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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QI7H

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00324

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245542**

2.STATE VENDOR OR MEDICAID NO.
(L2) **477605100**

3. NAME AND ADDRESS OF FACILITY
(L3) **LITTLEFORK MEDICAL CENTER**
(L4) **912 MAIN STREET**
(L5) **LITTLEFORK, MN** (L6) **56653**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2016**

6. DATE OF SURVEY **09/19/2018** (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 **49** (L18)
13.Total Certified Beds **49** (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
	49			
(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 :
Debra Vincent HFE - NE II 09/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/24/2018 (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
04/24/1991
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered September 24, 2018

CMS Certification Number (CCN): 245542

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

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:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

Electronically delivered
September 24, 2018

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

RE: Project Number H5542012, H5542013 and S5542027

Dear Administrator:

On August 20, 2018, we informed you that the following enforcement remedies would remian in effect:

- State Monitoring effective June 20, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective August 24, 2018.

In addition this Department recommended to the CMS Region V office the following remedy:

- Civil Money Penalty.

This was based on the deficiencies cited by this Department for a standard survey completed on August 3, 2018 by the Department of Health and on July 31, 2018 by the department of Public Safety. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 19, 2018, the Minnesota Department of Health and Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an standard, completed on August 3, 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 standard survey, completed on August 3, 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:

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

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

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 24, 2018

Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

Re: Reinspection Results - Project Number S5542027

Dear Administrator:

On September 19, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 3, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QI7H

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(L4) **912 MAIN STREET**
(L5) **LITTLEFORK, MN** (L6) **56653**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2016**

6. DATE OF SURVEY **08/03/2018** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

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04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

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From (a) :
To (b) :

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	49			
(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 :
Rebecca Haberle, HFE - NE II 08/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/21/2018 (L20)

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

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X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

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3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/24/1991
(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 delivered
August 20, 2018

Mr. Geoffrey Ryan, Administrator
Littlefork Medical Center
912 Main Street
Littlefork, MN 56653

RE: Project Number H5542012, H5542013 and S5542027

Dear Mr. Ryan:

On June 5, 2018, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints 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.

On June 15, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective June 20, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective August 24, 2018.

This was based on the deficiencies cited by this Department for an abbreviated extended survey completed on June 5, 2018 that included an investigation of complaint number H5542012 and H5542013. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On August 3, 2018, the Minnesota Department of Health and on July 31, 2018 the Department of Public Safety completed a standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on June 5, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on June 5, 2018.

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the standard survey findings:

- The Category 1 remedy of state monitoring effective June 20, 2018, will remain in effect.

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective August 24, 2018 will remain in effect. (42 CFR 488.417 (b))

As we notified you in our letter of June 15, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 24, 2018.

Based on the findings of this visit, we are recommending to the CMS Region V Office the following additional remedy:

- Civil money penalty

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

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

DEPARTMENT CONTACT

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Include electronic acknowledgement signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 5, 2018 (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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@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
	245542	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

(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 for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on July 30 -August 3, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On July 30 through August 3, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 567 SS=D	Protection/Management of Personal Funds CFR(s): 483.10(f)(10(i)(ii) §483.10(f)(10) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds. (i) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with	F 567		9/10/18

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

Electronically Signed | 08/29/2018

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
	245542	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

(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 567	Continued From page 1 the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid: The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 identified resident (R20) who had personal funds deposited with the facility, had access to the personal funds after hours and on weekends. This practice had the potential to affect all other residents in the facility with personal funds accounts.	F 567	F567 Protection/Management of Personal Funds 1) R20 will have access to her personal funds at all times including after hours and weekends. R20 was educated by the Activity Director on the Resident Trust Fund Policy and process for accessing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

(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 567	Continued From page 2 Findings include: R20's quarterly MDS dated 6/19/18, indicated R20 was alert and oriented with diagnoses including anxiety, depression. On 7/30/18, at 5:54 p.m. R20 stated she was unable to obtain money from her personal funds account on the weekends. R20 stated the facility had a cash box, however, it only contained twenty dollars and was unavailable when the activity staff were not in the facility. On 8/2/18, at 4:40 p.m. the director of nurses (DON) stated all of the resident had their own money and they would have access to the monies when they wanted it. -At 4:43 p.m. licensed practical nurse (LPN)- B stated if a resident requested to have monies from their personal trust account, a registered nurse (RN) would have to be notified as she did not have access to any monies for the residents. LPN-B stated she had been at the facility for four months and had not been given access to petty cash if a resident wanted money. -At 4:44 p.m. RN-B stated the resident petty cash was kept in the activity department and the nursing staff did not have access to it. -At 4:45 P.M. the DON stated the activity director had the petty cash. -At 4:48 p.m. the activity director stated the facility practice was for the petty cash to be kept in the activity closet. The petty cash available was twenty dollars and the residents were able to	F 567	her funds after hours and on weekends on 8/14/18. 2) All residents have the potential to be impacted by this practice. 3) All residents will have petty cash available to them at all times including after hours and weekends. 4) DON and/or designee will educate all staff on the Resident Trust Fund Policy. A petty cash box containing $50 will be available at all hours for any resident who requests personal funds. This cash box will be available for all Licensed Nurses to access when a resident requests funds. It will be located in the Medication Room and all staff will be educated regarding the availability of it. 5) Activity Director and/or designee will educate all current residents on the Resident Trust Fund Policy and how to access his/her personal funds after hours and weekends. Social Services Director will educate all new admissions going forward to the Resident Trust Fund Policy and how to access his/her personal funds after hours and weekends. 6) Activity Director and/or designee will perform random audits interviewing residents whether they understand how and where to access their personal funds after hours and on weekends beginning on 9/3/18, 4x/week x 4 weeks, then 2x/week x 4 weeks then once weekly thereafter. 7) Activity Director and/or designee will perform random audits interviewing staff on process of accessing residents personal funds and location of cash box beginning on 9/3/18, 4x/week x 4 weeks,	

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	245542	A. BUILDING _____ B. WING _____	08/03/2018

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F 567	Continued From page 3 obtain the money anytime an activity staff member was in the facility. The activity director stated if a resident wanted more than twenty dollars, they would have to make arrangements with the business office Monday - Friday during business office hours. The activity director stated the petty cash had been kept in the nurses station in the past, however, due to missing monies, the cash had been placed with the activity staff. The activity director confirmed the residents did not have access to their money, and only twenty dollars was available for them to receive. On 8/3/18, at 8:20 a.m. the business office manager confirmed R20 had an personal trust account and the petty cash available after hours was twenty dollars. A policy related to resident trust accounts was requested and none was provided.	F 567	then 2x/week x 4 weeks then once weekly thereafter. 8) Audit results will be brought to the QAPI committee quarterly for review and further recommendation. Completion date is 9/10/18	
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the	F 583		9/10/18

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F 583	Continued From page 4 right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal privacy for 1 of 10 residents (R42) observed to receive personal cares. In addition, the facility failed to discuss personal medical information in a private area for 1 of 1 resident (R9) who was questioned about medical decisions in a public area. Findings include: R42's quarterly Minnimum Data Set (MDS) dated 7/16/18, indicated R42 had severe cognitive impairment and diagnoses including Alzheimer's dementia and depression. The MDS indicated R42 required total assistance with bed mobility, transfers and all other aspects of activities of daily living (ADL).	F 583	F583 Personal Privacy/Confidentiality of Records 1) R42 will be provided privacy during all personal cares. 2) NA-H will be educated on need to ensure curtains are closed prior to performing personal cares in order to provide for privacy by the DON and/or designee. 3) All residents have the potential to be impacted by this practice. 4) DON and/or designee will provide education to all nursing staff regarding our Dignity Policy, including reminders to provide privacy to all residents when providing personal cares and to report any mechanical issues with the privacy curtains to maintenance.	

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F 583	Continued From page 5 R42's care plan dated 2/6/18, indicated R42 was unable to express her needs verbally due to advanced dementia. The plan directed the staff to anticipate R42's needs. On 7/30/18, at 7:14 p.m. nursing assistant (NA)-H was observed to assist R42 to her room. Once in her room, R42's roommate (R25) was noted to be resting in her bed. NA-H pulled the privacy curtain between the two residents. NA-H proceeded to assist R42 with undressing her upper body and providing assistance with washing hands, face and upper body, and donning a hospital gown. -At 7:24 p.m. NA-H connected R42 to a full body ceiling lift which was positioned on a track system with a rail noted on both sides of the room, next to the outside walls. A crossbar track system was connected to the side tracks and contained a mechanical device which connected to R42's sling which allowed R42 to be lifted from the chair. However, when the crossbar track was moved, the privacy curtain was pushed back. NA-H lifted R42 from the chair and positioned her above the bed, pulled down her pants and opened her incontinence brief while the privacy curtain was pulled back. R25 was positioned on her side and was in full view of R42 during the transfer. -At 7:26 p.m. NA-H disconnected the ceiling lift and returned it to its resting position against the north wall and closed the privacy curtain. On 8/1/18 at 12:10 p.m. the director of nursing (DON) stated she would expect the staff to provide privacy during all personal cares. The	F 583	5) Environmental Service Director and/or designee will complete an audit of all privacy curtains to ensure all are functioning and do not interfere with ceiling lifts. Then random audits will be conducted 4x/week x 4 weeks beginning 9/3/18, then 2x/week x 4 weeks then once weekly thereafter. 6) DON and/or designee will perform random personal care audits to ensure privacy 4x/week x 4 weeks beginning 9/3/18, then 2x/week x 4 weeks then once weekly thereafter. 7) R9□s confidential information will be discussed in a private location. Social Services Director followed up with R9 on 8/2/18 to ensure she did not have any distress r/t the confidential information being discussed in a common area. 8) LPN-B will be educated on the Dignity Policy and ensuring that discussions regarding medications and treatments are completed in a private location by the DON and/or designee. 9) All residents have the potential to be impacted by this practice. 10) DON and/or designee will educate all nursing staff on the Dignity Policy and to ensure all discussions regarding confidential information will be done in a private location. 11) DON and/or designee will perform random audits to ensure confidential information is completed in a private location 4x/week x 4 weeks beginning 9/3/18, then 2x/week x 4 weeks then once weekly thereafter. 12) Audit results will be brought to the	

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F 583	Continued From page 6 DON stated she was unaware of any concerns related to the privacy curtains being opened by the ceiling lift track system. On 8/1/18, at 1:20 p.m. the DON observed R42's room and confirmed the ceiling track system interfered with the ability to keep the privacy curtain closed. The DON stated the track system had been in place for many years, but a concern related to privacy had not been brought forward in the past. The DON stated alternative methods for providing privacy while in the ceiling lift would have to be explored. R9's MDS dated 5/22/18, indicated R9 had severely impaired decision making skills, had difficulty hearing in some environments, usually understood others, and usually made herself understood. On 7/30/18, at 7:15 p.m. R9 was observed in the lobby area, seated in a wheelchair with her eyes closed and head down. R32 and R43 were in close proximity of R9. Licensed practical nurse (LPN)-B approached R9, aroused her by saying her name, and proceeded to ask R9 if it was alright if she was charged $3.99 a month for vitamins the doctor had ordered for her because her insurance would not cover the charge. R30 did not respond so LPN-B slightly rephrased the question and in an elevated tone in which R30 again did not respond. LPN-B stated to R30, "will you answer me please." R9 stated something that was not audible, in which LPN-B stated, "come on, I know you can hear me" and continued to ask the question again, "the nurse practitioner wants you to take the multivitamin, the pharmacy said your insurance does not cover it, is it ok if we charge you the amount of $3.99?"	F 583	QAPI committee quarterly for review and further recommendation. 13) Completion date is 9/10/18.	

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F 583	Continued From page 7 On 8/2/18, at 10:10 a.m. the licensed social worker (LSW) confirmed the aforementioned conversation should have occurred in a private area and without any distractions. -At 1:56 p.m. LPN-D stated a conversation pertaining to medical treatments should have been conducted in the resident's room, in private. -At 2:05 p.m. registered nurse (RN)-A stated discussions pertaining to a resident's medications and/or treatments should be conducted in the resident's room because the information is private and privileged. On 8/03/18, at 11:39 a.m. the DON stated discussions pertaining to a resident's medication and treatments should be discussed in private, with the individual resident. The facility's Dignity policy dated 10/23/17, indicated each resident shall be treated with respect and dignity at all times and the staff would maintain an environment in which confidential information was protected. The policy also indicated that all staff were to promote, maintain, and protect resident privacy including bodily privacy during assistance with personal cares and treatment procedures.	F 583		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument.	F 636		9/10/18

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F 636	Continued From page 8 A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i)	F 636		

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F 636	Continued From page 9 through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure Minnimum Data Set (MDS) assessments were accurately completed in accordance to the Resident Assessment Instrument (RAI) manual for 1 of 1 resident (R20) identified with a deep tissue injury which was not identified on the MDS. Findings include: R20's quarterly MDS dated 6/19/18, indicated R20 was alert and oriented with diagnoses including anxiety, depression, and neurogenic bladder. R20 required extensive assistance for all activities of daily living and utilized an indwelling Foley catheter. The MDS indicated R20 was at risk for the development of pressure ulcers, however, R20 had no skin concerns at the time of the assessment. R20's Rainy Lake Medical Center Hospital admission history and physical dated 6/13/18, indicated R20 was admitted to the hospital with a "deep tissue injury to her buttocks and coccyx areas; no current stageable ulcer."	F 636	F636 Comprehensive Assessment and Timing 1) R20 will have a comprehensive skin assessment completed and RCA completed for any skin alterations noted by the Facility Wound Nurse. 2) All residents have the potential to be impacted by this practice. 3) DON and/or designee will educate all nursing staff who are completing comprehensive skin assessments, including skin assessments upon readmission, on the process of doing thorough skin assessments, including the removal of any dressings to assess skin underneath (unless ordered otherwise by the MD) and reviewing all medical records upon the resident□s admission/readmission to identify any previous skin alterations. MDS Coordinator will be re-educated on the importance of reviewing medical records, nursing documentation and coordinating with other nursing staff in gathering information about resident prior to completing Section M of the MDS for	

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F 636	Continued From page 10 R20's clinical record indicated R20 returned from the hospital on 6/18/18. R20's Admission/Readmission Skin Assessment dated 6/18/18, indicated R20 had an Allevyn dressing on her coccyx. However, the documentation did not identify what was under the dressing or any abnormal skin concerns on R20's buttocks. On 8/1/18, at 3:35 p.m. the director or nursing (DON) reviewed the R20's 6/18/18, hospital discharge summary and stated she was unaware R20 had been identified with a deep tissue injury while at the hospital. The DON stated the registered nurse (RN) charge nurse should have identified the concern when R20 returned from the hospital. The DON confirmed the 6/18/18, skin assessment completed upon R20's return from the hospital did not identify what type of skin injury was under the Allevyn dressing, and no further documentation regarding the deep tissue injury was noted in the record. On 8/2/18, at 3:45 p.m. RN-A/MDS coordinator confirmed she had completed R20's quarterly MDS on 6/19/18. RN-A stated she reviewed the clinical record and completed the assessment, however, had not observed R20's buttocks at the time of the assessment and was unaware the emergency room physician had identified a deep tissue injury on 6/13/18. RN-A confirmed the MDS was inaccurately coded. According to the RAI Manual 3.0 dated 10/2011, the RN completing section M (skin concerns) was to visibly inspect the residents skin. The manual directed the staff to:	F 636	accuracy according to the RAI manual. 4) Section M of all comprehensive MDS□s assessments, going back 3 months, will be reassessed by the MDS Coordinator to ensure accuracy of coding. 5) DON and/or designee will complete random audits of comprehensive skin assessments to ensure that they are completed accurately and include removal of any dressings to assess skin underneath (unless ordered otherwise by the MD) and that Section M is coded accurately according to the RAI manual on all comprehensive MDS assessments. These assessments will be audited beginning 9/3/18 4x/week x 4 weeks, then 2x/week x 4 weeks and then once weekly thereafter. 6) Audit results will be brought to the QAPI committee quarterly for review and further recommendation. 7) Completion date is 9/10/18.	

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F 636	Continued From page 11 1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurses ' notes, and pressure ulcer risk assessments. 2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident. 3. Examine the resident and determine whether any ulcers, scars, or non-removable dressings/devices are present. Assess key areas for pressure ulcer development (e.g., sacrum, coccyx, trochanters, ischial tuberosities, and heels). Also assess bony prominences (e.g. elbows and ankles) and skin that is under braces or subjected to pressure (e.g., ears from oxygen tubing).	F 636		
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. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		9/10/18

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F 655	Continued From page 12 (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 ensure a copy or summary of the comprehensive care plan which identified individualized care needs was given to the resident and/or representative within 21 days of admission for 1 of 1 resident (R14) recently admitted to the facility. Findings include: R14's 48 Hour Baseline Care Plan dated 5/24/18, indicated R15 required assistance of one to ambulate, wore glasses, was incontinent of bowel and bladder, required total assistance for bathing,	F 655	F655 Baseline Care Plan 1) R14□s representative will be provided a copy of the comprehensive care plan on 8/29/18 by the Social Services Director. 2) All new resident admissions have the potential to be impacted by this practice. 3) Social Services Director and/or designee will educate all staff involved with care planning and care conferences on the Care Planning Policy, including providing the resident or their representative with a copy of their comprehensive care plan within 21 days of admission.	

