assessment, R11 was using Fentanyl and Norco (narcotic pain medications) to manage her pain. The assessment indicated staff were to administer medications as ordered and to monitor for effectiveness. The assessment also indicated staff were to monitor for increased signs and symptoms of pain and intervene as needed. On 7/23/18, at 7:15 a.m. R11 was observed in the dining room vocalizing moaning sounds. Family member (FM)-A responded to R11 and inquired as to whether she was hurting. As the meal progressed FM-A asked R11 at 7:23 a.m. if she was "crying because she hurt." R11 continued to moan. At 7:27 a.m. FM-A was heard again asking R11 if she was crying because she hurt, to which R11 responded, "Yes." FM-A was heard telling R11 she had received pain medications, adding they, "must not be working. Let's eat quick and then get you laid down." R11 was reclined back in her wheelchair as FM-A assisted her to eat. At 7:29 a.m. R11 was heard moaning out loud, and FM-A was dabbing R11's eyes with a tissue. R11 was wheeled out of the dining room by FM-A at 7:30 a.m. On 7/23/18, at 8:35 a.m. R11 was observed resting in bed. R11 made moaning vocalizations, however, did not verbalize a response when asked whether she was experiencing pain. On 7/23/18, at 11:30 a.m. R11 was observed resting on her bed. R11 displayed facial grimacing, with her eyebrows and forehead furrowed with moisture in the corner of her eyes.	2 830		

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2 830	Continued From page 29 R11 was making rhythmic moaning noises, without discernible words. A review of the electronic records indicated a pain assessment was completed on 7/23/18, by registered nurse (RN)-B. The pain assessment indicated R11 experienced pain on her coccyx and right foot. The document indicated, "Resident states pain is occasional, and rated 4/10 at worst [10 being the worst], and does interfere with sleep and daily activities." The assessment further indicated R11 received scheduled Methadone (pain medication) 10 milligrams (mg) at 8:00 a.m., and 5 mg at 4:00 p.m. in addition to orders for morphine (narcotic) 10 mg and Tylenol 650 mg as needed. However, the assessment indicated the medications had not been used during the assessment period. Interventions identified for use of the pain medications included administration of medications as ordered, monitoring for effectiveness, monitor resident for signs and symptoms of pain, and intervene as needed. The assessment also indicated staff were to update the care provider as needed. The assessment did not indicate notification of Hospice regarding the pain assessment completion, or of concerns regarding effectiveness of the current pain regime. On 7/23/18, at 4:03 p.m. a call was placed to the Hospice agency to inquire whether about any contact regarding pain management for R11. The Hospice director (HD) stated she had not received any calls in follow up, and there had been no notification or contact regarding R11's increased pain level. The hospice registered nurse (HRN)-A who was R11's case manager was currently out of the office, but the HD stated she would advise her of the call and follow up. The HD stated when a resident is enrolled in	2 830		

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2 830	Continued From page 30	2 830		

Hospice and has increased pain, it was the expectation of Hospice for the nursing facility to contact the 24-hour nurse call line to advise them of the pain, so evaluation and coordination of current interventions could be done, with subsequent development of an appropriate plan of care for R11.

On 7/24/18, at 2:28 p.m. R11 was observed in her room resting on her bed lying on her back. R11 was resting quietly with relaxed facial expressions.

On 7/25/18, at 2:14 p.m. R11 was observed in her wheelchair with her legs elevated on the foot rests. R11's eyes were closed, her brows were furrowed, and R11 was moaning in a constant, rhythmic pattern. HRN-A was present in the room. Nursing assistant (NA)-G entered the room to provide cares, and placed R11's right leg on a pillow to provide full leg support. R11 continued to cry out with a moaning sound. Registered nurse (RN)-B entered the room to provide assistance. NA-G and RN-B assisted with placing a mechanical lift sling under R11, while R11 continued to constantly moan which intensified with physical movement. R11 was transferred to her bed, and the mechanical lift sling was removed. An acidic odor was noted in R11's room and HRN-A was unsure whether it was related to R11's foot wound, or bowel incontinence, so HRN-A requested staff check her incontinence brief. Incontinence care was provided by NA-G and RN-B with no noted incontinence of bowel. R11 had an open area on her coccyx with no dressing in place. HRN-A stated this area was not present when she had last seen R11 for evaluation. RN-B stated their Wound Care Consultant (WCC) had instructed them to leave the area open without placement of

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2 830	Continued From page 31 a dressing. HRN-A placed an Allevyn Sacral Dressing (foam moisture absorbing dressing that breathes) to the affected areas on the coccyx. R11 had ceased moaning while measurements were obtained, but resumed moaning and vocalizations which intensified with any increased movement. R11 was observed to hold her upper body in a semi-fetal position. Once R11 was repositioned, RN-B asked R11 where the pain was located. R11 continued with moaning vocalizations and did not identify where her pain was located. RN-B removed the pillows, and R11's vocalizations intensified. HRN-A offered suggestions to shift the pillow down to assure R11's heel was floating. A blanket was placed to provide less support/pressure than a pillow in an attempt to improve R11's comfort level. R11 vocalized crying out and moaning when her entire leg was moved. RN-B asked R11 to rate her pain however, R11 only amplified vocalizations with moaning. HRN-A rubbed R11's hand and arms, offering words of reassurance. HRN-A also asked RN-B about R11's recent pain medication status. RN-B stated she would follow up and exited the room. During interview with NA-G, following provision of cares on 7/25/18, at 2:46 p.m. NA-G stated when R11 was observed to be uncomfortable as evidenced by verbalizations, vocalizations, moving in chair, and facial expressions. NA-G stated she would assist with repositioning R11, offer to lay R11 down, and would advise the nurse if those measures were not beneficial in providing comfort. During the observation at that time, R11 began to cry out loudly, tear up, and displayed facial grimaces of her brows and forehead being furrowed. R11 also emitted a continuous moaning sound.	2 830		

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2 830	Continued From page 32 On 7/25/18, at 2:47 p.m. licensed practical nurse (LPN)-A entered R11's room to administer morphine liquid. When asked when the resident had previously received dosing of morphine, LPN-A stated R11 had not received the morphine liquid for several days. At 2:49 p.m., R11 continued to cry out with her lips quivering and tears present in both of her eyes. LPN-A offered to provide R11 assistance to contact FM-A. R11 continued to cry responding, "Mmmmmm." R11's lips continued to quiver, and tears were observed in the corners of both eyes. LPN-A placed a call to FM-A at 2:51 p.m. LPN-A held the phone to R11's left ear and R11 was observed to purse her lips, and to furrow her brows and forehead. R11's eyes were squinted closed, and R11 was actively crying with vocalizations and tears present. R11 cried into the phone, "Help me, help me, help me." At this time, the head of the bed was elevated, R11 was lying on her back, pillows were under her right leg, and HRN-A and LPN-A were observed to rub R11's shoulder and arm in a comforting motion. At 2:55 p.m. R11 continued to call out. LPN-A stated R11 did not consistently take her methadone (pain medication) for pain management. The HRN-A stated she had not been informed of R11's increased pain and added the methadone dosing had been increased two weeks ago, but the Hospice agency had not been informed of R11's refusals to take her medication. At 2:58 p.m. while being comforted by staff, R11 spoke into the telephone to FM-A, "It hurts." R11 continued to call out in an amplified tone of pain, and continued to moan. During this interaction, LPN-A stated R11 had Ativan (anti-anxiety) for symptom control when asked what interventions have been effective. LPN-A stated R11 had a family friend (FF)-A who visited frequently, and indicated FF-A may be more aware of what provided R11 comfort. LPN-A stated the television	2 830		

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2 830	Continued From page 33	2 830		

was put on as a distraction, but was not helpful. LPN-A was not aware of other non-pharmacological interventions implemented to provide R11 comfort. LPN-A stated R11 had not received her morning dose of morphine because there had been no supply available. LPN-A was unsure when the last dose of morphine had been administered, and stated she would follow up with the previous shift to check.

During a visit with R11 on 7/25/18, at 3:04 p.m. HRN-A stated this was the worse pain she had observed R11 experience. HRN-A stated she had not been notified by staff of the increased pain observed. HRN-A stated they had worked with FM-A, R11's primary medical provider, and the facility on R11's pain management. HRN-A said R11's methadone had been increased two weeks ago, and stated she had intended to consult with the hospice pharmacy and evaluate for a possible need to increase R11's methadone dosing. However, HRN-A stated Hospice had not been informed R11 had refused her medications, or that the facility was out of R11's methadone supply. HRN-A stated she would have expected the facility to advise Hospice of R11's refusal to take the medication, of any symptoms of R11 exhibiting increased pain, and of any lack of supply of methadone. HRN-A stated when she had increased the dosing two weeks ago she had verified with FM-A to assure an adequate supply was available. HRN-A stated the hospice medical director could have facilitated a refill of medications if needed, and if alerted. HRN-A stated the facility not having methadone available for administration was "concerning."

On 7/25/18, at 3:26 p.m. HRN-A continued to massage R11's hands and lower arms, and R11 was observed to decrease both the intensity and

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2 830	Continued From page 34	2 830		

frequency of her vocalizations. R11 responded, "Both" when asked if she was sad or in pain. HRN-A continued to massage R11's hands and offered to pray with R11. R11 started verbalizing a prayer out loud and continued to repeat this prayer, with her facial expression becoming more relaxed as evidenced by decreased furrowing of her brows, and absence of tears.

On 7/25/18, at 3:30 p.m. LPN-A returned to the room and informed HRN-A the last dose of methadone had been given the previous evening, and verified no morning dose of methadone had been given. LPN-A stated the pharmacy had been contacted to refill the medication and was awaiting a prescription. LPN-A stated the methadone supply was monitored by facility staff and also by the pharmacy, and stated R11's medical doctor (MD)-A had been in the facility that day conducting rounds, but staff had not obtained a written prescription for the methadone refill during rounds.

On 7/25/18, at 3:38 p.m. HRN-A stated the facility was responsible for ordering the methadone. HRN-A said the lack of methadone for dosing was of concern to her, and stated it was "irresponsible" of the facility.

A review of the medication administration sheet, in correspondence with the narcotic count book, R11 had last received methadone on 7/24/18 at 4:48 p.m. The documentation also reflected refusal of methadone dosing the morning of 7/24/18.

A review of the medication sheet for 7/25/18, indicated a refusal of morning dose of morphine, however, the individual narcotic record for R11 indicated a count of zero following the 4:45 p.m.

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2 830	Continued From page 35 7/24/18, dose. A review of the Medication Administration Record for 7/25/18, identified R11 received morphine 100 mg/ml, 0.5 ml (10 mg) at 3:00 p.m. and again at 4:50 p.m. for pain management. On 7/25/18, at 5:46 p.m. LPN-A stated R11 had received a second dose of morphine for pain management. LPN-A stated the methadone should be delivered in time for the evening dose. On 7/26/18, at 7:00 a.m. FM-A was at the resident's bedside. R11 was observed in bed, resting on her back with the head of her bed raised. R11 stated, "Good morning." FM-A stated she had been with R11 since early morning, and stated R11 was resting more comfortably at this time. On 7/26/18, at 10:45 a.m. R11 was observed in bed, and was noted to be awake. R11's facial expression was noted to be free from furrowed brows, squinted/tearful eyes, and pursed lips. Trained medication assistant (TMA)-A was in with R11, and stated R11 had received her routinely scheduled methadone, and an additional dose of morphine for pain management and was doing well. When asked, R11 responded she was, "Pretty good." During conversation on 7/26/18, at 10:58 a.m. HRN-A stated she had been contacted by the the facility the prior evening after R11 had received the second PRN dose of morphine, and was notified R11 was actively dying. A Hospice visit was offered to the facility and the facility declined. HRN-A stated R11 was demonstrating increased shallow breathing following the second dose of morphine. HRN-A stated R11's lethargy and	2 830		

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shallow breathing may have been related to the dosing of morphine. HRN-A stated historically, R11 had taken only one dose of morphine as needed throughout the course of a day. HRN-A stated R11 being out of methadone made a huge difference for her for pain, and receiving two doses of morphine impacted her response. HRN-A stated she used a dementia scale for pain with FLACC and would have classified R11 as a score of eight to nine on a scale of one to ten, indicating severe pain.

