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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: RI93

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **02/01/2017**
6. DATE OF SURVEY **06/27/2018** (L34)
8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Debra Vincent HFE - NE II 07/03/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/03/2018 (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
07/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/16/2018
(L33)

DETERMINATION APPROVAL

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

A survey was conducted by the Minnesota Department of Health on 3/19/18, through 3/27/18. The survey resulted in an Immediate Jeopardy (IJ) at F689 and F880. The IJ for F689 was removed on 3/27/18, at 12:00 p.m. after verification of a removal plan. The IJ for F880 was removed on 3/27/18, at 12:00 p.m. after verification of an appropriate removal plan.

An extended survey was conducted by the Minnesota Department of Health on 3/23/18 through 3/27/18.

On May 10, 2018 an onsite revisit found this facility to be in continued non-compliance.

Seond onsite revisit on June 27, 2018 found this facility to be in compliance.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245323
July 3, 2018

Mr. Brian Reindl, Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West PO Box 700
Walker, MN 56484

Dear Mr. Reindl:

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

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

Effective June 27, 2018 the above facility is certified for for:

40 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered

REVISED

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

July 13, 2018

Mr. Brain Reindl, Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West PO Box 700
Walker, MN 56484

RE: Project Number S5323027

Dear Mr. Reindl:

This letter will replace the Notice of Total Amount of Assessment for Nursing Homes dated July 3, 2018. The penalty assessment was not calculated correctly. The total amount due is $2,343.00. Please submit a check for the remaining fee of 30.00.

On July 13, 2018, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on June 27, 2018, imposed a daily fine in the amount of $1700.00.

A reinspection was held on June 27, 2018 and it was determined that compliance with the licensing rules was attained. A copy of this revised letter is being delivered electronically.

Therefore, the total amount of the assessment is $1700.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $643.00, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $2,343.00 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

Sincerely,

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
Shellae Dietrich, Licensing and Certification Program
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

Electronically delivered July 2, 2018

Mr. Brian Reindl, Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West Po Box 700
Walker, MN 56484

RE: Project Number S5323027

Dear Mr. Reindl:

On April 17, 2018, we informed you that the following enforcement remedies was being imposed:

- State Monitoring effective April 22, 2018. (42 CFR 488.422)

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

In addition, this Department recommended to the CMS Region V Office the following actions:

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

Also, on April 17, 2018 you were notified by this department, 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 March 27, 2018.

This was based on the deficiencies cited by this Department for an extended survey completed on March 27, 2018. The most serious deficiencies were found to be widespread deficiencies that constituted immediate jeopardy (Level L) were required.

On May 10, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 27, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on March 27, 2018.

As a result of the revisit findings, we notified you on May 25, 2018, that the Category 1 remedy of state monitoring would remain in effect.

Also on May 25, 2018 this department recommended to the CMS Region V Office the following actions:

- Civil money penalties be imposed. (42 CFR 488.430 through 488.444)

- Denial of payment for new Medicare and Medicaid admissions effective June 27, 2018 would remain in effect. (42 CFR 488.417 (b))

On June 27, 2018, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on May 10, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 15, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on June 27, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 27, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions:

- Civil money penalties will remain in effect. (42 CFR 488.430 through 488.444)

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

As we notified you in our letter of April 17, 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 March 27, 2018.

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

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

NOTICE OF TOTAL AMOUNT OF ASSESSMENT FOR NURSING HOMES

Electonically Delivered July 3, 2018

Mr. Brian Reindl, Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West PO Box 700
Walker, MN 56484

RE: Project Number S5323027

Dear Mr. Reindl:

On June 27, 2018, a Notice of Assessment for Noncompliance with Correction Orders was issued to the above facility. That Notice, which was received by the facility on June 27, 2018, imposed a daily fine in the amount of $1700.00.

A reinspection was held on June 27, 2018 and it was determined that compliance with the licensing rules was attained. A copy of the State Form: Revisit Report from this visit is being delivered electronically.

Therefore, the total amount of the assessment is $1700.00. In accordance with Minnesota Statutes, section 144A.10, subdivision 7, the costs of the reinspection, totaling $643.80, are to be added to the total amount of the assessment. You are required to submit a check, made payable to the Commissioner of Finance, Treasury Division, in the amount of $2,313.80 within 15 days of the receipt of this notice. That check should be forwarded to the Department of Health, Health Regulation Division, 85 East Seventh Place, Suite 220, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

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

Sincerely,

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
Shellae Dietrich, Licensing and Certification Program
Kami Fiske-Downing, Licensing and Certification Program
Penalty Assessment Deposit Staff

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RI93

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00995

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

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

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

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

6. DATE OF SURVEY **05/10/2018** (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 **40** (L18)
13.Total Certified Beds **40** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE - NF II 05/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 07/02/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/16/2018
(L33)

DETERMINATION APPROVAL

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

A survey was conducted by the Minnesota Department of Health on 3/19/18, through 3/27/18. The survey resulted in an Immediate Jeopardy (IJ) at F689 and F880. The IJ for F689 was removed on 3/27/18, at 12:00 p.m. after verification of a removal plan. The IJ for F880 was removed on 3/27/18, at 12:00 p.m. after verification of an appropriate removal plan.

An extended survey was conducted by the Minnesota Department of Health on 3/23/18 through 3/27/18.

On May 10, 2018 an onsite revisit found this facility to be in continued non-compliance.

Electronically delivered
May 25, 2018

Mr. Brian Reindl, Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West PO Box 700
Walker, MN 56484

RE: Project Number S5323027

Dear Mr. Reindl:

On April 17, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 22, 2018. (42 CFR 488.422)

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

Also on April 17, 2018, this department recommended to the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Civil money penalty for the deficiencies cited at F607, F686, F688, F689, F745 and F880. (42 CFR 488.430 through 488.444)

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

On May 17, 2018, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 27, 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 March 27, 2018. The deficiencies not corrected are as follows:

F0677 -- S/S D -- -- Adl Care Provided For Dependent Residents
F0686 -- S/S D -- -- Treatment/svcs To Prevent/heal Pressure Ulcer
F0688 -- S/S D -- -- Increase/prevent Decrease In Rom/mobility
F0758 -- S/S D -- -- Free From Unnec Psychotropic Meds/pm Use
F0810 -- S/S D -- -- Assistive Devices - Eating Equipment/utensils

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

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions:

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective March 27, 2018

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

- Civil money penalty for the deficiencies cited at F677, F686, F688, F758, and F810 effective May 17, 2018. (42 CFR 488.430 through 488.444)

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.

As we notified you in our letter of April 17, 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 March 27, 2018.

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" 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 September 27, 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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of

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

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

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

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.

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
	245323	A. BUILDING _____ B. WING _____	R 05/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments An onsite revisit was conducted to determine compliance with CMS Appendix Z Emergency Preparedness Requirements. The facility is now in compliance with Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 5/9/18, and 5/10/18, and found to have NOT corrected all the citations issued on the survey exited 3/27/18. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	{F 000}		
{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: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 1 of 3 residents (R23) who was totally dependent on staff for incontinence cares. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/9/18, identified R23 with severe cognitive impairment and diagnoses including dementia,	{F 677}	F677 SS=D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to provide	6/15/18

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

Electronically Signed | 06/06/2018

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{F 677}	Continued From page 1 history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living and indicated he was totally incontinent of bladder. R23's annual MDS dated 10/13/17, also identified R23 as being totally incontinent of bowel and bladder. R23's Urinary Incontinence CAA dated 10/9/17, identified R23 as being totally incontinent of bowel and bladder and directed the staff to assist to check and change R23's incontinence brief every two hours. R23's care plan provided on 5/10/18, directed staff to check and change R23's incontinence brief every two hours. During continuous observations on 5/9/18, from 4:20 p.m. to 8:20 p.m. R23 was not observed to receive assistance with incontinence cares. -At 4:20 p.m. nursing assistant (NA)-C and NA-A were observed to transfer R23 from bed to a wheelchair via a full body mechanical lift. -At 5:05 p.m. registered nurse (RN-B) wheeled R23 to the dining room. -At 5:22 p.m. NA-A assisted R23 with the evening meal. -At 6:19 p.m. R23 was wheeled into his room and remained in his room, seated in the wheelchair, until 7:40 pm. -At 7:40 p.m. NA-G stated she had arrived at the facility at 6:00 p.m. and had not received any type of report when she arrived and did not know when R23 had last been assisted with incontinence cares. NA-G stated she would try to get to him. -At 8:00 p.m. R23 continued to be seated in the wheelchair.	{F 677}	consistent quality care to residents needing assistance with their ADL□s. Some of the ways this is done is by gathering data through assessments to ensure all residents needing assistance with ADL□s such as ambulating, grooming, dressing, and toileting/incontinent care are identified and assisted appropriately. In this case, after the survey determined R23 did not receive adequate incontinent care and was identified as completely dependent on staff for incontinent care the staff were advised to ensure residents are changed timely and cares done according to care plan and care sheets. Since survey, staff have been educated on importance of providing incontinent care to residents based on their care plan and following their care sheets. R23 remains on every 2-hour check and change and repositioning at this time. 2. Because all residents have constantly changing needs all are potentially affected by the cited deficiency, on 6/1/2018, the regional nurse reviewed residents needing assistance with incontinence care and ensured plan of care is correct based on needs. MDS nurse will review each quarter if resident goals being met and ensure staff follow through with cares. A current review was completed of all residents with similar incontinent needs. Policy and procedure on incontinent care has been reviewed. No other residents were affected. 3. To enhance currently compliant operations and under the direction of the regional nurse, on 6/6/2018 all nursing	

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{F 677}	Continued From page 2 -At 8:15 p.m. NA-A stated she could not assist R23 as she was busy answering lights for other residents. NA-A confirmed R23 had not yet been assisted with incontinence cares. -At 8:20 p.m. the director of nursing (DON) and the Regional Director of Clinical Services approached R23 and connected him to a full body mechanical lift. NA-A entered the room and assisted the Regional Director of Clinical Services to transfer R23 from the wheelchair to the bed. -At 8:26 p.m. NA-A completed perineal cares. R23 was observed to be incontinent of urine. NA-A confirmed R23 had last been assisted with incontinence cares at 4:20 p.m. 4 hours and 6 minutes earlier. On 5/10/18, at 11:30 a.m. the DON stated R23 was to receive assistance with incontinence cares every two hours as directed by the plan of care. The Toileting policy and procedure dated 4/2/18, directed the staff to assist residents to the toilet in a timely manner in accordance to their individualized plan of care. The policy indicated that if a resident was unable to physically tolerate utilization of the toilet, the staff were to adhere to a check and change program based on a bowel and bladder assessment.	{F 677}	staff will receive in-service training incontinence care, dignity in cares and following care sheets. The training will emphasize the importance of monitoring time between incontinent care and reviewing that poor incontinent care can lead to skin breakdown. Reviewed staff expectations regarding following care sheets and performing ADL□s according to resident cares and staff expectations of job performance. 4. Effective 6/4/2018, a quality-assurance program was implemented under the supervision of the regional nurse and MDS to monitor residents needing assistance with ADL□s. The DON or designee will audit all residents daily for 5 days (days and evenings) to ensure all residents needing incontinent care are receiving appropriately. After the one week will monitor 5 residents weekly for 4 weeks and then 3 residents weekly for 2 months. All residents will be reviewed at time of quarterly or annual to ensure not a significant change. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON or designee will be responsible for this POC. 6. Completion date 6/15/18	
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	{F 686}		6/15/18

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{F 686}	Continued From page 3 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning assistance as directed by the care plan for 2 of 3 residents (R5, R23) reviewed who identified at risk for pressure ulcers and required staff assistance for repositioning. Findings Include: R5's quarterly Minimum Data Set (MDS) assessment dated 1/10/18, indicated R5 had moderate cognitive impairment and diagnoses including Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff for all activities of daily living including bed mobility and transfers. The MDS also identified R5 as at risk for development of pressure ulcers. R5's Pressure Ulcer Care Area Assessment (CAA) dated 9/6/17, identified R5 as at risk for development of pressure ulcers due to dependence upon staff for repositioning, and management of bowel incontinence. The	{F 686}	F686 SS=D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to provide treatment and services to prevent pressure ulcers. One of the many ways that this has been achieved for R5 and R23 was to have tissue tolerance test redone and identify skin condition and extent of redness. R5 and R23 were not repositioned q2h as suggested as intervention on their care plan to prevent further breakdown. After survey noted that the residents had not been repositioned per care plan it was noted they both scored high for potential in skin integrity due to their incontinence and ability to turn	

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{F 686}	Continued From page 4 assessment indicated staff were to complete weekly skin assessments and were to monitor R5's skin while assisting with personal cares. R5's Braden Scale (a tool utilized to predict pressure ulcer development) dated 5/8/18, identified R5 as at risk for development of pressure ulcers. R5's Tissue Tolerance Observation form dated 5/9/18, indicated R5 displayed a "slightly red" area over boney prominences. However, the form did not identify which boney prominences had skin change/susceptibility to pressure nor any skin care directives for the staff to implement. R5's care plan provided on 5/10/18, included interventions for staff to assist R5 with repositioning at least every two hours. On 4/27/18, at 4:27 p.m. nursing assistant (NA)-C was observed to transfer R5 from bed into a wheelchair via a full body mechanical lift. -At 5:05 p.m. R6 was wheeled into the dining room for supper -At 5:15 p.m. a visitor assisted R5 with the evening meal. -At 5:40 p.m. R5 was wheeled out of the dining room and to his room -At 6:00 p.m. until 7:05 p.m. R5 remained in his room, seated in the wheelchair. -At 7:05 p.m. NA-G entered R5's room and began to assist R5 with evening cares. -At 7:15 p.m. NA-G transferred R5 from the wheelchair to bed. R5's wheelchair was observed equipped with a pressure redistribution cushion. R5's buttocks were pink and the coccyx was noted to have a small crevasse with thin, fragile like skin covering it.	{F 686}	and reposition independently. R 5 has pressure reduction cushion, mattress, reassessed skin and on turn and repo q2h, and care plan updated. R23 has been assessed to have altered skin integrity. Skin check completed, on 2-hour repositioning and tissue tolerance reassessed; on turn and repo q2h. Care sheets and care plans updated. 2. Because all residents are at risk for potential to alteration in skin integrity due to illness or have potential for skin breakdown all are potentially affected by the cited deficiency, wound documentation has been reviewed, interventions for prevention are in place and documented clearly on care sheets. Weekly skin audits are completed, and staff update nurse management on any new areas noted immediately including reporting of any bruises, skin tears, skin breakdown or rashes. All current resident with needing turning and repositioning were assessed for weekly changes along with appropriate interventions. Implementation of those interventions is reviewed on skin checks. Staff to alert regional nurse if resident refuses otherwise. Staff educated on importance of offloading, repositioning, care plan updated, care sheets updated. No other residents were affected. The policy on prevention of skin breakdown has been reviewed. 3. To enhance currently compliant operations and under the direction of the regional nurse, on 6/6/2018 all staff will receive in-service training for monitoring skin and pressure areas, to ensure staff	

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{F 686}	Continued From page 5 -At 7:30 pm. NA-G stated she was unaware of the last time R5 had been assisted with repositiong. NA-G stated she had arrived at the facilty at 6:00 p.m. and had not received any type of shift report. R5 had not received assistance with repositioning for 2 hours and 48 minutes. On 5/10/18, at 9:00 a.m. NA-F was observed to transfer R5 from the wheelchair into bed via a full body mechanical lift. -At 10:55 a.m. the director of nursing (DON) stated R5 was to receive assistance with repositiong every two hours as directed by the care plan. R23 did not receive timely assistance with repositiong for greater than four hours on the evening of 5/9/18. R23's quarterly MDS dated 3/9/18, indicated R23 had severe cognitive impairment and diagnoses which included dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all bed mobility and transfers and was at risk for the development of pressure ulcers. R23's annual MDS dated 10/13/17, also identified R23 as being totally dependent upon staff for bed mobility, transfers and at risk for the development of pressure ulcer. R23's Pressure Ulcer CAA dated 10/9/17, identified R23 at risk for the development of pressure ulcers and directed the staff to utilize a pressure reducing mattress, chair cushion, and to assist R23 with offloading every two hours and as needed. R23's Braden Scale for Prediction of Pressure	{F 686}	always use interventions in place and understand turning and repositioning to prevent further alterations in skin integrity. The training emphasizes the importance of following all interventions for effective skin maintenance and reporting of changes in skin conditions as well as turning and repositioning according to care plan. Education done on importance of comprehensive assessment of skin, pressure ulcers and implementation of appropriate interventions. 4. Effective 6/4/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents on turning and repositioning plan to ensure appropriate follow through. The director of nurses or designated quality-assurance representative will perform the following systematic changes: audits of all residents that are dependent on staff for turning and repositioning daily for 5 days, then 5 residents for 4 weeks to ensure compliance than 2 residents weekly x 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON or designee will be responsible for this POC. 6. Completion date 6/15/18	

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{F 686}	Continued From page 6 Sore Risk dated 5/8/18, identified R23 at moderate risk for the development of pressure ulcers. The Tissue Tolerance Observation Tool dated 3/9/18, indicated R23 did not develop reddened areas after two hours in one position. R23's care plan provided on 5/10/18, directed staff to assist with repositioning every two hours. During continuous observations on 5/9/18, from 4:20 p.m. to 8:20 p.m. R23 was not observed to receive assistance with repositiong. -At 4:20 p.m. NA-C and NA-A were observed to transfer R23 from bed to a wheelchair via a full body mechanical lift. -At 5:05 p.m. registered nurse (RN-B) wheeled R23 to the dining room. -At 5:22 p.m. NA-A assisted R23 with the evening meal. -At 6:19 p.m. R23 was wheeled into his room. -At 6:30 p.m. until 7:40 p.m. R23 remained in his room, seated in the wheelchair. -At 7:40 p.m. NA-G stated she had arrived at the facility at 6:00 p.m. and had not received any type of report when she arrived at the facility and did not know when R23 had last been repositioned. NA-G stated she would try to get to him. -At 8:00 p.m. R23 remained seated in the wheelchair. -At 8:15 p.m. NA-A stated she could not assist R23 as she was busy answering lights for other residents. NA-A stated R23 had not yet been assisted with repositioning/cares. -At 8:20 p.m. the DON and the Regional Director of Clinical Services stated they had assisted R23 with repositiong by lifting him out of the chair with the full body mechanical lift sling. The regional	{F 686}		

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{F 686}	Continued From page 7	{F 686}		

director stated she and the DON had lifted him out of the chair with the lift but did not complete any type of repositioning, rather R23 back down into the chair.
-At 8:25 p.m. the DON and regional director approached R23 in his room and connected him to a full body mechanical lift. NA-A entered the room and assisted the Regional Director of Clinical Services to transfer R23 from the wheelchair to the bed. R23's wheelchair was equipped with a pressure redistribution cushion. R23's buttocks were pink and intact.
-At 8:26 p.m. NA-A confirmed R23 had last been assisted with repositiong at 4:20 p.m. 4 hours and 6 minutes earlier.

On 5/10/18, at 11:30 a.m. the DON stated R23 was to receive assistance with repositiong every two hours as directed by the plan of care. The DON stated when she and the regional director of clinical services had repositioned R23 by lifting the mechanical lift sling, R23 was out of the chair for only 10-30 seconds. The DON confirmed in order for full tissue perfusion to be accomplished, the resident would have to be off of the bony prominences for a minimum of one minute. The DON confirmed R23 had not been out of the chair for a full minute.

Superior Healthcare Management Minnesota Region policy and procedure, Pressure Ulcer Risk Assessment effective 12/23/17, indicated the following:
-pressure ulcers are usually formed when a resident remained in the same position for an extended period of time causing increased pressure or decrease of circulation
-if pressure ulcers are not treated when

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{F 686}	Continued From page 8 discovered, they can become larger, painful, and infected -pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (feces, urine, soap, discharge), decline in nutrition, and hydration status, acute illness or decline in the resident's physical and/or mental condition -pressure ulcers are a serious skin condition for the resident -routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. -Skin would be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. The Superior Healthcare Management Minnesota Region, Repositioning policy and procedure reviewed 4/2/18, indicated the purpose of the procedure was to provide guideline for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. The policy also indicated repositioning was critical for a resident who was immobile or dependent on staff for repositioning. A repositioning program was defined as a specific approach that was organized, planned, documented, monitored and evaluated.	{F 686}		
{F 688} SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility.	{F 688}		6/15/18

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{F 688}	Continued From page 9 §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the need for range of motion (ROM) services for 1 of 3 residents (R23) observed with limitations in ROM without the assessment and development of a ROM program in order to prevent a decline or maintain current ROM abilities. In addition, the facility failed to follow the therapist's direction related to the application of splints for 1 of 1 resident (R5) who was currently receiving occupational therapy. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/9/18, indicated R23 had severe cognitive impairment and diagnoses which included dementia, history of stroke and aphasia (inability to speak). The MDS indicated R2 required extensive assistance with all activities of daily	{F 688}	F688 SS=D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure resident do not have decline in ROM unless anticipated by clinical condition. R23 had not been evaluated for ROM decline and R5 was having changes in his splinting due to contractures. After survey noted the missing splints on R5 and asked staff where they were staff had not remembered conversation with regional. R23 had been evaluated for OT for	

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{F 688}	Continued From page 10 living. R23's annual MDS dated 10/13/17, indicated R23 required total staff assistance for all activities of daily living. R23's care plan provided on 5/10/18, directed the staff to have physical therapy (PT) and occupational therapy (OT)evaluate and treat R23 as directed by the physician. The care plan also directed the staff to report signs and symptoms of immobility, or contractures forming or worsening. The care plan did not direct the staff to assist R23 with ROM exercises. R23's Therapist Progress and Discharge Summary dated 4/13/17, indicated R23 had lower extremity limitations in ROM. The physical therapist indicated nursing staff was to provide R23 ROM with manual stretches including bilateral hamstrings. The frequency of the exercises was not indicated. R23's Therapist Progress and Discharge summary dated 4/14/17, indicated R23 had limitation in ROM in the upper extremities. The occupational therapist indicated R23 was to receive ROM exercises however, the frequency of the services was not identified. R23's OT Evaluation and Plan of Treatment dated 4/17/18, indicated R23 had been evaluated by OT for feeding assistance devices, but did not include a ROM program evaluation or directions for a restorative program. Review of the facility's Restorative nursing documentation did not include a restorative nursing program for R23. Review of R23's electronic medication record did	{F 688}	adaptive equipment but no plan in place and not evaluated by therapy. R5 was wearing splints that were not his nor made for him so they were removed and while being assessed OT was to use pillows and wash cloths. Resident was able to move hands better and shoulders loosened up although he is neurological so as a rule its natural for arms to cling to chest which appear more contracted. When resident reminded to put arms down did. Since not everyone was on same page OT was unhappy with discontinuation however had not noticed that resident splints were not his per name so did reinitiate and did order new hand splints fitted to him and elbow splints. OTA and regional at time determined resident had more spasticity than tone and forcing his elbows open was not helpful as wouldn□t fix the position however when state noted OT note saying it was helpful order changed back. R23 had screen for PT. Noted no limitations to right side and mild to left. Is being assessed for adaptive eating device. Care sheets and care plans updated. 2. Because all residents have potential for decline or improvement all are potentially affected by the cited deficiency, decline in ROM triggers have been pulled, documentation has been reviewed, interventions for prevention are in place and documented clearly on care plans. Passive ROM to be completed with cares in morning and at night on staff when ordered by therapy based on screens from last survey. ROM orders will be clear	