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F 655	Continued From page 13 required assistance with dressing and bed mobility and the use of a back brace. R14's admission Minnimum Data Set (MDS) dated 6/5/18, indicated R14 displayed cognitive impairment and had diagnoses including lung cancer with metastasis, a history of alcohol abuse and was receiving hospice care. The assessment indicated R14 required extensive assistance for bed mobility and personal cares. R14 had been bed bound since the admission to the facility. On 7/31/18, at 10:00 a.m. R14 stated she could not recall receiving a copy of her comprehensive care plan or a summary of how the facility would be caring for her. Review of R14's clincial record lacked evidence which indicated R14 or a family member/representative had been given a copy of the initial care plan or summary. On 8/3/18, at 9:15 a.m. the director of nurses (DON) stated she was unaware if the facility gave a copy of the care plan or a summary to R14 or her representative. -At 9:26 a.m. registered nurse (RN)-B stated the facilty completed a checklist type 48 hour care plan which was kept in the resident's hard copy record. RN-B stated newly admitted resident's care needs would be discussed at the initial care conference, however, the facility did not provide a copy of the care plan to the residents' or their representatives. -At 10:08 a.m. RN-A stated the facility did not have a process in place to provide a summary of	F 655	4) Social Services Director and/or designee will provide all current new resident admissions or their representative, with a copy of their comprehensive care plan going back 3 months and going forward. 5) Social Services Director and/or designee will audit all new admissions to ensure that the resident or his/her representative is given a copy of his/her comprehensive care plan within 21 days of admission. These audits beginning 9/3/18 will occur 3x/week x 4 weeks, then 2x/week x 4 weeks and then once weekly thereafter. 6) Audit results will be brought to the QAPI committee quarterly for review and further recommendation. 7) Completion date is 9/10/18	

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F 655	Continued From page 14 the care plan or a copy of the care plan to newly admitted residents rather, a copy would be given only if the family requested one. RN-A stated he was not aware of the regulation which required the comprehensive care plan or a summary of the plan to be given to the resident or representative. -At 10:18 a.m. the licensed social worker (LSW) confirmed the facility did not routinely give a summary of care or the care plan to the residents or families. The Care Planning policy dated 10/23/18, read: "A summary or copy of the baseline 48 hour care plan will be given to the resident and /or representative."	F 655		
F 656 SS=D	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 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	F 656		9/10/18

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F 656	Continued From page 15 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 facilty failed to develop a comprehensive care plan for 1 of 1 resident (R25) who was receiving chemotherapy. Findings include: R25's admission Minimum Data Set (MDS) dated 3/30/18, indicated R25 had mild cognitive impairment and diagnoses including diabetes mellitus (DM), breast cancer, dementia and hypertension. The MDS indicated R25 required extensive assistance with all activities of daily living. R25's Physican Orders dated 7/9/18, and again	F 656	F656 Develop/Implement Comprehensive Care Plan 1) R25 is no longer receiving chemotherapy. 2) All residents receiving chemotherapy or on isolation precautions have the potential to be impacted by this practice. 3) DON and/or designee will educate all licensed nurses involved in the care planning process to ensure all residents who are receiving special treatments like chemotherapy or on isolation precautions have these areas care planned with directions on providing cares for staff. 4) IPCO Nurse will review and update, as needed, all residents care plans and	

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F 656	Continued From page 16 on 7/30/18, indicated R25 was to be in contact (used to prevent the spread of infections, diseases, or germs that are spread by touching the resident or items in the resident's room) precautions for 48 hours following chemotherapy treatment. R25's orders did not indicate what type of chemotherapy R25 had received. R25's care plan dated 3/27/18, did not address chemotherapy or any type of interventions to implement following chemotherapy. On 7/30/18, at 6:18 p.m. isolation supplies were observed hanging off of R25's room door. The supplies consisted of face masks and gloves. Licensed practical nurse (LPN)-F stated R25 had received chemotherapy earlier on 7/30/18, and was required to be in contact precautions for 48 hours following the treatment. LPN-F stated the staff were to apply gowns, gloves and masks when providing personal cares for R25 in case they were to come in contact with any type of bodily fluids. LPN-F stated the staff were to wear gloves only if assisting R25 with simple tasks which would not involve contact with bodily fluids. -At 7:30 p.m. LPN-F was heard to say "oh I don't feel well." LPN-F stated she had a cold. LPN-F proceeded to donne gloves, enter R25's room and handed R25 a souffle cup of bedtime pills. LPN-F was did not apply a mask prior to entering R25's room. R25's Progress Note (PN) dated 7/30/18, at 5:42 a.m. indicated R25 was to have nothing by mouth as she would be receiving chemotherapy in the morning. The PNs did not identify when R25 had left for chemotherapy or when she returned.	F 656	NAR care sheets who are currently receiving special treatments like chemotherapy or on isolation precautions. 5) DON and/or designee will educate all staff on the Care Planning Policy and following the residents plan of care for all residents receiving special treatments like chemotherapy or on isolation precautions. 6) DON and/or designee will educate all staff on the Transmission Based Precautions Policy and use of proper PPE for residents on isolation. 7) DON and/or designee will audit all current residents care plans and NAR care sheets, that are receiving special treatments like chemotherapy or on isolation precautions, to ensure accuracy and proper PPE utilized per care plan. Random audits will then be done beginning 9/3/18 4x/week x 4 weeks, then 2x/week x 4 weeks, then once weekly thereafter. 8) Audit results will be brought to the QAPI committee quarterly for review and further recommendation. 9) Completion date will be 9/10/18.	

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F 656	Continued From page 17	F 656		

R25's clinical record also lacked documentation related to R25's physical condition upon returning from chemotherapy.

Review of R25's clinical record lacked direction related to the specification for contact precautions for R25 following chemotherapy.

On 7/31/18, at 8:55 a.m. R25 was observed seated in the dining room, eating breakfast.
-At 10:27 a.m. NA-A stated the staff were to wear gowns, gloves and mask while caring for R25 and to her knowledge none of the staff in the facility were pregnant.
-At 10:30 a.m. NA-H stated the staff were to wear gowns, gloves and masks while caring for R25.
-At 10:40 a.m. LPN-E confirmed R25 had received chemotherapy on 7/30/18. LPN-E stated she did not know what type of chemotherapy R25 had received as family members accompanied R25 to the appointment. LPN-E stated staff members who had colds should wear masks or not provide cares for R25 for 48 hours following chemotherapy.

-At 11:08 a.m. the Rainy Lake Medical Center (RLMC) Infusion registered nurse (RN) was interviewed via telephone. RLMC- RN indicated R25 had received a dose of Kadcyla and for 48 hours following the medication, the staff were to initiate contact isolation which meant wearing gowns, gloves and masks when providing personal cares to R25. R25 was to have a designated bathroom and staff members with colds should wear a mask or have alternative staff care for R25 following the therapy.

On 8/1/18, at 9:11 a.m. nursing assistant (NA)-A was observed to donne a regular hospital gown

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F 656	Continued From page 18 (no isolation gowns were noted in the isolation supply on the door), and a mask and enter R25's room. Shortly thereafter, NA-A exited R25's room wearing the gown and mask, returned to the room with gloves and proceeded to assist R25 to the restroom for morning cares. -At 9:21 a.m. RN-B called NA-A out of the room and provided NA-A with a yellow isolation gown. NA-A removed the hospital gown and donned the isolation gown and returned to complete R25's personal cares. Upon completion of the cares, NA-A removed the isolation garb, and washed her hands. On 8/2/18, at 2:30 p.m. RN-B confirmed R25 was on contact isolation for 48 hours following chemotherapy treatments. RN-B reviewed R25's care plan and confirmed the plan did not address R25's chemotherapy or isolation precautions. RN-B stated R25 was scheduled for an additional dose of chemotherapy, however, the facility did not have a date for the next appointment. The Care Planning policy dated 10/23/17, indicated the facility would develop a comprehensive care plan for the services that were to be furnished at the facilty to attain or maintain the residents highest practicable physical, mental and psychosocial well-being.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by:	F 677		9/10/18

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F 677	Continued From page 19 Based on observation, interview and document review, the facility failed to ensure timely assistance with incontinence cares was provided for 1 of 2 residents (R20) who was dependent upon staff for cares. Findings include: R42's quarterly Minnimum Data Set (MDS) dated 7/16/18, indicated R42 had severe cognitive impairment and diagnoses including Alzheimer's dementia and depression. The MDS indicated R42 required total assistance with bed mobility, transfers and all other aspects of activities of daily living (ADL). In addtion, the MDS indicated R42 was completely incontinent of bowel and bladder. R42's Bladder Care Area Assessment (CAA) dated 4/14/18, indicated R42 was completely incontinent of bowel and bladder and was to receive assistance with incontinent cares every four hours. R42's Care Plan dated 8/16/16, indicated R42 was completely incontinent of bowel and bladder and directed the staff to check and change the incontinent brief upon rising and every 2-3 hours during the day. On 7/30/18, at 4:50 p.m. R42 was observed seated in a wheelchair, in the dining room receiving total staff assistance to eat. -At 6:00 p.m. R42 was wheeled from the dining room to a lounge area and positioned in front of the television. R42 remained in front of the television until 7:06 p.m. -At 7:06 p.m. nursing assistant (NA)-H wheeled R42 to her room then exited the room. -At 7:14 p.m. NA-H returned to the room and	F 677	F677 ADL Care Provided for Dependent Residents 1) NA-A and NA-H will be educated on the importance of following resident□s care plans regarding toileting schedules by the DON and/or designee. 2) R42 will have a comprehensive bowel and bladder assessment completed by the MDS Coordinator, including review of a 3 day bowel and bladder diary, indicating type of incontinence and developing a toileting plan that is individualized based on comprehensive review of bowel and bladder status. 3) R42 bowel and bladder care plan and NAR care sheets will be reviewed and updated to reflect accurate toileting schedule based off the comprehensive bowel and bladder assessment by the MDS Coordinator. 4) All residents who are dependent for toileting needs have the potential to be impacted by this practice. 5) DON and/or designee will educate all nursing staff on the Urinary Incontinence Program Policy and the importance of following all resident□s individualized care plans regarding toileting schedules. 6) DON and/or designee will educate all licensed nurses who complete comprehensive bowel and bladder assessments to ensure assessments include review of a 3 day bowel and bladder diary, indicate type of incontinence and that the toileting plan is individualized based on comprehensive review of the residents bowel and bladder status. 7) DON and/or designee will audit all	

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F 677	Continued From page 20 began assisting R42 with evening care. -At 7:24 p.m. R42 was transferred from the wheelchair to the bed via a ceiling lift. -At 7:27 p.m. R42 was noted to have been incontinent of urine.. -At 7:33 p.m. NA-H stated R42 had been assisted out of bed around 3:30 p.m. -At 8:02 p.m. NA-H reviewed the nursing assistant assignment sheet and verified R42 had last been assisted with incontinence cares at 3:15 p.m. a total of 4 hours and 10 minutes earlier. On 8/1/18, at 7:23 a.m. R42 was observed in the television lounge area, seated in a wheelchair. -At 8:31 a.m. R42 was wheeled into the dining room. NA-B began feeding R42 the meal. -At 8:42 a.m. R42 was wheeled into the television lounge. -At 9:35 a.m. R42 was transferred from the wheelchair to the bed via a ceiling full body lift. -At 9:38 a.m. R42 was observed to have been incontinent of urine. -At 9:45 a.m. NA-A stated R42 had last been assisted out of bed/incontinence care at 6:30 a.m., a total of 3 hours earlier. Upon further review of R42's clinical record, a comprehensive bladder assessment which would include documentation related to a three day bladder diary, identification of the type of incontinence and rational for the current check and change schedule of every four hours per the CAA, and two to three hours according to the care plan could not be located. -At 11:55 a.m. the director of nursing (DON) stated R42 was completely incontinent of bowel and bladder and verified R42's clinical record lacked a summary of a bladder diary and the type	F 677	current residents, who are dependent on staff for toileting needs, care plans and NAR care sheets to ensure toileting plans are accurate based off of the comprehensive bowel and bladder assessment. 8) All residents with urinary incontinence who are dependent on staff for toileting needs will be reassessed to ensure the appropriate interventions have been developed/implemented in conjunction with their next MDS by the MDS Coordinator. 9) DON and/or designee will perform random audits to ensure resident toileting care plans are being followed beginning 9/3/18 at the frequency of 4x/week x 4 weeks, then 2x/week x 4 weeks then once weekly thereafter. 10) DON and/or designee will perform random audits to ensure resident toileting care plans and NAR care sheets match the bowel and bladder assessment toileting plan beginning 9/3/18 at the frequency of 4x/week x 4 weeks, then 2x/week x 4 weeks then once weekly thereafter. 11) Audit results will be brought to the QAPI committee quarterly for review and further recommendation. 12) Completion date will be 9/10/18.	

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F 677	Continued From page 21 of incontinence had not been determined. The DON confirmed R42's CAA and care plan did not match and a 2-3 hour check and change schedule was not based from data gathered to create a comprehensive bladder assessment. The DON confirmed R42 did not have an individualized bladder assessment. In addition, the DON confirmed R42 had not received assistance for 4 hours and 10 minutes on 7/30/18, and for 3 hours on 8/1/18. A policy related to comprehensive bladder assessments and toileting cares was requested and none was provided.	F 677		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the skin condition and implement interventions in order to prevent the worsening of moisture related skin damage for 1 of 1 resident (R43) who had a history of moisture related skin damage. This failure resulted in actual harm for R43 due to the observed worsening of the skin condition. In addition, the facility failed to identify, assess and monitor a right arm wound for 1 of 1 resident (R7)	F 684	F684 (G) Quality of Care 1) DON and/or designee will implement the following for R43 affected by this: An updated Tissue Tolerance lying and sitting will be completed by the Facility Wound Nurse. A new Braden Scale will be completed by the Facility Wound Nurse. A new head to toe assessment and RCA assessment will be completed by the	9/10/18

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F 684	Continued From page 22 observed to have a wound without staff identifying its presence. In addition, the facility failed to ensure diabetic residents received the highest practicable care for 3 of 3 diabetic residents (R6, R7, R25) who had abnormal blood sugar results without evidence of action taken by the staff related to the treatment or physician notification of the abnormal readings. Lastly, the facility failed to ensure proper wheelchair positioning for 1 of 3 residents (R18) observed to utilize a rock and go wheelchair. Findings include: R43's facility Face Sheet dated 8/1/18, indicated R43's diagnoses included cerebrovascular disease, peripheral vascular disease and history of a stroke. R43's quarterly MDS dated 7/17/18, indicated R43 had moderate cognitive impairment and required extensive assistance from two plus staff for transfers and bed mobility, and was dependent on two plus staff for toileting, and had an indwelling urinary catheter. The MDS also indicated R43 had diagnosis of hemiplegia (paralysis on one side of the body) and a seizure disorder. The MDS further indicated R43 was at risk for pressure ulcers, had moisture associated skin damage (MASD) and required a pressure-reducing cushion in the chair and bed, a turn/repositioning program, application of non-surgical dressings, and application of ointments/medications. However, R43's clinical record lacked evidence of an assessment of the MASD for the MDS dated 7/17/18. R43's most recent Braden Scale for Predicting Pressure Sore Risk assessment dated 4/18/18,	F 684	Facility Wound Nurse on and updated in the Skin and Wound Section of the residents medical record. Treatment orders were clarified by the provider on 8/23/18. The provider will assess/review the wound, evaluate treatment and make any treatment changes they see necessary. R43□s care plan and NAR care sheet will be reviewed for appropriate skin interventions to promote wound healing and prevent further skin breakdown based off of the comprehensive assessment by the Facility Wound Nurse. NA-M and NA-N will be re-educated on following the residents repositioning care plans and asking for assistance if needed. 2) All residents with MASD have potential to be impacted by this practice. 3) All current residents with MASD will be reassessed for correct identification of skin alteration and to ensure appropriate treatments and interventions are in place to promote wound healing by the Facility Wound Nurse. 4) The Facility Wound Nurse will complete a new comprehensive skin assessment and review the RCA for all residents with MASD including a Tissue Tolerance Test and Braden Scale. The provider will review any residents with MASD. The resident□s care plan and NAR care sheets will be reviewed and updated to reflect accurate interventions to promote wound healing for all residents with MASD by the Facility Wound Nurse. 5) DON and/or designee will educate the Facility Wound Nurse on the Skin Ulcer Protocol Policy and monitoring and	

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F 684	Continued From page 23 identified R43 was at moderate risk. The tool indicated R43 had moist skin. R43's skin care plan dated 8/15/16, indicated R43 was at risk for skin breakdown related to history of stroke and left sided weakness. History of abrasions to buttocks and scrotum. The care plan directed the following: -A&D ointment to scrotum and buttocks every shift with incontinent care and bathing per standing orders. -alternating air mattress. -Assess skin daily with morning and evening cares and weekly on bath days. Apply Vanicream to dry areas. -Avoid shearing resident's skin during positioning, transferring, and turning. A felty can be used for positioning. -Cotton snap pants during day and nothing at night. -Position scrotum with Interdry under the scrotum at BEDTIME. -Treatments per MD orders. - staff to turn and reposition every 3-4 hours (The bed mobility care plan dated 4/24/17, directed staff to reposition every 3 hours). -Use cleansing cream and Tena dry wipe for peri care. No wipes. -Use pressure reducing gel cushion on wheelchair. R43's nursing assistant care guide dated 7/27/18, conflicted with the care plan and indicated R43 required repositioning every 2-3 hours. R43's last Tissue Tolerance Observation tool (tool used to determine repositioning needs based on ability of skin to withstand pressure) was completed on 1/16/18, was incomplete as it did	F 684	documenting the effectiveness of treatments, updating the MD on wound status when requesting treatment changes, documenting the implementation of contact precautions when initiated, reviewing treatment orders for accuracy weekly with wound rounds, reviewing NAR care sheets and care plans for accuracy weekly with wound rounds, and completing a new comprehensive skin assessment when a wound worsens. 6) DON and/or designee will educate all nursing staff on the Care Planning Policy, Repositioning Policy and following the residents care plan interventions in regards to skin. 7) DON and/or designee will perform random audits of nursing skin assessments 4x/week x 4 weeks starting week of 9/3/18, then 2x a week x 4 weeks, then weekly there after to ensure skin assessments/treatments are appropriate/effective. 8) DON and/or designee will perform random audits of ensuring residents care plan is being followed for skin interventions 4x/week x 4 weeks, starting the week of 9/3/18, then 2x/week x 4 weeks, then weekly there after. 9) DON and/or designee will implement the following for R7 affected by this practice: R7 right arm lesion was evaluated by NP on 8/9/18 and identified them as multiple skin lesions self-inflicted. R7 Skin and Wound was updated to identify the area by the Facility Wound	

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F 684	Continued From page 24 not identify a repositioning schedule when lying. The tool indicated R43 required every two hour repositioning when sitting. The record lacked evidence of an assessment/evaluation of tissue perfusion recovery over bony prominences over time that would reflect the determination R43 required every 3-4 hour repositioning to prevent and or reduce the risk of pressure ulcers/skin impairment. R43's physician orders for skin treatment included: -Barrier cream two times a day in morning and evening: Tena protective Cream 10% zinc oxide (start date 6/19/18) -Interdry two times per day at 8:00 a.m. and 8:00 p.m. place Interdry under scrotum and bring out along the thighs keep on at all times. (start date 4/16/18- end date 7/30/18) -Interdry one time per day during the night. Place at bedtime under scrotum and bring out along the thighs. Keep on all times. (start date 7/30/18) -Allevyn dressing to buttocks change every three days and as needed. (verbal order on 6/4/18) -Duoderm trial to perineum for two weeks. (telephone order 6/11/18) -Antifungal cream per standing orders topically for fungal rash for five days. (telephone order (6/18/18) -Augmentin (antibiotic) 875 milligrams (mg) twice per day for 10 days. (telephone order 6/29/18) -Cipro (antibiotic) 500 mg twice a day by mouth for 7 days. (telephone order 6/29/18) -Bactrim DS (antibiotic) 1 tab twice daily for 10 days for MRSA. (start date 7/12/18) R43's Skin Condition/Wound Progression Notes revealed the following:	F 684	nurse and is monitored on weekly wound rounds. All residents have the potential to be impacted by this practice. DON and/or designee will educate all nursing staff on the Skin Ulcer Protocol Policy and Skin Documentation Policy monitoring skin daily with cares and to notify the licensed nurse if any skin alterations are noted for further assessment of the area and MD notification. Licensed Nurse to assess skin weekly for any skin alterations. DON and/or designee will perform random skin check audits to ensure skin alterations have been identified 4x/week x 4 weeks, starting the week of 9/3/18, then 2x/week x 4 weeks, then weekly there after. 10) DON and/or designee will update R6, R7 and R25 primary physician inquiring if they have specific parameters for notification with BG > or < or if they want to follow the HSO for Diabetic Protocol or any other changes with their diabetes management. Orders will be updated to reflect any changes. Diabetic Care Plans will be reviewed and revised with any updates needed. 11) All residents who are diabetic have potential to be impacted by this practice. 12) Medical Director reviewed and revised the House Standing Orders Diabetic Protocol on 8/29/18. Dietary Manager and/or designee will visit with all diabetic residents and/or their representative with regarding their resident meal choice and will provide	