On 7/26/18, at 11:24 a.m. a call was received from FM-A. FM-A stated she had seen R11 on 7/19/18, and again on 7/22/18. FM-A described R11's pain on 7/22/18, as "really bad." FM-A reported on 7/22/18, R11 had been crying, and had stated she was having pain in her buttocks, legs and back, and had been laying all day. FM-A stated R11 had been observed on 7/22/18, to cry for about two and a half hours. FM-A said she contacted staff and requested they transfer R11 into bed. FM-A stated staff stopped by a few times, but added, "sometimes when I am there they just let us be." FM-A stated, "The nurse on Sunday told me [R11] had refused medications on occasion and they had discussed alternate routes." FM-A stated she was at the facility on 7/23/18, at 7:00 a.m. and R11 was crying at the breakfast table. FM-A stated R11 had been just sitting there "kind of moaning." FM-A stated when R11 was asked what was wrong, R11 stated her "butt hurt" and was crying. FM-A stated if R11 was experiencing pain, she should have received pain medication, and stated staff had not asked her what types of things R11 might find soothing. FM-A stated R11 previously had watched old time television like the Andy Griffith show, and stated R11 enjoyed country western music. Although FM-A said R11 had been out to music activities,

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2 830	Continued From page 37 FM-A was unaware of whether R11 had music provided in her room. FM-A stated she was not aware R11 had not received her methadone on 7/25/18, and stated the methadone had been very effective for R11 historically. FM-A further stated R11 did not like to use morphine as needed because she did not like the way the medication made her feel. FM-A stated she had contacted the administrator approximately the third week in June regarding transferring R11, because R11 would call out in pain with moment. FM-A stated they had since been much better about trying to keep her comfortable. A review of the treatment administration record for pain management was reviewed and noted R11 was recorded as exhibiting no pain from the 15th to the 25th of July during the 6:00 a.m. to 2:30 p.m. shift. R11's pain levels from the 2:30-10:00 p.m. for the same period was rated with zero to one. R11's pain monitoring sheets for the 11:00 p.m. to 6:00 a.m. shift, indicated R11's pain levels were all recorded at zero with the exception of 7/26/18, at which time the pain level was recorded at one. On 7/27/18, at 1:37 p.m. the director of nursing (DON) stated if a resident was noted to experience pain with movement, staff could try to medicate before assisting the resident to reposition. When the pain assessment completed 7/23/18, was reviewed with the DON, the DON stated she would expect Hospice to be contacted regarding R11's increased presence of pain, to review current interventions and modify her plan of care as necessary. A review was completed with the level of pain recorded on the treatment administration record in comparison to the narrative notes and medications administered. The DON stated the level of pain recorded should	2 830		

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correspond with the interventions in place. The DON stated she was unaware R11 had not received her morning dose of methadone until she was informed she was out of methadone in the afternoon. The DON stated controlled substances are ordered from the pharmacy through a routine refill process. The DON stated if staff note the supply is down to a one day supply, they were supposed to fax and call the pharmacy to advise them of this. The DON stated at the time they were out of medication, the pharmacy was to be called and a plan of action coordinated. The DON further confirmed she was unaware of the need for a prescription form from MD-A until he had left the facility following rounds.

On 7/27/18, at 3:35 p.m. the administrator stated she had spoken to FM-A regarding R11's status. The administrator stated she had discussed FM-A's concerns regarding management of comfort for R11. The administrator stated at times it was difficult to determine the underlying causes for vocalizations as R11 had made moaning vocalizations in a positive manner with pet visits. The administrator also stated FM-A had expressed concerns with R11's comfort interventions, especially when turning and repositioning the resident.

R250's undated Admission Record identified R250 was admitted to the facility on 7/12/18. R250's admission orders signed 7/12/18, identified orders for Tramadol (narcotic for pain management) 50 mg every 6 hours PRN for severe pain, and Tylenol 325 mg every 6 hours PRN, for mild pain or fever.

R250's undated, Initial/ Comprehensive Care Plan section for pain and comfort was blank and did not identify R250's risk for pain, any goals, or

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2 830	Continued From page 39 interventions to manage pain. R250's Pain Evaluation dated 7/21/18, indicated R250 had frequent lower back pain,and rated her pain a 3 out of 10. The evaluation indicated R250 had been taking Tramadol 50 mg as needed for pain, and indicated the pain did not interfere with her sleep but did interfere with her activities of daily living. On 7/23/18, at 11:21 a.m. R250 was observed lying in her bed. At that time, R250 stated she had chronic lower back pain, and rated her pain a 6 out of 10. R250 described the pain as throbbing, and stated she had been prescribed Tramadol and it helped relieve her pain, but stated it had been 4-5 days since she received any Tramadol because she had been told by facility staff she was out of the medication. R250 stated other medications did not help, so she had stopped asking for medication. On 7/25/18, at 2:28 p.m. R250 was lying in her bed. She sat up to the edge of her bed and placed her right hand on her lower back and grimaced. Once seated at the edge of her bed, she removed her hand from her back and was no longer grimacing. She stated she had not heard what was going on with her pain medication and was now rating her pain at a 7 out of 10. She stated her pain was better with movement, and lying in bed most of the day did not help relieve her pain. R250's MAR for July 2018, identified R250 received 15 doses of Tramadol 50 mg from 7/12/18, until 7/17/18. No further doses of Tramadol 50 mg were administered. During interview on 7/25/18, at 2:36 p.m. NA-B	2 830		

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stated R250 was very independent and had little interaction with her, but if she was having pain she would let the trained medication aid or nurse know.

During interview on 7/25/18, at 2:42 p.m. TMA-A stated R250 had not complained of any pain.

On 7/25/18, at 5:16 p.m. the medication cart was reviewed with LPN-A. LPN-A stated R250 did not have any Tramadol on the medication cart, and no longer had an order for Tramadol. LPN-A stated R250 had chronic lower back pain. LPN-A was unaware of what non-pharmacological interventions were supposed to be attempted with R250. LP:N-A stated R250 had not been asking for pain medications for about the last week, and added staff should be asking R250 to rate her pain when they gave her pain medications.

During interview on 7/25/18, at 6:50 p.m. RN-A stated R250 had chronic back pain, and had been admitted with Tramadol to manage her pain. RN-A stated she was responsible for completing the baseline care plan, and verified it was not completed. RN-A said a baseline care plan should have been developed to include interventions for pain control. RN-A was not aware until that afternoon that R250 had been complaining of back pain, had requested pain medications, or that R250 was out of Tramadol. RN-A stated she left a message with the on-call physician and called the pharmacy to get her pain medication. RN-A stated the TMA or nurse on the cart should have re-ordered R250's pain medication when there were 5 doses left. RN-A stated if there were only 2 doses left and additional pain meds had not been received, the pharmacy should have been called. RN-A stated the facility could have definitely done more to

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2 830	Continued From page 41 manage R250's pain. A facility policy for pain management was requested, but was not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pain to assure they are receiving the necessary treatment/services to prevent pain. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure management of pain. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A 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: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and	2 890		9/10/18

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2 890	Continued From page 42 This MN Requirement is not met as evidenced by: Based on observation, interview and document the facility failed to ensure a range of motion program for upper and lower extremities was implemented for 1 of 2 residents (R35) who had limited range of motion. Findings include: R35's face sheet, undated, identified diagnoses of dementia, muscle weakness and muscle wasting. R35's annual Minimum Data Set (MDS) on 6/18/18 identified R35 had moderate cognitive impairment, limited range of motion of her upper extremities on one side, and no nursing rehabilitation program. R35's rehabilitation Care Area Assessment (CAA), 6/13/18, identified R35 had a daily range of motion program. R35 was observed on 07/23/18 at 11:39 a.m. with her right hand curled around and under the arm of her wheelchair. Her right hand was closed and her wrist was bent and pulled inward towards the resident. On 07/25/18 at 5:58 p.m. R35 was in her wheelchair at the dining room table with her right hand closed and her wrist bent inward. There was no splints or supports on her right hand. She used her left hand to eat her evening meal, while her right hand laid on her lap. R35 was observed during evening cares on 07/25/18 at 7:04 p.m. with nursing assistant (NA)-J. NA-J placed a sling under R35's arms and hooked it to a mechanical lift (EZ stand). NA-J instructed R35 to grasp the handles of the EZ stand so she could hold herself while being transferred with the mechanical lift. R35 tells	2 890	Corrected.	

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2 890	Continued From page 43 NA-J my right hand does not do too much and she was unable to grasp the handle of the EZ stand, but was able to use her left hand to hold onto the stand. NA-J then transfers R35 to the bathroom for evening cares using the EZ stand. NA-J washes R35 under R35's arms, back and perineal care. After washing NA-J placed a clean gown on R35 and transferred R35 back to bed with the EZ stand. During this time NA-J made no attempts to provide any range of motion to R35's upper extremities. During interview on 7/25/18 07:33 p.m. NA-J stated R35 had no behaviors and they provide all personal cares, and use the EZ stand so she stands for a few minutes during cares for strengthening. NA-J stated she does not complete range of motion for R35 and thought therapy provided this. The quarterly restorative review dated 3/12/18, identified R35 had assisted range of motion (AROM), lower extremities (LE)/upper extremities (UE), with participation in AROM documented 4 of 7 days in assessment period with 3-5 reps for 10 minutes documented each shift. The review identified R35 attends exercises in activities when offered. Exercise was effective in maintaining movement and prevent further decline, will continue with plan. There were no other assessments identified since 3/12/18. R35's care plan, 6/27/18 identified a problems with limited physical mobility related to dementia, and osteoarthritis. Staff were directed to implement active range of motion (AROM) lower and upper extremities twice a day and encourage to attend exercise in activities when scheduled. There was no mention of splints or supports for her right hand.	2 890		

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2 890	Continued From page 44 Review of the facility Follow Up Question Report identified AROM UE/LE daily up to 8 minutes. The May thru July 2018 reports identified the following: May 2018 report identified R35 received AROM 30 times out of 62 opportunities, and ranged from 1-15 minutes of time for AROM. R35 refused AROM 10 times, and not applicable 10 times. June 2018 report identified R35 received AROM 23 times out of 60 opportunities, and ranged from 2-20 minutes of time for AROM. R35 refused AROM 16 times, and was not applicable 12 times. July 2018 to date (7/26/18) identified R35 received AROM 30 times out of 52 opportunities, and ranged from 2-15 minutes for AROM. R35 refused AROM 11 times, and was not applicable 4 times. During interview on 7/26/18 09:00 a.m. physical therapist (PT)-A stated they don't have R35 on their case load, and any functional maintenance program would be completed by nursing. On 07/26/18 09:03 a.m. occupational therapist registered (OTR)-A stated some residents go to the exercise group but this would not work for R35 because she can not follow the program and would not be effective. During interview on 7/26/18 10:47 a.m. NA-D, who provided morning cares for R35, stated she completed AROM while she gets R35 dressed and ready for the day. She stretches and extends each arm and leg, doing 10 repetitions on each extremity. She does nothing with her hands or	2 890		

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2 890	Continued From page 45 wrists, she only does AROM with her arms and legs. On 07/26/18 11:14 a.m RN-A stated when NA's get R35 dressed they are expected to provide AROM, for R35's upper and lower extremities along with doing AROM of her elbow, wrist and hand. They should be completing at least 5-10 repetitions of each movement everyday. RN-A was unaware the NA's were not completing AROM to R35's hand or wrists and stated they should be doing this. On 7/26/18 11:25 a.m. certified occupational therapy assistant (COTA)-A evaluated R35 right hand which was closed with her wrist bent, and curled in towards the residents. COTA-A opened R35's hand and was able to straighten her hand but it "was tight." R35 stated she was unable to open her right hand or move her right wrist herself. COTA-A stated we need to pick her up for therapy and do some strengthening, and maybe a splint to keep it straight. Her upper extremities are tight along with her shoulders, she was unable to determine if this is worse because they had not evaluated R35. The occupational therapist completed an assessment of R35 on 7/26/18, which identified decreased right wrist ROM and was at risk for further decline. Plan to fit resdient with appropriate splint to promote correct wrist positioning and establish a wearing schedule. SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of motion services or those at risk for decline. The facility could develop systems to audit range of	2 890		

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2 890	Continued From page 46 motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct a comprehensive assessment/reassessment related to pressure ulcers and implement pressure ulcer interventions to reduce the risk of development of multiple pressure ulcers for 2 of 2 residents (R24, R11) who were reviewed for pressure ulcers. This resulted in actual harm for R24 and R11 who developed multiple pressure ulcers as a result of friction and shear without	2 900	Corrected.	9/10/18

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2 900	Continued From page 47 adequate interventions. Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 1 Pressure Injury: Non-blanchable erythema of intact skin Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. Stage 3 Pressure Injury: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar	2 900		

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obscures the extent of tissue loss this is an Unstageable Pressure Injury.

Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss
Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed.