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{F 688}	Continued From page 11 not direct the staff to assist with ROM. On 5/9/18, at 1:20 p.m. R23 was observed to be transferred from the wheelchair to the bed via a full body mechanical lift with the assistance of nursing assistant (NA)-B and NA-C. R23's shirt and pants were observed to be saturated with milk therefore the NA's changed his clothing. R23 held onto the staff with his right hand and kicked at staff with his right leg. While changing his pants, NA-B moved R23's left leg which revealed no limitations in ROM. NA-C assisted R23 to change his shirt in which R23 was noted to have full ROM in the right arm, however, the left arm moved approximately 4-5 inches with limitation in ROM in the left shoulder noted. On 5/10/18, at 11:40 a.m. the director of nursing (DON) stated R23 had been screened by therapy for ROM needs, however, R23 had not been added to the therapy list. Upon review of the OT evaluation dated 4/17/18, the DON confirmed R23's ROM needs had not been evaluated and should have been. On 5/10/18, at 1:15 p.m. the certified occupational therapy assistant (COTA)-A stated R23 had been evaluated for his adaptive equipment needs at meals, however, R23 was not evaluated by OT for ROM needs. R5's quarterly MDS dated 1/10/18, indicated R5 had moderate cognitive impairment and diagnoses which included Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff for bed mobility, transfers and all activities of daily living, and had bilateral functional limitation in range of motion of the upper and lower extremities. R5's	{F 688}	with which exercises and for how long. Staff update DON or MDS nurse on any new declines. All current residents have new baseline and the charting system for nursing aids indicates if staff notice decline in ROM. Therapy to evaluate any resident triggering for decline in ROM. Implementation of those interventions is reviewed in IDT. Staff to alert DON is resident refuses otherwise. No other residents were affected. The policy on ROM has been updated. 3. To enhance currently compliant operations and under the regional nurse, on 6/6/2018 all staff will receive in-service training on ROM and monitoring declines. The training emphasizes the importance of following all interventions for effective prevention of contractures. Education also done on importance of comprehensive assessment of ADL□s, contractures and implementation of appropriate interventions. 4. Effective 6/4/2018, a quality-assurance program was implemented under the supervision of therapy, nursing and MDS to monitor residents for changes in ROM, ROM exercises and splinting. The director of nurses or designated quality-assurance representative will perform the following systematic changes: audit splinting and ROM 4 residents weekly x4 weeks than 2 residents weekly x 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or	

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{F 688}	Continued From page 12 admission MDS dated 9/1/17, indicated R5 was dependent upon staff for all activities of daily living and had bilateral functional limitation in ROM of the upper and lower extremities. R5's Activities of Daily Living Care Area Assessment (CAA) dated 9/6/17, indicated R5 required total staff assistance all activities of daily living related to encephalopathy (brain disease, damage or malfunction), spinal fusion and weakness. The CAA indicated R5 was participating in therapy. R5's Occupational Therapy Evaluation and Plan of Treatment dated 4/8/17- 5/7/18, indicated R5 had bilateral arm contractures and was being treated by OT for the evaluation and implementation of interventions to minimize arm contractures. The identified short term goal indicated R5 was to utilize a resting hand splint and a resting pan-mitt splint and elbow extension splints for greater than eight hours without signs and symptoms of redness, swelling, discomfort or pain. The long term goal was to ensure R5 was able to wear the splints without redness or discomfort. The Occupational Therapy Treatment Encounter Notes revealed the following information: - 4/11/18, PROM (passive range of motion) completed, applied braces to elbows and hands. - 4/12/18, PROM to upper extremities and splints applied. - 4/16/18, PROM to upper extremities patient expressed discomfort with stretches. - 4/17/18, PROM to the upper extremities and splints applied. - 4/19/18, PROM to upper extremities and splints	{F 688}	corrective action. 5. DON will be responsible for this POC	

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{F 688}	Continued From page 13	{F 688}		

adjusted for proper fit.
- 4/23/18, PROM to contractures, applied elbow splints.
- 4/25/28, PROM and educated nursing staff present for proper application of splints.
- 4/26/18, PROM, educated staff on prolonged stretches and splint application.
- 4/30/18, PROM and splint application.
- 5/1/18, PROM and splint application.
- 5/3/18, PROM and splint application. Educated NA's on proper placement of splints
- 5/7/18, PROM with stretches, communicated with DON on application of splints and prolonged stretching for R5.
- 5/8/18, PROM and application of elbow and hand splints.

Review of R5's Progress note dated 4/30/18, indicated the staff had removed R5's right braces due to the knuckles being red.

R5's care plan provided on 5/10/18, included directions dated 5/9/18, which directed the staff: "Resident now using pillows to position arms in chair and staff to remind to extend throughout the day. Washcloths in hands at night."

On 5/9/18, at 1:00 p.m. R5 was observed seated in a wheelchair in his room. R5's arms were noted to be contracted at the elbows, wrists, hands and shoulders. R5 was not utilizing any type of braces.
- At 2:00 p.m. R5 was observed in bed, no splints were observed.
- At 4:30 p.m. R5 was transferred from bed to wheelchair via a full body mechanical lift. NA-C assisted with the transfer. Once in the chair, NA-C was not observed to encourage R5 to do any type of stretches and pillows were not placed.

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{F 688}	Continued From page 14 - At 7:10 p.m. NA-G assisted to transfer R5 from the wheelchair to bed and complete bedtime cares. NA-G did not apply any type of brace, pillows or washcloths into R5 hands. NA-G stated R5 was to utilize splints, however, NA-G was not able to locate the splints as they were not in R5's room. NA-G stated she had not received any new directions for R5's care. - At 7:53 p.m. licensed practical nurse (LPN)-C stated R5 was to utilize hand splints at bedtime. Upon review of the electronic treatment record, LPN-C reported the splints had previously been recorded on the electronic treatment record, however, they had been removed. LPN-C stated she had not received any type of new directions related to R5's contractures or splint use during shift report. On 5/10/18, at 7:05 a.m. R5 was observed seated in a wheelchair in his room. R5's arms continued to be contracted, no pillows, washcloths or splints wer observed to be in place. - At 7:08 a.m. NA-B stated she had been informed of new pillow placements for R5's arms. NA-B stated the Regional Director of Clinical Services had explained how to place the pillows for R5's comfort but she could not recall exactly how they were to be placed. NA-B stated R5 did not have washcloths in his hands when she assisted him out of bed. NA-B proceeded to complete PROM for R5. R5's right arm was able to be extend to a 90 degree angle at the elbow, the shoulder was able to be moved approximately 2-3 inches, the wrist was unable to be straighten and the fingers of the right hand were unable to be opened more than an inch from the palm. R5 held the right hand in a fisted position. The left elbow moved to about a 90 degree angle, the wrist, fingers and shoulders were contracted.	{F 688}		

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{F 688}	Continued From page 15	{F 688}		

When NA-B had completed the exercises, she placed a pillow under R5's elbows to extend them away from his body.

- At 8:15 a.m. R5 was observed being fed in the dining room. R5 did not have a pillow or splints in place at the time of the meal.

Review of R5's clinical record lacked a comprehensive assessment of the discontinuation of the splints and the application of the pillows and washcloths.

- At 11:10 a.m. the DON stated the therapist had discontinued the splints on 5/9/18, and had directed the staff to use pillows and washcloths. The DON stated the staff were to have been informed of the change via shift report and the care plan.

- 1:10 p.m. R5 was observed seated in his wheelchair in his room. The regional director of clinical services confirmed R5 did not have pillows in place as directed. the regional director then placed pillows under R5's arms.

- At 1:20 p.m. COTA-A stated an unidentified COTA and the regional director of clinical services had reviewed R5's splints yesterday and chose to discontinue them without contacting the OT prior to discontinuation. COTA-A stated she had contacted the OT and informed her of the discontinuation of R5's splints and stated the OT was "unhappy" with this change as the OT had not initiated the change in treatment and R5 had not yet been discontinued from occupational therapy. COTA-A stated the OT was returning to the facility to complete an additional evaluation of R5.

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{F 688}	Continued From page 16 OT-A was not available for interview during the survey. The Range of Motion Exercises policy dated 4/2/18, directed the staff to exercise the residents' joints and muscles. The policy also directed the staff to verify a physician order for ROM had been received and if there was no order, the staff were to contact the attending physician to obtain an order, as needed. In addition the staff were directed to record the following in the resident clinical record: - The date and time of the exercises. - The name of the person providing the exercise. - The type of ROM exercises. - Whether the exercise was active of passive. - How long the exercise was conducted. - If and how the resident participated in the procedures or any changes in the resident's ability to participate. - Any problems or complaint made by the residents related to the procedure. - If the resident refused the treatment and reason why along with interventions taken.	{F 688}		
{F 758} SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant;	{F 758}		6/15/18

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{F 758}	Continued From page 17 (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.	{F 758}		

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{F 758}	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an as needed (PRN) antianxiety medication had a documented rational for the continued use of the medication exceeding 14 days for 1 of 1 resident (R3) who received PRN antianxiety medication without the justification for its use longer than 14 days. In addition, the facility failed to monitor the sleep pattern for 1 of 1 resident (R13) reviewed who received a daily hypnotic without adequate monitoring to ensure medication efficacy and as ordered by the physician. Findings include: R3's face sheet dated 5/10/18, included diagnoses of heart failure and chronic respiratory failure. R3's Consultant Pharmacist's Medication Review (PMR) dated 4/19/18, identified an irregularity related to the Center for Medicare/Medicaid Services (CMS) regulations which required a clear risk vs. benefit analysis and documentation to be in place to warrant the continuation of a PRN psychotropic medication beyond 14 days and unfortunately hospice orders are included in these regulation. The recommendation further indicated to the physician, to please consider providing clinical documentation of continued need and consider how you feel it could improve the patient's quality of live. Could consider scheduling medication as was scheduled in the past. The physician's response dated 4/24/18, rejected the recommendation and indicated the current dosing and as needed nature of the order was appropriate for this hospice patient and	{F 758}	F758 SS=D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to follow guidelines regarding use of PRN psychotropic medications. For R3 the facility failed to ensure these residents who received their prn antianxiety medications had rationale for utilization of the medication longer than the 14-day regulation. R13 was on hypnotic and did not have sleep study done to determine if effective. R3 recommendation sent to MD for follow up documentation. R13 did have sleep study completed. All medications have been reviewed with consultant and discussed at QAPI in April. The framework has been set to ensure adequate follow up with dose reductions, proper diagnoses, sleep monitoring, target behaviors put in place on TAR and overall compliance with the 14-day regulation. MAR□s and TAR□s updated and care plans updated. 2. Because many residents have orders for PRN psychotropics, many are potentially affected by the cited deficiency, staff were reminded to ensure safe	

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{F 758}	Continued From page 19 scheduling a benzodiazepine was not appropriate. R3's Order Summary Report, dated 5/10/18, identified an order for Lorazepam 0.5 mg (antianxiety) every four hours PRN for anxiety with a start date of 2/27/18. The order lacked a duration for its use. R3's record lacked evidence of a physician's evaluation to extend the duration for use beyond 14 days. R3's medication administration record (MAR) indicated between 5/1/18, and 5/10/18, Ativan 0.5 mg was administered on 13 occasions. From 4/1/18, and 4/30/18, Ativan 0.5 mg was administered on 50 occasions. On 5/10/18, at 2:10 p.m. the director of nursing (DON) verified R3's Ativan PRN order required a physician justification and duration for the use beyond 14 days and stated R3's physician should have documented a clear rational and a duration for the continued use. The DON verified the facility had not readdressed R3's PRN Ativan order with the physician. R13 received a daily hypnotic without adequate sleep monitoring to ensure efficacy and as directed by the physician. R13's Pharmacy review dated 4/24/18, identified R13 received a Trazadone 50 mg (hypnotic) daily and recommended the facilty ensure a sleep study was completed. A note was faxed to R13's physician requesting an order for a sleep study in which the physician responded with an order for a sleep study. R13's Order Summary Report dated 5/9/18, included an order dated 2/13/18, for Trazadone	{F 758}	environments and necessary interventions to redirect behaviors before utilizing medications if medications are needed consistently MD to schedule if medications needed often or discontinued if not used. This will occur every 14 days. All residents have been reviewed for current as needed psychotropic meds for appropriate use. Residents on medication for sleep will have sleep study completed. No other residents were affected. The policy on PRN psychotropics and sleep monitoring been reviewed and revised. 3. To enhance currently compliant operations and under the direction of the DON, on 6/6/2018 all nursing staff will receive in-service training on utilizing PRN psychotropic medications that are ordered PRN for more than 14 days and the importance of physician doing visit to order continued use or schedule if needed consistently, indicating target behaviors noted in documentation, and non-pharmacological approaches. Psychotropic medications will be reviewed at quarterly and annual reviews to determine need, effectiveness or dose reduction. 4. Effective 6/6/2018, a quality-assurance program was implemented under the supervision of pharmacy and nursing to monitor residents with prn orders for psychotropic meds and those on sedatives/hypnotics for monitoring of sleep studies. The DON or designated quality-assurance representative will perform the following systematic audits on residents with orders for prn psychotropic and those needing	

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{F 758}	Continued From page 20 (hypnotic) 50 mg at bedtime for insomnia and depressive disorder. The report also included an order dated 10/1/15, which directed the staff to monitor R13's sleep pattern the first seven days of every month. One time a day starting on the 1st and ending on the 8th of every month for sleep study per the recommendations of the facility's pharmacy consultant. Record the number of hours awake during the night, number of hours asleep during the night, yes or no to behavioral changes during the night-if yes, write a brief summary. Hours of stud will be 8:00 pm. to 4:00 a.m. R13's care plan printed on 5/9/18, indicated at risk for sleep pattern disturbance due to diagnosis of sleep disturbance and use of Trazadone for sleep. The plan directed the staff to administer the medication as ordered by the physician and to assess for adverse side effects and to offer non-pharmacological interventions such as a back rub, relaxation techniques, soft or relaxation music. R13's clinical record lacked evidence of a sleep pattern study/documentation having been initiated. On 5/9/18, at 12:32 p.m. R13 was observed in his room, seated in his electric wheelchair. When asked, R13 denied any sleep disturbances. On 5/9/18, at 1:32 p.m. registered nurse (RN)-B reviewed R13's clinical record and stated she was unable to locate any type of documentation related to a sleep pattern study. On 5/9/18, at 3:58 pm. the regional director of clinical services confirmed R13's clinical record	{F 758}	sleep studies; 50 % of residents x 4 weeks, then 25% of residents weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly quality-assurance committee meeting for further review or corrective action. 5. The Pharmacy and DON will be responsible for this POC. 6. Completion date is 6/15/18	

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	245323	A. BUILDING _____ B. WING _____	R 05/10/2018

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

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{F 758}	Continued From page 21 lacked evidence of R13's sleep pattern and stated the sleep pattern study/documentation was not initiated when ordered. Superior Healthcare Management Minnesota Region policy and procedure dated 12/23/17, identified the facility would make every effort to comply with state and federal regulations related to the use of psychopharmacological medications to include regular review for continued need, appropriate dosage, side effect, risks and/or benefits. Additionally, the facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environment, medical, and/or behavioral interventions, as well as psychopharmacological medications could be utilized.	{F 758}		
{F 810} SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adaptive equipment in order to promote independence with eating for 1 of 1 resident (R23) reviewed for nutrition and observed to display difficulty eating and drinking. Findings include: R23's quarterly Minimum Data Set (MDS) dated	{F 810}	F810 SS=D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and	6/15/18

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{F 810}	Continued From page 22 3/9/18, identified R23 with severe cognitive impairment and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living including eating. R23's annual MDS dated 10/13/17, also identified R23 as requiring extensive assistance with eating. R23's Nutritional Status Care Area Assessment (CAA) dated 10/20/17, indicated R23 displayed disruptive behaviors and threw food during meals. R23's Occupational Therapy OT evaluation and Plan of Treatment dated 4/17/18, indicated R23 was totally dependent upon staff for feeding and no further treatment or recommendations were warranted. R23's Care Plan dated 1/20/18, indicated R23 was to utilize a covered shaker cup for drinking and a coated spoon or silverware while eating. On 5/9/18, at 5:05 p.m. R23 was observed seated in a wheelchair, in the dining room. Nursing assistant (NA)-A was assisting R23 with his meal. NA-A utilized a coated spoon as she fed R23 the meal which consisted of ground hamburger with gravy, broccoli and macaroni and cheese. R23 held and drank from the covered "shaker" cup throughout the meal. -At 5:55 p.m. R23 had eaten 75% of the meal and had drank approximately 240 cc (cubic centimeters) of juice independently. -At 7:30 p.m. R23's room was not observed to have any type of water glass for R23. On 5/10/18, at 8:40 a.m. R23 was wheeled into	{F 810}	federal law. 1. It is the policy of the facility to provide adaptive equipment to all residents in conjunction with OT to ensure resident remains as independent and high functioning as they can. R23 was noted to have divided plate, shaker cup and adaptive silverware on care, on diet card. Although adaptive equipment was in place staff member assisting with meals refused to use with resident regardless of order. Upon notification by surveyor of this occurrence, discussed situation with staff and ensured that all orders will be followed as determined by resident□s care plan. 2. Because many residents need adaptive devices many are potentially affected by the cited deficiency. This was discussed with administration and HR and determined based on faulty practice of employee correction would be made and resident will always be able to utilize utensils that best meet his needs without changes made by staff. All residents with adaptive devices have been reviewed for use and appropriateness. No other residents were affected. 3. To enhance currently compliant operations all staff will be updated at in-service 6/6/2018 about adaptive equipment and importance of offering it or alerting charge nurse if further follow up is needed to find another option. Reviewed respect and dignity with and importance of giving residents the tools they need to be successful in their ADL□s. 4. Effective 6/4/2018, a quality-assurance program was	

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{F 810}	Continued From page 23 the dining room for breakfast. The health unit coordinator (HUC) was served R23 hot cereal, toast, juice and milk. The HUC utilized the coated spoon as she fed R23. R23's covered "shaker" cup was on the table, however, the HUC assisted R23 to drink from a standard cup. At no time throughout the meal was R23 observed to be encouraged to utilize the covered cup. -At 9:00 a.m. R23 had finished 100% of the breakfast meal and approximately 50% of the liquids. The HUC cleared the table including the clean unused covered cup. The HUC stated she did not like the covered cup and R23 drank just fine without it so she felt R23 did not need to use the covered cup. The HUC confirmed she had not utilized the adaptive equipment as identified on the care plan and proceeded to wheel R23 out of the dining room. -At 10:00 a.m. R23's room was observed. A water glass or fluids were not observed in R23's room. -At 11:30 a.m. the director of nurses (DON) confirmed R23 was to utilize the covered cups and the coated spoon as directed on the care plan. The DON stated she was unaware R23's adaptive eating equipment was not being utilized during meals or in R23's room. The DON stated all residents were to have water or fluids available in their rooms including residents who required adaptive equipment. -At 12:00 p.m. the dietary director was observed to place a covered cup of water in R23's room. Superior Healthcare Management Adaptive Equipment policy dated 4/2/18, directed the staff	{F 810}	implemented under the supervision of the dietary manager to monitor adaptive devices and residents needing assistance. The dietary manager or designated quality-assurance representative will perform the following systematic changes: audits on residents with adaptive devices or needing devices for all meals for first week then 3 audits per resident per week x 4 weeks, then 1 audit x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. All staff will be responsible for this POC. 6. Compliance date is 6/15/18	

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{F 810}	Continued From page 24 to provide adaptive equipment to assist residents at mealtimes for easier independent eating.	{F 810}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on June 27, 2018.

June 27, 2018

Mr. Brian Reindl, Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West PO Box 700
Walker, MN 56484

Re: Project # S5323027

Dear Mr. Reindl:

On May 10, 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 March 27, 2018 with orders received by you electronically on April 26, 2018.

State licensing orders issued pursuant to the last survey completed on March 27, 2018 and found corrected at the time of this May 10, 2018 revisit, are listed on the State Form: Revisit Report Form.

State licensing orders issued pursuant to the last survey completed on March 27, 2018, found not corrected at the time of this May 10, 2018 revisit and subject to penalty assessment are as follows:

20895 -- MN Rule 4658.0525 Subp. 2.B -- Rehab - Range Of Motion	$350.00
20900 -- MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers	$350.00
20910 -- MN Rule 4658.0525 Subp. 5 A.B -- Rehab - Incontinence	$350.00
20945 -- MN Rule 4658.0530 Subp. 1 -- Assistance With Eating - Nursing Personnel	$350.00
21426 -- MN St. Statute 144A.04 Subd. 3 -- Tuberculosis Prevention And Control	$ 0.00
21540 -- MN Rule 4658.1315 Subp. 2 -- Unnecessary Drug Usage; Monitoring	$300.00

The details of the violations noted at the time of this revisit completed on May 10, 2018 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $1700.00 per day beginning on the day you receive this notice.
The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to:

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

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

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

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

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

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

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

Sincerely,

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
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00995	A. BUILDING: _____ B. WING _____	R 05/10/2018

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

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on May 9 and 10, 2018. During this visit it was determined that the following correction orders were NOT Corrected: 0895, 0900, 0910, 0945, 1426, and 1540. These uncorrected orders will remain in effect and will be reviewed for possible penalty assessment/s.	{2 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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

Electronically Signed | 06/06/18

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{2 000}	Continued From page 1	{2 000}	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
{2 895}	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	{2 895}		6/15/18

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{2 895}	Continued From page 2 B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 3/27/18, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to assess the need for range of motion (ROM) services for 1 of 3 residents (R23) observed with limitations in ROM without the assessment and development of a ROM program in order to prevent a decline or maintain current ROM abilities. In addition, the facility failed to follow the therapist's direction related to the application of splints for 1 of 1 resident (R5) who was currently receiving occupational therapy. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/9/18, indicated R23 had severe cognitive impairment and diagnoses which included dementia, history of stroke and aphasia (inability to speak). The MDS indicated R2 required extensive assistance with all activities of daily living. R23's annual MDS dated 10/13/17, indicated R23 required total staff assistance for all activities of daily living. R23's care plan provided on 5/10/18, directed the staff to have physical therapy (PT) and occupational therapy (OT)evaluate and treat R23	{2 895}	2895 □ see F688	

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{2 895}	Continued From page 3 as directed by the physician. The care plan also directed the staff to report signs and symptoms of immobility, or contractures forming or worsening. The care plan did not direct the staff to assist R23 with ROM exercises. R23's Therapist Progress and Discharge Summary dated 4/13/17, indicated R23 had lower extremity limitations in ROM. The physical therapist indicated nursing staff was to provide R23 ROM with manual stretches including bilateral hamstrings. The frequency of the exercises was not indicated. R23's Therapist Progress and Discharge summary dated 4/14/17, indicated R23 had limitation in ROM in the upper extremities. The occupational therapist indicated R23 was to receive ROM exercises however, the frequency of the services was not identified. R23's OT Evaluation and Plan of Treatment dated 4/17/18, indicated R23 had been evaluated by OT for feeding assistance devices, but did not include a ROM program evaluation or directions for a restorative program. Review of the facility's Restorative nursing documentation did not include a restorative nursing program for R23. Review of R23's electronic medication record did not direct the staff to assist with ROM. On 5/9/18, at 1:20 p.m. R23 was observed to be transferred from the wheelchair to the bed via a full body mechanical lift with the assistance of nursing assistant (NA)-B and NA-C. R23's shirt and pants were observed to be saturated with milk therefore the NA's changed his clothing.	{2 895}		

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{2 895}	Continued From page 4	{2 895}		

R23 held onto the staff with his right hand and kicked at staff with his right leg. While changing his pants, NA-B moved R23's left leg which revealed no limitations in ROM. NA-C assisted R23 to change his shirt in which R23 was noted to have full ROM in the right arm, however, the left arm moved approximately 4-5 inches with limitation in ROM in the left shoulder noted.

On 5/10/18, at 11:40 a.m. the director of nursing (DON) stated R23 had been screened by therapy for ROM needs, however, R23 had not been added to the therapy list. Upon review of the OT evaluation dated 4/17/18, the DON confirmed R23's ROM needs had not been evaluated and should have been.