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F 684	Continued From page 25 -4/16/18, Superficial breakdown related MASD to perineal and gluteal areas. Scrotal areas healed this assessment. No exudate at this time. Irregular border. The tissue blanches, is of equal temperature and slightly darker in color to surrounding tissue, overall area appears dry, scant bloody exudate noted to two areas, no visible wound bed. There continues to be no evidence of internal tissue damage or infection at this assessment. MASD appears to be healing on coccyx region. Continue with 50% A&D ointment and Calamine lotion mixture. Interdry added to scrotal folds at all times. Toileting schedule per tissue tolerance remain effective continue with current treatment. R43's record did not reflect a physician order for the A&D ointment and Calamine mixture. -4/29/18, indicated superficial breakdown related to MASD to perineal and gluteal areas. No exudate and two scab areas that measured 1.0 centimeter(cm) x 1.0 cm in size with irregular border. MASD appears to be healing on coccyx region. No visible wound bed, trial of Duoderm dressing. Continue with the A&D ointment mixture. -5/7/18, superficial breakdown related to MASD to perineal and gluteal folds. No exudate, scabbed areas not visible. A 3.0 cm x 1.0 cm open area is noted to posterior scrotum. No exudate at this time, new Interdry applied. MASD to perineal and gluteal remains intact with no visible exudate. Irregular border. Color is darker red and purple to surrounding tissue. Continues to be no evidence of internal damage or infection. Half of coccyx covered with border Duoderm. A&D ointment mixture continues and Interdry.	F 684	education and update care plan, as needed. DON and/or designee will update all diabetic residents primary MD requesting if they have specific parameters for notification with BG > or < or if they want to follow the HSO for Diabetic Protocol or any other changes with their diabetes management. All residents will have their diabetic orders and care plans updated to reflect any changes. DON and/or designee will provide diabetes education to all licensed nurses regarding our House Standing Orders for Diabetic Protocol, documenting blood glucose results, initiating and documenting interventions provided for low or high blood glucose levels, and initiating and documenting follow-up after interventions provided, including notification of physician based off of ordered parameters or HSO, to ensure blood glucose levels are WNL for that resident. Also, will be educated on ensuring Oral Glucose Gel and IM Glucagon is available, and if used, re-ordered immediately. DON and/or designee will provide diabetes education to all nursing staff including monitoring for s/s of hypo/hyperglycemia and notifying of a licensed nurse immediately if any signs and symptoms are observed. DON and/or designee will identify all Diabetics on the NAR care sheets and all NARs will be educated on how to identify a resident on the NAR care sheets. 13) DON and/or designee will perform random audits of blood glucose readings	

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F 684	Continued From page 26 -5/14/18, MASD to perineal and gluteal remains intact with no visible openings. Small scab is noted to posterior scrotum. Indicated overall all appearance remains dry and color is darker purple in color to surrounding tissue. MASD appears to be healing. Continue with A&D ointment and Interdry. -5/21/18, assessment did not indicate any changes according to the documentation, other than large area of flaking skin to right and left gluteal regions and color remained darker red and purple. -5/29/18, assessment indicated no visible openings and significant reduction in flaking skin. Skin remained discolored and darker red and purple color to surrounding tissue. No change in treatments -6/5/18, assessment indicated a large open area 7.0 cm x 4 cm x 2 mm deep irregular open area on buttocks. Slight bleeding and blanches. Area was cleansed and Allevyn dressing was applied. Intervention changed to resident would be placed in bed for at least two hours between meals an repositioned on his side, with no Chux (absorbent mattress protector). -6/11/18, assessment indicated MASD to perineum and scrotal areas, numerous partial thickness openings, scant serious drainage. Dressing is 75% contained with fecal material. Wound bed is pink with ill defined borders. Peri-wound is raised thickened, and darker in color, and blanches. No signs and symptoms of infection. Indicated the treatment of Allevyn dressing was ineffective barrier from bowel	F 684	to ensure any BG < or > their parameters have documented s/s of hypo/hyperglycemia, interventions, follow-up, including notification of MD beginning 9/3/18 4x/week x 4 weeks, then 2x/week x 4 weeks, then once weekly thereafter. 14) R18 will have an evaluation completed by the Physical Therapist for wheelchair positioning. 15) All residents who utilize a Rock-n-Go wheelchair have potential to be impacted by this practice. 16) DON and/or designee will assess all residents who utilize a Rock-n-Go wheelchair to ensure they are seated properly. If the resident is assessed as not seated properly, then orders will be obtained for PT eval and tx for wheelchair positioning. 17) Adaptive and Positioning Equipment Policy was reviewed and revised by the DON. 18) DON and /or designee will educate all staff on the Adaptive and Positioning Equipment Policy and notification of the licensed nurse if a resident is observed not seated properly in their Rock-n-Go wheelchair. 19) DON and/or designee will perform random audits on residents who utilize Rock-n-Go wheelchairs to ensure proper positioning beginning 9/3/18 4x/week x 4 weeks, then 2x/week x 4 weeks, then once weekly thereafter. 20) All audit results will be brought to the QAPI committee quarterly for review and further recommendation.	

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F 684	Continued From page 27 incontinence and causing additional MASD. Trial Duoderm's to perineum in addition to the barrier ointment. Intervention also included Interdry and turning and repositioning schedule. The assessment lacked assessment of the open wound that was identified on 6/5/18. -6/18/18, assessment indicated changes to the MASD to scrotal and perineum areas. No current openings, skin in scrotal area and inner thighs noted to have an odor, bright red rash with defined border. Indicated Duoderm was contraindicated due to infection of skin. MD consulted with new order for antifungal cream obtained. Other interventions remained the same except for as noted. R43's skin progress note dated 6/25/18, indicated MASD was present on the rectal area. MASD to perineum and scrotal areas, no current openings, yellow/green exudate (drainage) noted to incontinent products. Skin to scrotal area and inner thighs bilaterally noted to have an odor, bright red rash, with defined border present. Contacted provider regarding color of exudate. R43's communication to the physician dated 6/25/18, included antifungal cream to area ineffective. Drainage noted coming from urethral meatus, bright red perineum and scrotum, and afebrile. The note also indicated drainage was bright green on the incontinent garment, concerned infection of pseudomonas type. Communication recommended a culture. R43's physician telephone order dated 6/25/18, included culture and sensitivities of meatus and perineum. R43's laboratory culture and sensitivity results dated 6/29/18, indicated infection of	F 684	21) Completion will be 9/10/18.	

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pseudomonas aeruginosa therefore R43's physician telephone order dated 6/29/18, included Augmentin 875 milligrams (mg) twice a day for 10 days and Ciprofloxacin 500 mg twice a day for seven days.

R43's 6/30/18, PN indicated peri area had Interdry in place and the skin appears less red today. Dimethicone applied after morning cares.

R43's laboratory culture and sensitivity results dated 7/1/18, revealed infection of Methicillin-resistant Staphylococcus aureus (MRSA). R43's physician telephone order dated 7/12/18, included Bactrim DS one tab twice a day for 10 days for diagnosis of MRSA. Contact precautions.

R43's progress notes (PN) and skin condition record were reviewed since the start of the antibiotic prescribed on 6/29/18. The record lacked evidence of ongoing side effect monitoring and the effectiveness of the antibiotics. In addition, the progress note lacked implementation of the contact precautions as a result of the positive culture of MRSA.

-7/1/18, PN indicated on Cipro and Augmentin for positive skin cultures. Had two large loose stools/semi formed bowel movements today. Will continue to monitor.
-7/2/18, Skin Progression note indicated presence of MASD to perineum and scrotal areas. Skin to scrotal area and inner thighs bilaterally noted to have odor, bright red rash with defined border present. Skin to coccyx including bilateral ischial tuberosity is dry and flaking, raised, thick, blanches, no current openings although scab is noted to right gluteal region, no exudate noted due to incontinent of loose bowel.

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F 684	Continued From page 29 Healing interventions included; antibiotics after culture obtained. -7/4/18, PN indicated had smearing of soft stool, no unusual odor noted. Buttocks and scrotal skin is improving and no drainage noted. Will continue to monitor. Cipro and Augmentin continue. Had two bowel movements yesterday and one the day before. -7/8/18, Skin Progression note indicated MASD to rectal area, perineum, and scrotal areas. Skin to scrotal area and inner thighs bilaterally noted to be odorless, faded red rash with defined border present. Skin to coccyx including bilateral ischial tuberosity is dry but not flaking at this assessment, remains raised and thickened, blanches, no current scabs noted. Rash and MASD appear to be healing. Resident continues on antibiotic treatment for a few more days. -7/12/18, PN indicated resident seen on physician rounds. Medication: Bactrim 1 tablet twice a day for MRSA. R43's physician visit note dated 7/12/18, indicated R43 was seen related to culture of penile drainage returned with MRSA. The note indicated plan for Bactrim DS for 10 days with a repeat culture in three weeks. The visit note lacked evidence of a physical examination or assessment of the impaired skin integrity by the physician. The Physical exam section did not include skin examination. -7/16/18, Skin Progression note indicated MASD to rectal, perineum and scrotal area. Skin to scrotal area and inner thighs bilaterally noted to be odorless, faded red rash with defined borders present. Occasional spots of bright red noted. Skin to coccyx including bilateral ischial tuberosity is dry but not flaking at this assessment, remains	F 684		

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raised and thickened, blanches, no current openings or scabs noted. Healing interventions included antibiotics. Notified today that 3rd bacteria was isolated culture MRSA, antibiotic already initiated, contact precautions currently in place. Resident continues on antibiotic treatment for several more days with a plan to re-culture at end of treatment.

-7/23/18, PN indicated has completed Bactrim. The buttocks is dry, slightly reddened and no drainage. The scrotum has no open areas and there is redness on the inner thighs with no drainage.
-7/24/18, PN indicated bottom and groin area continue to be red and raw
-7/25/18, Skin Progression note included: MASD to rectal, perineum, and scrotal areas. Skin to scrotal area and inner thighs bilaterally noted to be odorless, bright red rash with defined border present. Skin to coccyx including bilateral ischial tuberosity is dry with minimal flaking at this assessment, remains raised and thickened, blanches, no current openings or scabs noted. Interventions included: antibiotics completed. Continue current plan, continue on contact isolation. Follow up culture obtained per MD to verify if MRSA has resolved.

R43's telephone physician order dated 7/25/18, included: Re-culture meatus and perineum for diagnosis of MRSA.
R43's culture results for swab of perineum indicated ongoing moderate amount of the bacteria Proteus Mirabilis and susceptibility was not performed. The lab results also indicated negative for MRSA. However, R43's record revealed the positive culture for Proteus Mirabilis was not followed up on until 7/30/18, when a

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communication to the physician questioned if treatment was wanted and if isolation precautions were to be continued. The physician returned the communication with an order to discontinue isolation precautions. The communication did not reflect communication of the ongoing impaired skin integrity to the R43's bottom.

-7/30/18, Skin Progression note indicated MASD to rectal, perineum, and scrotal areas is healed. Skin to scrotal ara and inner thighs bilaterally noted to remain darker pink then surrounding skin, odorless, defined border remains present. Skin to coccyx including bilateral ischial tuberosity is dry and smooth without flaking at this assessment, tissue itself remains raised and thickened in appearance of scar tissue, blanches, no current openings or scabs noted. Antibiotics completed. Culture revealed normal flora, no current infection, MRSA resolved, isolation precautions discontinued. Highly pigmented skin as noted above appears to be scar tissue and has remained stable (not spreading).

-7/31/18, Skin Progression note indicated site clarification 7/31/18, MASD to perineum and scrotal areas was inadvertently healed out yesterday as there was no additional maceration remaining at that assessment. On today's assessment, skin to coccyx including bilateral ischial tuberosity is dry with mild flaking of barrier ointment, However, skin to scrotal and inguinal area is wet preventing barrier ointment from sticking in multiple spots. Skin to coccyx area, and inner thighs remains darker, raised, and thickened in appearance of scar tissue, blanches throughout, and no current openings visualized. One superficial dry scab with irregular border, triangular shape, measuring 2.2 centimeters (cm)

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by 1.5 cm to left buttock. This area was identified yesterday but mistaken for fecal smear. Culture results from 7/28/18, identify proteus mirabilis consistent with normal flora, recent MRSA and pseudomonas skin infection has resolved and isolation precautions were discontinued. However, R43's record lacked evidence the physician had evaluated the impaired skin integrity even after the course of antibiotics.

On 7/30/18, at 4:45 p.m. continuous observations began:

-At 4:45 p.m. p.m. R43 was observed in the dining room, seated in the wheelchair for the evening meal. When R43 completed his meal, an unidentified staff member wheeled R43 into the adjacent living room area and remained seated in the wheelchair without staff assistance until 7:53 p.m.
-At 7:53 p.m. R43 wheeled himself out of the living room area back into the dining room area. R43 stated he was tired.
-At 7:55 p.m. nursing assistant (NA)-M referenced the nursing assistant care guide and stated R43 was supposed to be repositioned every 2-3 hours. NA-M indicated she had thought R43 had been out of bed since around 4:30. NA-M indicated she had not written down on the care guide what time he gotten out of bed and confirmed R43 had not been repositioned since getting out of bed.
-At 8:56 p.m. NA-M and NA-N stated they were working without a bath aide so did not have the time to reposition the residents' as they were supposed to. The NAs transferred R43 from the wheelchair to the toilet using the ceiling mechanical lift. R43's bottom was not totally visible to surveyor at this time, however,

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appeared reddened with white flaking ointment on the buttocks. No Interdry was present in groin areas. R43 had remained seated without pressure relief assistance for four hours and 11 minutes.
-At 9:18 p.m. licensed practical nurse (LPN)-B stated R43's bottom has had skin breakdown for a long time and had previously been on antibiotics. LPN-B stated, "I'm sure there is skin issues, but it was better."

On 7/31/18, at 2:14 p.m. R43 was observed lying in bed. NA-Q removed soft cotton underwear which exposed the groin and bottom. R43's bilateral groin areas had remnants of white ointment, and the inner upper thighs, groin, scrotal areas were bright red and very excoriated. NA-Q stated the area was very red and asked R43 if it hurt. R43 replied by stating it hurt and burned. No Interdry was present in the groin areas. R43 rolled to his left side exposing his buttocks. Both buttocks were reddened in color and had dry flaking barrier ointment on the outer aspects. The Left buttock revealed an area that was approximated 2.0 cm by 1.0 cm irregularly shaped with a very thin reddish/yellowish/brownish scab present.

On 8/1/18, at 8:21 a.m. R43 was observed lying in bed. Registered nurse (RN)-B/acting wound nurse viewed the wound and stated R43 has had long history of moisture associated skin damage, "he sweats a lot." RN-B confirmed R43 developed infections in the MASD areas and was on antibiotics. RN-B stated the wound on the left buttock currently was not considered unstageable and was assessed as MASD because that area had historically formed thin layers of scabs that sheared off and would then reform. RN-B further

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indicated the shape of the wound was also not consistent with a pressure ulcer because it was irregular. RN-B stated the reddened areas of the buttock were related to hyperpigmentation of the skin from having the long history of moisture problems. RN-B stated R43 should be repositioned according to the care plan.

8/01/18, at 2:17 p.m. RN-B verified the lack of extent and/or area of the skin damage and lacked documentation of root cause analysis of impaired healing with the interventions that were in place. RN-B stated she didn't think the physician had ever physically examined the impaired skin integrity. RN-B indicated the facility's standing orders included the different types of ointment, however, the current physician's orders did not reflect the A&D mixture, and stated the physician's orders should have been followed and/or updated.

On 8/2/18, at 2:05 p.m. RN-A verified there was no assessment for skin in the General Nurse's Observation for the MDS completed on 7/17/18. RN-A indicated a skin assessment should have been completed after worsening of the MASD was identified.

On 8/3/18, at 11:30 a.m. The director of nursing (DON) stated she expected staff to follow the care plan for repositioning. DON indicated Braden Scales were supposed to be done quarter and with change of condition and Tissue Tolerance Observations were supposed to be done upon admission, upon hospital returns, significant changes, and changes in surface such as a new wheelchair cushion.

R7's facility Face Sheet dated 8/2/18, indicated

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F 684	Continued From page 35 R7's diagnoses included excoriation disorder, disorder of the skin and subcutaneous tissue, type II diabetes, and history of local skin subcutaneous tissue infection. R7's quarterly MDS dated 5/15/18, indicated R7 had moderate cognitive impairment, could usually make self understand, and could usually understand others. The MDS also indicated R7 had a diagnosis of diabetes. R7's physician orders dated 8/2/18, indicated R7 picked at skin and ordered wound care which consisted of: picked sites once a day during evening. Special instructions: apply skin prep each evening. Cover with tegaderm, change weekly and as needed. R7's endocrine care plan dated 8/17/16, directed staff to report any slow or unhealing wounds (skin tears, ulcers, ect.) The skin care plan dated 8/17/16, indicated R7 was at risk for skin breakdown and potential for infections due to excoriations secondary to dermatillomania (Excoriation disorder also referred to as chronic skin-picking is a mental illness related to obsessive-compulsive disorder) and directed the following: -apply dressings to open areas as ordered as needed -observe for any changes in skin and report to nursing -wound care as ordered. On 7/30/18, at 6:31 p.m. R7's right upper arm, directly under the tattoo, revealed a quarter sized raised lesion that was open with scant amount of reddish, light yellow drainage partially covered with a thin scab. R7 stated it had been there for a	F 684		

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long time and did not itch or hurt. R7 stated he was not aware if staff knew about the area on his arm or not.

On 7/31/18, at 2:25 p.m. R7 was observed walking down the hallway. The lesion on the right arm remained open and uncovered, no drainage was present.

On 8/1/18, at 7:12 a.m. R7 was observed seated on the side of his bed. The lesion on his right upper arm remained uncovered with a thin red scab with small open areas that were not draining. R7 denied the area itching and stated it was not from picking at his skin. R7 again stated the area had been there for a long time but could not recall when the area first developed.

R7's skin records, PNs, and treatment administration records were reviewed since 7/1/18, which lacked identification of the lesion on the right upper arm. R7's PNs reflected the following:

-PN dated 7/7/18, indicated no skin concerns.
-PN dated 7/15/18, indicated R7 was picking at his right upper arm but stopped when asked. The progress note did not identify injuries obtained as a result.

On 8/1/18, at 1:26 p.m. without looking at the right arm, RN-B stated the lesion was scar tissue from a picked site. The ADON was then asked to look at the area on R7's arm. RN-B viewed the lesion and stated it was not scar tissue or a picked at site. RN-B stated an unawareness of the lesion and could not recall ever seeing the lesion before. RN-B asked R7 how long the area had been present to which R7 responded it had

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been there for a long time and was not able to articulate the date or time frame of onset. RN-B palpated the lesion and indicated it was firm to touch. RN-B measured the area and asked R7 if he would like it evaluated by the physician in which R7 agreed to have the area looked at and further evaluated. RN-B confirmed the clincial record lacked identification of the area and stated it was expected that the nurses performed a weekly skin inspection and document any changes to skin integrity.

-At 1:28 p.m. the DON confirmed R7's clinical record did not identify the skin lesion and the last documentation of a skin evaluation was on 7/7/18. The DON stated the nursing assistants were to be looking at the resident's skin every evening and were to report if/when they observed any changes to the nurses. if/when they observed any changes in the skin and were supposed to be looking at the skin every evening.

Facility policy Skin Ulcer Protocol dated 11/1/15, included steps for identifying residents at risk for skin breakdown. Monitoring interventions to start if an open area is noted on any shift and to implement the following general measures:
-all open skin ulcers are to be reported to the facility wound nurse.
-repeat Tissue Tolerance Test, G. Repeat Braden/Norton Scale (address all identified risk areas-care plan),
-review all current interventions to ensure remain appropriate including pressure relieving devices.
-wound nurse to complete a root cause analysis of any new skin issue. Rule out pressure, Preventive interventions that were in place. Wound nurse to obtain a physician order for the wound type along with treatment for it.

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-moisture and its impact--exposure to urine and feces contain substances which may make skin more susceptible to skin breakdown. Perineal dermatitis appears as a more diffuse area of erythema or skin discoloration where urine and stool have come into contact with the skin. Minimize exposure to moisture and keep skin clean from urine and fecal contamination. Apply a barrier cream, as individually assessed to be appropriate, following cleansing.
-documentation: may request physician documentation related to the ulcer or potential ulcer development. Difficult/complex cases may also be reviewed by the medical director on a monthly basis.

R6's facility Face Sheet dated 8/2/18, indicated R6's diagnoses included type II diabetes with hyperglycemia (high blood sugar).

R6's quarterly Minimum Data Set (MDS) dated 5/10/18, indicated R6 had severe cognitive impairment and staff were to anticipate her needs. The MDS also identified R6 had a diagnosis of diabetes mellitis (DM), dementia and hypertension.