R24's annual Minimum Data Set (MDS) dated 4/21/18, identified R24 had intact cognition and was able to communicate her needs and wishes. The MDS identified R24 was noted to have an indwelling urinary catheter in place to manage urinary functions, and was incontinent of bowel. The MDS indicated R24 received extensive assistance to complete tasks of daily living (ADLs) which included transfers, turning and repositioning, and personal cares. The MDS identified diagnoses of diabetes, a neurological disorder which affected mobility, generalized muscle weakness, and morbid obesity. The MDS identified R24 was at risk for the development of pressure ulcers, and identified pressure reduction devices for R24's chair and bed. R24 was also identified as receiving treatment/ointment other than for foot problems, however, the MDS did not identify R24 had any skin problems.

R24's Care Area Assessment (CAA) worksheet dated 5/4/18, indicated R24 was at risk for pressure ulcers related to multiple risk factors that included obesity, diabetes, neurological diseases, chronic pain, and muscle spasms. The CAA indicated R24 would receive staff assistance

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2 900	Continued From page 49 to turn and reposition every two hours, use of a pressure reduction mattress, and a cushion in the wheelchair. R24's care plan revised on 7/6/18, identified R24 received assistance to complete her ADLs related to her level of strength. The care plan indicated R24 required extensive assistance of two staff to turn and reposition in bed every two hours, and as necessary. The care plan also directed staff to provide R24 with assistance to complete personal hygiene including skin cleansing, and completion of incontinence cares every two hours. The care plan identified R24 went to the Wound, Ostomy, Continence (WOC) nurse at the hospital for wound follow up, and as needed (PRN). The care plan was revised on 7/10/18, to identify an abrasion on R24's right buttocks. The care plan identified staff were to monitor skin integrity during cares, and to complete weekly documentation. The care plan lacked identification of weekly wound care services provided by Integrated Wound Care (wound care consultant). The nursing assistant care sheet identified under the heading Offload Reposition "Assist of two." The care sheet lacked the frequency of every two hours repositioning as directed by the care plan. During observation on 7/23/18, at 9:02 a.m. nursing assistant (NA)-K provided assistance to complete personal dressing and grooming for R24. NA-K completed peri cares, and proceeded to provide cleansing to abdominal folds. Upon turning onto the left side to complete cares, R24's coccyx, gluteal cleft, labia, rectal area, and skin extending down from buttocks to upper thighs were covered with white cream. NA-K proceeded to wash this area with soap and water and	2 900		

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applied Calmoseptine. NA-K stated the nurses will come in to assess areas if there are concerns. NA-K stated at times the area is "So sore that it bleeds" adding the areas were bleeding last week.

During observation of personal care on 7/23/18, at 9:14 a.m. R24 right gluteal cleft and upper thigh had an area macerated with a slough-like appearance and measured approximately 18 centimeters (cms) by 23 cms in a triangular shape. R24's left buttocks had a smaller area measuring approximately 13 cms by 13 cms. R24 also had an area on her labia, which registered nurse (RN)-B described as, "Scabs." The area had approximately a 5 cm area with light yellow (serous) drainage. RN-B stated these areas were considered friction or sheering, adding a pressure area would not be blanchable.

During observation on 7/26/18, at 7:21 a.m. personal cares were provided with NA-F, NA-L, and RN-B. Upon removing the incontinence product, RN-B stated R24's areas had a build up of tissue or scabs. During provision of care, R24 commented the area was "Sore" and "It burns." RN-B completed measurement of the areas as follows:
Left buttocks area was 17 cm by 11.6 cm and was described by RN-B as oval in shape.
The alteration in skin integrity on the labia and perirectal area was measured by RN-B at 3.7 cm by 2.4 cm.
Right buttocks area measured at 9.9 cm by 9.5 cm.

During interview with RN-B (during provision of cares) RN-B stated R24 should be off loaded (shifting and removing pressure from affected areas) and repositioned every two to two and a

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half hours. R24 commented aloud that on 7/25/18, she was assisted to bed at approximately 9:10 p.m. and was not assisted to reposition until she put her call light on after 5:00 a.m. to request repositioning (over seven hours between being turned and repositioned).

Immediately following the provision of cares and skin measurements on 7/26/18, at 7:21 a.m. RN-B reviewed the plan of care for R24 which directed staff to turn and reposition R24 at least every two hours and more often as requested. RN-B stated the presence of an incontinence pad would cause increased moisture sweat/body heat, which would "keep the wound moist, not letting it dry out," increasing effects of friction and pressure. RN-B stated she was unaware of R24 not being repositioned, adding R24 had not informed her of this concern.

A review of the Integrated Wound Care (Wound Care Consultant, WCC) progress note was completed with RN-B on 7/26/18, at approximately 7:45 a.m. which identified the following findings:

6/5/18:
R24 was identified to have a single partial thickness buttock wound with a listed duration of 1 week. The wound was a mixed disease which was not healed, and measured 9 centimeters (cm) length by (X) 7 cm width; with an area of 63 squared (sq) cm.

6/12/18:
A single partial thickness buttock wound was listed with measurements recorded of 2 cm length X 2 cm width; with an area of 4 sq cm. A scant amount of serous drainage (clear, thin, watery drainage) was noted, with the peri-wound

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2 900	Continued From page 52 skin being normal. 6/19/18: A single partial thickness buttock wound was listed with measurements recorded of 0.5 cm length X 0.5 cm width; with an area of 0.25 sq cm. Again, scant serous drainage was observed and the surrounding skin was normal. The dictation identified, "The wound is improving." 6/26/18: A single partial thickness buttock wound was listed with measurements recorded of 0.5 cm length X 0.5 cm width; with an area of 0.25 sq cm. Again, scant serous drainage was observed and the surrounding skin was normal. The dictation identified, "The wound is improving." 7/3/18 : R24 was now identified to have two buttock wounds. Right buttocks: Partial thickness mixed disease with a status of not healed. Measurement of 1 cm in length by 3 cm in width. Left buttocks: Mixed pressure/ friction area, not healed. Measurements of 1 cm in length by 5 cm in width. Wound status: Deteriorating. A wound care visit by WCC was not completed on the week of 7/10/18. 7/17/18: Right buttocks: Measured 14 cm by 14 cm. Skin status denoted as improving. Left buttocks: Mixed pressure and friction. Deteriorating. A measurement of the area was not documented by the wound care nurse. 7/24/18: Right buttocks: Partial thickness mixed disease.	2 900		

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2 900	Continued From page 53 Not healed. Measurement: 14 cm x 16 cm. Left buttocks: Mixed pressure/friction. Deteriorating. Measurement: 14 cm by 16 cm. After this review on 7/26/18, RN-B stated with a deterioration in skin condition, an assessment should have been done to address the potential causes of the deterioration. A review of the facility documents titled, Weekly Pressure Wound Evaluation, were reviewed from 5/29/18, to 7/26/18, which identified the following: 5/29/18: Coccyx: (site unspecified): Shearing with no recorded measurements. No staging was completed of the wound. A "Date wound identified" was recorded of 5/22/18. Further, "Coccyx sheering has improved and not as red and irritated this week." 6/5/18: Coccyx (site unspecified): Shearing with no recorded measurements. No staging was completed of the wound. Further, "Sheering [sic] is looking less red and more pink, less painful for the resident." 6/12/18: Coccyx (site unspecified): Shearing with no recorded measurements. No staging was completed of the wound. Further, "Sheering [sic] has decreased in size and now only over the center coccyx and not past the buttock." 6/19/18: Coccyx (site unspecified): Shearing with no recorded measurements. No staging was completed of the wound. A "Date wound identified" was now recorded of 6/19/18. Further,	2 900		

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2 900	Continued From page 54 "Sheering [sic] is only around the coccyx area and slightly pink. Almost healed." 7/3/18: Three wounds were now listed. Coccyx (Site unspecified) : Sheering: 1 cm x 3 cm. Stage 2 Coccyx (Site unspecified) ; Sheering: 1 cm x 5 cm. Stage 2 Coccyx (Site unspecified) : Sheering: (no measurement) Stage 1 Narrative note indicates that coccyx is close to being healed, with the exception of two open areas on her left coccyx. 7/10/18: No documentation to reflect areas on coccyx. Addressed skin concerns with legs. 7/17/18: Coccyx (Site unspecified) : Sheering: 14 cm by 14 cm Narrative note identified R24 received assist of two to transfer with a mechanical lift but did not identify frequency of turning, repositioning, or offloading. 7/20/18: Buttocks (Site unspecified): Type: Pressure. No size or stage documented. 7/24/18: Buttocks/Upper thigh: Pressure: Size 14 cm by 16 cm. 7/26/18: Right buttocks: Pressure (No staging or size identified). Left buttocks: Pressure: (No staging or size identified).	2 900		

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2 900	Continued From page 55 Narrative note indicated R24 was educated as to risk and benefits and reviewed with the director of nursing (DON), which included decreased healing time and increased pain. A review of the nursing assistant care documentation was completed for R24 for the months of June and July, 2018, and documentation was unavailable for 14 days during this period of 56 days possible. On 12 occasions it was noted to be greater than four hours between checks or "repo" (repositioning). The documentation had no record of resident refusing to be turned or repositioned. On 7/27/18, at 1:18 p.m. the DON indicated R24's open areas were noted in the documentation on 7/26/18, by RN-B as a pressure ulcer. The DON stated she was unaware R24 was not being turned and repositioned every two hours, however, stated she was aware R24 would refuse to do so at times. The DON stated refusals should be reflected in staff's documentation. The DON stated when a skin area is not improving, assessment for potential cause should be completed, and staff should monitor for consistent repositioning. The DON stated staff had reviewed the risks and benefits with R24 on 7/26/18, which included potential worsening of the skin condition, delay in healing, and alteration in comfort if not routinely repositioned. The benefits of routine repositioning would be prevention of further deterioration of skin breakdown, improved healing, and comfort. The DON stated she did have not have specific information or documentation of R24's refusal to turn or reposition, and stated this should have been documented if this had occurred. The DON stated review of risks and benefits of routine turning and positioning is a routine process for residents with	2 900		

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2 900	Continued From page 56	2 900		

skin care concerns, however, she was unable to provide any documentation to reflect this had been completed, nor was it included on R24's care plan prior to 7/26/18.

The WCC was called on 7/27/18, at 2:46 p.m. regarding R24's skin condition. The WCC returned the phone call on 8/1/18, at 4:45 p.m. The WCC stated she does consultation for skin care, and received a consultation for R24 on 6/5/18. The WCC stated R24's skin condition was caused by a mix of things: pressure, friction, and shearing. The WCC stated the pressure ulcer had deteriorated as identified in the progress notes, and there were multiple areas that were involved for R24. This was related to lack of frequency of repositioning R24, the process of repositioning R24, and items underneath R24 while laying on her bed or up in her wheelchair.

R11's significant change MDS dated 4/30/18, indicated R11 exhibited severe cognitive impairment and received extensive assistance to complete her ADLs including mobility and personal cares. R11's diagnoses included anemia, chronic kidney disease, diabetes, dementia, and generalized weakness. The MDS identified R11 was identified as having a Stage 1 pressure ulcer or greater, was at risk for development of additional pressure ulcers, and R11 had an unhealed Stage 1 pressure ulcer. R11's most severe stage of pressure ulcer was noted to be eschar/unstageable. R11 was identified as having a pressure reduction chair and bed, and received pressure ulcer care.

Review of the Hospice Interdisciplinary note on 7/20/18, identified a wound on R11's buttocks had healed.