On 5/10/18, at 1:15 p.m. the certified occupational therapy assistant (COTA)-A stated R23 had been evaluated for his adaptive equipment needs at meals, however, R23 was not evaluated by OT for ROM needs.

R5's quarterly MDS dated 1/10/18, indicated R5 had moderate cognitive impairment and diagnoses which included Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff for bed mobility, transfers and all activities of daily living, and had bilateral functional limitation in range of motion of the upper and lower extremities. R5's admission MDS dated 9/1/17, indicated R5 was dependent upon staff for all activities of daily living and had bilateral functional limitation in ROM of the upper and lower extremities.

R5's Activities of Daily Living Care Area Assessment (CAA) dated 9/6/17, indicated R5 required total staff assistance all activities of daily living related to encephalopathy (brain disease,

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{2 895}	Continued From page 5 damage or malfunction), spinal fusion and weakness. The CAA indicated R5 was participating in therapy. R5's Occupational Therapy Evaluation and Plan of Treatment dated 4/8/17- 5/7/18, indicated R5 had bilateral arm contractures and was being treated by OT for the evaluation and implementation of interventions to minimize arm contractures. The identified short term goal indicated R5 was to utilize a resting hand splint and a resting pan-mitt splint and elbow extension splints for greater than eight hours without signs and symptoms of redness, swelling, discomfort or pain. The long term goal was to ensure R5 was able to wear the splints without redness or discomfort. The Occupational Therapy Treatment Encounter Notes revealed the following information: - 4/11/18, PROM (passive range of motion) completed, applied braces to elbows and hands. - 4/12/18, PROM to upper extremities and splints applied. - 4/16/18, PROM to upper extremities patient expressed discomfort with stretches. - 4/17/18, PROM to the upper extremities and splints applied. - 4/19/18, PROM to upper extremities and splints adjusted for proper fit. - 4/23/18, PROM to contractures, applied elbow splints. - 4/25/28, PROM and educated nursing staff present for proper application of splints. - 4/26/18, PROM, educated staff on prolonged stretches and splint application. - 4/30/18, PROM and splint application. - 5/1/18, PROM and splint application. - 5/3/18, PROM and splint application. Educated	{2 895}		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 895}	Continued From page 6 NA's on proper placement of splints - 5/7/18, PROM with stretches, communicated with DON on application of splints and prolonged stretching for R5. - 5/8/18, PROM and application of elbow and hand splints. Review of R5's Progress note dated 4/30/18, indicated the staff had removed R5's right braces due to the knuckles being red. R5's care plan provided on 5/10/18, included directions dated 5/9/18, which directed the staff: "Resident now using pillows to position arms in chair and staff to remind to extend throughout the day. Washcloths in hands at night." On 5/9/18, at 1:00 p.m. R5 was observed seated in a wheelchair in his room. R5's arms were noted to be contracted at the elbows, wrists, hands and shoulders. R5 was not utilizing any type of braces. - At 2:00 p.m. R5 was observed in bed, no splints were observed. - At 4:30 p.m. R5 was transferred from bed to wheelchair via a full body mechanical lift. NA-C assisted with the transfer. Once in the chair, NA-C was not observed to encourage R5 to do any type of stretches and pillows were not placed. - At 7:10 p.m. NA-G assisted to transfer R5 from the wheelchair to bed and complete bedtime cares. NA-G did not apply any type of brace, pillows or washcloths into R5 hands. NA-G stated R5 was to utilize splints, however, NA-G was not able to locate the splints as they were not in R5's room. NA-G stated she had not received any new directions for R5's care. - At 7:53 p.m. licensed practical nurse (LPN)-C stated R5 was to utilize hand splints at bedtime. Upon review of the electronic treatment record,	{2 895}		

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{2 895}	Continued From page 7 LPN-C reported the splints had previously been recorded on the electronic treatment record, however, they had been removed. LPN-C stated she had not received any type of new directions related to R5's contractures or splint use during shift report. On 5/10/18, at 7:05 a.m. R5 was observed seated in a wheelchair in his room. R5's arms continued to be contracted, no pillows, washcloths or splints wer observed to be in place. - At 7:08 a.m. NA-B stated she had been informed of new pillow placements for R5's arms. NA-B stated the Regional Director of Clinical Services had explained how to place the pillows for R5's comfort but she could not recall exactly how they were to be placed. NA-B stated R5 did not have washcloths in his hands when she assisted him out of bed. NA-B proceeded to complete PROM for R5. R5's right arm was able to be extend to a 90 degree angle at the elbow, the shoulder was able to be moved approximately 2-3 inches, the wrist was unable to be straighten and the fingers of the right hand were unable to be opened more than an inch from the palm. R5 held the right hand in a fisted position. The left elbow moved to about a 90 degree angle, the wrist, fingers and shoulders were contracted. When NA-B had completed the exercises, she placed a pillow under R5's elbows to extend them away from his body. - At 8:15 a.m. R5 was observed being fed in the dining room. R5 did not have a pillow or splints in place at the time of the meal. Review of R5's clinical record lacked a comprehensive assessment of the discontinuation of the splints and the application of the pillows and washcloths.	{2 895}		

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{2 895}	Continued From page 8 - At 11:10 a.m. the DON stated the therapist had discontinued the splints on 5/9/18, and had directed the staff to use pillows and washcloths. The DON stated the staff were to have been informed of the change via shift report and the care plan. - 1:10 p.m. R5 was observed seated in his wheelchair in his room. The regional director of clinical services confirmed R5 did not have pillows in place as directed. the regional director then placed pillows under R5's arms. - At 1:20 p.m. COTA-A stated an unidentified COTA and the regional director of clinical services had reviewed R5's splints yesterday and chose to discontinue them without contacting the OT prior to discontinuation. COTA-A stated she had contacted the OT and informed her of the discontinuation of R5's splints and stated the OT was "unhappy" with this change as the OT had not initiated the change in treatment and R5 had not yet been discontinued from occupational therapy. COTA-A stated the OT was returning to the facility to complete an additional evaluation of R5. OT-A was not available for interview during the survey. The Range of Motion Exercises policy dated 4/2/18, directed the staff to exercise the residents' joints and muscles. The policy also directed the staff to verify a physician order for ROM had been received and if there was no order, the staff were to contact the attending physician to obtain an order, as needed. In addition the staff were directed to record the following in the resident	{2 895}		

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{2 895}	Continued From page 9 clinical record: - The date and time of the exercises. - The name of the person providing the exercise. - The type of ROM exercises. - Whether the exercise was active of passive. - How long the exercise was conducted. - If and how the resident participated in the procedures or any changes in the resident's ability to participate. - Any problems or complaint made by the residents related to the procedure. - If the resident refused the treatment and reason why along with interventions taken.	{2 895}		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The	{2 900}	2900 □ see F686	6/15/18

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{2 900}	Continued From page 10 original licensing order issued on 3/27/18, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to provide timely repositioning assistance as directed by the care plan for 2 of 3 residents (R5, R23) reviewed who identified at risk for pressure ulcers and required staff assistance for repositioning. Findings Include: R5's quarterly Minimum Data Set (MDS) assessment dated 1/10/18, indicated R5 had moderate cognitive impairment and diagnoses including Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff for all activities of daily living including bed mobility and transfers. The MDS also identified R5 as at risk for development of pressure ulcers. R5's Pressure Ulcer Care Area Assessment (CAA) dated 9/6/17, identified R5 as at risk for development of pressure ulcers due to dependence upon staff for repositioning, and management of bowel incontinence. The assessment indicated staff were to complete weekly skin assessments and were to monitor R5's skin while assisting with personal cares. R5's Braden Scale (a tool utilized to predict pressure ulcer development) dated 5/8/18, identified R5 as at risk for development of pressure ulcers. R5's Tissue Tolerance Observation form dated 5/9/18, indicated R5 displayed a "slightly red" area over boney prominences. However, the form did not identify which boney prominences had	{2 900}		

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{2 900}	Continued From page 11 skin change/susceptibility to pressure nor any skin care directives for the staff to implement. R5's care plan provided on 5/10/18, included interventions for staff to assist R5 with repositioning at least every two hours. On 4/27/18, at 4:27 p.m. nursing assistant (NA)-C was observed to transfer R5 from bed into a wheelchair via a full body mechanical lift. -At 5:05 p.m. R6 was wheeled into the dining room for supper -At 5:15 p.m. a visitor assisted R5 with the evening meal. -At 5:40 p.m. R5 was wheeled out of the dining room and to his room -At 6:00 p.m. until 7:05 p.m. R5 remained in his room, seated in the wheelchair. -At 7:05 p.m. NA-G entered R5's room and began to assist R5 with evening cares. -At 7:15 p.m. NA-G transferred R5 from the wheelchair to bed. R5's wheelchair was observed equipped with a pressure redistribution cushion. R5's buttocks were pink and the coccyx was noted to have a small crevasse with thin, fragile like skin covering it. -At 7:30 pm. NA-G stated she was unaware of the last time R5 had been assisted with repositiong. NA-G stated she had arrived at the facilty at 6:00 p.m. and had not received any type of shift report. R5 had not received assistance with repositioning for 2 hours and 48 minutes. On 5/10/18, at 9:00 a.m. NA-F was observed to transfer R5 from the wheelchair into bed via a full body mechanical lift. -At 10:55 a.m. the director of nursing (DON) stated R5 was to receive assistance with repositiong every two hours as directed by the care plan.	{2 900}		

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{2 900}	Continued From page 12 R23 did not receive timely assistance with repositiong for greater than four hours on the evening of 5/9/18. R23's quarterly MDS dated 3/9/18, indicated R23 had severe cognitive impairment and diagnoses which included dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all bed mobility and transfers and was at risk for the development of pressure ulcers. R23's annual MDS dated 10/13/17, also identified R23 as being totally dependent upon staff for bed mobility, transfers and at risk for the development of pressure ulcer. R23's Pressure Ulcer CAA dated 10/9/17, identified R23 at risk for the development of pressure ulcers and directed the staff to utilize a pressure reducing mattress, chair cushion, and to assist R23 with offloading every two hours and as needed. R23's Braden Scale for Prediction of Pressure Sore Risk dated 5/8/18, identified R23 at moderate risk for the development of pressure ulcers. The Tissue Tolerance Observation Tool dated 3/9/18, indicated R23 did not develop reddened areas after two hours in one position. R23's care plan provided on 5/10/18, directed staff to assist with repositioning every two hours. During continuous observations on 5/9/18, from 4:20 p.m. to 8:20 p.m. R23 was not observed to receive assistance with repositiong. -At 4:20 p.m. NA-C and NA-A were observed to	{2 900}		

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{2 900}	Continued From page 13 transfer R23 from bed to a wheelchair via a full body mechanical lift. -At 5:05 p.m. registered nurse (RN-B) wheeled R23 to the dining room. -At 5:22 p.m. NA-A assisted R23 with the evening meal. -At 6:19 p.m. R23 was wheeled into his room. -At 6:30 p.m. until 7:40 p.m. R23 remained in his room, seated in the wheelchair. -At 7:40 p.m. NA-G stated she had arrived at the facility at 6:00 p.m. and had not received any type of report when she arrived at the facility and did not know when R23 had last been repositioned. NA-G stated she would try to get to him. -At 8:00 p.m. R23 remained seated in the wheelchair. -At 8:15 p.m. NA-A stated she could not assist R23 as she was busy answering lights for other residents. NA-A stated R23 had not yet been assisted with repositioning/cares. -At 8:20 p.m. the DON and the Regional Director of Clinical Services stated they had assisted R23 with repositiong by lifting him out of the chair with the full body mechanical lift sling. The regional director stated she and the DON had lifted him out of the chair with the lift but did not complete any type of repositioning, rather R23 back down into the chair. -At 8:25 p.m. the DON and regional director approached R23 in his room and connected him to a full body mechanical lift. NA-A entered the room and assisted the Regional Director of Clinical Services to transfer R23 from the wheelchair to the bed. R23's wheelchair was equipped with a pressure redistribution cushion. R23's buttocks were pink and intact. -At 8:26 p.m. NA-A confirmed R23 had last been assisted with repositiong at 4:20 p.m. 4 hours and 6 minutes earlier.	{2 900}		

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{2 900}	Continued From page 14 On 5/10/18, at 11:30 a.m. the DON stated R23 was to receive assistance with repositiong every two hours as directed by the plan of care. The DON stated when she and the regional director of clinical services had repositioned R23 by lifting the mechanical lift sling, R23 was out of the chair for only 10-30 seconds. The DON confirmed in order for full tissue perfusion to be accomplished, the resident would have to be off of the bony prominences for a minimum of one minute. The DON confirmed R23 had not been out of the chair for a full minute. Superior Healthcare Management Minnesota Region policy and procedure, Pressure Ulcer Risk Assessment effective 12/23/17, indicated the following: -pressure ulcers are usually formed when a resident remained in the same position for an extended period of time causing increased pressure or decrease of circulation -if pressure ulcers are not treated when discovered, they can become larger, painful, and infected -pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (feces, urine, soap, discharge), decline in nutrition, and hydration status, acute illness or decline in the resident's physical and/or mental condition -pressure ulcers are a serious skin condition for the resident -routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. -Skin would be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated.	{2 900}		

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{2 900}	Continued From page 15 The Superior Healthcare Management Minnesota Region, Repositioning policy and procedure reviewed 4/2/18, indicated the purpose of the procedure was to provide guideline for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed or chair bound residents and to prevent skin breakdown, promote circulation and provide pressure relief for residents. The policy also indicated repositioning was critical for a resident who was immobile or dependent on staff for repositioning. A repositioning program was defined as a specific approach that was organized, planned, documented, monitored and evaluated.	{2 900}		
{2 910}	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	{2 910}		6/15/18

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{2 910}	Continued From page 16 This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 3/27/18, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 1 of 3 residents (R23) who was totally dependent on staff for incontinence cares. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/9/18, identified R23 with severe cognitive impairment and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living and indicated he was totally incontinent of bladder. R23's annual MDS dated 10/13/17, also identified R23 as being totally incontinent of bowel and bladder. R23's Urinary Incontinence CAA dated 10/9/17, identified R23 as being totally incontinent of bowel and bladder and directed the staff to assist to check and change R23's incontinence brief every two hours. R23's care plan provided on 5/10/18, directed staff to check and change R23's incontinence brief every two hours. During continuous observations on 5/9/18, from 4:20 p.m. to 8:20 p.m. R23 was not observed to receive assistance with incontinence cares. -At 4:20 p.m. nursing assistant (NA)-C and NA-A were observed to transfer R23 from bed to a	{2 910}	2910 □ see F810	

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{2 910}	Continued From page 17	{2 910}		

wheelchair via a full body mechanical lift.
-At 5:05 p.m. registered nurse (RN-B) wheeled R23 to the dining room.
-At 5:22 p.m. NA-A assisted R23 with the evening meal.
-At 6:19 p.m. R23 was wheeled into his room and remained in his room, seated in the wheelchair, until 7:40 pm.
-At 7:40 p.m. NA-G stated she had arrived at the facility at 6:00 p.m. and had not received any type of report when she arrived and did not know when R23 had last been assisted with incontinence cares. NA-G stated she would try to get to him.
-At 8:00 p.m. R23 continued to be seated in the wheelchair.
-At 8:15 p.m. NA-A stated she could not assist R23 as she was busy answering lights for other residents. NA-A confirmed R23 had not yet been assisted with incontinence cares.
-At 8:20 p.m. the director of nursing (DON) and the Regional Director of Clinical Services approached R23 and connected him to a full body mechanical lift. NA-A entered the room and assisted the Regional Director of Clinical Services to transfer R23 from the wheelchair to the bed.
-At 8:26 p.m. NA-A completed perineal cares. R23 was observed to be incontinent of urine. NA-A confirmed R23 had last been assisted with incontinence cares at 4:20 p.m. 4 hours and 6 minutes earlier.

On 5/10/18, at 11:30 a.m. the DON stated R23 was to receive assistance with incontinence cares every two hours as directed by the plan of care.

The Toileting policy and procedure dated 4/2/18, directed the staff to assist residents to the toilet in a timely manner in accordance to their individualized plan of care. The policy indicated

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{2 910}	Continued From page 18 that if a resident was unable to physically tolerate utilization of the toilet, the staff were to adhere to a check and change program based on a bowel and bladder assessment.	{2 910}		
{2 945}	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the attending physician. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 3/27/18, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to provide adaptive equipment in order to promote independence with eating for 1 of 1 resident (R23) reviewed for	{2 945}	2945 see correction 810	6/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00995	A. BUILDING: _____ B. WING _____	R 05/10/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 945}	Continued From page 19 nutrition and observed to display difficulty eating and drinking. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/9/18, identified R23 with severe cognitive impairment and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living including eating. R23's annual MDS dated 10/13/17, also identified R23 as requiring extensive assistance with eating. R23's Nutritional Status Care Area Assessment (CAA) dated 10/20/17, indicated R23 displayed disruptive behaviors and threw food during meals. R23's Occupational Therapy OT evaluation and Plan of Treatment dated 4/17/18, indicated R23 was totally dependent upon staff for feeding and no further treatment or recommendations were warranted. R23's Care Plan dated 1/20/18, indicated R23 was to utilize a covered shaker cup for drinking and a coated spoon or silverware while eating. On 5/9/18, at 5:05 p.m. R23 was observed seated in a wheelchair, in the dining room. Nursing assistant (NA)-A was assisting R23 with his meal. NA-A utilized a coated spoon as she fed R23 the meal which consisted of ground hamburger with gravy, broccoli and macaroni and cheese. R23 held and drank from the covered "shaker" cup throughout the meal. -At 5:55 p.m. R23 had eaten 75% of the meal and had drank approximately 240 cc (cubic centimeters) of juice independently.	{2 945}		

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{2 945}	Continued From page 20 -At 7:30 p.m. R23's room was not observed to have any type of water glass for R23. On 5/10/18, at 8:40 a.m. R23 was wheeled into the dining room for breakfast. The health unit coordinator (HUC) was served R23 hot cereal, toast, juice and milk. The HUC utilized the coated spoon as she fed R23. R23's covered "shaker" cup was on the table, however, the HUC assisted R23 to drink from a standard cup. At no time throughout the meal was R23 observed to be encouraged to utilize the covered cup. -At 9:00 a.m. R23 had finished 100% of the breakfast meal and approximately 50% of the liquids. The HUC cleared the table including the clean unused covered cup. The HUC stated she did not like the covered cup and R23 drank just fine without it so she felt R23 did not need to use the covered cup. The HUC confirmed she had not utilized the adaptive equipment as identified on the care plan and proceeded to wheel R23 out of the dining room. -At 10:00 a.m. R23's room was observed. A water glass or fluids were not observed in R23's room. -At 11:30 a.m. the director of nurses (DON) confirmed R23 was to utilize the covered cups and the coated spoon as directed on the care plan. The DON stated she was unaware R23's adaptive eating equipment was not being utilized during meals or in R23's room. The DON stated all residents were to have water or fluids available in their rooms including residents who required adaptive equipment. -At 12:00 p.m. the dietary director was observed	{2 945}		

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{2 945}	Continued From page 21 to place a covered cup of water in R23's room. Superior Healthcare Management Adaptive Equipment policy dated 4/2/18, directed the staff to provide adaptive equipment to assist residents at mealtimes for easier independent eating.	{2 945}		
{21426}	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 3/27/18, will remain in effect. Penalty assessment issued.	{21426}	21426 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of	6/15/18

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{21426}	Continued From page 22 Based on interview and document review, the facility failed to ensure 1 of 1 resident (R10) and 2 of 5 employees (administrator, NA-G) reviewed received a two-step tuberculin skin test (TST) and/or TB prescreening in accordance to the Centers for Disease Control and Prevention (CDC). Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Setting, 2005, directed that all residents must receive a baseline TB screening. The baseline TB screening should consist of assessment for TB risk factors and history, assessment for current symptoms of active TB, and testing for the presence of infection with mycobacterium tuberculosis. In addition to screenings, the residents and employees were to receive a two-step tuberculin skin test (TST) or a laboratory screening for the presence of TB. If an employee or resident tested positive for any of aforementioned tests, a chest x-ray and/or medical examination by a medical practitioner was to be completed to rule out active disease. Resident: During the original survey exited 3/27/18, it was noted that R10 was admitted to the facility on 6/20/17. R10's Baseline TB screening Tool for Nursing Home and Boarding Care Home Residents dated 6/20/17, indicated R10 had received a single step TST on 6/30/17. During the onsite follow up visit exited 5/10/18, R10's medical record continued to lack evidence of a complete 1st and 2nd step TB testing having been conducted.	{21426}	this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to provide effective infection control program in regard to tuberculosis screening to all staff and residents per CDC guidelines. One of the many ways that this has been achieved for R10 was to complete 2 step TB test and also completed on administrator and NA. Employee files have been completed and resident chart is updated. 2. Because all residents and staff are required to have necessary baseline testing, all are affected by the lack of monitoring of this system. Resident charts were reviewed for compliance as well as employee files. All staff and residents missing Mantoux tests have been corrected. The policy on trach care has been reviewed and updated. 3. To enhance currently compliant operations and under the regional nurse, on 6/6/2018 all staff will receive in-service training for appropriate procedure for 2 step Mantoux□s and screening/monitoring to ensure baseline results are on file. The training emphasizes the risk of TB and signs and symptoms of monitoring. 4. Effective 6/4/2018, a quality-assurance program was implemented under the supervision of the HR director to monitor employee records for compliance and the infection control nurse or designee to monitor staff. The director of nurses or designated quality-assurance representative will	

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{21426}	Continued From page 23 Employees:: Nursing assistant (NA)-G was hired on 3/6/18. NA-G's employee record did not include a screening for TB or a TST test. The Administrator was hired on 5/7/18. The Administrator's employee record lacked evidence of a two step TST test having been conducted. On 5/10/18, at 2:30 p.m. the regional director of clinical services (RDCS) confirmed R10's TB testing was not completed. In addition, the RDCS stated although R10 had been cited for lack of TB testing during the initial survey exited on 3/27/18, she was not aware of this deficient practice until now, when discussed with the surveyor. The RDCS also confirmed NA-G's TB screening had not been completed. On 5/10/18, at 3:05 p.m. the Administrator confirmed his employee record lacked evidence of the two step TST test. Following the survey, the administrator faxed evidence of a 1st step TB test having been conducted on 8/7/17, at his previous place of employment, however, there was no evidence a 2nd step TB test had been conducted. A Tuberculosis policy was requested and none was provided.	{21426}	perform the following systematic changes: all residents and all staff will be audited and corrected immediately if out of compliance. A checklist will document discrepancies and be put into plan of correction as well as corrected immediately by initiating 2 step process or chest x-ray if required. The findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. ED, nursing and HR will be responsible for this POC.	
{21540}	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing	{21540}		6/15/18

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{21540}	Continued From page 24 home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Uncorrected based on the following findings. The original licensing order issued on 3/27/18, will remain in effect. Penalty assessment issued. Based on observation, interview and document review, the facility failed to ensure an as needed (PRN) antianxiety medication had a documented rational for the continued use of the medication exceeding 14 days for 1 of 1 resident (R3) who received PRN antianxiety medication without the justification for its use longer than 14 days. In addition, the facility failed to monitor the sleep pattern for 1 of 1 resident (R13) reviewed who received a daily hypnotic without adequate monitoring to ensure medication efficacy and as ordered by the physician.	{21540}	21540 □ see F758	