R6's standing orders for Diabetic monitoring/treatment dated 2/22/18, indicated the following:

1. Any new admission with a diagnosis of DM and no order for accu-checks, may have accu-checks up to four times a day until a further order was obtained.
2. Blood glucose checks as needed per nurse discretion.
3. Notify physican if two blood sugar results are lower than 70 mg/dl or greater than 400 mg/dl in

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a 24 hour period and/or when there was a change in condition. (unless otherwise ordered when on a sliding scale.)
4. If hypoglycemic (blood sugar less than 70), if able to swallow, may administer eight ounces of fruit juice or milk or six ounces of a supplement. Recheck blood sugar in 15 minutes. If no improvement, give oral gluose gel, and recheck blood gluose in 15 minutes. If still no improvement notify physician or nurse practitioner.
5. If unable to swallow or with altered consciousness, administer Glucagon 1 milligram (mg) intramuscularly (IM) and recheck blood sugar after 15 minutes. If still no improvement, administer an additional dose of 1 mg Glucagon IM, call for emergency assistance and notify the physican or nurse practioner.

R6's care plan dated 8/4/16, indicated R6 was at risk for hyperglycemic or hypoglycemic episodes related to her diagnosis of diabetes and the goal was to prevent these episodes. Interventions directed staff to not administer insulin more than 15 minutes before meals, obtain fasting blood sugars as ordered, insulin administration as ordered, lab work and report all abnormalities as ordered, monitor weight, and to provide R6 with a menu listing of low calorie/low carbohydrate selections as ordered. An order to monitor for signs and symptoms of hypo-hyperglycemia and to report to the medical doctor was initiated on 3/20/18.

R6's PN dated 3/12/18, at 4:32 p.m. indicated R6 had a blood sugar (BS) reading of 60 mg/dl. however, did not identify any further action related to the low BS.
-The PN at 6:56 p.m. indicated R6 fell from her

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wheelchair to her knees. However, the PN had not indicated if a physican was called regarding the fall or the low blood sugar. Approximately 1.5 hours after the fall.
-The PN at 8:25 p.m. indicated R6's BS level was 59 mg/dl. and did not identify any action taken related to the low BS and no monitoring of R6's blood sugars was identified.
Although R6's PNs revealed two low blood sugars within a 24 hour period, including a fall, there was no evidence of physician notification as directed by the standing order protocol.

Additional PNs revealed the following:

-3/13/18 at 4:16 p.m. BS level was 47 gm/dl, however, no further action was identified.
-3/17/18, at 12:13 p.m. BS level was 56 mg/dl, however, no further action was identified.
-3/18/18, at 5:54 p.m. BS level was 42 mg/dl, however, no further action was idenfied.
-3/20/18, at 4:23 p.m. BS level was 40 mg/dl, R6 was given eight ounces of orange juice.
-3/26/18, at 11:37 p.m. BS level was 46 mg/dl, R6's insulin was held until R6 ate a meal.
-3/27/18, at 4:39 p.m. BS was 36 mg/dl, R6 was not responding, was sweating heavily, skin was pale, and flaccid muscle tone. Glucose syrup 15 grams (gms) was administered by licensed practical nurse (LPN). BS 35 mg/dl following the glucose syrup administration. An ambulance was called and R6 was transferred to the hospital for a hypoglycemic episode.

R6's Rainy Lake Medical Center Emergency Department form dated 3/27/18, indicated R6 was treated for hypoglycemia. The form did not identify what type of treatment R6 received while there.

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F 684	Continued From page 41 R6's PN dated 3/27/18, at 10:56 p.m. indicated R6 returned to the facility. Upon R6's return, a change to her physician orders was noted and were to begin 3/28/18. The orders were as follows: -Humalog (insulin lispro) 100 unit /ml administer 21 units subcutaneous (under skin) one time per day at 7:30 a.m.. Give no more than 15 minutes before breakfast. Report blood sugars >400 mg/dl or <100 mg/dl to provider. -Humalog (insulin lispro) 100 units/ml administer 34 units subcutaneous one time per day at 11:30 a.m. Report blood sugars >400 mg/dl or <100 mg/dl to provider. - Humalog (insulin lispro) 100 units/ml administer 36 units subcutaneous one time per day at 4:30 p.m.. Do not give more than 15 minutes before mealtime. Report blood sugars >400 mg/dl or <100 mg/dl to provider. -Toujeo solostar (insulin glargine) 300 units/ml administer 36 units subcutaneous 1 time per day at 8:00 p.m. Report blood sugars > 400 mg/dl < 100 mg/dl to provider. The new orders revealed parameters which were different from the facility's standing orders and directed the facility to notify the provider if R6's BS was > 400 mg/dl or < than 100 mg/dl. R6's Diabetic Log indicated the following readings outside of the doctor ordered blood sugar notification parameters with no evidence of action taken by staff or physican notification as directed by the physician orders: -4/5/18, at 11:58 a.m. BS level was 463 mg/dl -4/21/18, at 4:40 p.m. BS level was 64 mg/dl -4/22/18, at 4:42 p.m. BS level was 75 mg/dl	F 684		

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-4/25/18, at 5:13 p.m. BS level was 82 mg/dl
-4/26/18, at 5:18 p.m. BS level was 57 mg/dl
-5/1/18, at 11:47 p.m. BS level was 61 mg/dl
-5/06/18, at 4:02 p.m. BS level was 63 mg/dl
-5/09/18, at 7:34 p.m. BS level was 97 mg/dl
-5/10/18, at 8:46 p.m. BS level was 71 mg/dl. R6 was fed a banana with pudding and a glass of orange juice. No further BS check was documented.
-5/12/18, at 8:37 p.m. BS level was 92 mg/dl
-5/23/18, at 7:21 p.m. BS level was 53 mg/dl
-5/26/18, at 4:11 p.m. BS level was 91 mg/dl
-5/29/18, at 4:46 p.m. BS level was 89 mg/dl
-5/30/18, at 4:37 p.m. BS level was 72 mg/dl
-6/1/18, at 7:35 a.m. BS level was 98 mg/dl
-6/2/18, at 9:38 p.m. BS level was 78 mg/dl
-6/4/18, at 7:55 a.m. BS level was 91 mg/ld
-6/4/18, at 7:22 p.m. BS level was 89 mg/dl
-6/5/18, at 7:33 a.m. BS level was 89 mg/dl
-6/8/18, at 4:43 p.m. BS level was 60 mg/dl
-6/9/18, at 8:17 p.m. BS level was 78 mg/dl
-6/11/18, at 4:57 p.m. BS level was 51 mg/dl. Staff assisted her with her meal and gave her some pudding before bed time. R6's BS at bed time was 160 mg/dl.
-6/16/18, at 5:32 p.m. BS level was 74 mg/dl. R6 ate 50% of her supper with assistance.
-6/20/18, at 4:40 p.m. BS level was 83 mg/dl
-6/21/18, at 8:55 p.m. BS level was 82 mg/dl
-6/24/18, at 4:58 p.m. BS level was 52 gm/dl
-6/27/18, at 5:05 p.m. BS level was 72 mg/
-6/27/18, at 7:22 p.m. BS level was 88 gm/dl. R6's BS in the morning was 119 mg/dl.
-6/28/18, at 4:14 p.m. BS level was 83 gm/dl
-6/28/18, at 7:21 p.m. BS level was 83 mg/dl
-7/3/18, at 5:07 p.m. BS level was 49 mg/dl
-7/17/18, at 5:16 p.m. BS level was 90 mg/dl
-7/17/18, at 10:14 p.m. BS level was 78 mg/dl
-7/19/18, at 4:59 p.m. BS level was 52 mg/dl

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F 684	Continued From page 43 -7/23/18, at 5:00 p.m. BS level was 79 mg/dl -7/30/18, at 4:29 p.m. BS level was 86 mg/dl On 8/2/18, at 2:48 p.m. LPN-A stated when R6 was hypoglycemic she was "kind of out of it" and did not respond well, would also have difficulty with communication, became sleepy and somewhat clammy. LPN-A stated she would try to get eight ounces of juice in R6, wait 15 minutes and then recheck the BS. If the BS remained low/hypoglycemic she would give R6 glucogel. If the R6 did respond to the glucogel, she would call the provider. LPN-A stated they obtained the glucogel from the pharmacy or the facility E-kit (emergency medication supply) and when the last glucogel was used, the staff were to order more from the pharmacy. -At 3:50 p.m. trained medication assistant/Nursing assistant (NA)-A stated R6's blood sugars had not been low when she had checked them and if they had been, she would give a nourishment and recheck the BS in 15 minutes and report to the nurse. -At 3:50 p.m. RN-B stated the nurses should call the provider if a BS was less than 70 mg/dl or greater than 400 gm/dl in 24 hours and if critical, it needed to be addressed. RN-B stated she would not know if a resident was running low BS's unless the LPNs or trained medication assistants reported it to her as she did not review the residents' PNs to see the results of their blood sugar checks. At 4:22 p.m. RN-A stated the staff would have to review the resident's documentation in order to identify if a pattern was noted and then RN would then report that information at the morning	F 684		

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meetings.

On 8/2/18, at 5:00 pm. the DON stated all the residents care needs were specified in their care plans and provider's orders. The DON stated if a blood sugar was outside the normal range, the staff were to notify the provider.

On 8/3/18, LPN-D stated if a resident had a low blood sugar, she would try to give them orange juice or something sugary. If there was no glucogel in house, she would probably call the ambulance, and it the resident was unconscious, she would just call the ambulance.

R7's facility Face Sheet dated 8/2/18, indicated R7's diagnoses included type II diabetes with hyperglycemia.

R7's quarterly MDS dated 5/15/18, indicated R7 had moderate cognitive impairment, could usually make self understand, and could usually understand others. The MDS also identified R7 had a diagnosis of diabetes and received insulin daily during the MDS assessment reference period.

R7's physician orders dated 8/2/18, included:

-Metformin 1000 milligrams (mg) twice per day at 8:00 a.m. and 5:00 p.m. (start date 8/17/16)
-Novolog (insulin Aspart) 100 unit/ml: administer 8 units subcutaneous one time per day at 7:30 a.m. (start date of 1/12/18)
-Novolog (insulin Aspart) 100 unit/ml: administer 6 units subcutaneous one time per day at 11:30 a.m. Do not administer more than 15 minutes prior to lunch. (start date of 1/12/18)
-Novolog (insulin Aspart), 100 unit/milliliter (ml):

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F 684	Continued From page 45 administer 6 units subcutaneous (under skin) one time a day at 4:30 p.m. Do not administer more than 15 minutes prior to supper (start date 1/11/18) -Bascular Kwikpen U-100 (insulin Glargine) 100 units/ml: inject 16 units one time per day at 7:30 p.m. (start date of 7/12/18) -Monitor for signs and symptoms of hypo/hyperglycemia. Do accucheck (blood sugar check) if signs and symptoms noted three times a day: day, evening, and night. Special instructions: signs and symptoms including: cold clammy skin, fainting, irritability, shaking, change in level of consciousness. Hyperglycemia: increased thirst, confusion, agitation, weight loss, and increased urination. Document in progress notes if exhibiting signs and symptoms. R7's facility standing orders for Diabetic monitoring/treatment was dated 2/22/18. R7's endocrine care plan dated 8/17/16, indicated R7 had potential complications related to diabetes. R7's goal indicated fasting blood glucose levels would continue to be under 200 and he would not show signs of hypoglycemia/hyperglycemia. A1C (blood glucose levels over time) would stay below 8. The care plan directed staff to -administer insulin and oral antidiabetic medications per physician orders -check blood glucose levels per physician orders, monitor for signs and symptoms of hyperglycemia and hypoglycemia. - -A1C to be checked as ordered by practitioner, at least every three months. -Document and report refusal of meals/liquids. Instruct resident on importance of not skipping meals or snacks.	F 684		

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LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

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R7's clinical record lacked evidence of A1C lab monitoring every three months as directed on the care plan.

R7's record indicated the last time the physician evaluated and/or mentioned R7's blood sugars was dated 5/18/18. The note indicated R7 had a history of organic brain syndrome secondary to an episode of prolonged hypoglycemia; which was stable. The note also indicated a review of his blood sugars showed most of these to be in within normal limits, although, he had several lows at 29 and a 49, and did not believe they were symptomatic. Last A1C in December was 7.0. R7's record reflected R7's nest A1C obtained 7/18/18, in which lab results indicated the A1C increased from 7.0 to 8.2. R7's record lacked physician follow-up related to the increased A1C.

Review of R7's blood sugar monitoring results revealed a lack of documentation of actions taken by staff or physician notification:

-5/7/18, at 4:16 p.m. BS was 432 mg/dl
-5/7/18, at 6:31 p.m. BS was 305 mg/dl
-5/12/18, at 8:23 p.m. BS was 68 mg/dl
-5/13/18, at 11:18 a.m. BS was 312 mg/dl
-5/13/18, at 7:40 p.m. BS was 62 mg/dl
-5/14/18, at 4:46 p.m. BS was 297 mg/dl
-5/15/18, at 11:31 p.m. BS was 311 mg/dl
-5/15/18, at 8:24 p.m. BS was 70 mg/dl
-5/18/18, at 7:24 p.m. BS was 382 mg/dl
-5/23/18, at 8:46 p.m. BS was 43 mg/dl
-5/24/18, at 4:18 p.m. BS was 351 mg/dl
-5/29/18, at 12:13 p.m. BS was 392 mg/dl
-6/1/18, at 4:30 p.m. BS was 498 mg/dl
-6/8/18, at 7:40 p.m. BS was 58 mg/dl

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F 684	Continued From page 47 -6/13/18, at 430 p.m. BS was 350 mg/dl -6/13/18, at 7:39 p.m. BS was 306 mg/dl -6/15/18, at 4:31 p.m. BS was 300 mg/dl -6/21/18, at 11:49 a.m. BS was 334 mg/dl -6/22/18, at 11:39 a.m. BS was 339 mg/dl -6/22/18, at 4:00 p.m. BS was 371 mg/dl -6/25/18, at 7:25 p.m. BS was 322 mg/dl -7/1/18, at 8:22 p.m. BS was 313 mg/dl -7/2/18, at 7:18 a.m. BS was 295 mg/dl -7/2/18, at 7:18 a.m. BS was 285 mg/dl. -7/2/18, at 4:54 p.m. BS was 346 mg/dl -7/4/18, at 5:11 p.m. BS was 400 mg/dl -7/9/18, at 8:37 a.m. BS was 327 mg/dl -7/9/18, at 8:54 am. BS was 327 mg/dl -7/11/18, at 5:10 p.m. BS was 345 mg/dl -7/11/18, at 8:19 p.m. BS was 63 mg/dl On 7/12/18, a new physician order included Bascular Kwikpen U-100 (insulin Glargine) 100 units/ml: inject 16 units one time per day at 7:30 p.m. -7/13/18, at 4:33 p.m. BS was 341 mg/dl -7/20/18, at 9:03 p.m. BS was 401 mg/dl -7/21/18, at 8:44 p.m. BS was 350 mg/dl -7/25/18, at 4:37 p.m. BS was 300 mg/dl -7/28/18, at 8:36 p.m. BS was 400 mg/dl On 7/30/18, at 6:31 p.m. R7 stated and received insulin. He wasn't on any really special diet and would eat whatever he wanted to, and sometimes used artificial sweetener. R7 stated he could not really tell when his blood sugar was too low or too high and that the nurses checked his blood sugar and would tell him what it is. On 7/30/18, at 9:09 p.m. LPN-B was observed to check R7's blood glucose. The blood glucose was identified as 86 mg/dl. LPN-B administered	F 684		

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F 684	Continued From page 48 16 units of lantus insulin and directed R7 to go to the dining room for a snack. -At 9:30 p.m. R7 was observed eating a meat sandwich and a glass of juice in the dining room. On 8/1/18, at 1:51 p.m. RN-B stated the physician reviewed the blood sugars during routine rounds. RN-B also stated the staff followed the physician standing orders and only notified the physician when there were two blood sugars within 24 hours that are below 70 mg/dl or above 400 mg/dl and with as change in condition. RN-B indicated the standing orders did not direct staff to notify the physician for single blood sugars over 400 mg/dl for residents that did not have sliding scale insulin available, or direct staff on how to decrease or how often to monitor the blood sugar after the hyperglycemic BS results. RN-B explained the physician would have been contacted if there were emergent cases where glucagon had to be administered. RN-B verified the lack of documentation of interventions for low/high blood sugars and stated if blood sugars reflected hyper/hypoglycemia the nurses were expected to document the signs and symptoms displayed, and the interventions that were used to bring the blood sugar back to normal limits. RN-B stated lab results went directly to the physician for review and were then sent to the facility. RN-B confirmed there had no been any follow up related to to R7's increase in A1C level. On 8/2/18, at 8:02 a.m. LPN-D stated she would contact the provider based on the individual orders and/or follow the standing orders. LPN-D verified the lack of documentation of signs and symptoms of hypo/hyperglycemia and the lack of interventions used. LPN-D confirmed there should have been documentation of signs and	F 684		

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symptoms and interventions used to return the BS back to baseline. LPN-D was able to articulate the protocol for low blood sugars without difficulty. LPN-D indicated when R7's blood sugars were low, he seemed asymptomatic.

-At 8:16 a.m. LPN-E was able to articulate signs and symptoms of hypo/hyperglycemia. LPN-E verified the lack of documentation for low/high blood sugars and interventions used to return BS back to baseline and indicated the signs/symptoms and interventions should have been documented. LPN-E stated if there was a blood sugar over 400 mg/dl she would notify the RN and then recheck it again in 15-20 minutes. LPN was not able to articulate protocols for sustained hyperglycemia over 300 mg/dl. LPN-E was not able to articulate the standing orders for the use of glucagon administration and indicated she would administer glucagon then recheck the blood sugar after 30 minutes and was not sure if a second dose could be administered. LPN-E indicated when R7's blood sugars were low, he seemed asymptomatic.

-At 8:47 a.m. RN-B was not able to articulate R7's standing orders and stated she would not administer a second dose of glucagon and would send a resident to the emergency room if the blood sugar did not increase after the first injection. RN-B stated if a resident was hypoglycemic, the nurses should notify the RN, and the RN would call the physician. RN-B stated it was ideal if the LPNs reported to the RN prior to the administration of glucagon, but reporting was not required.

-At 8:52 a.m. the DON stated it was not expected for the nurses to report blood sugars under 70 or

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over 400 mg/dl to the physician because it was not what the standing orders directed. The DON indicated the nurses were following the standing orders as written and would only contact the physician regarding blood sugars according to the physician orders.

R25's admission MDS dated 3/30/18, indicated R25 had mild cognitive impairment and diagnoses including DM, breast cancer, dementia and hypertension. The MDS indicated R25 required extensive assistance with all activities of daily living.

Review of R25's clinical record lacked an assessment related to R25's diabetic care.

R25's care plan dated 3/27/18, did not include a plan related to diabetic treatment rather, the plan directed the staff to assist R25 with the administration of medications in accordance to the physican orders.

R25's admission orders dated 3/23/18, included a diabetic monitoring protocol for hypoglycemia which consisted of:

-If blood glucose is less than 70 mg/dl, if able to swallow as needed medication, use Glucose Gel 40% as directed. May administer 8 ounces (oz) of fruit juice or milk or six ounces of supplement,
-Recheck blood sugar in 15 minutes and if no improvement give oral glucose gel and recheck the blood gluose in another 15 minutes. If still no improvement notify the physican or nurse practitioner. R25's physican orders did not address high blood sugars.