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2 900	Continued From page 57 R11's care plan revised on 7/24/18, identified R11 was at risk for alteration in skin integrity related to immobility, incontinence, weight loss, and diagnosis of hypertension. The care plan directed staff to turn and reposition R11 every two to two and a half hours. Staff were directed to lift, not slide to decrease friction. Staff were also directed to encourage R11 to lie on her side while in bed to offload the pressure on her bottom. The care plan identified that the care plan was updated regarding the pressure ulcer on the coccyx on 7/23/18, and turning and repositioning was changed on 7/24/18 (during survey) from every 2 hours to every 2 1/2 hours. During observation on 7/23/18, at 8:33 a.m. R11 was resting on her bed on her back with a mat on the right side of the bed, with the bed in the low position. Review of the facility progress note of 7/23/18, indicated R11 received a bed bath that morning and had, "Pressure ulcers on right heel and coccyx. Resident heel has no change, and coccyx is smaller and is light red in color." R11 was being repositioned every 2- 21/2 hours and as needed (PRN). The note indicated R11 was incontinent of bowel and bladder, and wore an incontinence pad to aide in keeping the skin dry. The documentation did not reflect a plan of treatment for the coccyx pressure ulcer. During observation on 7/24/18, at 2:28 p.m. R11 was observed in her room resting on her her back, with two pillows under her right leg to support her foot off of the bed. There were no additional pillows in place to attempt to alleviate pressure from the coccyx.	2 900		

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2 900	Continued From page 58 A review of the WCC wound note of 7/24/18, indicated R11 had a reddened area on her coccyx 1 cm x 1 cm as WCC had noted per the narrative assessment by the nurse manager on 7/17/18, however, the WCC did measure the wound at the visit. The narrative note directed staff to apply a Mepilex (soft silicone foam dressing minimizes trauma to the pressure ulcer) dressing border to R11's coccyx, and change every three days. Additional interventions outlined by the WCC included for staff to reposition R11 every two to two and a half hours, air mattress to bed, pressure reduction cushion in wheelchair per hospice recommendations, daily skin checks with cares, and weekly skin assessments by nurse. The WCC documentation indicated R11 preferred to lay down in bed. During observation on 7/25/18, at 2:14 p.m. R11 was seated in her wheelchair with her legs elevated on foot rests. R11 was sitting with her eyes closed, brows furrowed, and moaning in a constant, rhythmic pattern. The hospice nurse was present in room. NA-G entered R11's room in response to R11 crying out. NA-G proceeded to reposition R11's right leg, however, R11 continued to cry out with a moaning noise. RN-B then entered the room to provide NA-G assistance to transfer R11 into bed. R11 continued with a constant moan while being assisted to transfer to the bed with the use of mechanical lift. An acidic odor was noted in the room and hospice registered nurse (HRN)-A was unsure if this was related to the pressure ulcer or bowel incontinence, and requested R11's incontinence brief be checked. R11 had not been incontinent of bowel, however, R11 had an open area present on her coccyx with no dressing in place. HRN-A stated this area was not present when she last saw R11. The coccyx had drainage	2 900		

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2 900	Continued From page 59 on the incontinence brief which was described by HRN-A as circular, blood tinged drainage and measured 2.5 cm by 2 cm. The coccyx also had two areas on the left side which were moist and HRN-A stated it appeared, "as if it could slough." The area on the left measured 2.5 cm by 1 cm, and the second measured 1.8 by 0.6 cm. On the right side of the coccyx there was an open area 2.5 cm by 1.7 cm with a center bridge of slough present measuring 0.3 cm in width and 1.0 cm in length. RN-B stated the WCC had instructed them to leave the area open without placement of a dressing. The HRN-A placed an Allevyn sacral dressing (dressing that removes fluid) to the open areas on the coccyx. Once R11 was positioned, RN-B asked R11 where her pain was. RN-B offered to remove some of R11's pillows and R11's vocalizations of pain intensified. HRN-A offered suggestions to shift the pillow down and assure R11's heel was floating. During interview following provision of cares at 7/25/18, at 2:46 p.m. NA-G stated R11 was uncomfortable as evidenced by verbalizations/vocalizations, moving in the chair, and facial expressions. NA-G stated she would assist to reposition, offer to lay down, and then would advise the nurse if this was not beneficial in providing comfort. NA-G stated the importance of positioning for areas identified on R11's right foot but did not indicate any specific interventions to alleviate pressure on R11's coccyx. NA-G stated she was unsure of specific interventions for this. On 7/25/18, at 3:36 p.m. HRN-A met with RN-B and requested orders for wound care to R11's coccyx. RN-B stated the WCC followed the resident for skin care needs. HRN-A stated the area on R11's coccyx had been healed with most recent visit. A copy of the Hospice	2 900		

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2 900	Continued From page 60 Interdisciplinary Team (IDT) note identified on 7/20/18, indicated a wound on R11's buttocks was healed at that time. On 7/26/18, at 11:24 a.m. family member (FM)-A stated R11's pain level on 7/22/18, was "really bad." On that day, FM-A stated R11 was observed crying out, stating her back and coccyx hurt once she had been gotten up for lunch. FM-A stated R11 cried continuously for about two and a half hours on 7/22/18, and attempts at diversion by propelling her in the wheelchair and reclining the wheelchair were of little benefit. FM-A stated R11 ceased crying once assisted into bed per family request. This was a period of greater than three hours between repositioning. FM-A stated staff will usually not intervene or provide care to R11 when family is visiting. FM-A stated on 7/23/18, at 7:00 a.m. R11 was noted to be crying and moaning while up in her wheelchair, and she expressed pain in her coccyx. FM-A stated she had spoken to the facility about the frequency of repositioning for R11 towards the end of June, and had agreed upon a plan to turn and reposition her every one and a half hours. FM-A stated earlier in July, FM-A stated there was a period of one week between visits and upon her return visit, she observed R11 had developed a "bedsore." On 7/27/18, at 1:37 p.m. the DON stated she was aware R11 had a reddened coccyx, but was unaware of any open areas on R11's coccyx. The DON stated with observation of the reddened open area of the coccyx, the medical provider should be contacted. The DON stated staff should re-evaluate the turning and repositioning program to assure completion, and determine if anything should be done differently. The DON noted on 3/29/18, a tissue tolerance (to determine	2 900		

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2 900	Continued From page 61	2 900		

the length of time pressure can be tolerated to an area of the body) assessment was completed for R11. The DON stated a subsequent tissue tolerance assessment should have been completed with the development of a pressure area, a significant change, and with enrollment into Hospice. The DON state R11 met all three identified triggers for evaluation. The DON stated she was unaware of any concerns addressed by R11's family.

On 7/27/18, at 3:35 p.m. the administrator stated she had spoken to FM-A regarding the family's concerns about R11 not being positioned timely, and R11's pain management. The administrator stated she had followed up with staff regarding the concerns related to turning and repositioning. The administrator stated it was difficult to determine the underlying cause of R11's vocalizations at times, because R11 made similar vocalization in a positive response to pet visits.

On 7/27/18, at 2:46 p.m. The WCC was called to review current skin conditions, and plan of treatment for R11. A phone call was returned form the WCC on 8/1/18, at 4:45 p.m. The WCC stated she had initiated wound care consultation most recently on 6/12/18. Initial measurements of R11's Stage 3 pressure ulcer on the coccyx were 2.5 cm by 2.5 cm. The narrative note of 7/24/18, by the WCC was based on the nurse manager's measurement of 7/17/18, which indicated wound measurement as a 1 cm x 1 cm reddened area on R11's coccyx. A review of measurements obtained with HRN-A on 7/25/18, at 2:14 p.m. identified R11 was observed to have had drainage on the incontinence brief which was described by HRN-A as circular, blood tinged drainage, and measured 2.5 cm by 2 cm. The coccyx also had two areas on the left side which

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2 900	Continued From page 62 were moist and HRN-A stated it appeared, "as if it could slough." The area on the left measured 2.5 cm by 1 cm, and the second measured 1.8 by 0.6 cm. On the right side of the coccyx there was an open area was 2.5 by 1.7 cm with a center bridge of slough present measuring 0.3 cm in width and 1.0 cm in length. The WCC stated the underlying cause of the pressure ulcers was from pressure, and stated it was important to reposition R11 every two hours. The WCC stated these areas were caused from sitting in wheelchair, and laying in bed on her back. The WCC stated it was important to reposition R11 every two hours, utilize the pressure reduction mattress on the bed, and the pressure reduction cushion in her wheelchair. A facility policy titled, Skin Assessment and Wound Management dated 7/20, directed updates with ongoing skin problems would be relayed to the providers as indicated. The policy did not identify specific interventions to be implemented if the skin condition was noted to be deteriorating. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document the facility failed to implement a therapy recommended walking program was not implemented consistently for 1 of 1 residents (R23) who needed staff assistance with walking. Findings include: R23's significant change Minimum Data Set (MDS) dated 4/17/18, identified R23 had moderate cognitive impairment, and had a functional limitation in range of motion to one lower extremity. R23 needed extensive assistance with mobility. The MDS identified a diagnosis of arthritis. R23's activities of daily living	2 915	Corrected.	9/10/18

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2 915	Continued From page 64 (ADL) Care Area Assessment (CAA) dated 4/30/18, identified R23 fractured her right hip on 4/9/18, and was surgically repaired. R23 was receiving physical and occupational therapy with a goal to utilize her walker again. On 7/23/18, at 8:10 a.m. R23 was seated in a wheelchair in her room. She had a seated four wheeled walker in the corner of her room. R23 stated she had broke her right hip a few months ago and was supposed to be walked twice a day by staff. Further, staff were not walking her as directed. R23's Therapy Recommendations dated 5/9/18, instructed staff to walk R23 with her four wheeled walker (FWW) with one staff member twice daily. R23's care plan revised on 7/21/18, identified R23 needed an assistance of one to walk. R23 has a nursing rehabilitation program, which directed staff to walk R23 twice a day to promote daily exercise and help maintain and improve her strength. R23's nursing rehabilitation program documentation included: - May 2018, identified 16 out of 24 opportunities to walk were documented as not applicable. - June 2018, identified 12 out of 29 opportunities to walk were documented as not applicable. - July 2018, identified 19 out 37 opportunities to walk and were documented as not applicable. During interview on 7/26/18, physical therapy assistant (PTA)-A stated the physical therapy recommendations were given in writing to nursing staff and the nursing staff were to follow through with the therapy recommendations.	2 915		

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2 915	Continued From page 65 On 7/26/18, at 10:46 a.m. nursing assistant (NA)-A stated the nursing assistants were supposed to walk R23 twice a day, once on the day shift and once on the evening shift. NA-A stated R23 "probably" did not get walked every day. The staff were to offer walking to her and only occasionally did she refuse. The aids then documented resident refusal and were to let the charge nurse know. During interview on 7/26/18, at 3:01 p.m. NA-B stated if the nursing assistants chart not applicable in the nursing rehab section it meant it was not offered and was not completed. When interviewed on 7/26/18, at 3:03 p.m. registered nurse (RN)-A stated R23 was on a therapy recommended walking program. The nursing assistants were to let her know if they were not able to walk R23 or if she refused so a nursing note could be put in the residents chart. RN-A was not aware R23 was not walking as recommended. Not applicable meant the task was not completed. METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		9/10/18

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21375	Continued From page 66 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 follow contact and enteric precautions for 2 of 2 residents (R100 and R3) who were place on transmission based precautions. Findings include: R100's face sheet undated, identified he was admitted to the agency on 7/18/18, with urinary retention and an indwelling urinary catheter. R110 hospital discharge summary on 7/18/18 identified, he was admitted to the hospital for acute kidney injury, and urinary tract infection with Methicillin-resistant Staphylococcus aureus (MRSA) organism in his urine. MRSA is an infection caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections, and is classified as a multi drug resistant organism. R100's Initial/Comprehensive Careplan, 7/18/18, identified infection. R100 had a current infection of MRSA, with interventions of antibiotic medication per physician order, all staff to follow isolation precautions, isolation precautions per protocol and sign on resident's door. During interview on 7/23/18 08:37 a.m. registered nurse (RN)-A stated R100 had MRSA in his urine,	21375	Corrected.	

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and has an indwelling catheter for urinary retention.

During observation on 7/22/18 at 8:40 a.m. R100's room had an isolation bag on his door that contained gloves, gowns and sani cloths with bleach. There was sign on the door that read, Contact Precautions, in addition to Standard Precautions. Everyone must, clean hands when entering and leaving room. Doctors and Staff Must: gown and glove at the door, use patient dedicated or disposable equipment. Clean and disinfect shared equipment. The back of the sign identified contact precautions and listed common conditions of MDRO's, which included MRSA. Equipment and supplies, use dedicated or disposable equipment when available. Clean and disinfect reusable equipment including IV pumps, cell pone or pages, and other electronic, supplies and equipment prior to removing from residents room. Transport, assure resident is in clean clothes, clean and disinfect assistive devices.

During an interview on 07/23/18 01:06 p.m. R100 was in the room with a vinyl bag that covered his indwelling catheter bag which was hanging from the back of his wheelchair under his seat. R100 stated staff come in his room, with "stuff on" usually a gown and gloves. If they don't I tell them they need to do this and they are good about it.

During observation on 07/25/18 02:27 p.m. physical therapist (PT)-A entered R100's room with no gloves or gown on. He unhooked R100's urinary catheter bag from the wheelchair and hooks it onto his walker handling the catheter tubing and bag. PT-A then touches the handles of R100's walker and places a transfer belts around the resident without first washing his

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soiled hands. PT-A assists R100 to stand up, and places his clip board on the residents wheelchair cushion, where the resident was sitting. PT-A then assisted R100 to stand with his walker while holding onto the back of R100's transfer belt. PT-A walks with R100 holding onto his transfer belt, and ambulate with resident. PT-A does not wash his hands after touching the catheter tubing and catheter bag. Before leaving the room, PT-A picks up his clip board, and holds it while walking with R100 to the therapy room down the hallway.