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{21540}	Continued From page 25 Findings include: R3's face sheet dated 5/10/18, included diagnoses of heart failure and chronic respiratory failure. R3's Consultant Pharmacist's Medication Review (PMR) dated 4/19/18, identified an irregularity related to the Center for Medicare/Medicaid Services (CMS) regulations which required a clear risk vs. benefit analysis and documentation to be in place to warrant the continuation of a PRN psychotropic medication beyond 14 days and unfortunately hospice orders are included in these regulation. The recommendation further indicated to the physician, to please consider providing clinical documentation of continued need and consider how you feel it could improve the patient's quality of live. Could consider scheduling medication as was scheduled in the past. The physician's response dated 4/24/18, rejected the recommendation and indicated the current dosing and as needed nature of the order was appropriate for this hospice patient and scheduling a benzodiazepine was not appropriate. R3's Order Summary Report, dated 5/10/18, identified an order for Lorazepam 0.5 mg (antianxiety) every four hours PRN for anxiety with a start date of 2/27/18. The order lacked a duration for its use. R3's record lacked evidence of a physician's evaluation to extend the duration for use beyond 14 days. R3's medication administration record (MAR) indicated between 5/1/18, and 5/10/18, Ativan 0.5 mg was administered on 13 occasions. From 4/1/18, and 4/30/18, Ativan 0.5 mg was administered on 50 occasions.	{21540}		

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{21540}	Continued From page 26 On 5/10/18, at 2:10 p.m. the director of nursing (DON) verified R3's Ativan PRN order required a physician justification and duration for the use beyond 14 days and stated R3's physician should have documented a clear rational and a duration for the continued use. The DON verified the facility had not readdressed R3's PRN Ativan order with the physician. R13 received a daily hypnotic without adequate sleep monitoring to ensure efficacy and as directed by the physician. R13's Pharmacy review dated 4/24/18, identified R13 received a Trazadone 50 mg (hypnotic) daily and recommended the facilty ensure a sleep study was completed. A note was faxed to R13's physician requesting an order for a sleep study in which the physician responded with an order for a sleep study. R13's Order Summary Report dated 5/9/18, included an order dated 2/13/18, for Trazadone (hypnotic) 50 mg at bedtime for insomnia and depressive disorder. The report also included an order dated 10/1/15, which directed the staff to monitor R13's sleep pattern the first seven days of every month. One time a day starting on the 1st and ending on the 8th of every month for sleep study per the recommendations of the facility's pharmacy consultant. Record the number of hours awake during the night, number of hours asleep during the night, yes or no to behavioral changes during the night-if yes, write a brief summary. Hours of stud will be 8:00 pm. to 4:00 a.m. R13's care plan printed on 5/9/18, indicated at risk for sleep pattern disturbance due to	{21540}		

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{21540}	Continued From page 27 diagnosis of sleep disturbance and use of Trazadone for sleep. The plan directed the staff to administer the medication as ordered by the physician and to assess for adverse side effects and to offer non-pharmacological interventions such as a back rub, relaxation techniques, soft or relaxation music. R13's clinical record lacked evidence of a sleep pattern study/documentation having been initiated. On 5/9/18, at 12:32 p.m. R13 was observed in his room, seated in his electric wheelchair. When asked, R13 denied any sleep disturbances. On 5/9/18, at 1:32 p.m. registered nurse (RN)-B reviewed R13's clinical record and stated she was unable to locate any type of documentation related to a sleep pattern study. On 5/9/18, at 3:58 pm. the regional director of clinical services confirmed R13's clinical record lacked evidence of R13's sleep pattern and stated the sleep pattern study/documentation was not initiated when ordered. Superior Healthcare Management Minnesota Region policy and procedure dated 12/23/17, identified the facility would make every effort to comply with state and federal regulations related to the use of psychopharmacological medications to include regular review for continued need, appropriate dosage, side effect, risks and/or benefits. Additionally, the facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environment, medical, and/or behavioral interventions, as well as psychopharmacological medications could be utilized.	{21540}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RI93

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00995

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

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

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

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

6. DATE OF SURVEY **03/27/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE NE II 05/04/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/15/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted

April 17, 2018

Ms. Brooke Slaughter, Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West Po Box 700
Walker, MN 56484

RE: Project Number S5323027

Dear Ms. Slaughter:

On March 27, 2018, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;
Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on March 27, 2018, that the conditions resulting in our notification of immediate jeopardies have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

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

NO OPPORTUNITY TO CORRECT - REMEDIES

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

- State Monitoring effective April 22, 2018. (42 CFR 488.422)

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

• Civil money penalty for the deficiencies cited at F607, F686, F688, F689, F745 and F880. (42 CFR 488.430 through 488.444)

CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective March 27,2018

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June15, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 15, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has

been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Walker Rehabilitation & Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 27, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

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

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by June 15, 2018 , the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 27, 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
	245323	A. BUILDING _____ B. WING _____	03/27/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 3/19/18, through 3/27/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on 3/19/18, through 3/27/18. The survey resulted in an Immediate Jeopardy (IJ) at F689 and F880. An IJ was called at F689 for the following residents: - On 3/21/18, at 10:01 a.m. related to failure to comprehensively assess residents (R226) with exit seeking behavior and elopements from the facility; - On 3/22/18, at 12:00 p.m. related to failure to comprehensively assess residents (R2, R8) who were being transferred via a mechanical lift unsafely; and - On 3/22/18, at 1:10 p.m. related to failure to comprehensively assess residents at risk for falls (R14) and implement consistent fall interventions. The IJ for F689 was removed on 3/27/18, at 12:00 p.m. after verification of a removal plan. An IJ was called at F880 on 3/23/18, related to the facility's systemic failure to implement appropriate infection control practices to prevent the transmission of influenza A, when over 50% of the facility was diagnosed with influenza and/or had signs/symptoms of influenza. The IJ for F880 was removed on 3/27/18, at 12:00 p.m. after verification of an appropriate	F 000		

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

Electronically Signed | 04/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	Continued From page 1 removal plan. An extended survey was conducted by the Minnesota Department of Health on 3/23/18 through 3/27/18. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure reasonable accommodation of need related to call lights within reach for 1 of 2 residents (R14) with repeated falls. Findings include: R14's physician nursing home admission assessment dated 1/23/18, indicated R14 had	F 558	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure	5/6/18

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F 558	Continued From page 2 been admitted to the facility on 1/19/18, and had diagnoses that included, but were not limited to: closed nondisplaced fracture of the seventh cervical vertebra with routine healing, high blood pressure, type II diabetes, late onset moderately advanced Alzheimer's disease with behavioral disturbance. The admission Minimum Data Set (MDS) dated 1/26/18, indicated R14 had moderate cognitive impairment, suffered a fracture as a result of a fall prior to admission, not displayed any inappropriate behavior symptoms, required limited assistance of one person when ambulating in room, required extensive assistance of one person for transfers, required extensive assistance of one person for dressing and toilet use, and was frequently incontinent of bowel and bladder. R14 was observed on 3/20/18, at 12:48 p.m. laying in bed in his bedroom. It was noted R14 had a cervical collar around the neck connected to a thoracic lumbar sacral orthosis (TLSO) stabilizing brace that wrapped around the back and abdomen. R14's bed was low to the floor (approximately 12 inches from the floor) and there was fall mat placed next to the bed. R14 had not been provided the call light to summon assistance. R14 was again observed on 3/20/18, from 5:54 p.m. to 6:48 p.m. while seated up in the wheelchair in his bedroom. At no time did any facility staff stop into R14's room to check on R14 for safety. R14 did not have access to the call light to summon assistance. R14 was observed on 3/20/18, at 7:18 p.m.	F 558	reasonable accommodations to all residents. One of the many ways that this has been achieved for resident #14 is by making sure resident has call light in reach always when in room. Also, to make sure because of high risk for falls resident is checked on frequently to ensure he is safe and staff ask if he needs anything from staff. 2. Because all residents stay in our facility and often sit in room by themselves or lay in bed all need to have access to their call light to be able to call for assistance, so all are potentially affected by the cited deficiency. On 4/19/2018, the DON and SSC walked around and visited with staff and residents to make sure needs were met and call light in reach. All residents have been rounded on to ensure call lights are available and needs being met. If a room was noted to not have followed procedure, immediate correction was completed, and staff were reminded of the policy. The policy on answer call lights has been reviewed. No other residents were affected. Quarterly review of residents will include interdisciplinary review with resident and/or family to ensure reasonable accommodations are being met. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all staff will receive in-service training regarding state and federal requirements for reasonable accommodations and review the importance of aiding residents, checking on those that are fall risk, and having resident able to reach call light always.	

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F 558	Continued From page 3 during which it was noted R14 was provided evening care and assisted to bed. R14 continued to wear the TLSO, was in a low bed with a fall mat next to the bed. R14 had not been provided a call light to summon assistance at the end of observations. On 3/21/18, at 9:00 a.m. R14 was removed from the dining room and assisted to his bedroom via a wheelchair and placed in front of the television where he actively watched a television program. R14 was not provided a call light to summon assistance. Review of R14's care plan for falls dated 1/24/18, the following interventions were developed: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. The regional director of clinical services (RDCS) was interviewed regarding R14's fall incidents during which she confirmed R14 should have been provided the call light to summon assistance and minimize fall incidents. The Superior Healthcare Management Minnesota Region policy for Answering the Call light (undated) indicated in step 5. When a resident is bed or confined to a chair make sure call light is within easy reach of the resident.	F 558	Also, to remind resident to use call light to call for assistance and make sure resident is functionally able to utilize call light. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the DON to monitor residents to ensure call lights available. The DON or designated quality-assurance representative will perform the following systematic changes: audits of call light placement and rounds to be completed on all shifts for all residents each week for 6 weeks, then 50% of residents each week audited for call light placement and rounds on all shifts for 6 weeks. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly quality-assurance committee meeting. 5. The DON will be responsible for this POC.	
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in	F 576		5/6/18

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F 576	Continued From page 4 the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident mail	F 576	This Plan of Correction constitutes my written allegation of compliance for the	

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F 576	Continued From page 5 was delivered on Saturdays and reasonable access to the Internet was provided. This had the potential to affect all 23 residents residing in the facility. Findings include: During the resident council meeting held on 3/20/18, at 2:29 p.m. R17 and R13 both stated resident personal mail was not being delivered on Saturdays. On 3/25/18, at 9:20 a.m. nursing assistant (NA)-B confirmed the residents' mail was not delivered on Saturdays and had not been for about the past year. On 3/26/18, at 10:38 a.m. both the administrator and director of nursing (DON) stated they were unaware the residents' personal mail was not being delivered on Saturdays. The administrator stated she would assign a staff member to begin delivering the mail on Saturdays, as required. On 3/27/18, at approximately 9:00 a.m. both NA-B and NA-F stated they thought there was a computer for the residents to use in the resident lounge room, "or at least there used to be." -At 10:33 a.m. the administrator and DON stated there used to be a computer in the lounge room for the residents to use and upon observation of the room, confirmed it was not there. Both stated if the residents wanted a computer to use, they could put a computer in the activity room. Superior Healthcare Management Resident Mail policy and procedure dated 12/23/17, indicated the residents would have the opportunity to stay	F 576	deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to provide opportunity for residents to have right to forms of communication with privacy. In this case R17 and R31stated they did not get their mail on Saturdays. In this case, after the surveyor reported the faulty system, the administrator worked out a plan that a staff member would go to the post office every Saturday to get mail from post office box and staff would deliver. A computer is now on site and connected for residents to utilize as they wish. The area also assures privacy for the residents. 2. Because all residents have the right to communication with privacy, all are potentially affected by the cited deficiency. On 4/18/2018, the ED reviewed this policy with leadership team at stand up and all will make efforts to ensure policy is followed and mail is on site Saturday. Since survey mail has been delivered on Saturdays and the computer is up and available for all residents. No other residents were affected. The policy and procedure for mail delivery was reviewed and communication policy regarding computer use was developed. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all staff will receive in-service training regarding mail delivery	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING _____ B. WING _____	03/27/2018

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

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F 576	Continued From page 6 in contact with family/friends/community through mail services. The Living Center would provide mail delivery services and mail sending services within 24 hours of receipt of mail or residents request to send mail. This includes Saturdays delivery. Reasonable access to electronic mail would also be provided as available.	F 576	and computers for resident. The training will emphasize the importance of ensuring all residents have ability to get outside communications and send mail to others as well as expectations of residents and computer use. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the ED to monitor resident mail delivery and verify computer is properly working for residents. ED or activities will also speak with residents regarding use and policy at next resident council. Audits will be completed weekly for 8 weeks to assure compliance. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. ED and activities director will be responsible for this POC.	
F 607 SS=F	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F 607		5/6/18

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F 607	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement policies procedures related to the prevention of abuse/neglect and exploitation of residents and misappropriation of resident property. In addition, the facility lacked polices and procedures for identification, protection, reporting, and investigating resident to resident abuse, elopement, and injuries of unknown source for 4 of 4 residents (R13, R21, R226, R5) reviewed who had a resident to resident altercation, elopement, or an injury of unknown source which was not reported, investigated, resident protection was not provided, and interventions were not developed and implemented. This failure had the potential to affect all 23 residents residing in the facility. Findings include: On 3/20/18 at 1:41 p.m. when requested to review the facility abuse prevention policy and procedures, the administrator and director of nursing (DON) stated they were unable to locate it within the facility. On 3/21/18, at 8:40 a.m. the regional director of clinical services (RDCS) stated she had only been with the facility's management company for three weeks and this was her first time at the facility. At this time, the RDCS called the Superior Healthcare Management (SHM) executive who overseen this facility. The executive stated the company took over operation of the facility on 2/1/17, whereas there was a former employee who continued to work at the facility through the ownership transition phase	F 607	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to report all incidents and assure timely follow up on any incident that result in injury. In this case R13 and R21 were noted to have a history of not getting along and led to an altercation which was not addressed with management, incident reporting, interventions or reported as required. R226 had eloped from facility couple times and last time was returned via police; incident was not reported to state agency as required. R5 had bruise of unknown origin and no investigation had been completed nor any report made. In this case, after the surveyor reported the faulty system, the policy and procedure on abuse/neglect and reporting had been reviewed and updated. All staff were in-serviced, and information put at nursing station in case staff need clarification while survey was still in process. Nursing and SSC were also educated on importance of reporting all vulnerable adult cases to the OHFC (office of health facility complaints). All incidents and accidents are to be reviewed immediately for any potential abuse or neglect. On 4/17/2018 A resident protection manual	

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F 607	Continued From page 8 which ended June 2017, at which time a RDCS started working at the facility and was responsible for overseeing the clinical nursing operation until November 2017. Following this employees departure, there was no specific regional director assigned to this "property" therefore a clinical supervisor was not present on site, rather was available for consultation via the phone. The RDCS verified and acknowledged the lack of facility systems and stated she would create a binder to place the facility abuse prevention program policy and procedures in and provide staff education. On 3/22/18, the RDCS provided a Superior Healthcare Management Abuse Reporting and Investigation policy which was printed from the corporate website and was revised 1/30/17, indicated the facility would notify the State agency and other licensing agencies depending on the circumstances of the allegation or actual event in compliance with Federal and State regulations and Elder Justice Act. The Reporting Abuse to Facility Management policy and procedure indicated it was the responsibility of their employees to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The administrator or DON must be immediately notified of suspected abuse or actual incidents of abuse. The undated Resident to Resident Altercations policy and implementation form indicated all altercations including those that represent resident to resident abuse would be reported to the nursing supervisor, DON and to the administrator. The undated Elopement policy interpretation and implementation form indicated staff would report all cases of missing residents.	F 607	was created, put at nursing stations and educated to all staff to ensure the components of abuse and neglect are identified and immediately followed up on. 2. Because all residents receiving physical assistance are potentially affected by the cited deficiency and all residents are considered vulnerable all are potentially affected to potential for abuse/neglect. All incidents have since been investigated and reported accordingly. Since survey all incidents and accidents are reviewed, and any resident sustaining injury has been reviewed and reported immediately. No other residents were affected. The policy and procedure for abuse/neglect was reviewed and updated. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all staff will receive in-service training regarding minimizing accidents. The training will emphasize the importance of taking all statements of resident leaving seriously to prevent elopement, investigating all bruises and skin tears, and separating resident if altercation occurs and immediately notifying DON and ED of any of the previously mentioned incidents. Also reviewed abuse/neglect policy and safety, and resident protection manual. Staff educated on following plan of care, appropriate interventions, timeliness of reporting to OHFC. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor all incidents	

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F 607	Continued From page 9 The undated Superior Healthcare Management Minnesota Region Abuse Prevention Program policy and procedure interpretation and implementation printed from the corporate website indicated comprehensive policies and procedures had been developed to aid the facility in preventing abuse, neglect, or mistreatment or the residents. Their abuse prevention program provided policies and procedures that governed, as a minimum: -identification of occurrences and patterns of potential abuse/mistreatment -protection of residents during abuse investigations -the development of investigative protocols -timely and thorough investigations of all reports and allegations of abuse -the reporting and filing of accurate docents related to incidents of abuse -ongoing review and analysis of abuse incidents, and -the implementation of changes to prevent further occurrences of abuse. R13 stated during interview on 3/19/18, at 9:24 a.m. that R21 used to be his roommate and currently lived a couple doors from him, however, he could not get along with R21. R13 stated R21 would threaten to "beat him up" most recently being just two days ago. R13 stated about two months ago, when he was by the nursing station with staff present, R21 had "rolled up and punched him in the left shoulder." R13 denied being injured. R13 stated the staff who had witnessed the incident told R21 he had to "settle down." R13 denied being afraid of R21 and stated, "all he is, is one big mouth" and that he tried to stay away from R21 as much as he could.	F 607	and accidents to ensure following policy: All incidents, accidents and injuries will be reviewed to ensure follow up completed per resident protection manual and investigation log. The DON or designated quality-assurance representative will perform the following systematic changes: the DON in conjunction with SSC will make report immediately if any abuse/neglect or injury was suspected. All incidents/accidents or suspected abuse/neglect situations will be reviewed daily during the week at stand up. The DON or designee will complete audits of all reported incidents on residents for 8 weeks then 50% of incidents for 8 weeks to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly quality-assurance committee meeting for further review or corrective action. 5. ED, DON will be responsible for this POC.	

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F 607	Continued From page 10	F 607		

On 3/20/18, at 1:10 p.m. nursing assistant (NA)-B stated R21 and R13 used to be roommates who did not get along and would swear at each other so they got separate rooms. NA-B stated currently, when R13 would wheel past R21's room, R21 would call R13 names. NA-B stated approximately four months ago, she and another staff member who she could not recall which staff member it was, had witnessed R21 intentionally go up to R13 and punch him in the arm. NA-B stated as staff were moving R13 away from R21, R13 had called R21 the "F-word." NA-B stated this physical altercation was the only incident she was aware of between the two residents. NA-B also stated she had reported the altercation to a nurse but was not 100% sure which nurse she had reported to. The facility lacked evidence the aforementioned resident to resident altercation was reported to the administrator or the State agency within 2 hours as required, investigated or protection provided to R13 following the incident as well as the verbal abuse by R21.

R226 eloped from the facility according to the facility's computerized Risk Management Incident list. The note indicated R226 could not be located within the facility so a building and grounds search was conducted which was unsuccessful in locating R226 and 911 was called. When 911 was called, they informed the facility their missing resident was at the local police department. The police returned the resident to the facility, unharmed. The facility provided a copy of their facility Minnesota Incident Report from the Risk Management List which was dated 12/3/17, at 7:30 a.m. which indicated R226 had eloped from the facility and a temporary wanderguard was placed, and every 15 minute checks were

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F 607	Continued From page 11	F 607		

initiated. However, it lacked evidence the administrator or Stage agency was notified of the elopement within 24 hours, nor was a thorough investigation conducted.

On 3/20/18, at 6:30 p.m. cook (C)-A stated R226 was not happy about being at the facility and had eloped from the facility a couple of times. C-A stated the incident with the police department was not the only time R226 had gotten away or attempted to leave the facility. C-A recalled another incident which occurred "way" before the police department incident, where he was going to go pick up R226 after he had left the facility and was downtown at a gas station which was across from the police department. C-A stated "somebody" had called the facility and informed the staff that one of their residents was there, however, that "somebody" had given R226 a ride back to the facility before he could go get him. C-A stated R226 used a wheelchair and would have had to get downtown by wheeling himself down the middle of the street as that was the only area of the road that had been plowed open following the snow fall. C-A remembered R226 being appropriately dressed for the cold winter temperature. R226's medical record lacked evidence of this prior elopement as well as documentation indicating the incident had been reported to the administrator or State agency within 24 hours, nor was a thorough investigation conducted in order to identify and implement interventions to ensure R226's ongoing safety.

R5's Progress Note dated 3/13/18, at 11:20 p.m. indicated R5 had a 6.0 centimeter (cm) by 3.0 cm bruise which was yellow/green in color with some pinkness surrounding the bruise. The documentation did not identify where the bruise

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F 607	Continued From page 12	F 607		

was located on R5.

A Resident Bruise/Skin Tear/ Injury Report dated 3/13/18, indicated R5 had a 6.0 cm by 3.0 cm bruise on the right forearm which may have been caused by an arm brace. R5's physician, family and director of nurses were notified of the bruise. However, the State Agency was not notified within 24 hours, nor was a thorough investigation conducted in order to rule out potential abuse.

On 3/20/18 at 1:41 p.m. when requested to review the facility abuse prevention policy and procedures, the administrator and DON stated they were unable to locate it.

-At 1:49 p.m. the administrator and the DON confirmed R13's and R21's dislike for each other. The administrator, the DON and the RDCS were informed of the altercation and all stated they were unaware the altercation had occurred and confirmed it should have been reported to the administrator as well as the State agency, as required.

On 3/20/18, at 4:25 p.m. the RDCS, administrator and the DON confirmed R226 had eloped from the facility and the incident was not reported. When asked about the facility's abuse prevention program related to reporting, the RDCS stated the whole system needed to be "revamped." The administrator stated when her and the DON started at the facility, they became aware of the failure in the system and had begun educating the staff on the abuse prevention program policies and procedures.