R25's undated standing orders for diabetic

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F 684	Continued From page 51 monitoring/treatment indicated: 1. Any new admission with a diagnosis of DM and no order for accu-checks, may have accu-checks up to four times a day until further order is obtained. 2. Blood glucose checks as needed per nurse discretion. 3. Notify physican if two blood sugar results are lower than 70 mg/dl or greater than 400 mg/dl in a 24 hours period and/or when change in condition. (unless otherwise ordered when on a sliding scale.) 4. If hypoglycemic (blood sugar less than 70), if able to swallow, may administer eight ounces of fruit juice or milk or six ounces of supplement. Recheck blood sugar in 15 minutes. If no improvement, give oral gluose gel, recheck blood gluose in 15 minutes. If still no improvement notify physician or nurse practitioner. 5. If unable to swallow or with altered consciousness, administer Glucagon 1 milligram (mg) IM and recheck blood sugar after 15 minutes. If still no improvement, administer an additional dose of 1 mg Glucagon IM, call for emergency assistance and notify the physican or nurse practioner. R25's admission insulin order dated 3/23/18, indicated Humalog Mix 75/25 take 75 units in the morning and 80 units at 5:00 p.m.. Review of R25's BS Recording report dated 3/23/18 - 8/1/18, and corresponding PNs revealed R25 had multiple hyperglycemic (greater than 400) and hypoglycemic (less than 70) episodes. However, R25's clinical record lacked evidence R25's signs and symptoms of the hypo-hyperglycemia and nursing interventions	F 684		

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implemented at the time of the events. At no time was R25's physican notified of the events as they occurred. Examples include but are not limited to:

-PN dated 3/23/18, at 6:57 p.m. indicated a BS of 432 mg/dl.
-PN dated 3/24/18, at 11:50 a.m. indicated a BS of 508 mg/dl.
-PN dated 3/24/18, at 4:49 p.m. indicated a BS of 530 mg/dl.
-PN dated 3/24/18, at 8:10 p.m. indicated a BS of 496 mg/dl.
-PN dated 3/27/18, at 9:10 a.m. indicated a BS of 66 mg/dl. The PN indicated the BS was taken before a meal, however, the BS was not rechecked until 1:01 p.m. at which time it was 178 ml/dl.
-PN dated 3/28/17, at 12:01 p.m. indicated the BS was 60 mg/dl.

On 4/2/18, R25 had an insulin order change to Humalog 75/25, 94 units in the morning and 75 units at 5:00 p.m. .

-PN dated 4/3/18, at 8:22 a.m. indicated the BS was 51 mg/d. The PN indicated the BS was taken before meal. At 9:14 a.m. the PN indicated R25 had eaten breakfast which consisted of bacon, toast and cereal.
-PN dated 4/10/18, at 8:50 a.m. indicated the BS was 53 mg/d. The PN identified the BS but did not identify further intervention/actions or notification of the physican.

On 4/20/18, R25's insulin order changed to 70 units at 5:00 p.m. .

-PN dated 4/29/18, at 4:15 p.m. indicated the BS

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was 430 mg/dl. The PN identified the BS but did not identify further intervention/actions or notification of the physican.
-PN dated 5/5/18, at 5:42 p.m. indicated the BS was 42 mg/dl. The PN indicated the LPN had held R25's insulin and rechecked the BS at 6:00 p.m. which at that time was 153 mg/dl. R25 was able to feed herself. R25's bedtime blood sugar was 275 mg/dl and a bedtime snack was given. LPN-G indicated the night shit was to continue to monitor the blood sugar. The next recorded BS was on 5/6/18 at 7:11 a.m. with results of 275 ml/dl.
-PN dated 5/6/18, at 5:25 p.m. indicated the BS was 38 mg/dl. The PN identified the BS but did not identify further intervention/actions or notification of the physican.
-PN dated 6/8/18, at 4:45 p.m. indicated the BS was 51 mg/dl. The PN identified the BS but did not identify further intervention/actions or notification of the physican.
-PN dated 6/11/18, at 8:25 a.m. indicated the BS was 46 mg/dl. The PN identified the BS but did not identify further intervention/actions or notification of the physican.

On 6/13/18, R25's insulin order was changed to Humalog mix 75/25, 90 units in the morning and 60 units at 5:00 p.m.

-PN dated 7/1/18, at 9:20 a.m. BS was 53 mg/dl. The PN identified the BS but did not identify further intervention/actions or notification of the physican.

On 7/5/18, R25's Humalog 75/25 insulin was decreased to 62 units at 5:00 p.m.

-PN dated 7/6/18, at 9:03 a.m. indicated the BS

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was 56 mg/dl. The PN identified the BS but did not identify further intervention/actions or notification of the physican.
-PN dated 7/10/18, at 5:32 p.m. indicated the BS was 45 mg/dl. At 6:18 p.m. the PN indicated R25 had eaten supper. At 6:41 p.m. BS was 45 mg/dl and R25 was given a rice krispy bar. R25's next BS monitoring was on 7/11/18 at 5:27 a.m. at which time BS was 103 mg/dl .

On 8/2/18, at 10:11 a.m. the DON stated if a resident's blood sugar was below 70 mg/dl she would expect the staff to follow the standing orders. If a resident was hypoglycemic, the DON stated the staff were to encourage the resident to drink juice and recheck the BS every 15 minutes until the BS stabilized. In addition, the DON stated she would expect the staff to document any signs and symptoms of diabetic reactions in the resident's clinical record. If the blood sugar was over 400 mg/dl the staff were to notify the physican only if they had sustained two hyperglycemic events of greater than 400 mg/dl in a 24 hour period, as directed by the facility's standing orders. The DON stated it would be good nursing practice to recheck a resident with a high blood sugar, however, the facility standing orders did not direct the staff to recheck the BS if having a hyperglycemic episode as a low BS reading would be considered a "bigger issue." The DON stated R25's blood sugars had been running low since her admission to the facility and the nurse practitioner was made aware of the low BS reading and written subsequent multiple medication adjustment orders. The DON confirmed R25's primary physican had not been made aware of the hyper/hypoglycemic events at the time of the occurrences.
-At 10:33 a.m. the DON stated the facility had

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both oral and IM glucagon that could be given to a resident experiencing a hypoglycemic event.
-At 10:36 a.m. LPN-E opened the facility E-Kit. The kit was observed to contain two doses of IM Glucagon, however, the E-Kit did not contain any oral glucose gel. LPN-E opened the medication carts and confirmed the facility did not have a supply of oral glucose in the facility.
-At 10:40 a.m. the DON reviewed the standing orders and confirmed it directed the staff to administer oral glucose. The DON was unaware the facility did not have a supply of oral glucose in house.
-At 10:50 a.m. LPN-D stated R25 experienced frequent low blood sugars. LPN-D stated when hypoglycemic, R25 would become shaky, confused, sweaty and occasionally experienced muscle "jerking." LPN-D stated R25 recovered quickly from hypoglycemic episodes after eating a snack.
-At 11:05 a.m. the administrator/RN stated if a resident displayed low blood sugars, the nursing staff were to administer oral glucose and recheck the blood sugar every 15 minutes until the glucose level stabilized. If the resident was unconscious, the staff were to administer IM Glucagon. The administrator stated if a resident was experiencing high or low blood glucose levels, she would except the staff to monitor the sugar, document in the clinical record, and contact the physican as directed by the standing order. The administrator was unaware the facility did not have a supply of oral glucose gel in house.

-At 2:52 p.m. the DON reviewed R25's blood sugars and confirmed on 3/24/18, R25's blood sugar was greater than 500 twice within a 24 hour period and the facility did not notify the physican

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in accordance with the standing order. The blood sugar of 38 mg/dl identified on 5/8/18, was reviewed on 5/10/18, by the physican two days after the event.

On 8/3/18, at 12:40 p.m. the administrator reported the facility had received a supply of oral glucose and it had been placed in each medication cart.

On 8/3/18, at 1:43 p.m. the medical director was interviewed via telephone. The medical director stated any resident with a blood glucose lower then 60 mg/dl was to be given a snack or glucose and the sugar was to be checked every 20 minutes until it had stabilized. If a resident had a blood sugar greater than 400 mg/dl, he would expect the facility to notify the attending physican for further guidance and receive orders for additional insulin and continued monitoring. Upon review of the current standing orders, the medical director stated the current standing orders were not correct as he would expect to be notified after a single hyper/hypoglycemic event and not after two events within a 24 hour period. The medical director stated the standing orders were in need of revision.

The undated Diabetic Monitoring for Resident Choice Meal Plan, directed the staff to follow the KHS standing orders during episodes of hypoglycemia. The policy did not address hyperglycemia.

Wheelchair positioning:

R18's quarterly MDS dated 6/18/18, indicated R18 had severe cognitive impairment and diagnosed including dementia and a left below

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the knee amputation. The MDS also indicated R18 required total assistance with all activities of daily living, was non-ambulatory, and required total assistance of one staff for mobility on and off of the nursing unit.

R18's General Nurse's Observation dated 12/18/17, indicated R18 had a left below the knee amputation and was missing two toes from the right foot due to a history of ulcers. The observation indicated R18 was dependent upon staff for mobility and required the use of a wheelchair.

R18's care plan dated 4/5/17, indicated R18 was dependent upon staff for wheelchair mobility.

On 7/31/18, at 9:02 a.m. R18 was observed seated in a rock and go wheelchair by the nurses station. R18's right leg was in a dangling dependent position and did not touch the floor.

On 8/1/18, at 7:15 a.m. NA-A was observed to assist R18 from bed to the wheelchair (Rock and Go- rocking wheelchair) via a full body ceiling lift. NA-A applied a foam boot to R18's right foot and proceeded to wheel R18 to the dining room. R18's foot dangled, unsupported, from the chair. NA-A did not place any type of foot rests on the chair. R18 was continuously observed until 10:00 a.m. to remain in the chair in a reclining position, with the right leg unsupported and dangling. R25's right foot did not touch the floor. At times, R18 was noted to cross his right leg over the left amputated leg and place his foot on the metal bar which connected to the chair and was approximately 1/2 inch by three inches. The bar R25 rested his leg on was the bar in which a leg rest would be attached. At no time were the staff

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F 684	Continued From page 58 observed to place a foot rest on the wheelchair. On 8/2/18, at 4:07 p.m. the DON verified R18 had a history of foot ulcers resulting in amputation of the left lower leg and two toes on the right foot, but did not have any type of foot ulcers at the time of the survey. However, the DON stated she was unaware R18 had not been utilizing foot rests while in the wheelchair. - At 5:20 p.m. R18 was observed seated in the rock and go wheelchair without foot rests. R18's legs were crossed with his right foot resting on metal bar for the foot rests. At no time were the staff observed to provide or offer R18 a foot rest. The nurse consultant observed R18 seated in the chair and confirmed alternative leg supports while in the chair could be reviewed. A policy related to wheelchair positioning was requested and none was provided.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer 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.	F 686		9/10/18

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F 686	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately assess/reassess the skin condition and ensure timely repositioning was provided as directed by the individualized care plan in order to minimize the prevention of and/or promote the healing of pressure related ulcers for 4 of 6 residents (R42, R20, R9, R32) in the sample identified at risk for pressure ulcers and/or had active pressure related ulcers. This failure resulted in actual harm for R42 due to the development of pressure ulcers, and for R20 who was diagnosed with a deep tissue injury which was not identified or comprehensively assessed in order to identify appropriate interventions. Findings include: R42's quarterly Minimum Data Set (MDS) dated 7/16/18, indicated R42 had severe cognitive impairment and diagnoses including Alzheimer's dementia and depression. The MDS also indicated R42 required total assistance with bed mobility, transfers and all other aspects of activities of daily living (ADL). In addition, the MDS indicated R42 was at risk for the development of pressure ulcers and did not have pressure related ulcers. R42's Pressure Ulcer Care Area Assessment (CAA) dated 4/14/18, indicated R42 had a moisture associated skin damaged area on her coccyx. The CAA identified superficial skin damage to the perineal and coccyx related to bladder incontinence. The CAA also indicated R42 had superficial skin damage on the gluteal fold which measured 1.0 centimeter (cm) x 1.2	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer 1) DON and/or designee will implement the following for R42, R20, R9, and R32 affected by this practice: An updated Tissue Tolerance lying and sitting will be completed and reviewed by the Facility Wound Nurse. A new Braden Scale will be completed and reviewed by the Facility Wound Nurse. A head to toe assessment will be completed along with a new RCA assessment for any skin alterations noted by the Facility Wound Nurse. Areas will be updated in the Skin and Wound section of residents medical record. The provider will assess/review the wound, evaluate treatment and make any treatment changes. R42 was seen by MD on 8-3-18 and identified area as a sacral decubitus. Skin Care Plan and NAR care sheets will be reviewed and updated for appropriate skin interventions to promote wound healing and prevent further skin breakdown based off of the comprehensive assessment by the Facility Wound Nurse. R32 and R9 will have a new bowel and bladder assessment completed and NAR Care Sheets and Care Plan will be updated to reflect this information by the MDS Coordinator. NA-A and NA-H will be educated on following the residents repositioning care plans and asking for assistance if needed.	

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F 686	Continued From page 60 cm with minimal clear exudate. The staff were to apply barrier cream with cares. R42's care plan dated 5/9/17, indicated R42 required assistance with bed mobility, was at risk for skin breakdown and directed the staff to assist with repositioning every three hours. R42's Braden Scale assessment (tool used for the prediction of pressure sore risk) dated 7/15/18, indicated R42 was at high risk for the development of pressure ulcers. R42's Tissue Tolerance Assessment (tool to use to determine the amount pressure tissue can sustain over bony prominences over time) dated 1/14/18, indicated R42 was able to tolerate being positioned in the same position for three hours. On 7/30/18, at 4:50 p.m. R42 was observed seated in a wheelchair, in the dining room. Staff were providing R42 total assistance to eat the supper meal. -At 6:00 p.m. R42 was assisted to living room area and positioned in front of the television. -At 7:06 p.m. nursing assistant (NA)-H wheeled R42 from the living room to her room. Once in her room, NA-H exited the room. R42 remained seated in the wheelchair. -At 7:14 p.m. NA-H returned to the room and began assisting R42 with evening care. -At 7:24 p.m. R42 was transferred from the wheelchair to the bed via a ceiling lift. R42's wheelchair was noted to be equipped with a pressure redistribution cushion on it. -At 7:27 p.m. NA-H positioned R42 on her side, which exposed a thin Duoderm (hydrocolloid dressing used for the management of lightly exuding wounds) on R42's coccyx which was	F 686	NA-N, NA-O and NA-M will be educated on providing repositioning, toileting and peri-cares per resident care plan. 1) All residents at risk for pressure ulcers have potential to be impacted by this practice. 2) DON and/or designee will educate all nursing staff who are completing comprehensive skin assessments, including skin assessments upon readmission, on the process of doing thorough skin assessments, including the removal of any dressings to assess skin underneath (unless ordered otherwise by the MD) and reviewing all medical records prior to the resident□s admission/readmission to identify any previous skin alterations. MDS Coordinator will be re-educated on the importance of reviewing medical records, nursing documentation and coordinating with other nursing staff in gathering information about resident prior to completing Section M of the MDS for accuracy according to the RAI manual. 3) DON and/or designee will educate all nursing staff on the Urinary Incontinence Program Policy, Skin Ulcer Protocol Policy, Skin Documentation Policy and Repositioning Policy, to ensure we are following residents toileting and repositioning plans. Education will also be provided to change a residents incontinent product if it indicates a resident was incontinent. 2) Facility Wound Nurse will reassess all residents at risk for developing pressure ulcers or with current pressure ulcers, to ensure the appropriate interventions have	

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F 686	Continued From page 61 peeling off. NA-H informed licensed practical nurse (LPN)-E that the dressing was coming off. LPN-E observed the wound and stated she would notify the registered nurse. -At 7:33 p.m. NA-H stated R42 had been assisted out of bed and into the wheelchair around 3:30 p.m. -At 7:37 p.m. registered nurse (RN)-B removed the Duoderm dressing which revealed an approximately three inch by two inch area on R42's coccyx with two open areas within the wound. The wound bed had deep red / purple colored areas which were not bleeding. RN-B stated R42 had a history of very acidic stools which caused skin damage to the area RN-B cleansed the wound and applied a fresh Duoderm dressing over the area. RN-B stated the wound was not due to pressure rather was due to moisture related skin damage. -At 7:58 p.m. LPN-E stated she had not seen the wound for several days, however, thought the wound appeared worse than it had a week ago. -At 8:02 p.m. NA-H reviewed the nursing assistant assignment sheet and confirmed R42 had last been assisted with repositioning at 3:15 p.m. (a total of 4 hours and 10 minutes without repositioning). Review of R42's Skin Contrition/Wound Progression documentation revealed the following: - 6/25/18, at 1:06 p.m. R42 was observed to have moisture associated skin damage on the left gluteal fold/coccyx region. Measurements of the area were not recorded. The area was described as having ill defined borders, denuded (missing layers of the skin) in multiple area with erythema (redness) throughout. Moist wound bed which	F 686	been implemented to promote wound healing and prevent skin breakdown. 3) DON and/or designee will perform random audits of nursing skin assessments 4x/week x 4 weeks starting week of 9/3/18, then 2x a week x 4 weeks, then weekly there after to ensure skin assessments/treatments are appropriate/effective. 4) DON and/or designee will perform random audits of ensuring residents are repositioned and toileted per their care plan 4x/week x 4 weeks, starting the week of 9/3/18, then 2x/week x 4 weeks, then weekly there after. 5) Audit results will be brought to the QAPI committee quarterly for review and further recommendation. 6) Completion date will be 9/10/18.	

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F 686	Continued From page 62 was blanchable and painful to touch. The treatment was to apply a barrier cream for skin protection. - 7/2/18, the wound measured 4.5 cm x 3.5 cm. The wound bed was moist, pale pink with scant serosanguinous draining. The dressing at the time was Allevyn dressing (foam dressing). The staff were educated on the application of ointments, frequency of peri-cares, importance of off-loading and protecting the skin from shearing forces. - 7/9/18, the wound measured 5.0 cm x 3.5 cm. The wound bed was moist, pale pink with moderate serosanguinous draining noted to 50% of the old dressing. The wound was painful to touch. - 7/16/18, the wound measured 5.3 cm x 4.5 cm. - 7/24/18, the wound measured 5.5 cm x 5 cm. - 7/30/18, the wound measured 4.2 cm x 3.7 cm. The wound bed was moist, beefy red with no visible drainage. Dressing of Duoderm (hydrocolloid dressing) to the area. - 7/31/18, clarification of 7/30/18, documentation: wound bed was not "beefy red" it was bright red and bleeding due to the removal of barrier cream prior to assessment. - 7/31/18, the wound measured 5.5 cm x 3.5 cm x 0.1 mm in depth. Wound bed forms four separate open areas, irregular wound edges. Wound bed is very wet, pink and white in color, pool of clear fluid noted under Duoderm when dressing was removed. All wound edges and bed macerated in appearance. Buttock skin is moist to touch. Area shows improvement within the wound bed itself but the location and edges have extended towards the sacral region compared to the initial assessment due to further skin breakdown of the area. Denudation of the periwound migration towards boney prominences.	F 686		

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Increased moisture to area is causing impaired healing and is continued to be at a high risk of skin breakdown. Multiple wound dressings have been attempted including but not limited to Allevyn, Mepilex, foam with Tegaderm and Duoderm. A trial of different incontinent products had been attempted without success.

On 8/1/18, at 7:23 a.m. R42 was observed seated in a wheelchair, in the television lounge.

-At 8:31 a.m. R42 was wheeled into the dining room and was fed breakfast by NA-B.
-At 8:42 a.m. R42 was wheeled back into the television lounge.
-At 9:35 a.m. R42 was transferred from the wheelchair to the bed via a ceiling full body lift.
-At 9:38 a.m. R42 was rolled onto her side. No dressing was on the open area on her coccyx and the area was noted to be actively bleeding.
- At 9:43 a.m. RN-B measured the wound and reported it was 5.2 cm x 3.3 cm x 0.1 cm. R42 winced and moaned when the wound was touched. RN-B stated the nurse practitioner had been contacted and discontinued the Duoderm dressing on 7/31/18, and the staff were directed to leave the wound open to air as much as possible. RN-B confirmed the area was bleeding but stated this was an improvement of the wound.
-At 9:45 a.m. NA-A stated R42 had been assisted out of bed at 6:30 a.m. a total of 3 hours earlier.
-At 9:51 a.m. RN-B stated R42's wound was related to moisture, therefore, pressure was not involved with the development of the skin breakdown. RN-B stated R42's wound started as a moisture / macerated area, however, it was now open and bleeding. RN-B stated R42 was to be repositioned every three hours according to the care plan and should not have been in the

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wheelchair for greater than four hours without repositioning assistance, therefore, pressure may have been a contributing factor in the area opening.