At 07/25/18 03:20 p.m. PT-A and R100 were in the physical therapy room exercising. The soiled clip board which was in R100 room, was lying on an overbed table in therapy department. At 3:22 p.m. PT-A leaves R100's room and has a gait belt rolled up and under his arm touching his clothing while he cleansed his hands with a gel sanitizer. PT-A stated the gait belt, under his arm, was from R100. He was told yesterday by physical therapy assistant (PTA)-A that he did not need to use dedicated equipment for R100. PT-A was unsure what to do with R100's equipment or other items since he was on contact precautions. PT-A reviewed the instructions on R100's door, that identified using dedicated patient care equipment. He stated there was a transfer belt in R100's room, and he should use that equipment and will sanitize the gait/transfer belt he had in his hands. PT-A also stated he will clean the clipboard and the bedside stand that it was sitting on in the therapy room. He will ask the nurses and double check in the future what he needs to do when precautions are implemented.

During interview on 7/26/18 at 9:00 a.m. LPN-C stated all staff need to wear glove and gown, when working with R100. R100 has been

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emptying his own indwelling catheter bag, and we are unsure of his techniques so it is important to wear gloves, gown and wash hands. If someone is using a gait/transfer belt they need a clean one each time, or use the one in R100's room since he is on contact precautions.

During interview on 7/26/18 at 2:00 p.m. the PT-A observation was discussed with RN-A who stated all staff need to follow the precautions on R100's door and use the dedicated equipment.

Facility policy, titled, Contact Precautions, undated, identified use gown and gloves when you anticipate direct contact with body fluids.

R3's quarterly minimum data set (MDS) dated 4/03/18, indicated diagnoses including anxiety, depression and malnutrition.

R3's care plan dated 7/23/18, indicated she was on contact isolation for c-Diff (Clostridium difficile bacterial infection) The care plan further indicated all staff were to follow contact precautions.

R3's door to her room indicated she was on "Contact Enteric Precautions". The note also indicated "They must wear gloves and gown while in the room and remove them before leaving. They must also wear mask and goggles."

A facility policy indicated that Contact Enteric Precautions (CEP) meant it "will be used in the care of all residents known or suspected to be infected with organisms that are transmitted by contact with the patient or contaminated surfaces and are particular to infections pertaining to gastrointestinal organisms that are difficult to kill or are easily transmissible.

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21375	Continued From page 70 The Policy further indicated "Residents whom contact enteric precautions are clinically indicated to include some of the following common conditions." 1. Residents who have acute diarrhea of unknown etiology. 2. Residents who have Clostridium difficile (is a bacterium that can cause symptoms ranging from diarrhea to life-threatening inflammation of the colon). 3. Residents with Norovirus or Rotavirus (stomach flu). During observation on 7/23/18, at 9:38 a.m. maintenance assistant (MA)-A entered R3's room and stated he was going to put a new footboard on R3's room. MA-A did not put on a gown or gloves and proceeded to touch R3's bed, bed linen while mounting the footboard on the frame of R3's bed. MA-A was in R3's room for approximately 10 minutes, and left the room without first washing his hands. During interview on 7/24/18, at 3:00 p.m. the interim director of nursing (DON) stated all staff who go into R3's room "should gown and glove" including dietary and maintenance staff. The Director of Nursing (DON) or designee could review facility policies/procedures regarding isolation precautions for resident and provide staff education regarding the policies. Additionally, the DON or designee could perform audits to ensure policies are being followed to ensure on-going compliance. Time Period for Correction 21 (twenty-one) days.	21375		

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21530	Continued From page 71	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist'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 assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality	21530		9/10/18

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21530	Continued From page 72 assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pharmacist recommendations were acted upon timely, and appropriate rationale was recorded for not implementing recommendations for 1 of 5 residents (R29) reviewed for unnecessary medication use. Findings include: NOT ACTED UPON: R29's quarterly Minimum Data Set (MDS) dated 5/25/18, identified R29 had dementia with a severe cognitive impairment. In addition, R29's Diagnosis Report printed 7/27/18, identified R29 had numerous medical diagnoses including anxiety disorder, high blood pressure, and major depressive disorder. R29's Order Summary Report signed 7/19/18, identified R29 had current physician orders for several psychotropic medications including: - Celexa (an antidepressant) 10 milligrams (mg) everyday, - Lorazepam (an antianxiety medication) 0.5 mg orally, "... as needed for anxiety give twice daily [BID]." R29's Consultant Pharmacist's Medication Review dated 5/14/18, identified the consulting pharmacist (CP) dictated an irregularity as, " ... Non-antipsychotic PRN psychotropics such as this [R29's lorazepam] are limited to 14-day	21530	Corrected.	

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duration, unless the prescriber chooses to extend treatment by providing clinical rationale and documenting intended duration." CP requested the physician to re-evaluate R29's current lorazepam therapy and document their clinical evaluation/rationale of the resident if treatment was going to be continued. A listed section labeled, "Follow-Up or Action Taken," directed the physician to circle if they accepted or rejected the recommendation with a time frame to be completed in, "... ASAP but no later than 60 days." However, neither of these were circled nor did the report have any signature from the physician to demonstrate it had been reviewed and/or addressed.

R29's subsequent Pharmacist's Medication Review dated 6/28/18, identified CP again identified the same irregularity with R29's lorazepam use, and requested the physician re-evaluate R29's current lorazepam therapy and document their clinical evaluation/rationale of the resident if treatment was going to be continued. As prior, a section labeled, "Follow-Up or Action Taken," directed the physician to circle if they accepted or rejected the recommendation with a time frame to be completed in, "... ASAP but no later than 60 days." However, neither of these were circled nor did the report have any signature from the physician to demonstrate it had been reviewed and/or addressed.

R29's additional, subsequent Pharmacist's Medication Review dated 7/11/18, identified CP again identified the same irregularity with R29's lorazepam use, and requested the physician re-evaluate R29's current lorazepam therapy and document their clinical evaluation/rationale of the resident if treatment was going to be continued. As prior, a section labeled, "Follow-Up or Action

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Taken," directed the physician to circle if they accepted or rejected the recommendation with a time frame to be completed in, "... ASAP but no later than 60 days." However, neither of these were circled nor did the report have any signature from the physician to demonstrate it had been reviewed and/or addressed.

When interviewed on 7/27/18, at 10:28 a.m. registered nurse (RN)-B stated R29's lorazepam was originally ordered in April 2018, and she continued to use the as-needed lorazepam when looking at the Medication Administration Records (MAR). RN-B stated their had been no follow-up to CP's identified concerns with R29's lorazepam therapy despite several months of it being recommended. RN-B added, "We're not following through," and it was important to make sure these identified irregularities were acted upon timely to make sure the resident is kept safe.

During interview on 7/27/18, at 2:17 p.m. the interim director of nursing (DON) stated there had been a "lack of follow through" with making sure the pharmacy recommendations were addressed and it was "not appropriate." DON explained this should have occurred as it was "what's best for the resident."

During telephone interview on 7/27/18, at 2:32 p.m. CP stated the facility should be communicating with the physician to ensure the identified irregularities are addressed timely. CP expressed some "better communication" was needed, and their systems to ensure the reports are addressed "need to be worked on."

LACK OF DOCUMENTED RATIONALE:

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21530	Continued From page 75 R29's Order Summary Report signed 7/19/18, identified R29 had current physician orders for dual doses of Tylenol (an anti-inflammatory; which can cause liver damage in high doses). These orders directed: 1) "Tylenol Extra Strength Tablet 500 mg ... Give 2 tablet orally as needed for pain tid [three times a day," and, 2) "Tylenol Tablet 325 mg ... Give 325 mg orally as needed for Pain/Fever May give 650 mg [2 tabs] every 4 - 6 hours as needed for pain/fever. Not to exceed a total daily dose of 4 gm [grams] in 24 hours." R29's Consultant Pharmacist's Medication Review dated 3/16/18, identified the consulting pharmacist (CP) identified an irregularity with R29's dual Tylenol orders and listed a, "Suggested Course of Action" which directed, "Please consider discontinuing one of the [as needed] orders." A section labeled, "Follow-Up or Action Taken," instructed the physician to circle if they accepted or rejected the recommendation. This was circled as "Rejected" and signed by the physician. This was dated 5/17/18, by the health unit coordinator (HUC). The report lacked any explanation or dictation by the physician as to why this recommendation was rejected despite having potential to expose R29 to potentially high doses of Tylenol. Further, the bottom of the report identified a statement, "*(1) Per regulatory guidelines, a brief explanation of why the recommendation is rejected is required." R29's medical record was reviewed and lacked any other documentation or dictation from R29's physician regarding the dual Tylenol orders, despite being identified by the consulting	21530		

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21530	Continued From page 76 pharmacist as a potential irregularity in March 2018. When interviewed on 7/27/18, at 10:28 a.m. RN-B stated she reviewed R29's medical record and was unable to locate any documentation to demonstrate or support why the physician rejected CP's recommendation to discontinue one of the as-needed Tylenol orders. RN-B stated the facility was not "following through" and staff needed education. During interview on 7/27/18, at 2:17 p.m. the DON stated the lack of rationale was a result of a "lack of follow through" and staff should have faxed it back to the physician asking for the rationale. A facility policy on pharmacy recommendations was requested, however, none was received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could education staff regarding the monitoring and follow up of pharmacist's drug regimen review recommendations. The DON or designee could perform periodic chart audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
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	21540		9/10/18

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21540	Continued From page 77 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: Based on observation, interview and document review, the facility failed to ensure a physician's orders were followed and obtain daily weights to monitor diuretic medication use for 1 of 1 resident (R44) reviewed for unnecessary medication. Findings include: R44's admission Minimum Data Set (MDS) dated 4/27/18, included diagnoses of congestive heart failure, hypertension and renal insufficiency. The MDS also indicated R44 was cognitively intact. R44's current physician's orders dated 6/17/18, were reviewed and directed to obtain daily weight and to notify the doctor wight increases 3 lbs (pounds) in 24 hours. R44's orders also included two diuretic medications for congestive heart failure and high blood pressure: Bumetanide	21540	Corrected.	

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tablet 2 mg (milligrams) orally two times a day; and Spironolactone tablet 50 mg by mouth once a day.

During observation on 7/25/18, at 3:00 p.m., R44 was seated in her wheel chair, in her room. R44 presented a calm demeanor, and exhibited no sign of pain or distress. R44 had two bandages on her lower extremities, one on each leg, and there was no observed swelling or edema of the lower legs or ankles.

During interview on 7/25/18 at 3:11 p.m., R44 talked about her stay in the nursing home and her medications, including how often she got medication, and that she had to frequently get blood work. R44 stated they are supposed to weigh me everyday, "but they don't."

R44's weights from 6/1/18 to 7/26/18 were reviewed. The electronic medical record identified R44's weights were not obtained or documented per the MD order on the following dates: 6/1/18, 6/5/18, 6/7/18, 6/8/18, 6/15/18, 6/16/18, 6/17/18, 6/18/18, 6/28/18, 6/30/18, 7/1/18, 7/2/18, 7/6/18, 7/7/18, 7/10/18, 7/11/18, 7/14/18, 7/20/18, and 7/22/18 for a total of 19 times out of 56 opportunities. During July 2018, R44's documented weights have ranged from 190 lbs (pounds) to 193 lbs.