On 3/26/18, at 3:26 p.m. licensed practical nurse (LPN)-A stated she was shown the newly created

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F 607	Continued From page 13 facility abuse prevention program binder last "Tuesday" (six days prior) and verified the binder was kept at the nurses station and contained the facility's policy and procedures related to abuse prohibition in which staff were to refer to when needed. However, LPN-A stated she did not know if any changes had been made to the facility's abuse protocol because she had not reviewed the information yet.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		5/6/18

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F 609	Continued From page 14 incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure all allegations of abuse, neglect of care and injuries of unknown source were reported timely to the administrator and/or State agency for 1 of 1 resident (R13) who was intentionally hit by another resident, and for 1 of 1 resident (R226) who had eloped from the facility, twice. In addition, the facility failed to report injuries of unknown source to the State agency for 1 of 1 resident (R5) who was found to have a left forearm bruise of unknown source. Findings include: R13 stated during interview on 3/19/18, at 9:24 a.m. that R21 used to be his roommate and currently lived a couple doors from him, however, he could not get along with R21. R13 stated R21 would threaten to "beat him up" most recently being just two days ago. R13 stated about two months ago, when he was by the nursing station with staff present, R21 had "rolled up and punched him in the left shoulder." R13 denied being injured. R13 stated the staff who had witnessed the incident told R21 he had to "settle down." R13 denied being afraid of R21 and stated "all he is, is one big mouth" and that he tried to stay away from R21 as much as he could. On 3/20/18, at 1:10 p.m. nursing assistant (NA)-B stated R21 and R13 used to be roommates who did not get along and would swear at each other so they got separate rooms. NA-B stated currently, when R13 would wheel past R21's room, R21 would call R13 names. NA-B stated	F 609	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to report all incidents and do timely follow up on any incident that results in injury. In this case R13 and R21 were noted to have a history of not getting along and led to an altercation which was not addressed with management, incident reporting, interventions or reported as required. R226 had eloped from facility couple times and last time was returned via police □ incident was not reported to state agency as required. R5 had bruise of unknown origin and no investigation had been completed nor any report made. In this case, after the surveyor reported the faulty system, the policy and procedure on abuse/neglect and reporting had been reviewed and updated. All staff were in-serviced, and information put at nursing station in case staff need clarification while survey was still in process. Nursing and social service coordinator were also educated on importance of reporting all vulnerable adult cases to the OHFC (office of health facility complaints). 2. All residents are potentially affected	

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F 609	Continued From page 15 approximately four months ago, she and another staff member who she could not recall which staff member it was, had witnessed R21 intentionally go up to R13 and punch him in the arm. NA-B stated as staff were moving R13 away from R21, R13 had called R21 the "F-word." NA-B stated this physical altercation was the only incident she was aware of between the two residents. NA-B also stated she had reported the altercation to a nurse but was not 100% sure which nurse she had reported to. The facility lacked evidence the aforementioned resident to resident altercation was reported to the administrator or the State agency, within two hours as required. R226 eloped from the facility according to the facility's computerized Risk Management Incident list. The note indicated R226 could not be located within the facility so a building and grounds search was conducted which was unsuccessful in locating R226 and 911 was called. When 911 was called, they informed the facility their missing resident was at the local police department. The police returned the resident to the facility, unharmed. The facility provided a copy of their facility Minnesota Incident Report from the Risk Management List which was dated 12/3/17, at 7:30 a.m. and revised on 12/5/17, which indicated R226 had eloped from the facility and a temporary wanderguard was placed, and every 15 minute checks were initiated. However, it lacked evidence the Stage agency was notified. On 3/20/18, at 6:30 p.m. cook (C)-A stated R226 was not happy about being at the facility and had eloped from the facility a couple of times. C-A stated the incident with the police department was not the only time R226 had gotten away or attempted to leave the facility. C-A recalled	F 609	by the cited deficiency and lack of follow through. A new resident protection manual was created to educate staff on components of the abuse program. The program further educates staff on when to report and what to report to ensure that this type of situation does not occur again. The program also has an incident report guide to assist staff to determine what is reportable and who to notify when. Further discussed was the proper procedure for incident and accidents and the notification process to ensure DON is aware of any situation for immediate follow up. Policy and procedure for abuse/neglect listing content for reportable events was reviewed. No other residents were affected. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all staff will receive in-service training regarding requirements for investigating, preventing and correctly handling all incidents and accidents. Staff will also be advised with every incident regardless of how small or if no injury the DON needs to be informed as well as doctor, family/POA and documented accordingly in point click care. This will be reviewed daily during the week at stand up with interdisciplinary team. Any deficiencies will be corrected on the spot, documentation reviewed to include follow up nurse□s notes, and appropriate notification made to POA, MD, DON, also ED and OHFC if appropriate via DON, SSC or ED. 4. Effective 4/18/2018, a quality-assurance program was	

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F 609	Continued From page 16 another incident which occurred "way" before the police department incident, where he was going to go pick up R226 after he had left the facility and was downtown at a gas station which was across from the police department. C-A stated "somebody" had called the facility and informed the staff that one of their residents was there, however, that "somebody" had given R226 a ride back to the facility before he could go get him. C-A stated R226 used a wheelchair and would have had to get downtown by wheeling himself down the middle of the street as that was the only area of the road that had been plowed open following the snow fall. C-A remembered R226 being appropriately dressed for the cold winter temperature. R226's medical record lacked evidence of this prior elopement as well as documentation indicating the incident had been reported to the administrator or State agency. R5's Progress Note dated 3/13/18, at 11:20 p.m. indicated R5 had a 6.0 centimeter (cm) by 3.0 cm bruise which was yellow/green in color with some pinkness surrounding the bruise. The documentation did not identify where the bruise was located on R5. The quarterly Minimum Data Set (MDS) dated 1/10/18, indicated severe cognitive impairment, total assistance with activities of daily living and no resistance to cares. A Resident Bruise/Skin Tear/ Injury Report dated 3/13/18, indicated R5 had a 6.0 cm by 3.0 cm bruise on the right forearm which may have been caused by an arm brace. R5's physician, family and director of nurses were notified of the bruise. However, the State Agency was not notified within 24 hours as required of the bruise of unknown source.	F 609	implemented under the supervision of the DON and ED to monitor all incidents to ensure anyone with injury or suspected abuse is reported immediately to OHFC. All incidents, accidents and injuries will be reviewed to ensure follow up completed per resident protection manual and investigation log. The DON or designated quality-assurance representative will perform the following systematic changes: the DON in conjunction with SSC will make report immediately if any abuse/neglect or injury was suspected. All incidents/accidents or suspected abuse/neglect situations will be reviewed daily during the week at stand up. The DON or designee will complete audits of all reported incidents on residents for 8 weeks then 50% of incidents for 8 weeks to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON, ED and SSC will be responsible for this POC.	

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F 609	Continued From page 17	F 609		

On 3/20/18 at 1:41 p.m. when requested to review the facility abuse prevention policy and procedures, the administrator and director of nursing (DON) stated they were unable to locate it within the facility.

-At 1:49 p.m. the administrator and the DON confirmed R13's and R21's dislike for each other. The administrator, the DON and the regional director of clinical services (RDCS) were informed of the altercation and all stated they were unaware the altercation had occurred and confirmed it should have been reported to the administrator as well as the State agency, as required.

On 3/20/18, at 4:25 p.m. the administrator, RDCS, and the DON confirmed R226 had eloped from the facility and the incident was not reported. When asked about the facility's abuse prevention program related to reporting, the RDCS stated the whole system needed to be "revamped." The administrator stated when her and the DON started at the facility, they became aware of the failure in the system and had begun educating the staff on the abuse prevention program policies and procedures.

On 3/21/18, at 8:40 a.m. the RDCS stated she had only been with the facility's management company for three weeks and this was her first time at the facility. At this time, the RDCS called the Superior Healthcare Management (SHM) executive who overseen this facility. The executive stated the company took over operation of the facility on 2/1/17, whereas there was a former employee who continued to work at the facility through the ownership transition phase which ended June 2017, at which time a RDCS

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F 609	Continued From page 18	F 609		

started working at the facility and was responsible for overseeing the clinical nursing operation until November 2017. Following this employee's departure, there was no specific regional director assigned to this "property" therefore a clinical supervisor was not present on site, rather was available for consultation via the phone. The RDCS verified and acknowledged the lack of facility systems and stated she would create a binder to place the facility abuse prevention program policy and procedures in and provide staff education.

On 3/26/18, at 3:26 p.m. licensed practical nurse (LPN)-A stated she was shown the newly created facility abuse prevention program binder last "Tuesday" (six days prior) and verified the binder was kept at the nurses station and contained the facility's policy and procedures related to abuse prohibition in which staff were to refer to when needed. However, LPN-A stated she did not know if any changes had been made to the facility's abuse protocol because she had not reviewed the information yet.

On 3/22/18, the RDCS provided a Superior Healthcare Management Abuse Reporting and Investigation policy revised 1/30/17, indicated the facility would notify the State agency and other licensing agencies depending on the circumstances of the allegation or actual event in compliance with Federal and State regulations and Elder Justice Act. The Reporting Abuse to Facility Management policy and procedure indicated it was the responsibility of their employees to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility

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F 609	Continued From page 19 management. The administrator or DON must be immediately notified of suspected abuse or actual incidents of abuse. The undated Resident to Resident Altercations policy and implementation form indicated all altercations including those that represent resident to resident abuse would be reported to the nursing supervisor, DON and to the administrator. The undated Elopements policy interpretation and implementation form indicated staff would report all cases of missing residents,	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to conduct an investigation of allegations of potential abuse, neglect of care and injuries of unknown source for 1 of 1 resident (R13) who had been intentionally hit by another	F 610	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that	5/6/18

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F 610	Continued From page 20 resident,; for 1 of 1 resident (R226) who had eloped from the facility, twice; and for 1 of 1 resident (R5) who had forearm bruising of unknown source. Findings include: R13 stated during interview on 3/19/18, at 9:24 a.m. that R21 used to be his roommate and currently lived a couple doors from him, however, he could not get along with R21. R13 stated R21 would threaten to "beat him up" most recently being just two days ago. R13 stated about two months ago, when he was by the nursing station with staff present, R21 had "rolled up and punched him in the left shoulder." R13 denied being injured. R13 stated the staff who had witnessed the incident told R21 he had to "settle down." R13 denied being afraid of R21 and stated, "all he is, is one big mouth" and that he tried to stay away from R21 as much as he could. On 3/20/18, at 1:10 p.m. nursing assistant (NA)-B stated R21 and R13 used to be roommates who did not get along and would swear at each other so they got separate rooms. NA-B stated currently, when R13 would wheel past R21's room, R21 would call R13 names. NA-B stated approximately four months ago, she and another staff member who she could not recall which staff member it was, had witnessed R21 intentionally go up to R13 and punch him in the arm. NA-B stated as staff were moving R13 away from R21, R13 had called R21 the "F-word." NA-B stated this physical altercation was the only incident she was aware of between the two residents. NA-B also stated she had reported the altercation to a nurse but was not 100% sure which nurse she had reported to. R13's and R21's medical record	F 610	one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to investigate, prevent and correct alleged violations of residents. In this case in this case R13 was been punched in an altercation which was not addressed with management, no incident reporting done, nor interventions taken or reported as required. R226 had eloped from facility couple times and last time was returned via police; incident was not reported to state agency as required. R5 had bruise of unknown origin and no investigation had been completed nor any report made. In this case, after the surveyor reported the faulty system, the policy and procedure on abuse/neglect and reporting had been reviewed and updated. All staff were in-serviced, and information put at nursing station in case staff need clarification while survey was still in process. Nursing and SSC were also educated on importance of investigating all incident and reporting all vulnerable adult cases to the OHFC (office of health facility complaints). 2. Because all residents are potentially affected by the cited deficiency and lack of follow through, while survey still was being conducted, ED and DON reviewed with all staff the importance of investigating and reporting suspected violations. A new resident protection manual was created to educate staff on components of the abuse program. The program further educates staff on what should be investigated, what	

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F 610	Continued From page 21 lacked evidence the altercation occurred and was thoroughly investigated. R226 eloped from the facility according to the facility's computerized Risk Management Incident list. The note indicated R226 could not be located within the facility so a building and grounds search was conducted which was unsuccessful in locating R226 and 911 was called. When 911 was called, they informed the facility their missing resident was at the local police department. The police returned the resident to the facility, unharmed. The facility provided a copy of their facility Minnesota Incident Report from the Risk Management List which was dated 12/3/17, at 7:30 a.m. which indicated R226 had eloped from the facility and a temporary wanderguard was placed, and every 15 minute checks were initiated. However, there was no indication the incident had been thoroughly investigated. On 3/20/18, at 6:30 p.m. cook (C)-A stated R226 was not happy about being at the facility and had eloped from the facility a couple of times. C-A stated the incident with the police department was not the only time R226 had gotten away or attempted to leave the facility. C-A recalled another incident which occurred "way" before the police department incident, where he was going to go pick up R226 after he had left the facility and was downtown at a gas station which was across from the police department. C-A stated "somebody" had called the facility and informed the staff that one of their residents was there, however, that "somebody" had given R226 a ride back to the facility before he could go get him. C-A stated R226 used a wheelchair and would have had to get downtown by wheeling himself down the middle of the street as that was the only	F 610	is abuse/neglect and determining root cause of incident, when to report and what to report to ensure that this type of situation does not occur again. The program also has an incident report guide to assist staff to determine what is reportable and who to notify when. Further discussed was the proper procedure for incident and accidents and the notification process to ensure DON and ED are aware of any situation for immediate follow up. Policy and procedure for abuse/neglect was reviewed. No other residents were affected. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all staff will receive in-service training regarding requirements for investigating, preventing and correctly handling all incidents and accidents. Staff will also be advised with every incident regardless of how small or if no injury the DON needs to be informed as well as doctor, family/POA and documented accordingly in point click care. This will be reviewed daily during the week at stand up with interdisciplinary team. Any deficiencies will be corrected on the spot, documentation reviewed to include follow up nurse□s notes, and appropriate notification made to POA, MD, DON, also ED and OHFC if appropriate via DON, SSC or ED. 4. Effective 4/18/2018, a quality-assurance program was implemented under the supervision of the DON and ED to monitor all incidents to ensure anyone with injury or suspected abuse is reported immediately to OHFC.	

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F 610	Continued From page 22 area of the road that had been plowed open following the snow fall. C-A remembered R226 being appropriately dressed for the cold winter temperature. R226's medical record lacked evidence of this prior elopement as well as the completion of a thorough investigation. R5's Progress Note dated 3/13/18, at 11:20 p.m. indicated R5 had a 6.0 centimeter (cm) by 3.0 cm bruise which was yellow/green in color with some pinkness surrounding the bruise. The documentation did not identify where the bruise was located on R5. The quarterly Minimum Data Set (MDS) dated 1/10/18, indicated severe cognitive impairment, total assistance with activities of daily living and no resistance to cares. A Resident Bruise/Skin Tear/ Injury Report dated 3/13/18, indicated R5 had a 6.0 cm by 3.0 cm bruise on the right forearm which may have been caused by an arm brace. The physician, family and director of nurses were notified of the bruise. However, an investigation was not conducted in order to identify the source of the bruise and/or to rule out abuse. On 3/20/18 at 1:41 p.m. when requested to review the facility abuse prevention policy and procedures, the administrator and director of nursing (DON) stated they were unable to locate it. -At 1:49 p.m. the administrator and the DON confirmed R13's and R21's dislike for each other. The administrator, the DON and the regional director of clinical services (RDCS) were informed of the altercation and all stated they were unaware the altercation had occurred and confirmed it should have been thoroughly	F 610	All incidents, accidents and injuries will be reviewed to ensure follow up completed per resident protection manual and investigation log. The DON or designated quality-assurance representative will perform the following systematic changes: the DON in conjunction with SSC will make report immediately if any abuse/neglect or injury was suspected. All incidents/accidents or suspected abuse/neglect situations will be reviewed daily during the week at stand up. The DON or designee will complete audits of all reported incidents on residents for 8 weeks then 50% of incidents for 8 weeks to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON, ED and SSC will be responsible for this POC.	

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F 610	Continued From page 23	F 610		

investigation.

On 3/20/18, at 4:25 p.m. the administrator, RDCS, and the DON confirmed R226 had eloped from the facility and the incident was not reported. When asked about the facility's abuse prevention program related to investigation, the RDCS stated the whole system needed to be "revamped." The administrator stated when her and the DON started at the facility, they became aware of the failure in the system and had begun educating the staff on the abuse prevention program policies and procedures.

On 3/21/18, at 8:40 a.m. the RDCS stated she had only been with the facility's management company for three weeks and this was her first time at the facility. At this time, the RDCS called the Superior Healthcare Management (SHM) executive who overseen this facility. The executive stated the company took over operation of the facility on 2/1/17, whereas there was a former employee who continued to work at the facility through the ownership transition phase which ended June 2017, at which time a RDCS started working at the facility and was responsible for overseeing the clinical nursing operation until November 2017. Following this employee's departure, there was no specific regional director assigned to this "property" therefore a clinical supervisor was not present on site, rather was available for consultation via the phone. The RDCS verified and acknowledged the lack of facility systems and stated she would create a binder to place the facility abuse prevention program policy and procedures in and provide staff education.

On 3/26/18, at 3:26 p.m. licensed practical nurse

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F 610	Continued From page 24 (LPN)-A stated she was shown the newly created facility abuse prevention program binder last "Tuesday" (six days prior) and verified the binder was kept at the nurses station and contained the facility's policy and procedures related to abuse prohibition in which staff were to refer to when needed. However, LPN-A stated she did not know if any changes had been made to the facility's abuse protocol because she had not reviewed the information yet. On 3/22/18, the RDCS provided a Superior Healthcare Management Abuse Reporting and Investigation policy revised 1/30/17, which indicated the facility would thoroughly investigate all reports of suspected or alleged abuse, neglect, exploitation or injuries of unknown origin. The Resident to Resident Altercations policy and implementation form indicated all altercations including those that represent resident to resident abuse would be investigated. The undated Elopements policy interpretation and implementation form indicated staff would investigate all cases of missing residents	F 610		
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. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the	F 636		5/6/18

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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) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.

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F 636	Continued From page 26 (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 Care Area Assessments were completed for 2 of 12 residents (R13, R14) when their annual and/or significant change Minimum Data Set was completed. Findings include: R13's annual Minimum Data Set (MDS) dated 7/24/17, indicated R13 had moderate cognitive impairment, required limited to physical staff assistance for activities of daily living, urinary incontinence, no natural or fragmented teeth and was at risk for pressure ulcers. The Care Area Assessment Summary (CAA) indicated the following CAAs were identified as needing further comprehensive assessment/investigation to determine if R13 required interventions and care planning: Cognitive/Loss Function Activity of Daily Living/Rehabilitation Potential Urinary Incontinence Falls Nutritional Status Dental Care Pressure Ulcer However, R13's medical record lacked evidence	F 636	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to ensure all residents are assessed correctly via assessments and MDS to coordinate appropriate care plans. Some of the many ways that this has been achieved for R13 and R14 has been to have MDS nurse reopen and complete CAA□s regarding their care needs based on their assessments. In this case, after the surveyor reported all residents listed above the care area assessments were incomplete based on full review of triggers for these residents MDS□s. The care plans have been reviewed and updated, MDS nurse has reviewed proper completion of CAA guidelines and is aware of how to properly document on CAA□s. 2. Because all residents are assessed to determine their appropriate plan of care	

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F 636	Continued From page 27 of the completion of the identified CAAs. On 3/22/18, at 1:25 p.m. registered nurse (RN)-E stated she was responsible to complete the MDS assessments and the corresponding CAAs. RN-E confirmed R13's 7/24/17, triggered CAAs were not completed, as required. During interview with the administrator and director of nursing (DON) on 3/26/18, at 10:38 a.m. the administrator stated it would be expected that the CAAs be completed when triggered. R14's admission MDS dated 1/26/18, indicated R14 had moderate cognitive impairment, suffered a fracture as a result of a fall prior to admission, no inappropriate behavior symptoms, required limited assistance of one person when ambulating in room, required extensive assistance of one person for transfers, and required extensive assistance of one person for dressing and toilet use. The MDS indicated having books or newspapers to read, being around animals or pet visits, and participating in religious activities were somewhat important to R14. Review of R14's undated CAA for activities revealed the CAA had not been completed. There was no assessment of current activity interests, activity interests prior to admission, environmental or staffing issues that hindered participation, unique skills or knowledge the resident has that could be passed onto others, or issues that result in reduced activity participation. Review of R14's undated CAA for falls revealed the CAA had not been completed. There was no CAA assessment of physical limitations, medications, diagnoses, history of falls,	F 636	based on their assessments all are potentially affected by the cited deficiency, on 4/23/2018, the MDS nurse reviewed accuracy of CAA□s and MDS that surveyors noted to be inaccurate. All other resident CAA□s will be reviewed for timeliness and accuracy. Furthermore, all CAA□s being created as of 4/23/2018 will be double checked by regional reimbursement coordinator prior to submission to ensure compliance. Policy on MDS/CAA was reviewed. No other residents were affected. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all nursing staff will receive in-service training regarding state and federal requirements for documentation, assessments and proper follow up on all missing information to ensure clear and correct care plans. The training also emphasized the importance of the MDS nurse to follow up on items that are not being addressed during assessment period and ensuring care areas are complete. 4. Effective 4/18/2018, a quality-assurance program was implemented under the supervision of the MDS nurse to that all residents will be reviewed at time of admission or annual to ensure CAA□s are being completed thoroughly and completely. All triggers will be care planned and communicated to staff via care sheets and communication book if new interventions in place. Audits of CAA□s will be completed for accuracy and timeliness; they will be completed by MDS nurse 2 audits per week x 4 weeks	

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F 636	Continued From page 28 laboratory findings, or environmental factors. Additionally, there was no analysis of the findings of the CAA. The regional director of clinical services was interviewed on 3/22/18, at 8:29 a.m. during which she confirmed R14's CAA's for activities and falls had not been fully completed. The Superior Healthcare Management Minnesota Region MDS/CAA Policy effective 3/22/18, indicated would comply with all applicable federal and stated requirements related to the completion of the MDS and CAAs and directed each team member to complete their designated assessments and MDS sections along with the CAAs and care plan for the items that are triggered on their section of the MDS for which they completed. Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI) indicated: The RAI consisted of three basic components: Minimum Data Set (MDS) Version 3.0, Care Area Assessment (CAA) process and RAI Utilization Guidelines. The Care Areas triggered identified residents who had been or were at risk for developing specific functional problems and required further assessment. The completion of a CAA was the further investigation of the triggered areas in order to determine if the care area required interventions and care planning. The RAI manual further indicated that CAAs must be completed in conjunction with the completion of the resident's admission, annual, and significant change MDS	F 636	then 1 audit weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. MDS nurse will be responsible for this POC.	
F 660	Discharge Planning Process	F 660		5/6/18

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F 660 SS=D	Continued From page 29 CFR(s): 483.21(c)(1)(i)-(ix) §483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning	F 660		

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F 660	Continued From page 30 to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure an appropriate discharge	F 660	This Plan of Correction constitutes my written allegation of compliance for the	

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F 660	Continued From page 31 plan was developed and implemented for 1 of 1 resident (R24) who was discharged to home. Findings include: R24 was admitted to the facility on 12/15/17, with diagnoses that included but were not limited to: infection following a procedure, cerebrospinal fluid (CSF) leak, generalized muscle weakness, and headache. Review of the hospital dismissal summary dated 12/14/17, indicated R24 underwent a dural repair for a CSF leak following a lumbar fusion with a resulting infection. R24 was given IV antibiotics and sent to the nursing home to receive IV antibiotics until 12/21/17. R24 was admitted with a PICC (peripherally inserted central catheter) line. Review of R24's discharge planning revealed a progress note dated 12/20/17, indicating R24 was going to discharge on 12/21/17, or 12/22/17, via driving herself in her personal car. The note indicated R24 wanted her medications to be sent to a Walgreens close to where she lived. The note also identified R24 would would be working with her primary care physician to set up home health care and follow-up appointments. The next discharge planning note was dated 12/22/17, which indicated R24 discharged home via personal car at 10:00 a.m. R24 wore a back brace and was able to perform activities of daily living (ADL's) independently. There was no indication if R24 was able to independently don and doff the back brace, who would care for the PICC, if R24 could independently change the dressing on the lower spine or if R24 had dressing supplies to change the dressing.	F 660	deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to ensure all residents who discharge from facility have all the information and tools they need to discharge successfully. This would include but not limited to: medication list, medical and nonmedical appointments and treatments and recapitulation of resident stay. R24 was discharged home without appropriate discharge plan. When the surveyor reported lack of documentation, it was noted that the practice of discharge planning needed to start sooner and be complete for all residents upon discharging, this practice had not been followed per policy and best practice. Immediately policy and procedure on discharge planning was reviewed and social services would initiate discharge planning prior to resident discharge. 2. Because many residents that come to facility do so for short stays many are potentially affected by the cited deficiency. Immediately all residents being discharged were reviewed and discharge plan in place and sent with resident to ensure successful discharge. When staff are alerted a resident is discharging the planning should start immediately with therapy and then nursing to get current treatments, medications, adaptive equipment in check, along with current	