- At 11:38 a.m. the director of nurses (DON) reviewed R42's repositioning schedule and skin assessments. The DON stated R42's wound had initially started as a moisture related skin damaged area, however, she had not received assistance with repositioning. The DON stated R42's tissue tolerance/tissue perfusion test may not be accurate as the repositioning schedule for a resident with damaged skin would not be appropriate at an every 3 or 4 hour repositioning interval. The DON stated she had not visualized R42's skin breakdown, however, verified that the skin documentation noted the area appeared to have gotten larger.

-At 1:20 p.m. the DON observed R42's buttocks and confirmed the wound was open and bleeding. The DON stated she was not aware the area had started to bleed and confirmed the open area was due to prolonged pressure. The DON verified R42's pressure ulcer had developed while in the facility.

R20's quarterly MDS dated 6/19/18, indicated R20 had intact cognition, and diagnoses which included anxiety, depression, and neurogenic bladder. The MDS also indicated R20 required extensive assistance for all ADLs, utilized an indwelling urinary Foley catheter, had no skin concerns, and was at risk pressure related ulcers.

R20's Pressure Ulcer CAA dated 3/19/18, indicated R20 had a low risk for pressure related ulcers, required assistance with repositioning

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and utilized Nystatin (medicated powder) for moisture related irritation twice a day. The CAA did not identify any open areas at the time of the assessment.

R20's current Physician Orders dated 7/20/18, included an order in which R20 was to lay in bed for 1-2 hours after meals, three times a day, to prevent skin breakdown. The staff were to document refusals in the progress notes.

R20's Braden Scale for Predication Pressure Sore Risk dated 6/19/18, indicated R20 was at low risk for the development of pressure ulcers.

R20's care plan dated 8/15/16, indicated R20 was at risk for skin breakdown due to impaired mobility and history of incontinence associated dermatitis to the buttocks. The care plan directed the staff to encourage R20 to lay down in the afternoon and to complete skin inspections weekly. The plan indicated R20 required extensive assistance of 1-2 staff for repositioning, however, R20 frequently refused to reposition.

On 7/30/18, at 6:04 p.m. R20 stated she had developed a pressure sore on her bottom between her leg and thigh from the catheter tubing rubbing on her skin and it had been present for the past couple of weeks.

R20's Rainy Lake Medical Center Hospital admission History and Physical dated 6/13/18, indicated R20 was admitted to the hospital with a "deep tissue injury to her buttocks and coccyx areas; no current stageable ulcer."

R20's clinical record indicated R20 returned from the hospital on 6/18/18. R20's

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Admission/Readmission Skin Assessment dated 6/18/18, indicated R20 had an Allevyn dressing on her coccyx. However, the documentation did not identify what was under the dressing or any abnormal skin concerns on R20's buttocks.

R20's clinical record contained an Informed Consent dated 3/30/18, at which time the facility had discussed the risk benefits for non compliance with refusing to reposition out of the recliner. R20 was informed of potential continued skin breakdown, wounds, pain and infection at side due to decreased mobility, the development of pressure ulcer and potential infections. However, the clinical record did not include any type of education provided after returning to the facility on 6/18/18.

On 8/1/18, at 8:10 a.m. R20 was observed in bed while NA-A and NA-J assisted with morning cares. NA-A handed R20 a washcloth and R20 was observed to wash her upper body and perform perineal cares independently.

-At 8:11 a.m. LPN-D applied Nystatin powder under R20's abdominal folds. R20's perineum was dark red/purple in color on the right side, whereas, the left side was normal flesh tones. When questioned if R20 had any skin concerns, LPN-D stated R20's perineum was always darker on one side. The buttocks was not exposed at this time.

-At 8:16 a.m. NA-J and NA-A connected R20 to a full body ceiling lift. R20 sat up in the bed while the NAs placed the sling behind R20's back and under her thighs. The NAs were not observed to assist R20 to roll over as they placed the sling, therefore R20's buttocks was not exposed.

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F 686	Continued From page 67 Throughout the cares and transfer assistance R20's buttocks was not exposed and could not be visualized. -At 8:17 a.m. R20 was transferred from the bed to the toilet via the ceiling lift. R20's buttocks was noted to be dark on the right side with several superficial dry areas. R20's buttocks was observed to be bleeding, however, the area could not be fully visualized while in the lift. -At 8:21 a.m. R20 was transferred off of the toilet. While in the ceiling lift, LPN-D applied barrier cream to the buttocks. LPN-D confirmed R20 had open areas on her buttocks that were bleeding, however, LPN-D did not assess the areas prior to the application of the barrier cream. R20 was transferred into the wheelchair and seated on an incontinence brief. Review of R20's clinical record lacked documentation related to the deep tissue injury or open bleeding areas. -At 2:18 p.m. the DON stated she was not aware of any open bleeding areas on R20's buttocks. The DON stated R20 had a history of picking on the skin on her buttocks and often had open areas. The DON stated the areas would have to be assessed and documented. The DON confirmed the clinical record lacked documentation related to the open areas. -At 3:15 p.m. the DON and NA-D were observed to transfer R20 off of the toilet via the full body ceiling lift. When lifted into the air, R20's right buttocks from approximately mid buttocks to the perineal area was noted to be deep red/purple in color with multiple dry scaly areas. Blood dripped	F 686		

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onto the floor while R20 was in the lift, however, the area to which the blood was coming from could not be determined while in the lift. The DON confirmed R20's buttocks was bleeding, yet the DON did not complete a skin assessment to identify the bleeding area. R20 was transferred into a recliner which was equipped with an open incontinence brief.

-At 3:20 p.m. R20 stated she had been up in her wheelchair all day, but would inform the staff when it was time to be off of her buttocks and to sit in a different chair. R20 stated she made her own decisions.

- At 3:35 p.m. the DON reviewed the discharge summary from the hospitalization on 6/18/18, and stated she was unaware R20 had been identified with a deep tissue injury while at the hospital. The DON stated the RN charge nurse should have identified injury when R20 returned from the hospital. The DON also confirmed R20's skin assessment completed upon return from the hospital on 6/18/18, did not identify what type of skin injury was under the Allevyn dressing and no further documentation related to the deep tissue injury was noted in R20's record. The DON verified R20 did not receive a comprehensive skin assessment upon return from the hospital, interventions to prevent/minimize the risk of tissue injury were not added to the record and an investigation regarding the origin of the injury was not conducted.

On 8/2/18, at 3:45 p.m. RN-A/MDS coordinator confirmed she had completed R20's MDS on 6/19/18, and stated she reviewed the clinical record and completed the assessment. However, RN-A stated she had observed R20's buttocks at

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 69 the time of the assessment and was unaware of the deep tissue injury identified on 6/13/18. On 8/3/18, at 8:55 a.m. the DON provided a skin assessment completed on 8/2/18. R20's Skin Assessment Tool dated 8/2/18, indicated the following areas of concern: -A 0.5 cm x 0.1 cm oval shaped open area on the right inner thigh. -A 2.0 x cm x 3 cm area with 7-8 superficial opening areas that were irregularly shaped with jagged borders on the left buttocks. -A 0.3 x 0.3 cm open area was noted on the left buttocks. -The upper portion of both buttocks had a 12.0 cm area which was red in color. -The lower buttocks had a 14 cm area which was deep purple in color. - A superficial linear excoriation on the left buttocks with an open area of 0.1 cm x 0.5 cm. -The left labia had a 0.1 x 0.3 open area. -The right labia had five open areas measuring from 0.5 cm x 1.0 cm to 1.0 cm x 0.7 cm. The open areas were noted to have jagged borders and varied in depth. The assessment indicated all the aforementioned areas were blanchable. -The skin assessment also indicated R20 and RN-B had discussed the open areas identified on the assessment. R20 had a history of picking the skin on her buttocks and reported to RN-B she could not reach the areas of her skin identified on the assessment. RN-B assisted R20 into the restroom at which time R20 was observed to perform self rectal stimulation. -At 8:55 a.m. the DON confirmed R20 has a history of picking at her skin and self stimulating	F 686		

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her rectum. The skin assessment did not include a root cause of the identified areas and did not indicate when the areas had developed. The deep purple/red areas were identified, however, the assessment did not identify the area as a deep tissue injury. When asked, the DON stated the deep tissue injury diagnoses was "just a crazy ER [emergency room] doc [doctor]."

On 8/3/18, at 12:40 p.m. the administrator/RN reviewed R20's clinical record and confirmed the hospital had diagnosed R20 with a deep tissue injury. The administrator stated she would expect a comprehensive skin assessment to be completed upon return from the hospital.

-At 1:10 p.m. RN-B/wound nurse stated she had not identified R20's purple skin area upon return from the hospital and was unaware it had been diagnosed as a deep tissue injury by the emergency room physician. RN-B stated she felt the darkened skin may have been a side effect of a medication (Plavix) however, confirmed the area had not been identified in R20's record prior to the hospitalization. RN-B confirmed the skin assessment completed on 8/2/18, identified multiple open areas and a root cause analysis of the areas had not been completed. RN-B stated she did not feel the open or discolored areas were new for R20, however, RN-B was unable to provide additional documentation related to the identified areas.

R9's facility Face Sheet dated 8/1/18, indicated R9 was diagnosed with chronic renal disease.

R9's 30 day MDS dated 5/22/18, indicated R9 had severely impaired decision making skills, was dependent on two plus staff for bed mobility,

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and transfers and one staff member for toileting, dressing, and personal hygiene. The MDS further indicated R9 was always incontinent of bowel and bladder, was at risk for pressure ulcers, had a stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough, may present as an intact or open blister) which was not identified on the MDS dated 5/7/18, had stage III (full thickness tissue loss) pressure ulcer which was present upon re-admission to the facility. Pressure ulcer interventions included pressure reducing device for bed and wheelchair, and a turning repositioning program.

R9's General Nurse's Observation (facility Care Area Assessment documentation) dated 4/26/18, indicated R9 was at high risk for skin break down, was repositioned every two hours by staff, and peri-care was provided after soiling.

R9's bed mobility care plan dated 3/30/17, directed two staff to turn and reposition every two hours. The pressure ulcer care plan dated 7/20/18, identified a pressure ulcer to the left heel and directed staff to inspect skin weekly, observe skin daily with cares, turn, and to reposition every two hours. The wheeling care plan dated 5/11/17, indicated R9 used a tilt-n-space wheelchair. The skin care plan dated 8/12/16, indicated R9 was at risk for skin breakdown related to decreased mobility, poor dietary intake, and spending most time in bed. The skin care plan directed staff to conduct a systemic skin inspection weekly paying special attention to the bony prominences, keep skin clean and dry as possible, and to minimize skin exposure to moisture, and to report any signs of breakdown.

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R32's clinical record lacked evidence of periodic assessment or evaluation for a turning and repositioning schedule to prevent the development or reduce the risk of pressure ulcers.

On 7/30/18, at 4:48 p.m. R9 was observed lying in bed as NA-A and NA-N entered the room to get R9 up for dinner. NA-M checked R9's incontinent garment which showed yellow lines with two semi green lines which indicated some urinary incontinence. NA-M stated the yellow lines indicated dryness therefore she was not going to change R9's incontinent garment because it was not wet enough. NA-M stated the incontinent briefs were not changed unless there were only two yellow lines and the rest were blue.
-At 4:55 p.m. NA-N and NA-M transferred R9 into her wheelchair. R9 was not offered to use the toilet and/or bedpan and was not provided with incontinence peri-care.
-At 5:00 p.m. R9 was wheeled down to the dining room where she sat in her wheelchair until 6:11 p.m. at which time an unidentified staff member pushed her into the living room area.
-From 6:11 p.m. to 7:55 p.m. R9 remained in the living room, seated in the wheelchair. At this time, NA-M assisted R9 back to her room. NA-M stated R9 was supposed to be repositioned and have her incontinent brief checked and changed every two hours.
-At 8:10 p.m. NA-M and NA-N transferred R9 into bed. Once R9 was in bed, the incontinent brief was had shown all blue lines which indicated total urine saturation. Once the brief was removed, R9's left buttock revealed a half dollar size area of redness and the right upper buttock revealed five dime sized spots of redness.
-At 8:25 p.m. LPN-B and RN-B observed R9's

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buttocks and confirmed the areas of redness. RN-B stated the areas of redness were blanchable, and verified R9 was at risk for pressure ulcers and thought she was supposed to be repositioned every two hours.
R9 had not received repositioning assistance for three hours and 22 minutes.

On 8/1/18, at 7:38 a.m. R9 was observed lying in bed as NA-0 provided morning cares. NA-O stated she was not sure when the last time R9 was checked and changed and was supposed to be toileted every two hours. NA-0 further stated R9 could go on the toilet and knew when she had to go. NA-O stated R9 leaked urine when she coughed, but otherwise was continent of urine. R9's incontinent brief revealed incontinence demonstrated by four blue lines, R9's buttocks continued to show the same areas of blanchable redness as on 7/30/18. NA-0 asked R9 if she needed to go to the restroom in which R9 replied "no."
-At 8:45 a.m. NA-O assisted R9 to transfer into the wheelchair.

On 8/2/18, at 2:06 p.m. RN-A confirmed R9 was at risk for pressure ulcers and should be repositioned as directed by the care plan.

R32's facility Face Sheet dated 8/2/18, indicated R32's diagnoses included generalized muscle weakness, nutritional deficiency, chronic kidney disease stage 3, and Alzheimer's disease.

R32's quarterly MDS dated 7/17/18, indicated R32 had severely impaired decision making skills, and required extensive assist of two plus staff for bed mobility, transfers, and for toileting. In addition, the MDS indicated R32 was at risk for

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pressure ulcers an required a pressure relieving device for wheelchair and bed, and a turning and repositioning program.

R32's General Nurse's observations (facility documentation of Care Area Assessment) for skin dated 7/2/18, indicated R32 was at low risk for pressure ulcers, had urinary incontinence, and had a tendency to over wash the groin area which resulted in reddened skin. The CAA also indicated R32 was monitored and staff were directed to keep dry related to incontinence. The CAA did not reflect an assessment for a turning and repositioning program.

R32's Braden Scale indicated R32 was at low risk for pressure ulcers.

R32's bed mobility care plan dated 4/16/18, indicated R32 was dependent on two staff to reposition in bed. The skin care plan dated 8/15/16, indicated R32 was at risk for skin breakdown related to functional decline secondary to advanced Alzheimer's and incontinence. The interventions included reposition every 3-4 hours during the day, and on the first and last rounds during the night shift (last revised on 3/15/17). The toileting care plan indicated R32 was occasionally incontinent of bowel and bladder and to toilet every 3-4 hours.

R32's aide care guide last updated 7/31/18, conflicted with the care plan in that it directed staff to toilet every 2-3 hours.

R32's clinical record lacked evidence of a periodic assessment or evaluation for a turning and repositioning schedule to prevent the development or reduce the risk of pressure

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ulcers. The last Tissue Tolerance - Repositioning observation was dated 5/16/16, and indicated, R32 required repositioning while sitting and lying every four hours.

On 7/30/18, at 4:45 p.m. R32 was observed in the dining room, seated in the wheelchair. When completed with her meal, R32 was wheeled to the adjacent living room area.
-At 6:58 p.m. R32 continued to sit in the same position in her wheelchair in the living room area where she remained seated until 7:55 p.m.
-At 7:55 p.m. NA-M referenced her aide care guide and stated R32 was last repositioned at 4:20 p.m. and confirmed R32 was to be repositioned every 2-3 hours.
-At 9:06 p.m. R32 was wheeled to her room. NA-M and NA-N stated the bath aide had called in therefore they were working short staffed. NA-N stated that was why the residents were not getting repositioned/offloaded on time.
-At 9:14 p.m. NA-M and NA-N transferred R32 from the wheelchair to the bed. When R32 stood up, a strong urine odor was noted. R32's incontinent brief was saturated with urine. R32's skin did not have any areas of redness or breakdown. NA-B stated R32 was last checked for incontinence around 3:30 or 4:00 p.m.
-At 9:18 p.m. LPN-B stated R32 had been repositioned about 9:00 p.m. by tilting her wheelchair all the way back in order to change the load on pressure points.
R32 was not assisted to reposition for four hours and 29 minutes.

On 8/3/18, at 11:30 a.m. the DON stated she expected staff to follow the residents' toileting and repositioning care plans as directed. The DON also stated Braden Scale assessments were

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supposed to be done quarterly and with a change of resident condition, and Tissue Tolerance Observations were supposed to be done upon admission, upon hospital returns, significant changes, and changes in surfaces such as a new wheelchair cushion.

The Skin Ulcer Protocol dated 11/1/15, indicated the staff were to identify any skin concerns and document the findings in the clinical record.

The Facility's Repositioning Policy dated 10/23/16, indicated the following:
-All the residents would be repositioned per their individualized assessment.
-All residents would be repositioned based on the results of their individualized Tissue Tolerance Test.
-Nursing assistants may utilize the aide assignment sheet to track when the resident was actually repositioned. This sheet would include a list of the residents for which the nursing assistants were responsible for during their shift.
-At shift change, the nursing assistants would communicate the actual time the resident was last repositioned to the oncoming shift so a seamless transition occurred and the resident's repositioning schedule continued.

The undated Skin Documentation Policy, indicated the following information:

-A Braden Scale and Tissue Tolerance Test were to be completed upon admission and weekly for the first four weeks after admission, then quarterly, annually and with a significant change to assess any risk factors.
-A Tissue Tolerance Test lying and Sitting would be completed upon admission, annually and with

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F 686	Continued From page 77 any significant changes or changes in surfaces. -The nurse manager was to assess all risk factors for impaired skin integrity and/or delay wound healing and document findings in the medical record. -The wound nurse was to coordinate with the interdisciplinary team and complete a comprehensive care plan with all identified risk factors, goals and related interventions. -Any identified skin concerns were to be reported to the nurse immediately. -A nurse was to monitor the resident skin weekly -The primary care physician was to be notified within 24 hours of any new skin alteration, except when the physican requested to only be notified on routine rounds. -Any new wound discovered were to have a comprehensive review to ensure all risk factors are identified and current integrations were in place. The care plan was to be adjusted accordingly. -Any wounds would be monitored daily by licensed nurse. -Measurements of wounds will be taken and characteristics will be monitored until the wound is healed. -If no improvement with the wounds was noted within 2-4 weeks, a new treatment was to be attempted if necessary. -All wounds would be reviewed and discussed with the IDT weekly and as needed, at quality assurance performance improvement monthly (QAPI) meeting and QAPI meeting with the medical director.	F 686		
F 689 SS=E	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents.	F 689		9/10/18

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F 689	Continued From page 78 The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safe transfer requirements for 4 of 4 residents (R42, R20, R18, R43,) observed to be transferred via full body mechanical ceiling lifts. In addition the facility failed to comprehensively evaluate safe transfers for 2 of 2 residents (R9 and R32) who were unable to bear weight. Findings include: R42's quarterly Minimum Data Set (MDS) dated 7/16/18, indicated R42 had severe cognitive impairment and diagnoses including Alzheimer's dementia and depression. The MDS indicated R42 required total assistance with bed mobility, transfers and all other aspects of activities of daily living (ADL). R42's care plan dated 2/6/18, indicated R42 was to be transferred via a full body ceiling lift and was to use a medium sized full lift sheet. The staff were to remove the transfer sling from under R42 when in bed or chair. R42's clinical record contained a Progress Note (PN) dated 7/17/18, by the physical therapist which indicated R42 was to be transferred via a ceiling lift. The clinical record did not contain a comprehensive transfer assessment which would	F 689	F689 Free of Accident Hazards/Supervision/Devices 1) DON and/or designee will complete comprehensive transfer assessments on R42, R20, R18, R9, R32 and R43 to determine the safest transferring method and equipment. 2) DON and/or designee will update R42, R20, R28, R9, R32 and R43 Care Plans and NAR Care Sheets to reflect transferring method, including sling type and size. 3) All residents who need assistance with transfers have potential to be impacted by this practice. 4) DON and/or designee will educate all staff on the Mechanical Lift Policy, including utilizing the appropriate mechanical lift, sling type, sling size and 2 staff with all mechanical lift transfers and to update the licensed nurse immediately with any change in residents transfer status. 5) DON and/or designee will complete competencies for transferring with a mechanical lift with all nursing assistants. 6) DON and/or designee will assess all residents who need assistance with transfers to determine if they need mechanical assistance. If determined that	

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F 689	Continued From page 79 direct the staff regarding the type of lift to use, the type of sling to use, the size of sling or the number of staff members required to ensure safe transfers. On 7/30/18, at 7:24 p.m. R42 was observed to be assisted to transfer from her wheelchair to the bed via a full body ceiling lift. Nursing assistant (NA)-H was observed to lean R42 forward in her wheelchair and apply a toileting sling under her arms, and connected them to the ceiling lifting device. NA-H slid straps under R42's thighs, crossed the thigh straps and connected them to the ceiling lift device. NA-H pushed the lift controls and lifted R42 out of the chair. R42 was observed to have direct pressure in her axilla area while being transferred from the chair to the bed. NA-H was the only staff member in the room at the time of the transfer. On 8/1/18, at 9:35 a.m. R42 was observed seated in a wheelchair. Licensed practical nurse (LPN)-D and NA-A assisted to place a toileting sling behind R42's back and under her axilla, placed the leg straps under R42's thighs and connected the sling to the lift. LPN-D then utilized the machine and the two staff transferred R42 from the wheelchair to the bed. While R42 was in the lift, direct pressure was observed on R42's axilla. -At 10:16 a.m. NA-A stated she did not know how the slings were chosen for R42. NA-A stated R42 had been transferred to the toilet in the past, but had not utilized the toilet for several months. NA-A confirmed R42's arms had direct pressure on them while in the toileting sling. R42's PN dated 6/2/18, indicated R42 was noted	F 689	they need mechanical assistance, they will be assessed if they are appropriate to utilize a EZ Stand or if they will need to use a Hoyer/Ceiling lift. The assessment will include the type of lift, type of sling, size of sling, and all mechanical lifts require assist of 2 staff members. All residents Care Plans and NAR care sheets will be updated as needed based off of transfer assessment. 4) DON and/or designee will perform random audits on resident□s transfers to ensure they are being safely transferred and per their care plan, beginning 9/3/18 4x/week x4 weeks, then 2x/week x4 weeks, then once weekly thereafter. 5) Audit results will be brought to the QAPI committee quarterly for review and further recommendation. 6) Completion date will be 9/10/18.	