During interview on 7/26/18 at 8:03 a.m., licensed practical nurse (LPN)-D stated R44's received medication to control blood pressure. LPN-D stated they monitored R44's blood pressure by checking for any swelling or edema in her legs, checking blood pressures, following the fluid restrictions, "and we also do a daily weight." LPN-D stated if R44's weight was 3 pounds or more over from the previous weight, the doctor

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21540	Continued From page 79 was to be notified. LPN-D stated R44 had not recently had any serious weight gains. During interview on 7/26/18, at 3:39 p.m. registered nurse (RN)-A stated R44 was on a diuretic medication, and had current order for daily weights. RN-A stated R44 had symptoms of fluid overload and shortness of breath, and at one point in the hospital had 18 pounds of fluid removed. RN-A stated R44's monitoring included checking for edema, lungs, respiration rates and also included daily weights. RN-A stated it is the responsibility for the floor nurse and charge to make sure it is completed, and "I can't explain why" the weights are missing. When interviewed on 7/27/18, at 2:07 p.m. the interim director of nursing (DON) stated is a resident had doctor-ordered daily weights, she expected "they be completed daily." A policy regarding clinical monitoring of weights and vital signs was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIMEFRAME FOR CORRECTION: Twenty-one (21) days.	21540		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance	21695		9/10/18

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21695	Continued From page 80 Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain carpet in a clean, sanitary manner in 1 of 1 hallways observed to have visibly stained carpeting. This had potential to affect 2 of 2 residents (R36, R24) who voiced concerns with the carpeting and 35 additional residents identified to use the area on a routine basis. In addition, the facility failed to ensure a freezer door in the main kitchen was in working condition to prevent condensation and ice build up in the freezer to safely store food for 1 of 1 walk-in freezers reviewed. This had the potential to affect all 56 residents, visitors and staff who consumed food stored and subsequently served from this freezer. Findings include: DIRTY CARPET: R36's 14-day Minimum Data Set (MDS) dated 6/20/18, identified R36 had intact cognition. When interviewed on 7/24/18, at 2:27 p.m. R36 stated he would like to see some of the carpeting in the building replaced as it was unsightly. R36 expressed it made someone feel better if the furnishing and carpet were nice looking. R24's annual MDS dated 4/21/18, identified R24	21695	Corrected.	

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had intact cognition. During interview on 7/24/18, at 2:28 p.m. R24 stated the building needed new carpeting as it was so stained and soiled. R24 added, "Please get clean carpet in here."

On 7/27/18, at 1:19 p.m. the hallway outside the main dining room and chapel was observed. The floor was carpeted with a light gray center and dark maroon edging. The light gray area of the carpet had numerous, various sized dark brown colored stains which were present up and down the entire hallway. There were several tiles of the applied carpet which the perimeter of the individual tile(s) had visible edging of a dark black border. Further, several areas of the carpeting had visibly smashed substance(s) present on them which were dark black in color and sticky when touched with the bare hand.

A facility provided Service Order List printed 7/27/18, identified 35 residents who routinely used the hallway when going to meals and/or chapel services.

On 7/27/18, at 1:22 p.m. housekeeper (HK)-A observed the carpeting in the hallway with the surveyor and stated it had been in the same condition for approximately "three or four years." HK-A added the facility did shampoo it regularly and was "working on replacing this carpet" to her knowledge.

When interviewed on 7/27/18, at 1:24 p.m. the environmental services director (ESD) stated the maintenance team had been working on various repairs since taking over the building a few months prior. ESD explained the prior maintenance crews were not cleaning the carpets correctly, so moisture wasn't being wicked away properly which caused the edges of the carpet

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tiles to discolor and curl. ESD expressed their had been discussion on improving or replacing the carpet(s) in the nursing home, however, it had been "all talk" so far with no formal plans put into place. Further, ESD stated a tasking machine, like one used at some of their other managed sites, would help improve the carpet appearance.

A facility policy on carpet repair and/or cleaning schedules was requested, however, none was provided.

FREEZER DOOR IN DISREPAIR:

On 7/23/18, at 7:02 a.m. a brief tour of the facility kitchen was completed, and the walk in cooler/freezer combination unit was inspected. When the cooler door was opened, hanging plastic strips (in place to help maintain temperature) were pushed to the side and tucked behind serving carts. The freezer had its own entry door, inside the cooler. On the floor, in front of the freezer door, there was wet area, extending about 8" (inches) from the door, and as wide as the cooler, about 7' (feet). The ceiling in the cooler above the freezer door was dripping with condensation. The freezer door had ice/frost built up across its bottom, extending up from the floor to a height of approximately 4 inches in height and the ice build up was approximately 1" inch at the thickest point. Inside the freezer, hanging plastic strips had approximately 1/2" of frost build up on them, extending about 18" downward; and snowflake-like chunks fell off the strips when disturbed. The inside freezer door frame was encased with frost build up, some areas approximately 5" thick, and a pile of frost crystal was observed on the floor just inside the door.

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Expandable foam was in place around the door frame, some of which protruded from the frame and, in one section, forced the door approximately 1" away from the wall. An electrical box inside the freezer was labeled "caution" and was encased in frost build up. Various frozen meats and other foods were packaged on the shelving to the left and right of the door. On one upper shelf a bag of cubed chicken dated 7/22/18, had chunks of ice and ice crystals in the bag. On another top shelf, two pork tenderloin packages had ice chunks (about 2" by 4" in size) on each package.

During interview on 7/23/18, at 7:25 a.m. dining assistant (DA)-A stated it was "typical" for the ice/frost build up in the freezer, as well as the water on the floor and the humidity dripping from the ceiling. DA-A did not know how long this had been a problem.

On 7/25/18, at 6:39 p.m., the cooler/freezer unit was reviewed with the corporate dietician (CD) and culinary service staff (CSS)-A. Condensation was present and water dripped from the ceiling inside the cooler. The frost/ice build up on the outside of the freezer door had been removed. However, the frost/ice build up remained inside the door, the door frame and on the hanging plastic strips. The package of diced chicken was gone, but the packages of pork tenderloin with the ice chunks were still present and stored in the freezer.

When interviewed during the tour, the CD stated the frost on the outside of the door had been removed, as well as the package of chicken. The CD stated maintenance had the freezer door on a cleaning schedule, and was aware of the deficiency cited for the issue during the last

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21695	Continued From page 84 survey. At 6:45 p.m. the environmental service director (ESD) joined the conversation and talked about the interventions in place to deal with the freezer door. The ESD stated he created a log to track when they came in to check the freezer function and also came into the cooler every other week "to knock the ice down." The ESD stated they updated the exhaust system in the past three months to help keep the moisture down. The ESD stated he was unaware when the expandable foam had been placed to try and seal the door. The ESD stated although he was aware of the condition of the freezer door, there were no formalized plans to correct it. During interview on 7/27/18, at 3:31 p.m. the administrator stated the freezer had a faulty seal, and a vendor had been contacted who would coordinate installation of a new freezer door to correct the problem. A facility policy regarding maintenance of refrigerators and freezers was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of maintenance or designee could repair and/or replace soiled carpeting; or review and update carpet cleaning schedules to ensure they are maintained in a clean, sightly manner. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any	21730		9/10/18

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21730	Continued From page 85 condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement effective and timely pest control measures to reduce and/or eliminate flies in the facility. This had potential to affect all 56 residents living in the facility. Findings include: During observation on 7/23/18, at 7:48 a.m. during breakfast R13 was shooing flies away from his plate while eating. An adjacent resident, R6 had four flies on his plate. Dietary Aid (DA)-B offered to replace his meal, but R6 stated he was done. R13 stated it was like this "morning, noon, and night." DA-B stated there were flies present in the dining room during the summer months, and added staff were told they can't use flyswatters in the dining areas. On 7/23/18, at 8:11 a.m. in the south hallway day room area, a fly was buzzing about R33's face and upper body, and she crinkled her nose and blinked her eyes while the fly was near her face. During a subsequent observation at 8:16 a.m., R33 was in her room, seated in her wheelchair, and flies were present, circling her head and upper body. R33 closed her eyes and moaned out when flies landed on her. The flies circled her head, then rested on her nose, forehead and in the corner of her lips, which triggered R33 to	21730	Corrected.	

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21730	Continued From page 86 awaken and make more moaning noises. On 7/23/18, at 8:18 a.m. R11 was lying on her bed with her eyes closed, glasses on, and two flies were circling resident's upper body and landing on her face. Flies were on R11's forehead, corner of her lips, and crease between lips. R11 furrowed her brow and pursed her lips as flies landed. During a subsequent observation at 11:26 a.m., flies continued to be present in the room and continued to fly about and land on R11's forehead and mouth. On 7/23/18, at 11:18 a.m. with flies buzzing about her room, R8 stated "'he flies are terrible this fall." As she watched a fly, R8 stated "They're pesty!" While in the dining room on 7/23/18, at 12:33 p.m. R 20 stated the flies have been "Bad all summer". As a fly landed on her face and shooed it away, R20 stated "I hate flies!" and "I wish they could get them before we eat. " R20 expressed she wished the facility would get someone in to manage flies. R20 stated the aides and nurses were aware of flies, but nothing has changed. On 7/24/18, at 2:36 p.m. R100 was in his room with a purple fly swatter in his hand. R100 stated he has been using it to kill flies in the facility. During interview on 7/24/18, at 2:47 p.m. the environmental services director (ESD) was questioned about a portable, hand-held sprayer seen next to the business office. The ESD stated the pest control company was here looking at the fly situation and the exterior of the main doors were sprayed today. Additionally, the ESD said a fly light was installed in the dining room the afternoon of 7/23/18. The ESD stated there had	21730		

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been a fly light installed in the dish room several months ago. The cardboard collector strip that was installed 24 hours 24 hours ago in the dining room was reviewed, and the ESD counted six-full size flies and several gnats. The fly light collector cardboard was also checked in the dish room and stated there were at least 15 flies counted. The ESD stated he was aware only of flies near the entryways, but was not aware of any flies in the dining or resident rooms. The ESD stated there was no formalized system in place for pest control and insect management. The ESD stated he placed 10-12 flyswatters out in the building to help with fly management. During interview a fly was observed buzzing around surveyor's computer.

During interview on 7/26/18, at 10:32 a.m. nursing assistant (NA)-G stated she was aware of the flies and everyone was provided a fly swatter. NA-G stated flies had been present all summer, but had become increasingly "persistent" and "bad" the past couple of weeks. NA-G said residents had complained and stated she even spent helping the residents to kill them. NA-G stated maintenance was aware of the problem them "as far as I know" but was unsure of what was being done. NA-G stated big problem was mainly the flies in the residents' rooms.

When interviewed on 7/26/18, at 11:30 p.m. licensed practical nurse (LPN)-C stated the flies are "terrible in general" but became worse when it was really hot. LPN-C stated the staff had fly swatters to use.

During interview on 7/27/18, at 3:31 p.m. the administrator stated they have been having problems with flies in the building and had recently had the pest control agency out to treat.

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21730	Continued From page 88 A facility policy regarding pest control was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could educate staff regarding the importance of maintaining an effective pest control program. The DON or designee, could coordinate with maintenance and housekeeping staff to conduct periodic audits of areas residents frequent to ensure pests is controlled to ensure a clean, functional and homelike environment is maintained to the extent possible. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21730		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable	21800		9/10/18

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21800	Continued From page 89 accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to timely provide the required liability and appeal rights notices prior to discharge from Medicare A services for 2 of 3 residents (R39, R42) reviewed for beneficiary protection notification. Findings include: R39's last day of covered Medicare Part A Skilled Services was 6/20/18, as identified on the form CMS-20052 (SNF [skilled nursing facility] Beneficiary Protection Notification Review). R39's Notice of Medicare Non-Coverage (form CMS-10123) was signed by the authorized representative on 6/20/18, with a notation the authorized representative was called on 6/19/18. R39's Skilled Nursing Facility Advance Beneficiary Notice (SNFABN, form CMS-10055) lacked a signature and date from the resident or authorized representative.	21800	Corrected.	

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21800	Continued From page 90 R39's census record identified R39 currently resided in the facility. R42's last day of covered Medicare Part A Skilled Services was 7/5/18, as identified on the form CMS-2005 R42's census record identified R42 was discharged from the facility on 7/6/18. R42's medical record lacked evidence R42 or a family representative was provided the Notice of Medicare Non-Coverage (form CMS-10123) prior to R42's discharge. When interviewed 7/24/18, at 10:49 a.m. the regional director of operations (RDO) stated R39's authorized representative should have been contacted on 6/18/18, regarding the end of skilled coverage on 6/20/18. Further the CMS-100055 should have been signed by the authorized representative. The RDO stated R42's CMS- 10123 could not be located, and should have been signed by the resident on 7/3/18, at the latest. A former staff person was previously responsible for providing resident the required Medicare notices and the facility was working on a new procedure. A policy regarding beneficiary protection notices was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding ensuring Medicare liability notice(s) are provided timely and in accordance with applicable rules and regulations; then audit to ensure compliance.	21800		

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21800	Continued From page 91 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21800		
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 ensure dignity was maintained when bandages were conspicuously dated in large font for 2 of 2 residents (R47and R44) who needed face and leg dressings. Findings include: R47's admission Minimum Data Set (MDS) dated 6/22/18, indicated she was cognitively intact. On 7/23/18, at 7:09 a.m. R47 was observed being assisted into the dining room for breakfast. R47 had a skin colored bandage about 4" (inches) by 4 inches on her right cheek, which had a large date of 7/21/18 written in thick black marker which covered approximately 50% of the dressing and was easily readable across the width of the dining room (greater than 20 feet in distance). During observation on 7/25/18 at 8:00 p.m. R47 was seated in her recliner in her room. R47 had a 4" by 4" dressing was in place on her right	21805	Corrected.	9/10/18

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cheek, dated, A skin-colored bandage, about 4" (inches) by 4" was intact on R47's face and was dated "7/25/18" in black ink which covered about half the dressing. Licensed practical nurse (LPN)-A entered R47's room with evening medications.