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F 660	Continued From page 32 Additionally, there was no evidence of teaching of signs and symptoms of infection or when to call the primary care provider. There was no indication R24 received medications, what those medications were, and if R24 had been educated on those medications. Although R24 indicated a need for home care, there was no indication a referral to a home health agency had been completed and if R24 was accepted for admission. The document Discharge Summary and Post-Discharge Plan of Care dated 12/22/17, was found in R24's closed record. The summary was incomplete. The summary indicated R24 wanted home health agency recommendations and the names of two agencies and their telephone numbers were listed. However, there was no indication if the agencies were contacted. On 3/23/18, at 11:04 a.m. the director of nursing (DON) stated the facility did not have a system for discharging residents. The DON stated patient teaching should have been documented and indicated if R24 was able to don and doff the back brace, if R24 was able to independently change the dressing on the lower spine, if she had discharge medications and what they were, the PICC line should have been pulled or home care should have been set-up to ensure it's care, and a referral to a home health agency should have been initiated and set-up. Additionally, the signs and symptoms of infection should have been reviewed, and the surgeon and primary care physician phone numbers should have been provided. The DON stated the facility did not have a discharge policy and procedure at the time of R24's discharge, and provided a discharge policy and procedure dated 12/23/17.	F 660	level of ADL functioning. Discharging residents were audited by SSC to ensure all had appropriate discharge plan in place. No other residents were affected. The policy and procedure for discharge planning was reviewed on 4/18/2018. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all staff will attend in-service training regarding this policy and the importance of residents discharging with appropriate information regarding their care to have continuation of their care. The discharge summary and Post-Discharge Plan of Care form reviewed to assure interdisciplinary approach from each department documenting resident□s status in each discipline pre=discharge, education provided, follow up appointments that have been scheduled, and reviewed with resident and/or representative prior to discharge documented in PCC and copy filed in resident□s chart. 4. Effective 4/18/2018, a quality-assurance program was implemented under the supervision of the SSC in conjunction with DON to monitor any discharges to ensure appropriate planning was completed. The SSC or designee will complete audits on all residents who have transferred or discharged for next 8 weeks then 50% of residents for 4 weeks to ensure staff comply with current policy. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly	

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F 660	Continued From page 33	F 660	quality-assurance committee meeting for further review or corrective action. 5. SSC will be responsible for this POC.	
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure an appropriate discharge	F 661	This Plan of Correction constitutes my written allegation of compliance for the	5/6/18

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F 661	Continued From page 34 summary had been completed for 1 of 1 resident (R24) reviewed who was discharged to home. Findings include: R24 was admitted to the facility on 12/15/17, with diagnoses that included but were not limited to: infection following a procedure, cerebrospinal fluid (CSF) leak, generalized muscle weakness, and headache. Review of the hospital dismissal summary dated 12/14/17, indicated R24 underwent a dural repair for a CSF leak following a lumbar fusion. The spinal incision was cultured and was infected with staphylococcus epidermis and candida albicans. R24 was given IV antibiotics and sent to the nursing home to receive IV antibiotics until 12/21/17. Review of the HOME INFUSION ADULT ANTIBIOTIC report dated 12/4/17, indicated a PICC (peripherally inserted central catheter) was placed 12/13/17, and provided instructions for maintenance and care of the line. Review of R24's discharge planning revealed a progress note dated 12/20/17, indicating R24 was going to discharge on 12/21/17, or 12/22/17, via driving herself in her personal car. The note indicated R24 wanted her medications to be sent to a Walgreens close to where she lived. The note indicated R24 would be working with her primary care physician to set up home health care and follow-up appointments. The next discharge planning note was dated 12/22/17, which indicated R24 discharged home via personal car at 10:00 a.m.. R24 wore a back brace and was able to perform activities of daily	F 661	deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to ensure all residents who discharge from facility have all the information and tools they need to discharge successfully. This would include but not limited to: medication list, medical and nonmedical appointments and treatments and recapitulation of resident stay. R24 was discharged home without comprehensive discharge summary to ensure resident received continuous and coordinated person-center care. When the surveyor reported lack of documentation, it was noted that the practice of discharge planning needed to start sooner and be complete for all residents upon discharging, this practice had not been followed per policy and best practice. Immediately RDCS reviewed policy and procedure on discharge planning and social service coordinator would initiate discharge planning prior to resident discharge. 2. Because many residents that come to facility do so for short stays many are potentially affected by the cited deficiency. Immediately all residents being discharged were reviewed and discharge plan in place and sent with resident to ensure successful discharge. When staff are alerted a resident is discharging the planning should start immediately with	

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F 661	Continued From page 35 living (ADL's) independently. There was no indication if R24 was able to independently don and doff the back brace, who would care for the PICC, if R24 could independently change the dressing on the lower spine or if R24 had dressing supplies to change the dressing. Additionally, there was no teaching of signs and symptoms of infection or when to call the primary care provider. There was no indication R24 received medications, what those medications were, or if R24 knew what medications she was supposed to be taking. Although R24 identified the need for home care, there was no indication a referral to a home health agency had been completed. Further record review revealed a comprehensive discharge summary had not been completed to ensure R24 received continuous and coordinated, person-centered care following discharge. The document Discharge Summary and Post-Discharge Plan of Care dated 12/22/17, was found in R24's closed record which identified R24's functional level at the time of discharge, a minimal and non-inclusive medical history, and a minimal nursing summary which indicated R24 was admitted for IV antibiotic therapy and strengthening. The summary indicated R24 wanted home health agency recommendations. The names of two agencies and their telephone numbers were listed, but there was no indication if the agencies were contacted to ensure either one would be able to admit and provide for R24's needs. The summary did not include any information from physical and occupational therapy, information regarding R24's PICC and who would care for it, a description of the spinal surgical wound and drainage, and had not included information on medications at the time of	F 661	therapy and then nursing to get current treatments, medications, adaptive equipment in check, along with current level of ADL functioning so resident can get summary with them to ensure continuation of care. All residents discharging is now given full discharge summary at time of discharge. No other residents were affected. The policy and procedure for discharge planning was reviewed on 4/18/2018. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all staff will attend in-service training regarding this policy and the importance of residents discharging with appropriate information regarding their care to have continuation of their care. The discharge summary and Post-Discharge Plan of Care form reviewed to assure interdisciplinary approach from each department documenting resident□s status in each discipline pre=discharge, education provided, follow up appointments that have been scheduled, and reviewed with resident and/or representative prior to discharge documented in PCC and copy filed in resident□s chart. 4. Effective 4/18/2018, a quality-assurance program was implemented under the supervision of the SSC in conjunction with DON to monitor any discharges to ensure appropriate planning was completed. The SSC or designee will complete audits on all residents who have transferred or discharged for next 8 weeks then 50% of residents for 4 weeks to ensure staff	

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F 661	Continued From page 36 discharge. During interview with the director of nursing (DON) on 3/23/18, at 11:04 a.m. she confirmed a discharge summary with a recapitulation of R24's stay that included diagnoses, course of treatment, pertinent lab values, radiology and consultation reports, a final summary of the residents status, and a post discharge plan had not been completed for R24.	F 661	comply with current policy. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly quality-assurance committee meeting for further review or corrective action. 5. SSC will be responsible for this POC.	
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: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 2 of 2 residents (R2, R23) who were total dependent on staff for incontinence cares. In addition, the facility failed to assist 1 of 2 male residents (R23) with shaving. Findings include: R2's annual Minimum Data Set (MDS) dated 11/2/17, identified R2 with severe cognitive impairment and diagnoses including Parkinson's disease, dementia and anxiety. The assessment indicated R2 required extensive assistance with all activities of daily living and was totally incontinent of bladder and utilized a colostomy bag (for bowels.)	F 677	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to provide consistent quality care to residents needing assistance with their ADL's. Some of the ways this is done is by gathering data through assessments to ensure all residents needing assistance with ADL's such as ambulating, grooming, dressing, and bathing are identified and assisted appropriately. In this case, after the survey determined residents didn't get	5/6/18

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F 677	Continued From page 37 The Urinary Incontinence Care Area Assessment (CAA) dated 11/3/17, indicated R2 was incontinent of bladder and had a colostomy. R2's Bladder Assessment Form dated 12/31/17, indicated R2 had functional incontinence. Due to physical impairments and cognitive deficits, R2 was would be inappropriate for bladder retraining. R2's care plan dated 12/28/17, directed the staff to assist R2 with a check and change schedule of every two hours and as needed. On 3/22/18, during continuous observations from 7:05 a.m. to 10:00 a.m. R2 was not observed to be assisted with incontinence cares. - At 7:05 a.m. R2 was observed seated in a wheelchair in her room. - At 7:37 a.m. the health unit coordinator (HUC) wheeled R2 from her room to the dining room. - At 7:41 a.m. the HUC served R2 breakfast and was observed to assist R2 with the meal. - At 8:07 a.m. the HUC wheeled R2 out of the dining room as she had finished her meal. - At 8:12 a.m. R2 was wheeled back to the room. - At 8:57 a.m. R2 was wheeled into the activity room by the activity director. - At 9:53 a.m. nursing assistant (NA)-B stated R2 had been assisted out of bed at 6:30 a.m. and she had not had time to assist her since that time. - At 10:00 a.m. NA-B wheeled R2 to her room and assisted R2 to transfer from the wheelchair to the bed via a full body mechanical lift. Once in bed, NA-B changed R2's incontinence brief. R2 was observed to be incontinent of urine. -At 10:05 a.m. NA-B confirmed R2 had last been assisted with incontinence cares at 6:30 a.m. (a total of 3 hours and 30 minutes earlier).	F 677	the assistance they needed a review of residents was completed. R23 had facial hair and needed to have removed. His care plan states to shave daily. R2 and R23 needs assistance with incontinent care. It is identified both are completely dependent on staff for incontinent care. Since survey, staff have been educated on importance of providing cares to residents based on their care plan and following their care sheets. 2. Because all residents have constantly changing needs all are potentially affected by the cited deficiency, on 4/23/2018, the MDS nurse reviewed residents needing assistance with incontinence care and shaving and ensure plan of care is correct based on needs. MDS nurse will review each quarter if resident goals being met and ensure staff follow through with cares. A current review was completed of all residents with similar ADL needs. Policy and procedure on ADL's has been reviewed. No other residents were affected. 3. To enhance currently compliant operations and under the direction of the director of nurses, on 5/1/2018 all nursing staff will receive in-service training regarding changes in resident's condition, dignity in cares and following care sheets. The training will emphasize the importance of monitoring ADL's and reviewing that poor incontinent care can lead to skin breakdown. Staff were evaluated on ADL's and reviewed ADL competencies. Reviewed staff expectations regarding following care sheets and performing ADL's according to	

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F 677	Continued From page 38 On 3/22/18, at 2:58 p.m. registered nurse (RN)-E stated R2 was to be assisted with incontinence cares every two hours as directed by the care plan. R23's quarterly MDS dated 3/9/18, identified R23 with severe cognitive impairment and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activity of daily living and indicated he was totally incontinent of bladder. R23's annual MDS dated 10/13/17, also identified R23 as being totally incontinent of bowel and bladder. R23's Urinary Incontinence CAA dated 10/9/17, identified R23 as being totally incontinent of bowel and bladder and directed the staff to assist to check and change R23's incontinence brief every two hours. R23's care plan dated 7/19/17, directed staff to check and change R23's incontinence brief every two hours. During continuous observations on 3/22/18, from 7:13 a.m. to 10:07 p.m. R23 was not observed to receive assistance with incontinence cares. - At 7:13 a.m. NA-B and NA-C were observed to transfer R23 from bed to a wheelchair via a full body mechanical lift. - At 8:46 a.m. R23 was wheeled into the dining room. - At 8:48 a.m. R23 was assisted with the breakfast meal. - At 9:16 a.m. R23 was wheeled to the activity	F 677	resident cares and staff expectations of job performance. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the DON and MDS to monitor residents needing assistance with ADL's. The DON or designee will audit all residents daily for 5 days (days and evenings) to ensure all aspects of their ADL's are completed. After the one week will monitor 5 residents weekly for 4 weeks and then 3 residents weekly for 2 months. All residents will be reviewed at time of quarterly or annual to ensure not a significant change. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. MDS nurse will be responsible for this POC.	

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F 677	Continued From page 39	F 677		

room for church.
- At 9:35 a.m. R23 was wheeled from the activity room to the nurses station.
- At 10:00 a.m. R23 was wheeled to his room.
- At 10: 05 a.m. R23 was transferred by NA-B and NA-C to bed via a full body mechanical lift. R23 was observed to be incontinent of stool.
- At 10:10 a.m. NA-B and NA-C confirmed R23 had not received assistance with incontinence cares since 7:13 a.m. (a total of 2 hours and 50 minutes earlier).

On 3/23/18, at 10:35 a.m. RN-B stated R23 was to receive assistance with incontinence cares every two hours as directed by the care plan.

The Toileting policy and procedure dated 12/23/17, directed the staff to assist residents to the toilet in a timely manner in accordance to their individualized plan of care. The policy indicated that if a resident was unable to physically tolerate utilization of the toilet, the staff were to adhere to a check and change program based on a bowel and bladder assessment.

R23's care plan dated 12/22/17, indicated R23 required extensive assistance of one staff for all activities of daily living. The care plan did not specifically direct staff regarding the frequency of shaving facial hair.

On 3/19/18, at 10:40 a.m. family member (FM)-B stated the facility staff did not shave R23 on a regular basis. FM-B stated R23's personal preference was to be clean shaven. FM-B stated she had talked to the staff about shaving him, but R23 continued to be unshaven when he/she visited. FM-B could not recall which staff member she had spoken to.

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On 3/19/18, at 11:00 a.m. R23 was observed in the dining room. R23 was observed to have a 2-3 day growth of facial hair stubble.

On 3/20/18, at 5:00 p.m. R23 was observed in the dining room. R23 continued to be in need of a shave.

On 3/21/18, at 12:44 p.m. R23 was observed in the dining room. R23 continued to be in need of a shave.

On 3/21/18, at 1:40 p.m. the director of nursing (DON) stated residents were to be assisted with shaving daily according to their personal preference.

On 3/22/18, at 7:19 a.m. R23 was observed to receive assistance with morning cares by NA-B and NA-C. During the cares neither NA was observed to attempt to shave R23.

- At 7:21 a.m. NA-B stated the facility was short staffed and the NAs did the best they could, however, some days they did not have time to shave the residents. NA-B confirmed R23 had not been assisted with shaving.

On 3/23/18, at 8:26 a.m. R23 was observed in the dining room. R23 had not received assistance with shaving.

- At 10:35 a.m. RN-C stated male residents were to receive assistance with shaving in accordance to their previous preferences.

On 3/24/18, at 9:20 a.m. R23 was observed seated in the wheelchair in his room. R23's

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F 677	Continued From page 41 cheeks had been shaved, however, R23's neck and chin had not been shaved. - At 9:25 a.m. NA-B stated she had not had a chance to assist R23 with shaving all week and when she did shave him, he would not allow his neck or under his chin to be shaved. NA-B stated R23 was to receive assistance with shaving daily. A policy dated 12/23/17, Shaving the Resident, directed staff to provide cleanliness and skin care. The policy did not direct the staff on how frequently a resident was to receive assistance with shaving.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess resident centered activities preferences and develop individualized interventions for 1 of 2 residents (R14) reviewed for activities. Findings include:	F 679	F679 SS=D This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	5/6/18

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F 679	Continued From page 42 R14's physician nursing home admission assessment dated 1/23/18, indicated R14 had been admitted to the facility on 1/19/18, and had diagnoses that included, but were not limited to: closed nondisplaced fracture of the seventh cervical vertebra with routine healing, high blood pressure, type II diabetes, late onset moderately advanced Alzheimer's disease with behavioral disturbance. The admission Minimum Data Set (MDS) dated 1/26/18, indicated R14 had moderate cognitive impairment, suffered a fracture as a result of a fall prior to admission, had not displayed any inappropriate behavior symptoms, required limited assistance of one person when ambulating in room, required extensive assistance of one person for transfers, and required extensive assistance of one person for dressing and toilet use. The MDS indicated having books or newspapers to read, being around animals or pet visits, and participating in religious activities were somewhat important to R14. R14 was observed on 3/20/18, from 12:48 p.m. to 7:18 p.m., 3/21/18, from 9:00 a.m. to 1:00 p.m., and 3/22/18, from 8:02 a.m. to 2:30 p.m.. R14 was not provided activities and did not attend any activities during these times. R14's medical record was reviewed and there was no assessment of leisure pursuits or activities of interest completed. R14's undated Care Area Assessment (CAA) for activities revealed it had not been completed. There was no assessment of current activity interests, activity interests prior to admission, environmental or staffing issues that hindered	F 679	requirements established by state and federal law. 1. It is the policy of this facility to provide activities meet interest/needs of all residents. Some of the ways this is done is by gathering data through assessments to ensure all residents and family members can meet with activities to determine types of activities each resident may like and or participate in. In this case, after the survey determined lack of activity for R14.No interview completed with resident or family and resident was not offered any participation. No care plan identified resident interests nor were CAA completed. Assessments were completed, and care plan updated. 2. Because all residents should participate in some activities all are potentially affected by the cited deficiency. MDS nurse and activities reviewed all care plans to update accordingly. Will review each quarter if resident goals being met and ensure staff follow through with meeting activity interests. A current review was completed of all residents and activities to ensure all residents have opportunity to be involved in something that interests them. Policy and procedure on activities has been reviewed. No other residents were affected. 3. To enhance currently compliant operations and under the direction of the director of nurses, on 5/1/2018 all staff will receive in-service training regarding importance of activities and engaging all residents to reduce isolation. 4. Effective 4/17/2018, a quality-assurance program was	

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F 679	Continued From page 43 participation, unique skills or knowledge the resident had that could be passed onto others, or issues that result in reduced activity participation. Review of R14's activities care plan dated 1/29/18, indicated the following: "Invite the resident to activity programs that encourage physical activity, physical mobility, such as exercise group, walking activities to promote mobility." A copy of R14's activity participation log was requested but not provided. On 3/22/18, at 8:29 a.m. the regional director of clinical services (RDCS) was interviewed and confirmed R14 had not been comprehensively assessed for activities of interest and a comprehensive care plan with individualized interventions including activities of interest had not been developed. The Superior Healthcare Management Minnesota Region policy for Activities dated 12/23/17, indicated that within 14 day of a residents admission to the facility a residents activities would be assessed for and an activity plan based on the residents choices and preferences would be developed.	F 679	implemented under the supervision of the activities department to monitor resident's engagement. The activities coordinator will perform evaluation of all residents to review their activities of choice on residents 5/2/2018 and calendar for activities will be created based on resident needs. Week 2 all residents will be audited to ensure activities that interest them are available or that residents participated in activities of their choice according to their interests then 4 audits per week x 4 weeks then 2 audits weekly x 2 months to ensure compliance in this area. All residents will be reviewed at time of quarterly or annual to ensure not a significant change. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. Activity coordinator will be responsible for this POC.	
F 684 SS=D	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	F 684		5/6/18

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F 684	Continued From page 44 care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure routine pacemaker functionality checks had been performed for 1 of 1 resident (R6) reviewed who utilized a cardiac pacemaker. Findings include: R6's quarterly Minimum Data Set (MDS) dated 1/17/18, identified R6 with moderate cognitive impairment and diagnoses including: depressive disorder, chronic atrial fibrillation and mitral valve disease. The MDS also indicated R6 required limited assistance of one staff for all activities of daily living. R6's Hospital Discharge Summary dated 6/19/17, indicated R6 was to complete a pacemaker check over the telephone using a remote home monitor on 7/18/17. R6's care plan dated 6/28/17, identified R6 had a pacemaker due to atrial fibrillation and directed the staff to monitor for signs and symptoms of altered cardiac output or pacemaker malfunction such as dizziness, syncope, difficult breathing, pulse rate lower than programmed rate or lower than baseline blood pressures. The care plan did not direct the staff to assist to monitor the pacemaker via telephonic monitoring. R6's clinical record lacked documentation related to the pacemaker monitoring. On 3/22/18, at 9:30 a.m. R6 was observed to ambulate approximately 125 feet with stand by	F 684	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to assist with monitoring residents with chronic diseases for appropriate treatment and care in accordance of professional standards. Some of the many ways that this has been accomplished for R6 is by monitoring pace maker to ensure adequate checks and completed and documentation is in place to document results. Care plan and progress note updated. 2. Because many residents have potential for pacemakers many are potentially affected by the cited deficiency, on 4/17/2018, the DON reviewed R6 for appropriate pacemaker checks. Staff educated on consistent implementation of MD orders on any resident needing comprehensive monitoring and importance of documenting results. No other residents were affected. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all nursing staff will receive in-service training regarding normal monitoring, reporting data to physicians and follow up with pacemaker	

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F 684	Continued From page 45 assistance of one staff member. R6 was not observed to display shortness of breath, dizziness or fatigue while walking. - At 1:05 p.m. licensed practical nurse (LPN)-B confirmed R6 had a pacemaker and stated the scheduled telephonic monitoring was to be completed by the nursing staff. LPN-A stated the scheduled times were to be identified on the electronic Medication Administration Records (EMAR). LPN-B reviewed R6's EMAR and stated the EMAR did not include pacemaker monitoring. - At 1:17 p.m. LPN-B entered the medication room and located a pacemaker telephonic monitoring device. LPN-B confirmed she had no idea the last time R6 utilized the machine. - At 3:00 p.m. registered nurse (RN)-E reviewed R6's clinical record and stated the clinical record lacked documentation as to the last time it was checked. RN-E stated she would have to look into the concern. On 3/23/18, at 11:50 a.m. RN-E confirmed R6's medical record lacked documentation related to the pacemaker evaluations. On 3/27/18, at 9:25 a.m. LPN-A stated the pacemaker monitoring was scheduled in the nurse's appointment book at the desk. LPN-A then identified R6 had a pacemaker checked on 2/13/18. LPN-A stated she had not completed the pacemaker check. LPN-A stated that upon completion of the pacemaker monitoring, the clinic staff directed the staff as to when the next monitoring was to take place. Upon review of the calendar, LPN-A stated R6 did not have a scheduled pacemaker check in the next six	F 684	checks. All checks should be documented in PCC with corresponding note of results. All new admissions will be assessed if they have a pacemaker and proper follow up initiated at time of admission to assure compliance in system. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the DON to monitor R6. The DON or designated quality-assurance representative will perform the following systematic changes: audits done on all residents and new admissions with pacemaker for pacemaker checks next 6 months. Any deficiencies will be corrected on the spot, findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON will be responsible for this POC.	