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to have a blister in her left axilla. The documentation did not identify the size or any further description of the area. No further documentation related to R42's blister was noted in the clinical record.

On 8/1/18, at 12:01 p.m. the director of nurses (DON) stated the facility had two types of full body slings. The first was a full body sling which would cradle the resident's upper body during transfers. The second was a toileting sling which would allow the staff to assist with removing pants and the resident could be transferred onto the toilet. The DON stated R42 did not use the toilet therefore she should use the full body sling which would be easier on her arms. The DON stated it was the facility policy to ensure two staff members were present during full body mechanical lift transfers, however, the manufacture instructions identify that one person is safe to use the ceiling lift. The DON stated it was expected that two staff members to be present at the time of full body lift transfers. Upon review of R42's clinical record the DON stated she was unaware of the blister identified on 6/2/18, and would have to look into the concern.

R20's quarterly MDS dated 6/19/18, indicated R20 was alert and oriented with diagnoses including anxiety, depression, and neurogenic bladder. R20 required total assistance for transfers and extensive assistance for all other activities of daily living and utilized an indwelling urinary catheter.

R20's care plan dated 8/4/17, indicated R20 was unable to transfer independently. The plan directed the staff to assist R20 to transfer via a ceiling lift and two staff.

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R20's PN dated 6/21/18, at 4:03 p.m. indicated the physical therapist had identified R20 as being non-weight bearing and utilized a full body mechanical lift for transfers. The note did not indicate the size or type of sling R20 was to utilize or the number of staff members required to ensure safe transfers.

R20's clinical record did not contain a transfer assessment.

On 8/1/18, at 8:16 a.m. NA-J and NA-A connected R20 to a full body ceiling lift. R20 sat up in the bed while the NA's placed the sling behind R20's back and under her thighs. The NA's were not observed to assist R20 to roll over as they placed the sling.
-At 8:17 a.m. R20 was transferred from the bed to toilet via the ceiling lift. The thigh straps were observed to shift from R20's thighs to behind her knees. While in the lift, R20's knees were observed to be raised higher than her hips. R20's buttocks was observed to be approximately six inches lower than her hips and R20 held onto the upper body straps to hold herself up in the lift with her axilla and hands.

-At 8:21 a.m. R20 was transferred off of the toilet. While in the ceiling lift, the NA-J was observed to perform perineal cares. R20 was approximately four feet off of the ground and began to turn (twirl) while in the air. NA-J stopped R20 from turning and utilized the lift to transfer R20 from the bathroom to the wheelchair. NA-I was in the room at the time of the transfer but was not observed to help with the transfer.

-At 8:28 a.m. licensed practical nurse (LPN)-D

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entered R20's room. LPN-D confirmed R20 was hanging from her armpits and the thigh strap was not positioned appropriately to give support while in the lift.

-At 10:16 a.m. NA-A stated R20 was able to use a toileting sling during transfers, however, the straps had slipped down to her knees during the transfer at 8:20 a.m. NA-A stated when the straps were positioned properly, R20 was able to safely transfer via the ceiling lift. NA-A confirmed R20 should not have been allowed to twirl while in the sling. NA-A stated she should have held the sling to prevent it from spinning.

-At 3:15 p.m. R20 was observed to transfer off of the toilet via the full body ceiling lift by the DON and NA-D. When lifted into the air, R20's leg straps were again observed to be positioned behind R20's knees causing her hips to be lower than the knees. R20 was transferred from the toilet to a recliner.

On 8/1/18, at 3:58 p.m. the DON confirmed R20 required assistance of two staff for transfers. R20 had the ability to use the ceiling lift affect when the straps were positioned properly. The DON confirmed the leg straps were to be positioned under R20's thighs to ensure proper body alignment while the lift. The facility did not have a transfer assessment for R20 while in the lift.

R18's quarterly MDS dated 6/18/18, indicated R18 displayed severe cognitive impairments and required total assistance with all activities of daily living. The MDS indicated R18 was unable to ambulate.

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R18's Transfer Status Progress Note dated 12/16/17, indicated R18 was unable to bear weight and was to be assisted to transfer via a mechanical lift and two staff.

R18's care plan dated 1/17/18, indicated R18 was dependent upon staff for all transfers. The plan directed two staff to assist R18 with a full body mechanical lift.

On 8/1/18, at 7:15 a.m. R18 was observed to be assisted to transfer from the bed to a rock and go wheelchair (reclining wheelchair) via a full body mechanical ceiling lift. NA-A and NA-I positioned R18 onto a full body sling and connected it to a ceiling lift. Once R18 was connected to the lift, NA-A proceeded to transfer R18 from the bed to the chair, while NA-I made R18's bed. NA-I was not observed to participate in assisting R18 to transfer.

-At 10:16 a.m. NA-A and NA-I stated they did not know how the slings were chosen for each resident. NA-A stated R18 required the use of a full body sling because he would not keep his arms in the correct position while in the toileting sling.

On 8/2/18, at 3:35 p.m. RN-A stated stated R18 was to be assisted to transfer via a full body lift and two staff members.

On 8/2/18, at 4:10 p.m. the DON stated it was the facility policy to have two staff members assist with ceiling lift transfers, however, only one staff member was required in accordance with the manufactures guidelines. The DON stated she would expect two staff members to be present during ceiling lift transfers.

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F 689	Continued From page 84 R43's quarterly MDS dated 7/17/18, indicated R43 had moderate cognitive impairment and diagnoses of hemiplegia and seizure disorder. The MDS indicated R43 required extensive assistance from two plus staff for transfers. R43's care plan dated 4/26/17, indicated R43 required total assist of two staff to transfer with mechanical lift. The Care Plan directed the staff to utilize a medium lift sheet with a ceiling lift and encourage R43 to hold onto the lift sheet during transfers. On 7/30/18, at 2:41 p.m. R43 was observed seated in a wheelchair, in his room. NA-M and NA-N applied a lift sheet for the ceiling mechanical lift. NA's the lower straps of the lift sheet were crossed in between R43's legs and connected to the ceiling lift mechanism. R43 was lifted from the wheelchair to the bed; the lift sheet was applied appropriately and supported the R43 in an upright sitting position. -At 8:47 p.m. R43 sat in his wheelchair in his room. NA-M and NA-N applied the lift sheet, and placed the straps underneath R43's legs, however, did not crisscross the straps. NA's lifted R43 out of the wheelchair. R43 did not sit in an upright position, his knees were observed to be higher than the level of his hip causing his bottom to sit or hang lower than the legs. R43 was transferred to the toilet in the restroom. On 8/2/18, at 2:35 p.m. physical therapist (PT)-A stated the lift sheet leg straps should always be crossed in-between the legs on the full body lift to ensure safety.	F 689		

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F 689	Continued From page 85 On 8/3/18, at 11:39 a.m. the DON stated the lift sheet leg straps should always be crossed in-between the legs and then connected to the lift to ensure safety. R9's 30 day Medicare MDS dated 5/22/18, indicated R9 had severely impaired cognitive impairment and R9 was totally depend upon staff for bed mobility and transfers. R9's care plan dated 5/11/17, indicated R9 directed the staff to transfer R9 with assistance of two staff members, a gait belt and to ensure R9 utilized proper footwear. The plan indicated R9 was to have an evaluation by physical therapy. R9's Physical Therapy Progress note dated 6/19/18, indicated R9's transfer ability was improving. R9 had been transferred with assistance of two onto the toilet, but did require the stand aide to get off of the toilet and into bed. On 7/30/18, at 4:48 p.m. R9 was observed seated on the side of her bed. NA-M applied a transfer belt around R9's waist. NA-M and NA-N stood on either side of R9 and laced their arms underneath R9's arms and lifted R9 up to a standing position. R9 did not assist in the transfer from sit to stand position. The NA's continued to hold up R9 and turned her to sit in the wheelchair, R9 did not move her feet to assist in the turn. -At 7:55 p.m. R9 was observed seated in her wheelchair with NA-M and NA-N on either side of R9. The NA's applied a gait belt around R9's waist and lifted R9 out of the wheelchair. R9 did not assist in the transfer from the wheelchair to standing position. The NA's then turned R9 around to sit on the bed. R9 did not move her feet	F 689		

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during the transfer. NA-N stated R9 had been hospitalized in April of 2018. Upon returning from the hospital, R9 was weak and required a full body mechanical lift. However, R9 had improved and was able to bare her own weight, thus she had been changed to a two person transfer. NA-N confirmed R9 did not bare her own weight during the transfer and a full body lift could be considered because of the non-weight baring status.

On 8/1/18, at 7:38 a.m. R9 sat on the side of her bed. NA-0 and NA-P stood on each side of R9. The NA's applied a gait belt and lifted R9 to a standing position. R9 did not assist in the transition from sit to stand. NA-0 and NA-P were on the sides of R9 and turned R9 to sit in the wheelchair. R9 attempted to move her feet. NA-0 stated R9 was bearing some weight but not very much.

-At 9:55 a.m. the DON and NA-P transferred R9 from wheelchair to bed using a gait belt. R9 was not observed to bare weight during the transfer. NA-P confirmed R9 did not bare weight during the transfer.

On 8/2/18, at 2:35 p.m. the physical therapist (PT)-A stated in order for residents to be transferred with two staff they needed to be able to bear at least 70% of their own weight. If the resident was not able to bear at least 70% then a mechanical lift was to be utilized. PT-A further stated she was unaware of any concerns related to R9's transfer ability. PT-A indicated it was not appropriate or safe to lift a resident up underneath the arms and/or physically lifting a resident up from a sitting to standing position. PT-A indicated R9 was a full body mechanical lift

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upon returning from the hospital and the last transfer assessment was completed on 6/19/18. The assessment indicated different transfer modalities were attempted and it was determined the two person pivot transfer was safe because R9 could assist in the transfer and bear at least 70% of her own weight. PT-A stated it was an expectation if the NAs were noticing a change in the way the residents transfer they alert the nurse or physical therapist so a transfer evaluation could be completed.

-At 2:56 p.m. NA-A stated R9 was a two person pivot transfer and R9 did not transfer very well. NA-A stated R9 did not move her feet during the pivot and beared less than 10% of her weight, and R9 did not participate in transfers. NA-A stated R9 sometimes did better in the mornings, but by evening the transfers were worse.

-At 3:01 p.m. NA-D stated staff have to lift her up out of the chair as R9 did not assist from a seated to a standing position. Once R9 was standing she did not bear a lot of weight, and did not move feet when pivoted. NA-D stated she had had reported R9's decline in ability to transfer, however, to her knowledge R9 had not been re-assessed.

On 8/3/18, at 11:39 a.m. the DON indicated R9's transfer ability varied and was unaware of R9's inability to bare weight. The DON stated the NA were expected to report any changes in transfer ability to the nurse. The nurse was to assess the resident and expected to the primary physician and/or therapist as needed.

R32's quarterly MDS dated 7/17/18, indicated R32 had sever cognitive impairment and required

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F 689	Continued From page 88 extensive assistance of two staff for transfers. R32's care plan dated 4/16/18, indicated R32 was not ambulatory and required two staff to stand and pivot for transfers. R32's physical therapy progress note dated 7/3/18, included; R32 had some tightness in lower extremities, but was still functional. The note indicated R3 transferred with staff assist into and out of the bed and wheelchair as well as toilet transfers. The note further indicated R32 was unable to ambulate due to instability and scissoring her legs and leaning forward. On 7/30/18, at 9:06 p.m. R32 was observed seated in a wheelchair in her room. NA-M and NA-N applied transfer belt around R32's waist and stood on either side of her wheelchair. The NAs laced their arms underneath R32's arms and lifted R32 out of the wheelchair. R32 did not assist in the transition from sit to stand. Once standing R32 required assist from NAs to pivot around to the bed; while pivoting R32's feet crossed. NA's assisted R32 to a sitting position onto the bed. On 8/1/18, at 10:12 a.m. R32 was observed seated in a wheelchair in the bathroom. NA-O and NA-G applied a transfer belt around R32's waist. The NAs stood on the either side of the wheelchair and laced their arms underneath R32's arms. The NAs lifted R32 up to a standing position. R32 did not assist during the transition from sit to stand. Once R32 was in the standing position, R32 stood with extensive assist from both NAs. During the pivot turn to the toilet R32 legs crossed resulting in R32 becoming off balanced. The NA's assisted R32 to a seated	F 689		

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F 689	Continued From page 89 position on the toilet. Once R32 was done on the toilet, the NA's again laced their arms underneath R32's arms and lifted her off the toilet. R32 did not assist in the sit to stand transition. Again during the pivot turn, R32's feet crossed. The NA's verified R32 did not assist during the sit to stand transition and they lifted her up out of the chair to a standing position. NAs indicated once in a standing position R32 was able to stand with support, however, during the pivot turn her feet crossed. NA-G indicated when residents are unable to bare weight during transfers the staff were to utilize a mechanical lift. On 8/2/18, at 2:35 p.m. PT-A stated residents need to bare at least 75% weight in order to be transferred by staff, if they are not baring at least 75% then a mechanical lift was utilized. PT-A further stated she was unaware of R32's difficulty with transfers. PT-A indicated it was not appropriate or safe to lift a resident up underneath the arms and/or physically lift a resident up from a sitting to standing position. PT-A stated R32 was last evaluated for mobility and transfers on 7/3/18, and had some tightness in her lower extremities, especially in the ankles. PT-A indicated R32 the was to be transferred with assistance of two staff. PT-A indicated if staff had to physically lift R32 out of the chair and was not able to assist with the pivot turn then R32 would require a reassessment. -At 2:56 p.m. NA-A stated R9 was a two person pivot transfer however, R32 did not transfer very well. NA-A stated R32 required the NAs to bare 90-100% of her weight when assisting her from sit to stand position and then required NA's to bear about 20% of her weight during the rest of the transfer.	F 689		

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F 689	Continued From page 90 -At 3:01 p.m. NA-D stated R32 did not assist staff during sit to stand transitions, however was able to assist staff when in the standing position. 08/02/18 at 4:27 p.m. PT-A stated she had evaluated R32's transfers and R32 was leaning and pulling during the transfer. PT stated she made the recommendation that R32 be a full body mechanical lift transfer. On 8/3/18, at 11:39 a.m. the DON indicated R9's transfer ability varied and was unaware of R32's poor transfers. DON stated the expectation that NAs were to notify the nurse of any changes. The nurse was then to assess the resident and contact the primary physician or therapist as needed. A copy of the facility policy related to ceiling lift transfers was requested and none was provided. A copy of the manufactures guidelines for the use of the ceiling lift was requested and none was provided.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary	F 690		9/10/18

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F 690	Continued From page 91 incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure timely assistance with toileting was provided for 2 of 3 residents (R9, R32) who were dependent upon staff for toileting. Findings include: R9's significant change Minimum Data Set (MDS) dated 5/1/18, indicated R9 had moderate cognitive impairment, was non-ambulatory, was frequently incontinent of bowel and bladder, and	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI 1) DON and/or designee will implement the following for R9 and R32 affected by this practice: A comprehensive bowel and bladder assessment will be completed by the MDS Coordinator, including review of a 3 day bowel and bladder diary, indicating type of incontinence and developing a toileting plan that is individualized based on comprehensive review of bowel and	

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F 690	Continued From page 92 was not on a toileting program. The MDS also indicated R9 required total assist of two staff for bed mobility, and transferring. R9 required total assist of one person for hygiene, toileting, and dressing. The significant change corresponding written General Nursing Observation form dated 4/26/18, indicate the significant change MDS was completed following a 4/11/18, hospitalization. The Skin Assessment All Data collected section indicated R9 was incontinent of bowel and bladder and the staff provide peri care after soiling. R9's 30 day MDS dated 5/22/18, indicated R9's had severe cognitive impairment, was non-ambulatory, and required total assistance of one to two staff for activities of daily living. The MDS also indicated R9 was always incontinent of bowel and bladder and was not on a toileting program. R9's Progress Notes By Resident written assessment dated 5/22/18, indicated R9 continued to be weak, and at times R9 utilized a fracture pan for bowel and bladder, and could communicate needs to staff. R9's bowel and bladder care plan dated 4/26/18, indicated R9 was incontinent of bowel and bladder and directed the staff to provide peri-care after soiling, use large incontinent product, change as needed, and do not leave alone on the toilet. The care plan lacked an individualized toileting schedule or program. On 7/30/18, at 4:48 p.m. R9 was observed lying in bed. Nursing assistant (NA)-M and NA-N entered the room and proceeded to check R9's incontinent brief which showed yellow lines with two semi green lines which indicated some moisture. NA-M stated the yellow lines indicated	F 690	bladder status. Bowel and Bladder care plan and NAR care sheets will be reviewed and updated to review accurate toileting schedule based off the comprehensive bowel and bladder assessment by the DON and/or designee. NA-M, NA-O, NA-G and NA-N will be provided education about following care plans/care guides related to toileting times by the DON and/or designee. 2) All residents that are dependent on staff for toileting needs have the potential to be impacted by this. 3) DON and/or designee will educate all nursing staff on the Urinary Incontinence Program Policy, offering residents to use the toilet prior to transferring into bed or w/c, changing incontinent products if it indicates a resident was incontinent, and on following care plans/care guides related to toileting schedules. 4) DON and/or designee will educate all licensed nurses who complete comprehensive bowel and bladder assessments to ensure assessments include review of a 3 day bowel and bladder diary, indicate type of incontinence and that the toileting plan is individualized based on comprehensive review of the residents bowel and bladder status. 5) DON and/or designee will audit all current residents, who are dependent on staff for toileting needs, care plans and NAR care sheets to ensure toileting plans are accurate based off of the comprehensive bowel and bladder assessment.	