During interview on 7/25/18, at 8:00 p.m. LPN-A stated she thought the writing on R47's face bandage "should be less in size" and that the date could be written small and on the lower edge of the dressing. LPN-A stated the size of the date attracted more attention to the dressing.

R47's treatment administration record dated July 2018, directed to change foam border dressing to right cheek every 2-3 days and as needed.

During interview on 7/27/18, at 2:02 p.m. the interim director of nursing (DON) stated she heard about "the date" on R47's dressing on her face. The DON stated "that would be a dignity issue."

R44's admission Minimum Data Set (MDS) dated 4/27/18, indicated R44 was cognitively intact.

During observation on 7/25/18, at 5:04 p.m. R44 was seated in her wheel chair, dressed in shorts. On both R44's right and left shins was a tan-colored bandage, each approximately 4" (inches) by 4". The date "7/24" was written in a large, black font on each of the bandages, which was easily visible and seen by anyone nearby.

R44's treatment administration record for July 2018, directed to apply border foam dressings to abrasions to shins and cleanse with wound cleanser and apply new dressing every 3 days.

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21805	Continued From page 93 During interview on 7/25/18, at 5:04 p.m. R44 stated the bandages would come off when she got her bath tonight and added "I don't like the dates on my bandages." R44 stated she did not know why they had to do that and her knees "would look better without the dates on them." R44 stated staff put the dates on them the day they change the bandages and added "they could just document the dates in my chart instead. In a subsequent interview on 7/26/18, at 10:39 a.m. R44 stated it was not the fact the date was written on the bandage, but that it was written "so big" that was upsetting. R44 stated she'd be "ok" with the dates on her bandages if the date was written smaller. During interview on 7/26/18, at 12:22 p.m. the director of nursing (DON) stated the date was written on the bandages so we know when it was changed last. The DON then stated she did not know why the nurses were writing the date so big and if it's that big, "that concerns me for dignity" and the dates should be written smaller. A policy regarding dignity was requested, but none was provide. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and update polices pertaining to medical bandaging, then educate staff on applying and labeling dressings and bandages in a manner to maintain the dignity of the resident. The DON could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		

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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:	21830		9/10/18

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21830	Continued From page 95 (1) examining the personal effects of the 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	21830		

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21830	Continued From page 96 designated emergency contact. A county social 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 observation, interview and document review the facilty failed to ensure residents were given a choice of their meal preference for 1 of 1 resident (R9) who spoke Spanish as her primary language. Additionally, the facility failed to ensure residents were allowed the choice of bathing frequency for 1 of 1 (R24) reviewed for choices. Findings include: R9's quarterly Minimum Data Set (MDS) dated 7/26/18, identified R9 had diagnosis of dementia and depression with severe cognitive impairment. During interview on 07/25/18 5:44 p.m. with dietary aide (DA)-C and DA-D; DA-C stated at each noon meal residents are given a ticket for the next day's meal to choose from. They can either choose the main entree or alternate and circle or mark what they want for these meals. If they are unable to do this, then we or the nursing assistants (NA) help the resident complete this. They have a few staff in the dietary department that speak Spanish and they help R9 choose food item on the menu as well. If these dietary staff are not working, they point to the food item word, and ask her "see" yes in Spanish or "no" and she tells	21830	Corrected.	

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us, even though R9 is unable to read. DA-D stated nothing during this conversation.

R9 was observed on 07/25/18 06:01 p.m. at the table, and had just finished with her evening meal. She ate 1/2 of sandwich, 100% pear sauce and sips of her soup. There was a pile of filled out menu choices, and R9 menu preference was highlighted with a green marker. DA-B stated she helped R9 fill the menu out, and used Google translator on an iPad. DA-B found the iPad and proceeded to show how she used the translator with R9. DA-B placed the word potato in the translator, and showed it to R9, and the translator stated "papas". R9 just looked at DA-B, and started to laugh looking puzzled and confused. DA-B repeated the word "papas", and R9 again seemed puzzled, and said "No." The 7/26/18 menu had potatoes highlighted as R9's menu choice.

In an interview on 7/25/18 at 6:14 p.m. with R20, who was R9's table mate stated, I have been a table mate of R9's for two years now. I have never seen the facility use that computer or whatever that thing was. R9 never eats her bread or only a few bites, she always leaves it on her plate. They don't ask her what she wants for the next day, if they gave her a choice of food, she probably would eat more but they don't.

On 7/26/18 11:55 a.m. a.m. registered nurse (RN)-A stated she has never seen dietary staff use the Google Translator app on the iPad for R9.

Bathing Preferences:

R24's annual MDS completed on 4/21/18, identified R24 had intact cognition and was able to communicate her needs and wishes. R24 was

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noted to have a catheter in place to manage urinary functions and was incontinent of bowel. R24 received extensive assist to complete tasks of daily living (ADL's) which included personal grooming and mobility. R24's diagnoses included diabetes, arthritis, a neurological disorder which affected mobility, generalized muscle weakness, and morbid obesity.

R24's plan of care revised on 7/6/18, identified R24 received assistance to complete her ADL's related to R24's level of strength. The care plan indicated R24 required extensive assistance of turn and reposition in bed every two hours and as necessary. The care plan also directed staff to provide with assistance to complete personal hygiene, including skin cleansing, and completion incontinence cares every two hours. The care plan was revised on 7/10/18, to identify an alteration in skin integrity related to an abrasion on her right buttocks. The care plan identified staff were to monitor skin integrity during cares, with documentation weekly.

On 7/23/18, at 8:46 a.m. R24 stated she would like to receive a bath more frequently than a weekly for both comfort and health concerns. R24 stated she requested a second bath from the staff on the floor, though was unable to recall whom, and was told they were unable to do anything. R24 also stated she had asked a nurse when receiving meds, again was unable to recall whom, and they stated they didn't schedule baths, however, did not relay the request or direct her to the most correct person to assist.

During observation of morning cares on 7/26/18, at 7:21 a.m. viewed skin condition with registered nurse (RN)-B and viewed cleansing of calmoseptine (a zinc based barrier cream) off of

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skin prior to
measurements. RN-B stated the cream was removed with gentle cleansing, however, was most effective removed with a whirlpool bath. R24 stated she only received one bath weekly but felt she would benefit from more frequent whirlpool baths for comfort and cleanliness.

During interview on 7/26/18, at approximately 7:30 a.m. RN-B stated she was unaware of R24's request for additional baths and would follow up with this. RN-B stated staff should have relayed any requests for additional baths to either the floor nurse or to RN-B. RN-B stated she would add a second bath for R24.

On 7/27/18, at 11:49, R24 stated at this time she was unaware of any change in her bath schedule and to her knowledge was scheduled on Tuesdays. R24 had not received any additional assistance to bathe this week.

On 7/27/18, at 1:18 p.m. the director of nursing (DON) stated, upon review of the bath schedule that had been updated on 7/27/18 at 5:42 a.m. and R24 had been scheduled for a second bath and would have received a whirlpool this morning.

A facility policy was requested for resident choices and was not received.

SUGGESTED METHOD FOR CORRECTION:
The director of nursing (DON) or designee could develop and implement policies and procedures related to choices of bathing and menu choices and train staff on these policies. The quality assessment and assurance committee could perform random audits to ensure compliance.

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21830	Continued From page 100 TIME PERIOD FOR CORRECTION: Twenty (21) days.	21830		
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure allegations of abuse were identified timely; failed to ensure appropriate action was taken to immediately provide resident protection; and failed to thoroughly investigate the allegations for 1 of 1 residents (R44) who felt shamed and was unable to sleep following an incident with R36 who offered her money and touched her breasts when she did not want him to. In addition, the facility staff were unaware or knew why R44 was placed on 15 minute checks, and there were subsequent encounters between R44 and the perpetrator (R36). Furthermore, there was conflicting	21850	Corrected.	9/10/18

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information in the investigation. These allegations of abuse, and lack of facility investigation and protections resulted in an immediate jeopardy (IJ) situation for R44.

The IJ began on 7/14/18, at an unknown time, when R44 approached and self-reported to the facility staff that on that day R36 offered her money in exchange for touching her breasts, and she did not want him to. The facility failed to identify potential sexual abuse and immediately protect R44, or thoroughly investigate the circumstances to determine if actual abuse occurred. The facility administrator and director of nursing (DON) were notified on 7/26/18, at 5:00 p.m. of the IJ. The IJ was removed 7/27/18, at 3:50 p.m. however, non-compliance remained at the lower scope and severity of a D which is isolated with potential for more than minimal harm.

Findings include:

R44 was sexually abused when she was coerced into taking money in exchange for R36 (male resident) to touch and fondle her breasts. Once the incident occurred, R36 continued to enter R44's room, without her consent which caused R44 to become fearful, scared and afraid, resulting in making it difficult for her to sleep. Although R44 told the facility multiple times she did not want R36 in her room, the facility did not provide adequate protection for R44, after the sexual abuse occurred.

R44's OBRA Admission Minimum Data Set (MDS) dated 4/27/18, indicated she was cognitively intact, required extensive assistance of one staff with activities of daily living (ADLs), and used a wheelchair for mobility. R44's care

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plan dated 5/02/18, indicated diagnoses including depression, adjustment disorder, dementia, and mild cognitive impairment. R44's Care Area Assessment (CAA) dated 4/27/18, indicated she required assistance with ADLs, was alert and oriented, had deficits in judgement, and was impulsive.

R36's OBRA Admission MDS dated 6/13/18, indicated he was cognitively intact, and required extensive assistance of two staff with ADLs. R36's Initial Comprehensive Care Plan dated 6/6/18, indicated he was alert and orientated, and had weakness. The care plan further indicated R36 had no behaviors. R36's CAA dated 6/13/18, indicted he was alert and orientated, and received therapy due to a fall at his previous living situation. The CAA indicated R36 planned to return home.

A Facility Investigation Report submitted to the Office Of Facility Health Complaints (OHFC) on 7/14/18, at 11:29 p.m. indicated R44 reported to the nurse on duty that another resident (R36) had gone into her (R44's) room, closed the door, and offered her money to allow him to touch her breast, which he did. The report indicated the victim (R44) asked him to stop, which he did, then he left the room. The report further indicated R44 did not want R36 to touch her breast. An Internal investigation was initiated. A Facility Investigation Five Day Report dated 7/23/18, at 6:19 p.m. indicated R44's care plan was reviewed, and the administrator met with R44 to discuss the incident. The investigation report originally indicated R44 did not accept the cash, she did not want R36 to touch her. After a conversation, R44 informed the facility she did in fact accept the $10 in cash. R44 stated she and the alleged perpetrator (R36) went into her room,

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and closed the door behind them. R44 said someone knocked on the door, and asked them to keep the door open. R36 then suggested they go down to his room. R44 stated she followed R36 to his room, they closed the door, and she allowed him to touch her breast. R44 stated she did not want another encounter with R36, and wished for him to stay away from her. The facility indicated on the report R44 was placed on 15 minute checks, R36 was informed of R44's wishes to not meet with him again, and R36 agreed.

During interview on 7/25/18, at 1:54 p.m. the administrator stated there was an incident between R44 and R36 that occurred on Saturday, 7/14/18, and she was unsure what time it occurred. The administrator stated she was informed by the director of nursing (DON) about the incident, then reported the incident to the State Agency (SA) later that evening. The administrator stated she completed the investigation, and R44 informed her that R36 offered her $10 in exchange to touch her breasts. Further, the administrator stated R44 was placed on 15 minute checks, then the facility decided to also place R36 on 15 minute checks. The administrator stated she talked with R36, and he did admit to offering R44 money so he could touch her breasts. The administrator stated she informed R36 that R44 did not want this to happen again.

Although the incident between R44 and R36 occurred on 7/14/18, there was no mention of the incident in the medical record for either resident.