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F 684	Continued From page 46 months. - At 9:30 a.m. RN-D stated she had completed the pacemaker check via the telephone in February 2018, however, she had not documented the monitoring in the medical record. RN-D stated at the time of the monitoring, an additional appointment had not been made. RN-D stated the facility had not received any type of documentation from the pacemaker clinic which would indicate any concerns with the pacemaker. RN-D stated she would expect the clinic to contact the facility if there was a problem. - At 9:50 a.m. the Sanford Pacemaker Clinic staff was interviewed via telephone. The clinic staff stated R6's pacemaker check was completed on 2/13/18, and R6 was due for a cardiologist evaluation. R6 would be scheduled an appointment in the next two months for further review. - At 10:51 a.m. RN-D stated he/she had spoken to R6's family member who was aware R6 was to be seen in the clinic for a cardiac evaluations. RN-D confirmed the facility was not aware of the upcoming appointment.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and	F 685		5/6/18

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F 685	Continued From page 47 §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance to ensure hearing aids were available to maintain hearing/communication needs for 1 of 1 resident (R14) reviewed for hearing. Findings include: R14 had moderate cognitive impairment, according to the admission Minimum Data Set (MDS) dated 1/26/18. Additionally, the MDS indicated had not displayed any inappropriate behavior symptoms and used a hearing aid or other hearing appliance with no difficulty hearing when the hearing aid/appliance was used. R14's care plan dated 1/24/18, had not addressed the use of hearing aids for R14. The care plan was revised on 3/22/18, and directed staff to use bilateral hearing aides and if they were missing to look in R14's shirt pocket. On 3/20/18, at 12:48 p.m. it was noted that R14 was not wearing hearing aids, rather they were sitting on the bedside stand. R14 was observed on 3/21/18, at 9:00 a.m. and 11:00 a.m. and R14 did not have hearing aids in during either observation. On 3/22/18, at 8:02 a.m. R14 was observed after having a shower. R14 was assisted with dressing	F 685	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to ensure residents have treatments/devices to maintain hearing and vision. Some of the many ways that this has been accomplished for R14 is to have resident hearing aids kept on resident in morning and remove and place in med cart in evening. Spoke with friend about straps to keep in position but stated resident would likely still remove has never liked wearing them. Staff were educated if resident has them out look in shirt pocket as it is where he likes to put them. Plenty of batteries were placed in med cart so replacements are always available. Care plan and progress note updated. 2. Because many residents have either hearing or visual deficits many are potentially affected by the cited deficiency, on 4/17/2018, the DON reviewed all residents with hearing aids. Staff educated on consistent use of hearing aids and glasses. Ensure follow up on any	

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F 685	Continued From page 48 by nursing assistant (NA)-C who attempted to put R14's hearing aids in but could not because the hearing aids did not have batteries. NA-C was asked where R14's batteries were kept and NA-C stated she did not know. NA-C asked RN-D where R14's batteries were and RN-D stated she did not know. On 3/23/18, at 8:32 a.m. R14 was in activities reading an article about a motorcycle. The activity director stated R14 did not have his hearing aids in. R14 was asked where his hearing aids were and stated they were broke so didn't help his hearing. He stated because they were broke he did not want to wear them. On 3/23/18, at 10:33 a.m. R14 was seen with one hearing aide in and was leaving it in. The activity director was interviewed and explained that she wore hearing aids and looked at R14's hearing aids and identified one of the hearing aids had some missing parts, then put the batteries in the left hearing aid and put it in R14's ear. The activity director stated that R14 left the hearing aid in his ear and seemed to hear better. On 3/22/18, at 8:29 a.m. the regional director of clinical services was interviewed and confirmed R14 should have been assisted to wear hearing aids if that was his choice, and confirmed R14's current care plan had not identified R14 had hearing aids to wear. The Superior Healthcare Management Minnesota Region policy for hearing aid use dated 12/23/17, indicated to assist the resident with use and care of hearing aides for maximum effectiveness.	F 685	resident that does not utilize or have available any aids that are listed on care sheets. No other residents were affected. 3. To enhance currently compliant operations and under the direction of the director of nurses, on 5/1/2018 all staff will receive in-service training regarding use of hearing or visual aids. It is noted on care sheets and must be updated if there is a change or a problem with the aids supplied. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the DON to monitor residents with hearing aids. The DON or designated quality-assurance representative will perform the following systematic changes: audits done on all residents to ensure hearing aids and glasses on daily for one week then 3 residents for 2 weeks then on 1 resident weekly for 4 weeks to ensure compliance. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON will be responsible for this POC.	
F 686	Treatment/Svcs to Prevent/Heal Pressure Ulcer	F 686		5/6/18

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F 686 SS=G	Continued From page 49 CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate assessment, monitoring and interventions to prevent the development of pressure ulcers and promote healing of current pressure ulcers for 4 of 6 residents (R5, R18, R2, R23) in the sample who had current pressure ulcers. The facility's failure to adequately assess, monitor and/or implement interventions resulted in actual harm for R5 who developed pressure ulcers while at the facility and for R18 who had recurrent pressure ulcers. Findings Include: R5 was identified at risk for the development of pressure ulcers and did not receive timely assistance with repositioning and developed two pressure ulcers resulting in actual harm. R5's quarterly Minimum Data Set (MDS) dated	F 686	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to provide treatment and services to prevent pressure ulcers. One of the many ways that this has been achieved for R5, R22, R2, and R18 was to have pressure relieving cushions however nothing specific applied, documentation of wounds were not consistent, treatments not clear and resident can refuse to offload at times, but nothing was care planned about risk. R2 was not repositioned q2h as suggested as	

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F 686	Continued From page 50 1/10/18, indicated R5 had moderate cognitive impairment and diagnoses included Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff members for bed mobility, transfers and all activities of daily living. The MDS also identified R5 at risk for the development of pressure ulcers. R5's admission MDS dated 9/1/17, identified R5 as dependent upon staff for all activities of daily living and at risk for the development of pressure ulcers. R5's Pressure Ulcer Care Area Assessment (CAA) dated 9/6/17, identified R5 at risk for the development of pressure ulcers due to dependence upon staff for repositioning and bowel incontinence. The assessment directed staff to complete weekly skin assessments and to monitor R5's skin while assisting with personal cares. The Braden Scale (a tool utilized to predict pressure ulcer development) dated 11/22/17, identified R5 at risk for the development of pressure ulcers. R5's Tissue Tolerance Observation form dated 11/22/17, indicated R5 displayed a "pink, blanchable" area over boney prominences. The form did not identify which boney prominences had skin change/susceptibility to pressure nor any skin care directives for the staff to implement. R5's care plan dated 8/28/17, directed the staff to assist R5 with repositioning at least every two hours. R5's physician's order dated 11/29/17, directed	F 686	intervention on her care plan to prevent further breakdown. R18 was determined to be turned and repositioned q2h but during survey noted this was not happening as directed by care plan. Consistently no documentation of worsening/improvement of wounds, proper interventions not in place, and documentation as well as rounds are inconsistent. After survey noted the lack of the entire wound care system immediately a new structure was developed to have weekly rounds and proper follow up on all residents with impaired skin integrity. R 23 was reevaluated for pressure risk, tissue tolerance test completed and skin reviewed. Plan in place, skin intact, and care plan and care sheets updated. R 5 has had OT evaluate for assistive devices, air mattress has been put in place, reassessed skin and on turn and repo q2h, boots while in bed, treatments have been updated, and wounds are healing. R18 has been assessed to have altered skin integrity. Skin check completed, boots on while in bed, air mattress added, wound care been updated and turn and repo q2h. Care sheets and care plans updated. The DON received further training on wound program requirements. 2. Because all residents are at risk for potential to alteration in skin integrity or due to illness or have potential for skin breakdown all are potentially affected by the cited deficiency, wound documentation has been reviewed, interventions for prevention are in place	

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F 686	Continued From page 51 staff to apply a DermFilm Thick Sacral Dressing to the coccyx every three days, and as needed. In addition, R5's Order Summary also included an order for the same wound dated 10/3/17, which directed the staff to apply an Allevyn Dressing (foam dressing) to the left buttock wound and to change every three days until healed. Review of R5's Progress Notes (nurses notes) revealed the following information: - 2/2/18, R5's upper buttocks, coccyx and sacral area was red, barrier cream applied. - 2/3/18, redness to upper buttocks, coccyx and sacral area, barrier cream applied. - 2/4/18, redness to upper buttocks, coccyx, and sacral area, barrier cream applied. - 2/6/18, small superficial excoriated areas to upper buttocks and sacral areas. Barrier cream applied and repositioning every two hours provided. - 2/7/18, small excoriated area and redness to upper buttocks, coccyx and sacral area, barrier cream applied. - 2/12/18, scabbed area to left buttocks and small scabbed area to sacrum, barrier cream applied. -2/16/18, scabbed area to left buttocks and sacrum, barrier cream applied. -2/17/18, scabbed area to left buttocks and sacrum, barrier cream applied. -2/20/18, two superficial excoriated areas. Right buttocks measures 3.0 centimeters (cm) by 1.5 cm. The left buttocks measured 1.0 cm by 0.7 cm covered with hydrocolloid thin dressing (a stretchy dressing which adheres to the skin.) - 2/24/18, dressing changed, area is very dry. Presents as superficial sheer area, small amount of blood noted. Applied Duoderm (hydrocolloid) dressing.	F 686	and documented clearly on care sheets. Weekly skin audits are completed, and staff update DON on any new areas noted immediately including reporting of any bruises, skin tears, skin breakdown or rashes. All current resident with pressure ulcers were assessed for comprehensive assessment along with appropriate interventions. Implementation of those interventions is reviewed on rounds weekly. Staff to alert DON is resident refuses otherwise. Staff educated on importance of offloading, repositioning, care plan updated, care sheets updated. No other residents were affected. The policy on wound care has been updated. 3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/25/18 all facility RNs received an additional 6 hours of classroom training from mentor DON and her wound rounding nurse which consisted of handouts, question and answers, actual wound dressing change for resident, lecture and agenda focused on items identified needing improvement from POC and observations. In addition, on 5/1/2018 all staff received in-service training for monitoring skin and pressure areas, to ensure staff always use interventions in place and understand offloading to prevent further alterations in skin integrity. The training emphasizes the importance of following all interventions for effective skin maintenance and reporting of changes in skin conditions as well as turning and repositioning according to care plan. Education done on importance of comprehensive	

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F 686	Continued From page 52 - 2/26/18, friction shear to bilateral upper buttocks and sacral region, barrier cream applied, reposition every two hours. - 3/3/18, dry areas to upper buttocks and sacral region, barrier cream applied. - 3/4/18, dry areas to upper buttocks and sacral region, foam dressing (a foam pad to cover the wound with an adhesive edge to adhere to the skin) applied. - 3/6/18, dry areas to bilateral buttocks foam dressing applied. A Weekly Skin Review dated 3/10/18, indicated R5 had "superficial open area on sacral areas" and "excoriation on the buttocks." - 3/12/18, excoriated areas to bilateral buttocks, Tegaderm hydrocolloid placed - 3/16/18, continues with dry area to bilateral buttocks and sacral region, foam dressing applied. - 3/20/18, excoriated areas to upper bilateral buttocks, applying Tegaderm hydrocolloid dressing. Review of R5's clinical record lacked a weekly assessment of the wound which would include measurements of the wound, (length, width and depth), color of the wound and surrounding wound bed and current interventions. Review of R5's clinical record lacked indication R5's primary physician had been notified of the newly opened areas. Review of R5's Electronic Treatment Administration Record (ETAR), dated 3/18, revealed duplicative orders to apply Allevyn and DermFilm dressings every three days to the same	F 686	assessment of skin, pressure ulcers and implementation of appropriate interventions. 4. Effective 4/24/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents with impaired skin integrity and updating MD, family and care plans with any changes to ensure appropriate follow through. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will ensure audits of all residents that are dependent on staff for preventing skin breakdown (incontinent, unable to offload, need pressure relieving devices, existing skin breakdown, etc.) daily for 5 days, then 5 residents for 4 weeks to ensure compliance than 2 residents weekly x 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON will be responsible for this POC.	

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wound. The documentation revealed the nurses had initialed both dressings every three days which indicated they had both been applied to the wound, even though only one dressing was actually applied.

On 3/20/18, at 5:00 p.m. R5 was observed seated in a wheelchair in the main dining room waiting for supper.
-At 5:05 p.m. registered nurse (RN)-D fed R5 the evening meal.
-At 5:20 p.m. RN-D wheeled R5 back to his room, turned the television on and exited the room.
-At 5:55 p.m. R5 remained in his wheelchair. Nursing assistant (NA)-D entered R5's room and assisted R5 to wash his hands and face and change into a hospital gown. R5 was not repositioned.
-At 6:06 p.m. NA-D exited the room. R5 remained in the chair and continued to watch television.
-At 7:50 p.m. NA-D and NA-A returned to the room and transferred R5 from the wheelchair to bed. R5's wheelchair had a pressure redistribution seat cushion in place. R5's coccyx was covered with an intact thin Tegaderm hydrocolloid dressing. The skin along the edge of the wound was deep pink in color.
- At 7:55 p.m. NA-A stated R5 was assisted out of bed at 4:00 p.m. and confirmed R5 was not repositioned for 3 hours and 50 minutes. NA-A stated with only two NAs on staff, the staff were doing the best they could, however, they were unable to provide assistance with timely repositioning for all of the residents.

On 3/21/19, at 1:10 p.m. the director of nurses (DON) and the regional director of clinical services (RDCS) stated R5 was to receive assistance with repositioning every two hours as

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directed by the care plan. Upon review of the medical record, the DON stated she was unaware of the exact date R5's buttocks began to show signs of breakdown. The RDCS stated the facility should have completed a comprehensive skin assessment when the breakdown began. The DON stated she was unable to determine the size of the wound based on the facility documentation.

- At 2:05 p.m. RN-D was observed to remove a Duoderm dressing from R5's sacrum. Upon removal of the dressing, RN-D identified two newly opened areas under the dressing. RN-D measured the first open area on the left buttocks to be 1.0 cm x 0.3 cm. The second open area on the lower left buttocks measured 2.0 cm by 2.0 cm. In addition, under the dressing there were three deep red approximately one inch non blanchable areas. RN-D stated the wound had changed appearance since the last time she had observed it. RN-D stated the open areas were new and the wound looked worse.

- At 2:10 p.m. the DON observed R5's sacrum. The DON stated the last time she had observed R5's sacrum, the skin was dry and flaky but intact. The DON confirmed R5 had newly developed stage 2 ulcers (pressure ulcer in which partial thickness skin loss involving epidermis, dermis, or both). RN-D applied a Duoderm dressing over the ulcers.

Review of R5's clinical record on 3/23/18, (two days later) revealed a lack of documentation related to the newly developed pressure ulcer's wound care and measurements from 3/21/18.

On 3/23/18, at 9:30 a.m. RN-E reviewed R5's record and confirmed R5 had developed a

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pressure ulcer and the facility failed to complete any type of documentation or comprehensive assessment related to the new pressure ulcers identified on 3/21/18. RN-E verified R5 had two treatment orders for the same sacral wound and the ETAR indicated both dressings were being applied even though only one dressing had been applied to the wound. RN-E also verified R5's care plan had not been followed as directed and R5 had not received wound care in accordance with the facility policy.

R18 had developed a pressure related ulcer which had worsened and the staff failed to complete a comprehensive wound assessment to determine efficacy of current interventions, and failed to update the care plan.

R18's Admission Record dated 3/22/18, indicated R18 had diagnoses which included mild cognitive impairment, stroke, hemiplegia, and hemiparesis, muscle weakness, fatigue, venous insufficiency, and obesity.

R18's quarterly MDS dated 3/2/18, indicated R18 had severe cognitive impairment, required extensive assist from 2+ staff for bed mobility and toilet use, and was totally dependent on 2+ staff for transfers and hygiene. The MDS indicated at the time of assessment, R18 had one stage 2 pressure ulcer and two stage 3 pressure ulcers (Stage 3- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) which measured 2.0 x 6.0 x 0.4 cm. Ulcer treatments included pressure ulcer care, and pressure reducing device for bed and

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F 686	Continued From page 56 wheelchair. R18's Pressure Ulcer CAA dated 8/22/17, indicated R18 was at high risk for pressure ulcers, and had a history of pressure ulcers. The CAA further indicated R18 required a special mattress or seat cushion to reduce or relieve pressure. The CAA did not identify which type of special mattress and/or seat cushion R18 required. R18's care plan printed on 3/22/18, indicated R18 required extensive assist of one staff for dressing, bathing, grooming and bed mobility, and extensive assist of two staff for transfers with a mechanical lift. The care plan also indicated R18 "has pressure ulcers development" related to pressure ulcer areas to the coccyx, and had a potential impairment to skin integrity related to fragile skin, immobility, weakness, and history of pressure ulcers. The care plan directed the staff to implement the following interventions: -keep skin clean and dry, apply lotion on dry skin -report abnormalities, failure of skin to heal, maceration and sign/symptoms of infection to the physician -identify/document potential causal factors and eliminate/resolve where possible -use a draw sheet or lifting device to move the resident. -administer treatments as ordered and to monitor for effectiveness -apply barrier cream to buttocks twice a day and as needed -educate the resident/family/caregivers as to causes of skin breakdown including transfer/positioning requirements, importance of taking care during ambulating/mobility, good	F 686		

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nutrition and frequent repositioning.
-follow facility policies for the prevention/treatment of skin breakdown
-if the resident refused treatment, confer with the resident, interdisciplinary team and family to determine why and try alternative methods to gain compliance. Document the alternative methods.
-inform the res/family/caregivers of any new skin breakdown
-lift sling to be removed when in bed
-monitor dressing, if needed, every shift to ensure if remains intact and adhering. Report loose dressing to treatment nurse
-monitor nutritional status. serve diet as ordered, monitor intake and record
-monitor/document/report, as needed, any changes in skin status: appearance, color, wound healing, signs and symptoms of infection wound size, and stage.
- obtain and monitor lab work
-teach resident/family importance of changing positions for the prevention of pressure ulcers and encourage small frequent position changes
-turn and reposition R18 at least every two hours, more often if needed or requested
-provide a pressure relieving/reducing device on bed/chair, however, does not identify which type of cushion to be used.
- use fracture bed pan in bed. encourage R18 to be on bedpan ten minutes, observe skin and report any redness or open areas to nurse
-weekly skin observation. If open area, treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue exudate (drainage).

Although the care plan addressed pressure ulcers, the care plan did not address the newly developed pressure ulcers and/or was not revised

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to reflect the pressure ulcers identified on the 3/2/18, MDS assessment. In addition, the care plan lacked identification of the type of pressure reducing mattress required for R18's needs.

R18's Tissue Tolerance Observation dated 2/24/18, indicated R18 was at high risk for pressure ulcers with risk factors that included current or history of pressure ulcers, history of stroke, and was not cooperative with positioning. The evaluation indicated skin over bony prominences was pink and blanchable after sitting for one and two hour time frames. The evaluation also identified when R18 was in a lying position after 1/2 hour, one hour, and two hours the skin over bony prominences was pink and blanchable. The evaluation did not identify where the pink areas were and did not identify a repositioning schedule.

R18's physician orders included:

-Complete weekly skin assessment on Mondays (start date 2/13/17)
-wound evaluation on left upper buttock every Monday per MD order (start date 2/20/17)
-Change Tegaderm hydrocolloid (maintains a moist wound bed) thin 4x4 dressing every three days in the morning and as needed; apply skin prep to coccyx before applying new dressing to prevent skin tears. (start date 8/23/17, stop date 3/20/18)
-Monitor Tegaderm hydrocolloid thin dressing to upper buttocks every shift to make sure dressing is in place, dressing is dry and intact every shift. Dressing to remain on until healed. (start date 9/30/17)
-Comfort foam (for medium to heavy drainage) with border dressing 4x4 to sacral and buttock

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F 686	Continued From page 59 wounds change every 3 days until healed (start date 3/21/18) -Roho cushion for wheelchair (start date 3/20/18) Weekly Skin Reviews (WSR) and progress notes (PN) reviewed form 1/1/18, through 3/20/18, lacked completed comprehensive evaluations and consistency of documentation in order to ascertain locations, worsening, and or healing stages. The record further lacked evidence of pressure relieving device efficacy. -WSR dated 1/1/18, Small pinpoint open area in mid coccyx slit, rest of area appears macerated, and a patch was applied per MD (medical doctor) orders. -WSR dated 1/8/18, Open area, had areas of maceration, applied patch per MD order to coccyx, had a small pinpoint area that is open. -PN note dated 1/14/18, included a hydrocolloid dressing placed to buttocks. Slit in coccyx was superficial, still very fragile. One open area to left buttock 1.0 cm x 1.0 cm and two small reddened areas on right buttock. -WSR dated 1/15/18, Continues to have maceration on coccyx, has on upper right buttock 1.0 centimeter (cm) open area. Red around wound. Applied dressing per MD orders. The record lacked evidence of any further wound evaluation or ongoing treatment. -WSR dated 1/22/18, Has maceration in gluteal fold, skin wet and white in color. Has 2.0 x 0.3 cm open area. On the right buttock has 2 open wounds. Proximal measures 1.0 x 0.9 cm. Distal measures 0.5 x 0.5. No drainage. Cleansed and applied Mepilex dressing. -PN dated 1/23/18, indicated the MD was contacted related to open areas on buttocks and coccyx not healing related to urinary	F 686		

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incontinence. MD ordered placement of an indwelling catheter for wound healing.
-WSR dated 1/29/18, continues to have on coccyx 1.0 cm x 0.6 millimeter (mm) open area on coccyx, noted maceration to area. Dressing applied after coccyx dried off. Will continue to monitor.
-Corresponding PN dated 1/29/18, indicated coccyx was healing post indwelling catheter placement and to refer to the weekly evaluation for full description.
-PN dated 1/30/18, indicated the coccyx wound was stage III pressure ulcer and measured 1.0 cm by 0.7 cm with depth of 0.5 cm with questionable tunneling in the center of the wound bed.
-PN dated 2/3/18 indicated the coccyx wound appeared smaller, and appeared to be a stage II. No odor, redness, or warmth.
-WSR dated 2/5/18, coccyx 1.0 x 1.0 cm with 0.4 cm depth. Moisture associated. Able to visualize wound bed. Dermallevyn thin to be applied and changed every 3 days.
-PN dated 2/6/18, MD made aware of the measurements of coccyx wound.
-WSR dated 2/12/18, Coccyx very macerated and left open to air for one hour and turned to scabs. Upper left coccyx thin pink skin area measures 3.0 x 1.0 cm, no depth superficial. Rest of coccyx and upper bilateral buttocks have 0.04 to 0.03 to 0.02 cm with brown dry scabs. With dry skin attached around scabbed areas.
-WSR dated 2/19/18, coccyx 1.0 x 0.4 cm purple area on coccyx. Not open at this time and left buttock small pinpoint 0.1 by 0.1 cm purple area. Not open but surrounding dry skin.
-WSR dated 2/26/18, center of coccyx measures 2.0 cm by 0.6 mm wound bed depth 0.4 mm, areas of eschar 0.5 mm and slough (defined as

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yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed) was present. Scant amount brown drainage with slight odor present on dressing and skin around the wound. Other areas on lower right buttock measure 2.0 cm x 0.5 cm with no drainage.
-Corresponding PN dated 2/26/18, indicated director of nursing (DON), MD, and family were notified of the changes.
-PN dated 3/2/18, included: skin assessment was completed related to skin breakdown. Stage 3 noted on coccyx 2.0 x 6.0 x 0.4 centimeters (cm). Stage 2 left of coccyx area approximately 1.0 x 1.0 x 0.2 cm skin sloughing off of the wound. Stage 2 right below coccyx area, small 0.5 x 0.5 x 0.1 cm area. Slough skin on top. Dressing to coccyx changed every three days and as needed. Offload side to side positioning while in bed. The note indicated the director of nursing was updated and an air mattress would be placed on 3/2/18. The note also indicated R18 had historically refused to offload (relieve pressure to an area to allow reperfusion to the skin) and repositioning and staff would monitor.
-WSR dated 3/5/18, 2.0 cm x 1 cm healing stage 3, no drainage appears macerated. Left buttock 0.2 x 0.2 cm scabbed area, skin around scab reddened. Left buttock 2.0 cm x 2 cm scabbed area, surrounding skin white. Also included resident non-compliant with turning and repositioning from side to side. Larger areas cleansed and applied Dermallevyn.
-WSR dated 3/12/18, coccyx area 0.5 mm circular, 0.03 mm depth. Wound bed is deep purple, other areas that were open healed.
-PN dated 3/16/18, included 2.0 x 2.0 red raised, painful area to right ischium. Question if may be some type of boil or beginning of a pressure ulcer. Foam dressing was applied, and MD would

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be notified.
-WSR dated 3/19/18, coccyx 1.5 x 1.0 cm. Wound bed 100% granulation tissue. Wound cleansed and Dermallevyn applied. Right buttock 1.0 cm x 1.0 cm presents as deep tissue injury (Suspected deep tissue injury-purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mush, boggy, warmer or cooler as compared to adjacent tissue. Evolution may include a thin blister over a dark wound bed). Not open bruise like appearance. Area covered with Dermallevyn. Left buttock has two wounds- each measuring 1.0 x 0.2 cm. Present as possible skin tears. Cleansed and applied Dermallevyn.