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F 690	Continued From page 93 dryness, therefore she was not going to change R9's incontinent brief because it was not wet enough. NA-M stated the incontinent briefs were not changed unless there were only two yellow lines and the rest were blue. R9 was not offered to use the toilet and/or bedpan and was not provided with incontinence peri-care. R9 was transferred into her wheelchair with by NAs at 4:55 p.m. -At 6:11 p.m. until 7:55 p.m. R9 remained seated in the wheelchair, in the living room area. NA-M assisted R9 back to her room. NA-M proceeded to wash R9's upper body at the bedside. NA-J stated R9 was supposed to have her incontinent product checked and changed every two hours. -At 8:10 p.m. NA-M and NA-N transferred R9 into bed. R9 was not asked if she had to use the toilet. Once R9 was in bed, the incontinent brief was visible which showed all blue lines, which indicated total urine saturation. Once the brief was removed, R9's left buttock revealed a half dollar size area of blanchable redness and right buttock revealed 5 dime sized spots of blanchable redness. The NA's provided incontinence care and did not offer R9 the bedpan. On 8/1/18, at 7:38 a.m. R9 was observed in bed as NA-O provided morning cares. NA-O stated R9 was to be toileted every two hours and was not sure when the last time this had occurred. NA-O further stated R9 could use the toilet and knew when she had to go. NA-O stated R9 leaked urine when she coughed, but otherwise was continent of urine. R9's incontinent brief was noted to be wet as evidenced by four blue lines on the incontinent brief. NA-O asked R9 if she	F 690	6) All residents with urinary incontinence who are dependent on staff for toileting needs will be reassessed to ensure the appropriate interventions have been developed/implemented in conjunction with their next MDS by the MDS Coordinator. 7) DON and/or designee will perform random audits to ensure resident toileting care plans are being followed beginning 9/3/18 at the frequency of 4x/week x 4 weeks, then 2x/week x 4 weeks then once weekly thereafter. 8) DON and/or designee will perform random audits to ensure resident toileting care plans and NAR care sheets match the bowel and bladder assessment toileting plan beginning 9/3/18 at the frequency of 4x/week x 4 weeks, then 2x/week x 4 weeks then once weekly thereafter. 9) Audit results will be brought to the QAPI committee quarterly for review and further recommendation. 10) Completion date is 9/10/18.	

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F 690	Continued From page 94	F 690		

needed to go to the restroom in which R9 replied "no."

-At 8:45 a.m. NA-O transferred R9 into her wheelchair.

-At 9:55 a.m. the director of nursing (DON) and NA-P assisted R9 back to her room and transferred her into bed. Neither the DON or NA-P asked R9 if she needed to use the restroom. Once in bed, NA-P asked R9 if she needed to use the bedpan to which R9 stated "yes." R9's incontinent brief was noted to be dry. R9 voided in the bed pan.

On 8/2/18, at 2:06 p.m. registered nurse (RN)-A stated when R9 came back from the hospital she was very deconditioned and was only able to use a bedpan. RN-A stated R9 should be offered toileting according to the care plan and was also able to tell staff if she had to use the bathroom. RN-A confirmed the MDS's and corresponding written assessment notes since the hospital return lacked a comprehensive bowel and bladder assessments and/or reevaluation in order to determine the type of urinary incontinence and an if an individualized toileting schedule and/or program would be beneficial for R9. RN-A stated a comprehensive review should ave been completed which would have included a bowel and bladder diary used to identified a toileting pattern/schedule.

On 8/3/18, at 11:30 a.m. the DON confirmed R9 was able to communicate and express her needs related to toileting and stated she expected staff to follow the toileting care plan, as directed.

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R32's facility Face Sheet dated 8/2/18, indicated R32's diagnoses included generalized muscle weakness, nutritional deficiency, chronic kidney disease stage 3, and Alzheimer's disease.

R32's quarterly MDS dated 7/17/18, indicated R32 had severely impaired decision making skills, required extensive assist of two plus staff for bed mobility, transfers and toileting, was frequently incontinent of bladder and occasionally incontinent of bowel, and was on a toileting program to manage incontinence.

R32's toileting care plan dated 10/11/16, indicated R32 was occasionally incontinent of bowel and bladder and directed the staff to toilet every 3-4 hours during the day and to check and change incontinent brief at first and last rounds during the night. The care plan did not identify the type of R32's urinary incontinence.

R32's aide care guide last updated 7/27/18, conflicted with the care plan in that it directed staff to toilet R32 every 2-3 hours.

On 7/30/18, continuous observations started at 4:45 p.m. and revealed the following:

-At 4:45 p.m. R32 was observed in the dining room, seated in her wheelchair eating her meal. When her meal was completed, R32 was wheeled to the adjacent living room area.
-At 6:58 p.m. until 7:55 p.m. R32 remained in the living room, seated in her wheelchair.
-At 7:55 p.m. NA-M referenced her aide care guide and stated R32 was last repositioned at 4:20 p.m. and verified R32 was to be toileted every 2-3 hours.
-From 7:55 p.m. to 8:44 p.m. R32 remained in the

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living room area, seated in her wheelchair.
-At 9:06 p.m. R32 was wheeled to her room. NA-M and NA-I stated the bath aide had called in therefore the facility was working short of staff. NA-N stated that was why residents were not getting repositioned/offloaded on time.
-At 9:14 p.m. NA-M and NA-N transferred R32 from the wheelchair to the bed. When R32 stood up, a strong urine odor was noted. R32's incontinent brief was saturated with urine. NA-M stated R32 was always incontinent of urine and did not void on the toilet. R32's skin did not have any areas of redness or breakdown. NA-N stated R32 was last checked for incontinence around 3:30 or 4:00 p.m.

On 8/1/18, at 7:15 a.m. R32 was observed in the dining room, seated in the wheelchair.
-At 9:43 a.m. NA-G wheeled R32 out of the dining room area and back to her room and proceeded to provide R32 range of motion exercises. NA-G did not offer toileting to R32.
-At 10:12 NA-O and NA-G wheeled R32 to the bathroom and transferred her to the toilet. R32's incontinent brief was moderately saturated with urine. Once on the toilet, R32 voided. NA-0 confirmed the brief was wet with urine. NA-G and NA-O stated R32 was supposed to be toileted every 3-4 hours and usually voided when put onto the toilet.

On 8/2/18, at 2:06 p.m. RN-O stated the staff were expected to follow the care plan, as directed.

On 8/3/18, at 11:30 a.m. the DON stated R9 was able to communicate and express her needs. The DON stated she expected staff to follow the toileting care plan as written and comprehensive

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F 690	Continued From page 97 bowel and bladder assessments should have been completed per facility policy. A policy related to comprehensive bladder assessments and toileting cares was requested and none was provided.	F 690		
F 880 SS=E	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, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		9/10/18

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F 880	Continued From page 98 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure isolation precautions were implemented as directed by the	F 880	F880 Infection Prevention & Control 1) R25 is no longer receiving chemotherapy.	

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F 880	Continued From page 99 physician orders for 1 of 1 resident (R25) who required isolation precautions following chemotherapy treatments. The facility also failed to ensure appropriate infection control measures were maintained during the care of indwelling urinary catheters for 3 of 3 residents (R20, R30 and R43) observed during the provision of catheter cares. Findings include: Chemotherapy Isolation: R25's admission Minimum Data Set (MDS) dated 3/30/18, indicated R25 had mild cognitive impairment and diagnoses including diabetes mellitus (DM), breast cancer, dementia and hypertension. The MDS indicated R25 required extensive assistance with all activities of daily living. R25's Physician Orders dated 7/9/18, and again on 7/30/18, indicated R25 was to be in contact precautions for 48 hours following chemotherapy treatment. R25's orders did not indicate what type of chemotherapy R25 had received. R25's care plan dated 3/27/18, did not address chemotherapy or any type of interventions to implement following chemotherapy. R25's Progress Note dated 7/30/18, at 5:42 a.m. indicated R25 was to have nothing by mouth as she would be receiving chemotherapy in the morning. R25's Progress notes did not indicate when she left for chemotherapy or when she returned. The record lacked an assessment of R25's physical condition upon returning from chemotherapy.	F 880	2) All residents receiving chemotherapy or on isolation precautions have the potential to be impacted by this practice. 3) DON and/or designee will educate all licensed nurses involved in the care planning process to ensure all residents who are receiving special treatments like chemotherapy or on isolation precautions have these areas care planned with directions on providing cares for staff. 4) DON and/or designee will educate all staff on the Care Planning Policy and following the residents plan of care for all residents receiving special treatments like chemotherapy and are on isolation precautions. 5) DON and/or designee will educate all staff on the Transmission Based Precautions Policy and use of proper PPE for residents on isolation. 6) DON and/or designee will audit all current residents on isolation precautions to ensure accuracy of care plan and NAR care sheets and proper PPE utilized. Then random audits will be done beginning 9/3/18 4x/week x 4 weeks, then 2x/week x 4 weeks, then once weekly thereafter. 7) R20, R30, and R43 Catheter Care Plans and NAR Care Sheets will be reviewed and revised as indicated by the IPCO Nurse for proper infection control interventions. 8) NA-P, NA-D and NA-P will be educated on the Catheter Care Policy and to ensure there is a barrier placed between the collection device and floor when emptying a drainage bag and to cleanse the drainage spout with an alcohol pad after emptying the drainage	

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F 880	Continued From page 100 On 7/30/18, at 6:18 p.m. isolation supplies were observed hanging off of R25's door. The supplies consisted of gloves and masks. Licensed practical nurse (LPN)-F stated R25 had received chemotherapy earlier on 7/30/18, and was required to be in contact precautions for 48 hours following chemotherapy. LPN-F stated the staff were to apply gowns, gloves and masks when providing personal cares for R25 in case they were to come in contact with any type of bodily fluids. LPN-F stated the staff were only to wear gloves if assisting R25 with simple tasks which would not involve contact with bodily fluids. -At 7:30 p.m. licensed practical nurse (LPN)-F was observed to say "oh I don't feel well." LPN-F explained she had a cold. LPN-F then donned gloves, entered R25's room and handed R25 a souffle cup of bedtime pills. LPN-F was not observed to apply a mask prior to entering R25's room. Review of R25's clinical record lacked documentation and staff instructions for contact precautions following chemotherapy. On 7/31/18, at 8:55 a.m. R25 was observed seated in the dining room eating breakfast. -At 10:30 a.m. nursing assistant (NA)-H stated the staff were to wear gowns, gloves and masks while caring for R25. -At 10:27 a.m. NA-A stated the staff were to wear gowns, gloves and mask while caring for R25. -At 10:40 a.m. LPN-E confirmed R25 had received chemotherapy on 7/30/18. LPN-E stated she did not know what type of chemotherapy R25 had received as family	F 880	bag prior to re-clamping. 9) All residents with catheters have potential to be impacted by this practice. 10) DON and/or designee will assess all residents with catheters care plans and NAR care sheets to ensure intervention in place to keep catheter bag off of the floor and for cleansing of drainage spout with alcohol wipe prior to re-clamping. 11) DON and/or designee will educate all nursing staff regarding the Catheter Care Policy, catheter care education and to ensure there is a barrier placed between the collection device and floor when emptying a drainage bag and to cleanse the drainage spout with an alcohol pad after emptying the drainage bag prior to re-clamping. 12) DON and/or designee will perform random audits on catheter cares to ensure proper placement of Urinary Drainage bags off of floor, barrier is placed between collection device and floor when emptying drainage bag, and that drainage spout is cleansed with an alcohol pad after emptying prior to re-clamping beginning 9/3/18 4x/week x 4 weeks, then 2x/week x 4 weeks, then once weekly thereafter. 13) Audit results will be brought to the QAPI committee quarterly for review and further recommendation. 14) Completion date will be 9/10/18.	

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members had accompanied R25 to the appointment. LPN-E stated staff members who had colds should wear masks or not provide cares for R25 for 48 hours following chemotherapy.

-At 11:08 a.m. the Rainy Lake Medical Center (RLMC) Infusion registered nurse (RN) was interviewed via telephone. RLMC-RN indicated R25 had received Kadcyla (chemotherapy medication) and for 48 hours following the medication, the staff were to initiate contact isolation, meaning gowns, gloves and masks were to be used while providing personal cares. R25 was to have a designated bathroom and staff members with colds should wear a mask or have alternative staff care for R25 following the therapy.

On 8/1/18, at 9:11 a.m. NA-A was observed to donne a regular hospital gown (no isolation gowns were noted in the isolation supply on the door), and a mask and entered R25's room and shortly thereafter, exited the room. NA-A continued to wear the gown/mask and proceeded to walk to the supply closet, retrieve gloves and returned to R25's room. NA-A assisted R25 to the restroom for morning cares.
-At 9:21 a.m. registered nurse (RN) called NA-A out of the room and provided NA-A with a yellow isolation gown. NA-A removed the hospital gown and donned the isolation gown. NA-A returned into the room and proceeded to complete personal cares for R25 which included perineal cares. After all cares were completed, NA-A removed the isolation garb and washed her hands.

On 8/2/18, at 2:30 p.m. RN-B confirmed R25 was

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on contact isolation for 48 hours following chemotherapy. RN-B stated staff members who had colds should have worn masks while in the same area as R25 and verified NA-A should not have left the room with the isolation garb on. In addition, RN-B confirmed NA-A should have obtained an isolation gown prior to entering the room and starting the cares. RN-B stated she was aware NA-A didn't have an isolation gown on thus the reason she had brought her a gown. RN-B stated the isolation supply container on the back of R25's door should have been stocked with adequate isolation precaution supplies. RN-A reviewed R25's clinical record and confirmed the record did not direct the staff how to care for R25 following chemotherapy and contact isolation precautions had not been followed.

-At 3:00 p.m. RN-B provided a chemotherapy handout from R25's physician office entitled "What to Expect from Outpatient Cancer Infusion Therapy." with a fax dated of 6/17/18. RN-B stated all of the staff members had received training on chemotherapy precautions, however, RN-B had no documentation of the education. The patient education pamphlet directed the cancer patient to follow precautions for 48 hours after chemotherapy. The precautions included:

-How to handle trash and laundry
-skin care
-Body wastes
- hand washing practices

-At 3:10 p.m. RN-B confirmed the facility had not followed isolation precautions for R25 following a chemotherapy treatment, as directed.

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F 880	Continued From page 103 Catheter Care R20's quarterly MDS dated 6/19/18, indicated R20 was alert and oriented with diagnoses which included anxiety, depression, and neurogenic bladder. R20 required total assistance for transfers, extensive assistance for all other activities of daily living, and utilized an indwelling urinary catheter. R20's care plan dated 5/1/17, indicated R20 had an indwelling urinary catheter related to a history of neurogenic bladder. The care plan directed the staff to perform catheter cares twice a day, and as needed. On 8/1/18, at 3:15 p.m. R20 was observed seated on the toilet as NA-A picked up a graduate, placed it on the floor, and began to empty R20's catheter drainage bag into the container. NA-A clamped the drainage bag tubing after approximately 900 cc (cubic centimeters) of urine had been drained and set the graduate of urine on the side of the sink. NA-D and the DON proceeded to assist R20 to transfer from the toilet to a recliner. Once in the chair, NA-D emptied the graduate into the toilet, returned to R20, placed the graduate directly on the floor and finished emptying the drainage bag into the graduate. NA-D clamped the drainage tubing and emptied the graduate into the toilet. At no time was NA-D observed to place any type of barrier between the graduate and the floor, nor was NA-D observed to utilize an alcohol wipe to cleanse the end of the drainage bag prior to replacing the drainage tubing into the tube holder. At no time during the observation was the DON observed to provide guidance to NA-D to ensure appropriate infection control measures were	F 880		

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F 880	Continued From page 104 being followed. -At 3:35 p.m. NA-D stated she was unaware the catheter tubing should have been cleansed with an alcohol swab prior to being placed in the drainage bag holder nor had she been directed to place a barrier between the graduate and the floor. -At 3:40 p.m. the DON confirmed NA-D had not provided a barrier between the graduate and the floor nor had the end of the drainage bag been cleaned properly. R30's quarterly MDS dated 5/14/18, indicated R30 had severe cognitive impairment and diagnoses including Alzheimer's dementia, status post stroke, and had a prostate disorder. The MDS indicated R30 required extensive assistance with all activities of daily living and utilized an indwelling urinary catheter. R30's Physician's Order dated 12/27/18, indicated R30 was to have the catheter indefinitely related to urinary retention secondary to an enlarged prostate. R30's care plan dated 12/20/17, indicated R30 had an indwelling catheter and directed the staff to provide catheter care in the morning and evening, empty the catheter bag using aseptic technique, keep catheter drainage bag off the floor, and keep the catheter drainage bag below the level of the bladder. On 8/1/18, at 7:24 a.m. R30 was observed lying in bed, the urinary catheter drainage bag was resting directly on the floor. NA-P donned gloves and placed a graduate directly on the floor,	F 880		

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LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

(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 105 cleaned the end of the drainage valve with an alcohol wipe, emptied the bag into the graduate and cleaned the valve again. At no time was NA-P observed to place a barrier between the floor and the graduate. On 8/3/18, at 11:39 a.m. the DON stated there was to be a barrier between the measuring graduate and the floor. R43's quarterly MDS dated 7/17/18, indicated R43 had mild cognitive impairment and diagnosis including seizure disorder and neurogenic bladder. The MDS indicated R43 required extensive assistance for all activities of daily living and utilized and indwelling urinary catheter. R43's care plan dated 1/18/17, indicated R43 had an indwelling catheter and directed the staff to keep the catheter bag below the level of the bladder and empty the catheter bag using aseptic technique. On 7/30/18 at 8:47 p.m. R43 was observed seated in a wheelchair, in his room. NA-N placed a graduate directly on the floor, opened the drainage valve of the collection bag and emptied the bag into the graduate. At no time was NA-N observed to place a barrier between the floor and the graduate or attempt to disinfect the drainage tubing before or after emptying the bag. NA-N verified she had not placed a barrier between the floor and the graduate, she had not utilized alcohol wipes on the drainage collection bag as there were none in R43's room. -At 9:04 p.m. NA-N had obtained an alcohol swab, removed the valve from the collection bag and then disinfected the valve.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING _____ B. WING _____	08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	912 MAIN STREET LITTLEFORK, MN 56653

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F 880	Continued From page 106 On 8/3/18, at 11:39 a.m. the DON stated the staff were to provide a barrier between the measuring graduate and the floor for possible splash when emptying, and the drainage valve should be disinfected with alcohol swabs after draining the bags. The undated KHS Catheter Care Policy directed the staff to empty the catheter drainage bag every shift. After the urine had emptied into the graduate the staff member was to wipe the end of the opening with a sterile alcohol pad and clamp shut.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245542	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	**912 MAIN STREET** **LITTLEFORK, MN 56653**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Littlefork Medical Center C & NC was found 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. The facility was surveyed as one building. Littlefork Medical Center C & NC was constructed at 2 different times. In 1978 the original building was constructed to the east of the 1964 hospital, is 1-story without a basement and is Type II (000) construction. In 1992 1-story additions were construction to the north and east wings and are Type II(000) construction. The facility is divided into 3 smoke zones by 30 minute fire barriers and separated from the old hospital building with a 2-hour fire barrier. The building is protected with a complete automatic fire sprinkler system and has a fire alarm system with smoke detection in all sleeping rooms, at the cross corridor smoke barrier doors and in common areas that is monitored for automatic fire department notification. The facility has a capacity of 49 beds and had a census of 43 at the time of the survey.	K 000		

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

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
	245542	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/31/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLEFORK MEDICAL CENTER	**912 MAIN STREET** **LITTLEFORK, MN 56653**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		