Review of R44's progress notes identified the following:

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21850	Continued From page 104 On 7/16/18, at 10:40 a.m. R36 was observed in R44's room, and then left her room. R36 went outside shortly after R44 went outside, and stated, "I'm going outside but I'm using a different door." Staff redirected R44 to go outside in the courtyard near the south nursing station, so she could be supervised by staff. R44 stated she would knock on the door if R36 came around her. On 7/25/18, at 12:30 p.m. at 11:00 a.m. that morning, R36 was observed by a staff member coming out of R44's room. R36 stated, "[R44's] busy." Staff asked R44 about R36 coming into her room, and R44 stated she was going to see her case worker and was leaving, and so R36 left her room. R44 also stated R36 did not touch her, or do anything else to her. As a result of the 7/14/18, incident, the facility initiated monitoring of R44 and R36. Both residents had a Resident Check List (RCL), and staff were directed to monitor and document R44's and R36's where abouts every 15 minutes for their safety. R44's 15 minute monitoring began on 7/18/18, at 10:30 a.m. (four days after the incident occurred). Review of R44's 15 minute checks did not identify that R36 was in R44's room on 7/25/18, at 11:00 a.m. but identified R44 was in the lobby during that time. R36's RCL indicated monitoring began on 7/18/18, at 10:00 a.m. and was stopped on 7/23/18, at 11:15 a.m. Although the facility implemented RCL for each resident, they were not consistently monitored to ensure resident safety. During an initial interview on 7/23/18, at 8:45 a.m.	21850		

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R44 stated she was in her room in her electric wheelchair when R36 came into her room and gave her $10. R44 stated she asked R36, "What for, I don't want your money." R36 told R44 he wanted her to show him her breasts, and he wanted to touch her breasts. R44 stated she tried giving R36 his $10 back, but he continued to touch her breasts. R44 stated she did not want him to do this. R44 stated she had reported this to a nurse who was working the night the incident occurred. R44 also stated the DON and the administrator were both aware of the incident, and they were both aware she wanted R36 to stay away from her.

During an additional interview with R44 on 7/25/18, at 5:00 p.m. R44 stated R36 came into her room, gave her $10.00, and stated he wanted to play with her breasts and she told him "no." R44 then stated R36 pulled on her shirt and rubbed her breast and continued to pull her shirt down and rubbed on her breast which made her feel "awful". She identified R36 came into her room again after the incident. R44 state, "[R36] just comes into my room without knocking on my door." R44 further stated she did not want R36 to come into her room.

During a subsequent interview on 7/26/18, at 10:07 a.m. regarding the incident on 7/14/18, R44 stated, "When he touched me, I wanted to hit him but I cant. After the incident I wanted to get away for awhile, go to town or do something. I cried after it happened. I didn't want to say anything but I knew I should, so I told the nurse and had her shut the door when I told her." R44 stated it made her feel "dirty" and feel "sexually harassed and abused." R44 added, "When he came into my room the last time [7/25/18] I was upset. My door was open and I told him he needed to move,

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which he did, and backed his wheel chair out of the room, and I closed the door in my room." R44 further indicated it made her feel humiliated and upset. While R44 was describing the incident her eyes became watery, and teary. R44 stated she was worried the incident would happen again, adding she had not been sleeping, and she was afraid. R44 reiterated she did not want R36 in her room.

During interview 7/26/18, at 10:53 a.m. R36 stated he had been at the facility for several months, and the administrator talked with him shortly after the incident occurred on 7/14/18. R36 stated the administrator told him that R44 did not want him to come around her. After the administrator talked to him, R36 said he told the administrator, "OK." R36 did not disclose he went back into R44's room on 7/16/18, and 7/25/18, after he was told by the administrator not to go into her room, and he had agreed to say out of her room.

Review of the facility 15 minute monitoring for R44 and R36 identified the following:

During interview on 7/25/18, at 7:00 p.m. nursing assistant (NA)-H stated she worked with R44, and was not aware of any incident between R44 and another resident. NA-H further stated she was not aware R44 was on 15 minute checks or monitoring. In addition, NA-H checked her nursing assistant care sheet, and verified there was no direction for monitoring for R44.

During interview on 7/25/18, at 7:21 p.m. NA-I stated she has worked with R44, and R44 had no behaviors. NA-I stated she was supposed to keep an eye on R44 every 15 or 30 minutes. NA-I further stated she was aware of an incident

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between R44 and another resident last week, but was not certain of what happened.

During interview on 7/25/18, at 7:27 p.m. resident companion (RC)-A stated she was not aware of any behaviors with R36, or if there was any special monitoring for R44 or R36.

During interview on 7/25/18, at 7:51 p.m. NA-J stated she was not aware of any monitoring for R44, and she was not aware of any incidents between R44 and any other resident.

During interview on 7/26/18, at 10:58 a.m. NA-F stated R36 was on 15 minute checks, and was not aware of the reason. NA-F stated nurses and nursing assistants are to document the 15 minute checks on a sheet at the nurses station.

During interview on 7/26/18, at 11:05 a.m. NA-G stated R36 was on 15 minute checks because of another resident, but was not sure which resident. NA-G stated she documents R36's location every 15 minutes.

During interview on 7/26/18, at 11:09 a.m. licensed social worker (LSW)-A stated on Monday, 7/23/18, she had heard bits and pieces of the incident between R44 and R36, but she was not involved. LSW-A further stated situations like this were discussed at morning meeting, but she had to step out during the meeting. LSW-A further stated she had not talked to R44 after the incident with R36, because LSW-A was on leave on 7/24/18.

During interview on 7/26/18, at 11:54 a.m. with the administrator and DON, the DON stated she was informed of the incident on 7/14/18, around 9:00 p.m. when RN-D informed her what

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occurred. The DON stated she informed the administrator of the incident, and the administrator filed a report to the SA. After she was informed of the incident, the DON stated she placed R44 on 15 minute checks, and a few days later decided R36 also needed to be placed on 15 minute checks. The DON stated when she was told about the incident she told the two nurses who were working that day, licensed practical nurse (LPN)-D, and RN-B to keep an eye on both residents. The DON stated she did not tell the nurse who was caring for R36 what actually occurred, because she wanted to keep R44's incident confidential. In addition, although the administrator stated R44 was placed on 15 minute checks, and a few days later R36 was also placed on 15 minute checks, the reports indicated both were placed on 15 minute checks on 7/18/18.

During interview on 7/26/18, at 2:20 p.m. LPN-B stated they were doing 15 minute checks on R44 to monitor her location. LPN-B further stated she found out about the incident through a nursing report, and indicated R44 had issues with another resident, but was not sure why.

During interview on 7/26/18, at 2:35 p.m. R44 stated the incident happened so fast he (R36) gave her the money and she took it and said, "What is this for?" R36 told her he wanted to touch her breasts, and she told him, "I don't want your money" but he would not take the money back. R44 indicated he touched her breasts through her shirt, and then removed her shirt strap, put his hand down her shirt and touched her breast. R44 stated she felt assaulted, and felt R36 tried to bribe her with the money. After the first incident occurred, R44 stated R36 told her again that he would give her another $10 to

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touch her breasts. R44 stated she told R36, "I don't want you to do this!" R44 stated she did not go to his room, and confirmed the incident occurred in her room.

During interview on 7/26/18, at 4:36 p.m. RN-B stated the facility stopped R36's 15 minute checks after their morning meeting on Monday, 7/23/18. RN-B stated no additional incidents occurred, and she was directed by the administrator to stop the 15 minute checks, even though R36 was in R44's room after the 15 minute checks were stopped.

During observation on 7/27/18, from 9:40 a.m. until 2:20 p.m. R44 was not observed to have contact with R36.

The facility's Abuse Prevention/Vulnerable Adult Plan undated, indicated abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain or mental aguish. The policy identified sexual abuse as non-consensual sexual contact of any type with a resident. The policy also directed to that immediately, upon learning of an incident, staff will take necessary steps to protect residents from possible subsequent incidents of misconduct or injury while the matter is being investigated. The facility policy directed to immediately report to the Minnesota Adult Reporting Center (MAARC). The facility policy also directed the facility's investigation team would review all incident reports regarding residents.

The IJ that began on 7/14/18, was removed on 7/27/18, at 3:50 p.m. when the facility conducted an investigation of the incident, and additional training was provided to the DON and

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21850	Continued From page 110 administrator, R44 had been placed on 15 minute checks, R36 was placed on 1:1 for close monitoring to ensure other residents were free from abuse, all verbal residents were interviewed to ensure they were free from abuse, neglect, mistreatment and exploitation, the facility Abuse Prevention/Vulnerable Adult Plan was reviewed, all staff were educated on the Abuse Prevention/Vulnerable Adult Plan, staff were educated on the reason for resident monitoring, and the administrator and DON were educated on the Abuse Prevention/Vulnerable Adult Plan specific to reporting resident abuse and sexual abuse. On 7/27/18, from 3:15 p.m. to 3:45 p.m. front line staff and nurses were interviewed, and stated they were educated on the Abuse Prevention/Vulnerable Adult policy, and the rational for R44 and R36's increased monitoring. The noncompliance remained at the lower scope and severity level of D which is isolated with potential for more than minimal harm. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could review, and /or revise policies and procedures to ensure all staff are aware of what constitutes abuse, and implementation a plan to prevent resident to resident abuse. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21850		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults	21980		9/10/18

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21980	Continued From page 111 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 agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision	21980		

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21980	Continued From page 112 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 observation, interview and document review the facility failed to ensure allegations of abuse were reported immediately, no later than 2 hour to the State Agency (SA) for 1 of 1 residents (R44) who alleged sexual abuse. Findings include: R44's admission Minnimum Data Set (MDS) dated 4/27/18, indicated she was cognitively intact, needed extensive assist of one with activities of daily living and used a wheelchair for mobility. R44's care plan dated 5/02/18, indicated she diagnoses including depression, adjustment disorder, dementia and mild cognitive impairment. R44's Care Area Assessment (CAA) dated 4/27/18, indicated she required assistance with activities of daily living (ADLs), was alert and oriented with deficits in judgement and being impulsive. R36's admission MDS dated 06/13/18, indicated he was cognitively intact and needed extensive assist of two with ADLs. R36's Initial Comprehensive Care Plan indicated he had weakness and was alert and orientated. The care plan further indicated R36 had no behaviors. R36's CAA dated 6/13/18, indicted he was alert	21980	Corrected.	

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and orientated and received therapy due to a fall at his previous living situation. The CAA indicated R36 planned to return back home.

During interview 7/25/18, at 1:54 p.m. the facility administrator stated an incident occurred on Saturday 7/14/18, between R44 and R36 but was not sure what time it occurred. The administrator then stated she was informed by the DON and she reported the incident to the state agency later that night due to an allegation of sexual abuse.

A facility report submitted to the Office Of Facility Health Complaints (OHFC) 7/14/18, at 23:29 (11:29 p.m.)indicated R44 reported to nurse on duty another resident had gone into her room, closed the door, and offered cash to allow him to touch her breast, which he did. Resident asked him to stop, which he did, then he left. The report further indicated resdient does not want him to touch her breast. An Internal investigation was initiated. A Facility Investigation Report dated 7/23/18, at 18:19:07 indicated R44's care plan was reviewed and administrator met with victim to discuss the incident. The investigation report originally indicated resident stated she did not accept the cash and did not want him to touch her. After a conversation, she informed the facility she did in fact accept the $10.00 in cash. The victim said she and the alleged perpetrator went into her room, closing the door behind them. The victim said someone knocked on the door and asked them to keep it open. The alleged perpetrator then suggested they go down to his room. Victim stated that she followed the perpetrator down to his room, they closed the door and she allowed him to touch her breast. Victim did state that she did not want another encounter and wished for him to stay away. The facility indicated on the report the victim was put

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21980	Continued From page 114 on 15 minute checks and the perpetrator was informed of the victim's wishes to not meet again and he agreed. During interview on 7/26/18, at 11:54 a.m. with the DON and adminstrator present, the DON stated she was informed of the incident on 7/14/18, around 9:00 p.m. by a floor nurse, after the DON returned to the facility from the town parade. The DON informed the administrator of the incident and stated the administrator filed the report. Although the facility was made aware of the incident that occurred on 7/14/18, at unknown time. The facility became aware of the allegation at 9:00 p.m. and the incident was not reported to the state agency until 11:29 p.m., two half hours later. The facility Abuse Prevention/Vulnerable Adult Plan dated 7/18, indicated Abuse is the willfully infliction of injury, unreasonable confinement, intimidation, or punishment with resulting in physical harm, pain or mental aguish. The policy defined sexual abuse at non-consensual sexual contact of any type with a resident. The policy directed: Suspected Abuse shall be reported to OHFC (state agency) online reporting process not later than 2 hours after forming the suspicion of abuse. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review abuse or maltreatment policies and procedures with staff regarding timely reporting of allegations, then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		

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