On 3/19/18, at 11:48 a.m. R18 was observed in her room, seated in the wheelchair. The seat cushion in the wheelchair was identified to be a standard pommel cushion (designed to stabilize seating position and support hip alignment which is made of dense foam to keep the resident from sliding out of the wheelchair). The mattress on the bed was standard foam perimeter mattress. R18 stated she had pressure ulcers on her bottom, had them for a long time, and experienced discomfort when she sat too long. R18 stated when staff changed her wound dressings she experienced discomfort, however, indicated pain medication was administered prior to the dressing changes. R18 stated she had wanted an air mattress on her bed but had never received one. R18 stated did not think her wheelchair cushion had been changed/replaced. R18 further stated staff did not always reposition her timely and felt they could probably offer to reposition her more often.

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F 686	Continued From page 63 On 3/20/17, at 1:17 p.m. NA-B was observed to transfer R18 from her wheelchair into bed using a full body mechanical lift. NA-B confirmed R18 had wounds on her bottom but had not seen R18's bottom since 3/16/18, and stated somebody had told her R18 had additional areas of skin breakdown. NA-B pulled down R18's pants, which exposed two hydrocolloid dressings positioned over the left buttock and sacral/coccyx region, and the mid right buttock. NA-B stated the wound on the left was new since last week. -At 1:39 p.m. medical doctor (MD)-B and health unit coordinator (HUC) entered R18's room. MD-B asked R18 if she had experienced pain from the sores, to which R18 responded she had some discomfort. As MD-B removed the tacky dressings, MD-B remarked she did not like this type of dressing because it rips the skin. MD-B assessed the wounds and verified the following: -upper coccyx sacral region stage 2, (healing stage 3) -left buttock open stage 2; the other wound below the open wound was superficial and "covered" and because of that was hard to stage. -left buttock above the stage 2 ulcer were two small superficial areas and stated those were probably caused from removing the adhesive bandage and were not considered pressure related. -Right buttock over ischium a small raised dark purple area with surrounding redness. MD-B stated the purple area was necrotic tissue (non-viable tissue due to reduced blood supply) and would be a stage 2 when it opened. -small stage 2 on the inner right buttock MD-B stated the sacral wound had shown	F 686		

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improvement since the insertion of an indwelling catheter. MD-B asked R18 how repositioning had been going to which R18 responded, not very well. MD-B reinforced importance of repositioning to R18. R18 agreed to go to the wound clinic for further evaluation. MD-B verified the wheelchair cushion was firm and flat and did not provide enough support and should be changed to something more pressure relieving. MD-B also stated R18 should have had an air mattress on her bed in order to provide more pressure relief support while in bed. HUC stated nursing staff had talked about putting an air mattress on the bed and was unaware why it had not been implemented.

On 3/22/18, at 7:57 a.m. NA-B stated R18 had a pretty set routine and was supposed to be repositioned every two hours from side to side, but often refused. NA-B stated if R18 refused repositioning, staff were to remind her of the risks of refusing such as skin breakdown. NA-B also stated she did not think there was enough staff because the residents were sometimes repositioned 10-30 minutes late. NA-B confirmed R18's mattress and chair cushion had never been changed and had always been the same as what she currently used.

-At 8:48 a.m. RN-D stated there was no designated RN to perform pressure ulcer/wound assessments, therefore were completed by whichever nurse was assigned to work that day. RN-D stated skin assessments were performed weekly, wound documentation should always include measurements, and if the wound was a pressure ulcer the nurse should indicate the stage of the ulcer. RN-D further stated the assessing nurse needed to determine possible

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causal factors of the breakdown and evaluate and implement appropriate interventions. RN-D stated if the pressure wounds were not healing, the interventions should be reassessed for effectiveness and the pressure relieving devices and surfaces should also be assessed for effectiveness.

-Continuous observation from 11:30 a.m. until 1:44 p.m. revealed the following:

-At 11:30 a.m. R18 was in her room, seated in the wheelchair, watching television.
-At 12:04 p.m. NA-B wheeled R18 to the dining room for lunch
-At 1:03 p.m. an unidentified staff member returned R18 to her room.
-At 1:08 p.m. R18 stated the staff member had not repositioned when returned to her room.
-At 12:49 p.m. RN-E verified the Weekly Skin Observations were not complete nor comprehensive. RN-E stated all the evaluations should have been completed to identify: measurements including depth, if pressure ulcer then staged, a complete description of the wound, drainage, odor, current treatment, progress toward healing, and if worsening then reassessment of interventions, implementation of new interventions, and notification to physician. RN-E stated the facility nurses were very inconsistent with their documentation and it was difficult to ascertain exactly what was going on with the skin. RN-E confirmed she had asked the maintenance director to put the air mattress on the bed on 3/2/18, and thought it had been implemented that same day.
-At 12:54 p.m. RN-E observed R18's bed and verified the mattress on R18's bed was not the air mattress she had requested to be put on the bed.

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RN-E confirmed R18's mattress was a standard foam mattress which all the residents in the facility used, and was not provided based on her pressure ulcer/pressure relief needs. RN-E indicated the only difference on R18's mattress was it had the edge perimeters.
-At 1:44 p.m. R18 remained seated in her wheelchair. R18 stated her routine was to stay up in the wheelchair until her television program was over at 2:00 p.m. R18 stated when the program was over she would call for staff to get laid down into bed.

On 3/22/18, at 3:10 p.m. the maintenance director confirmed she had not put the air mattress on R18's bed as requested because she was waiting for a doctor's order. But, the director stated she had not requested or asked the nursing staff for the specific order documentation so that she could place the air mattress on the bed.

Although staff identified refusal of cares, the quarterly interdisciplinary review dated 12/30/17, identified no behaviors which included refusal of cares. Additionally, the care plan printed as current on 3/22/18, failed to identify refusal of care or individualized interventions related to refusal of cares.

R2's annual MDS dated 11/2/17, indicated R2 had severe cognitive impairment and diagnoses which included Parkinson's disease, dementia and anxiety. The assessment indicated R2 required total assistance with bed mobility and transfers, and was at risk for the development of pressure ulcers.

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The Pressure Ulcer CAA dated 11/3/17, identified R2 at risk for the development of pressure ulcers due to the inability to reposition herself. The CAA directed staff to provide a redistribution cushion in her wheelchair and bed.

R2's Tissue Tolerance Observation form dated 10/31/17, indicated a Braden Scale had been completed and identified R2 at high risk for the development of pressure ulcers, however, R2's clinical record did not contain a copy of the Braden Scale. The observation indicated R2 had not developed reddened areas during the observation time. The observation tool did not identify the frequency of repositioning needs for R2.

R2's care plan dated 12/28/17, identified R2 at risk for the development of pressure ulcers and directed the staff to assist R2 with a repositioning every two hours.

On 3/22/18, during continuous observations from 7:05 a.m. to 10:00 a.m. R2 was not observed to be assisted with reposition.
- At 7:05 a.m. R2 was observed seated in a wheelchair in her room.
- At 7:37 a.m. the HUC wheeled R2 from her room to the dining room.
- At 7:41 a.m. the HUC served and assisted R2 with breakfast.
- At 8:07 a.m. R2 had finished the meal. The HUC wheeled R2 out of the dining room.
- At 8:12 a.m. R2 was wheeled back to her room.
- At 8:57 a.m. R2 was wheeled into the activity room by the activity director.
- At 9:53 a.m. NA-B stated R2 was assisted out of bed at 6:30 a.m. and she had not had time to

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assist/reposition her since that time.
- At 10:00 a.m. NA-B wheeled R2 to her room and assisted R2 to transfer from the wheelchair to the bed via a full body mechanical lift. A pressure redistribution cushion was noted on the seat of her wheelchair. Once in bed, NA-B changed R2's incontinence brief. R2's skin was pink and intact.
-At 10:05 a.m. NA-B confirmed R2 had last been assisted with repositioning at 6:30 a.m. a total of 2 hours and 30 minutes earlier.

On 3/22/18, at 2:58 p.m. RN-E confirmed R2 was to be assisted with repositioning every two hours as directed by the care plan.

R23's quarterly MDS dated 3/9/18, indicated R23 had severe cognitive impairment and diagnoses which included dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all bed mobility and transfers and was at risk for the development of pressure ulcers. R23's annual MDS dated 10/13/17, also identified R23 as being totally dependent upon staff for bed mobility, transfers and at risk for the development of pressure ulcer.

R23's Pressure Ulcer CAA dated 10/9/17, identified R23 at risk for the development of pressure ulcers and directed the staff to utilize a pressure reducing mattress, chair cushion, and to assist R23 with offloading every two hours and as needed.

R23's Braden Scale for Prediction of Pressure Sore Risk dated 3/9/18, identified R23 at moderate risk for the development of pressure

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ulcers.

The Tissue Tolerance Observation Tool dated 3/9/18, indicated R23 did not develop reddened areas after two hours in one position.

R23's care plan dated 7/19/17, directed staff to assist with repositioning every two hours.

During continuous observation on 3/22/18, from 7:13 a.m. to 10:07 p.m. R23 was not observed to receive assistance with repositioning.
- At 7:13 a.m. NA-B and NA-C were observed to transfer R23 from bed to a wheelchair via a full body mechanical lift.
- At 8:46 a.m. R23 was wheeled into the dining room.
- At 8:48 a.m. R23 was assisted with the breakfast meal.
- At 9:16 a.m. R23 was wheeled to the activity room for church.
- At 9:35 a.m. R23 was wheeled from the activity room to the nurses station.
- At 10:00 a.m. R23 was wheeled to his room.
- At 10: 05 a.m. NA-B and NA-C were observed to transfer R23 from the wheelchair to the bed via a full body mechanical lift. A pressure redistribution cushion was noted on R23's wheelchair seat. R23's skin was clear and intact.
- At 10:10 a.m. NA-B and NA-C confirmed R23 had not received assistance with repositioning since 7:13 a.m. a total of 2 hours and 50 minutes earlier.

On 3/23/18, at 10:35 a.m. RN-B stated R23 was to receive assistance with repositioning every two hours as directed by the care plan.

Superior Healthcare Management Minnesota

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

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F 686	Continued From page 70 Region policy and procedure, Pressure Ulcer Risk Assessment dated 12/23/17, indicated the following: -pressure ulcers are usually formed when a resident remained in the same position for an extended period of time causing increased pressure or decrease of circulation -if pressure ulcers are not treated when discovered, they can become larger, painful, and infected -pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (feces, urine, soap, discharge), decline in nutrition, and hydration status, acute illness or decline in the resident's physical and/or mental condition -pressure ulcers are a serious skin condition for the resident -routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown. -Skin would be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. Superior Healthcare Management Minnesota Region policy and procedure, Pressure Ulcer Treatment dated 12/23/17, included general guidelines and strategies for stage I, stage II, and stage III pressure ulcers which directed consistent assessment and documentation, implementation of appropriate interventions, and monitoring for efficacy of interventions, and making revisions in interventions based on assessment.	F 686		
F 688 SS=G	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)	F 688		5/6/18

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F 688	Continued From page 71 §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services as directed in order to prevent the decline in range of motion (ROM) abilities for 2 of 5 residents (R5, R2) observed to have had a decline in ROM. The lack of the provision of the services resulted in actual harm for R5 due to the development of upper extremity contractures; and actual harm for R2 due to the development of contractures in the lower extremities. Lastly, the facility failed to assess the need for ROM services for 1 of 5 residents (R23) observed with limitations in ROM without the assessment and development of a ROM program in order to prevent a decline or maintain current ROM abilities. Findings include	F 688	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure resident do not have decline in ROM unless anticipated by clinical condition. R2 developed contractures of lower extremities and R5 developed contractures of upper extremities. R5 entered building dependent and definite limitations of ROM, had been in therapy and was discharged with braces and	

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F 688	Continued From page 72 R5's quarterly Minimum Data Set (MDS) dated 1/10/18, indicated R5 had moderate cognitive impairment and diagnoses which included Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff for bed mobility, transfers and all activities of daily living, and had bilateral functional limitation in range of motion of the upper and lower extremities. R5's admission MDS dated 9/1/17, indicated R5 was dependent upon staff for all activities of daily living and had bilateral functional limitation in ROM of the upper and lower extremities. R5's Activities of Daily Living Care Area Assessment (CAA) dated 9/6/17, indicated R5 required total staff assistance all activities of daily living related to encephalopathy (brain disease, damage or malfunction), spinal fusion and weakness. The CAA indicated R5 was participating in therapy. R5's Therapist Progress and Discharge Summary dated 9/14/17, indicated R5 had bilateral contractures of the upper and lower extremities. The physical therapist directed the nursing staff to complete upper and lower extremity range of motion exercises in order to maintain mobility. R5's care plan dated 8/25/17, indicated R5 had limited physical mobility and directed the staff to provide gentle range of motion with daily cares. On 3/19/18, at 10:15 a.m. family member (FM)-A stated she was not aware of R5 receiving any type of range of motion services. FM-A stated R5's arms began to contract one year ago after an accident which resulted in R5's quadriplegia.	F 688	ROM to be done twice a day □ ROM had not been completed and has had definite decline per family and staff. R2 was noted to have a request from therapy for PROM to lower extremities and they had not been implemented. After survey noted the decline a review of ROM was completed, Therapy orders both residents received to assist with splinting and exercises. R5 changed to PROM with upper extremities in AM with cares, elbow splints, hand splints on at night, boots in bed. R2 will have PROM to extremities with hs cares, teddy bear for transfers for arms, and boots on at night. Care sheets and care plans updated, therapy consult in place. 2. Because all residents have potential for decline or improvement all are potentially affected by the cited deficiency, decline in ROM triggers have been pulled, documentation has been reviewed, interventions for prevention are in place and documented clearly on care plans. Passive ROM to be completed with cares in morning and at night, and staff update DON or MDS nurse on any new declines. All current residents have been assessed for decline during comprehensive assessment along with appropriate interventions. Therapy has completed all baseline screens of all residents'; screens reviewed on 5/2/18 to assure completion of all residents. Implementation of those interventions is reviewed in IDT. Staff to alert DON is resident refuses otherwise. No other residents were affected. The policy on ROM has been updated. 3. To enhance currently compliant operations and under the direction of the	

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F 688	Continued From page 73 FM-A stated R5 had received therapy right after the accident, however, had not received any therapy services since that time. FM-A stated R5 was to wear his braces daily, but felt R5's arms were getting worse. At this time, R5 was observed seated in a wheelchair with bilateral elbow braces on. The braces were applied to the inner aspect of the left and right elbows and extended to the mid upper and lower arms and were covered with a soft cloth padding and secured with velcro straps. The braces prevented further flexion of the elbows. R5's elbows were in a fixed position, and his hands rested in a fisted position. - At 12:40 p.m. NA-C stated the facility had 23 residents and only two NAs to provide direct care to all the residents during the day and evening shifts. One NA worked on the night shift. NA-A stated the NAs were able to provide the residents with basic cares but did not provide ROM services. NA-C stated ROM exercises were to be provided during the provision of morning caress, however, they [NAs] did not have to time complete the exercises. On 3/20/18, at 12:37 p.m. R5 was observed in his room, seated in a wheelchair, with bilateral elbow braces on. NA-B stated R5 was not able to fully straighten/extend his arms rather was only able to move them a few inches. R5 was observed to move his shoulders which also moved his arms approximately 1-2 inches. - At 5:55 p.m. NA-D was observed to assist R5 with evening cares. When NA-D removed the bilateral arm braces, R5's arms curled tightly to his chest and his hands remained in a fisted position. NA-D proceeded to lift up R5's right	F 688	director of nurses, on 5/1/2018 all staff received in-service training on ROM and monitoring declines. The training emphasizes the importance of following all interventions for effective prevention of contractures. Education also done on importance of comprehensive assessment of ADL□s, contractures and implementation of appropriate interventions. 4. Effective 4/23/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents for changes in ROM and updating MD, family and care plans with any changes to ensure appropriate follow through. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the therapy department will do baseline screens on all residents starting 5/2/2018 this will create a baseline for ROM. Staff will monitor in PCC that extremities are maintaining movement in upper and lower extremities q shift. MDS nurse will ensure all residents audited daily for splinting and changes in ROM x 5d. Then 4 residents weekly x 4 weeks then on 2 residents weekly for 4 weeks to ensure compliance than 2 residents weekly x 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON will be responsible for this POC.	

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elbow moving it slightly in order to remove R5's shirt sleeve. While lifting the elbow, his arm was unable to extend and his shoulder moved less than two inches away from R5's body resulting in NA-D maneuvering his shirt sleeve off his arm. NA-A slipped the shirt over R5's head and slid it off of the left arm. R5's left arm was not observed to move while the shirt was removed. NA-D proceeded to wash R5's hands and arms. When washing the hands, R5 was noted to extend his right fingers to an approximately 90 degree angle. R5's right hand fingers appeared fixed with NA-D only washing between his fingers. NA-D again washed R5's left hand as his hand was open with his fingers extended to a 45 degree angle and were unable to extend any further. NA-D completed the cares by dressing R5 in a hospital gown and applying lotion to R5's arms, elbows and shoulders. NA-D was not observed to provide R5 any upper extremity ROM exercises.

- At 6:16 p.m. NA-D stated the evening shift staff did not provide the residents' any ROM exercises because the day shift staff completed the ROM programs/exercises.

On 3/21/18, at 9:19 a.m. NA-C stated she had been the NA assigned to provide the residents' functional maintenance programs as established by the physical therapist. However, in February 2018, she was removed from rehab services and reassigned to provide resident personal cares. NA-C stated R5 had had a functional maintenance program in the past, however, now that there is not a specific employee assigned to provide the rehab services, the NAs were directed to provide the ROM services during the provision of personal cares. NA-C stated the staff

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simply did not have the time to provide ROM services in addition to routine personal cares.

On 3/21/18, at 9:21 p.m. licensed practical nurse (LPN)-B confirmed R5 had not been receiving ROM services and stated due to this, it had been getting more difficult to apply R5's elbow braces because his arms were more stiff and his contractures were getting tighter.

-At 9:30 a.m. registered nurse (RN)-D stated she could not recall R5 ever having received range of motion services and confirmed the braces were more difficult to apply due R5's increased stiffness of his upper extremities.

Review of R5's electronic Medication and Treatment Administration Record dated 3/2018, indicated the nursing staff were to apply hand braces at night and elbow braces during the day. The records did not direct the staff to perform range of motion services for R5.

- At 1:05 p.m. the director of nursing (DON) stated range of motion services was to be completed with personal cares. The DON stated she was not aware the exercises were not being completed as directed.

- At 1:10 p.m. the regional director of clinical services (RDCS) stated the facility did not have a restorative program, however, they had recently hired a new company to provide physical therapy to the residents. The RDCS stated she was unaware R5's braces were more difficult to apply due to decreased movement. The RDCS stated R5 would need to be re-evaluated by physical therapy.

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F 688	Continued From page 76 On 3/21/18, at 3:10 p.m. the contracted physical therapy assistant (PTA)-A stated R5 had not been evaluated by physical therapy, therefore his ROM abilities had not been assessed. On 3/22/18, at 2:46 p.m. RN-E confirmed NA-C had provided the residents' restorative services in the past and stated NA-C would be the most knowledgeable staff member who could identify if a resident had a decline in ROM ability. R2's annual MDS dated 11/2/17, indicated R2 had severe cognitive impairment and diagnoses which included Parkinson's disease, dementia and anxiety. The MDS also indicated R2 required extensive staff assistance for all activities of daily living, total staff assist for transfers, and had no functional limitations in ROM. The Activities of Daily Living CAA did not trigger at the time of the annual assessment, therefore an assessment of R2's ROM abilities was not conducted. R2's quarterly MDS dated 12/27/17, indicated R2 had functional limitations in bilateral upper and lower extremities. R2's Assessment of Functional Range of Motion dated 1/13/18, indicated R2 had bilateral limitations of ROM in the upper and lower extremities. R2's care plan dated 12/28/17, directed the staff to monitor and report changes in ROM ability, provide physical therapy referrals as order and as needed, and to monitor/document/report any signs or symptoms of immobility such as contractures forming or worsening. R2's clinical record did not include a physical or occupational therapy discharge summary.	F 688		

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R2's Restorative Record dated 1/2018, indicated R2 had received passive range of motion (PROM) to the bilateral lower extremities five times per week, and PROM to upper extremities five times a week.
The February 2018, Restorative Record indicated R2 had received ROM to the upper and lower extremities on 11 days, however, the documentation ended on 2/14/18. The record was blank from 2/15/18 - 2/28/18, and the March 2018, documentation was blank.

On 3/21/18, at 11:30 a.m. NA-C was observed to assist R2 with changing an incontinent brief. During the cares, R2's colostomy bag disconnected requiring R2's clothing to be changed. While changing R2's pants, R2 was noted to be unable to straighten her legs at the knees. NA-C stated she had previously been assigned to assist R2 with ROM exercises but in the middle of February 2018, she had been reassigned to assist with residents' with routine cares instead of completing ROM services. NA-C stated R2 used to be able to straighten her knees to about 50% full extension, but since she was no longer being provided ROM exercises, R2's knees had become tighter/more contracted. NA-C proceeded to assist R2 with applying a pair of pants.

-At 11:35 a.m. NA-C removed R2's shirt. R2's hands were held in a fisted position. R2 moved her left shoulder and extended her elbow, however, the right shoulder did not move more than two inches and she was unable to extend her arm at the elbow. NA-C stated R2 had had the ability to fully open both of her hands. NA-C manually opened R2's right hand to

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approximately a 90 degree angle and the left hand opened to approximately a 75 degree angle. NA-C confirmed R2 had limitations in her upper extremities, however, stated R2's upper extremity ROM ability had not changed since the ROM had stopped. NA-C stated the staff were to complete ROM exercises during morning cares, however, since the facility had only two NAs to provide care for the 23 residents, the staff did not have the time to complete ROM exercises, as directed.

- At 3:10 p.m. PTA-A stated R2 had not been evaluated by physical therapy in order to determine if services were needed.

R2's clinical record lacked any type of documentation related to R2's ability to participate in ROM exercises.

On 3/22/18, at 2:45 p.m. RN-E confirmed R2 was to be receive assistance with PROM exercises as directed by the care plan. RN-E stated NA-C had completed the ROM services in the past, therefore she would be the only staff member in the facility who could truly identify if a change in ROM had occurred. RN-E confirmed none of the licensed nurses had been monitoring or evaluating the ROM program in order to determine if the residents were receiving the services, evaluating their progress, or monitoring for a change in a residents' ROM ability. RN-E stated the NAs were to complete ROM exercises with morning cares and were directed to report any pertinent charge in a residents' ability to the charge nurse and the nurses were directed to document the ROM on the treatment administration records. Review of R2's electronic Treatment Record did not include documentation related to range of motion services having been

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provided. RN-E confirmed R2's record did not reflect a ROM program and verified R2 range of motion in her lower extremities had declined.

R23's quarterly MDS dated 3/9/18, indicated R23 had severe cognitive impairment and diagnoses which included dementia, history of stroke and aphasia (inability to speak). The MDS indicated R2 required extensive assistance with all activities of daily living. R23's annual MDS dated 10/13/17, indicated R23 required total staff assistance for all activities of daily living.

R23's care plan dated 7/19/17, directed the staff to have physical therapy and occupational therapy evaluate and treat R23 as directed by the physician. The care plan also directed the staff to report signs and symptoms of immobility, or contractures forming or worsening. The care plan did not direct the staff to assist R23 with ROM exercises.

R23's Therapist Progress and Discharge Summary dated 4/13/17, indicated R23 had lower extremity limitations in ROM. The physical therapist indicated nursing staff was to provide R23 ROM with manual stretches including bilateral hamstrings. The frequency of the exercises was not indicated.

R23's Therapist Progress and Discharge summary dated 4/14/17, indicated R23 had limitation in ROM in the upper extremities. The occupational therapist indicated R23 was to receive ROM exercises however, the frequency of the services was not identified.

Review of the facility's Restorative nursing

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documentation did not include a restorative nursing program for R23.

Review of R23's electronic medication record did not direct the staff to assist with ROM.

On 3/19/18, at 10:55 a.m. FM-B stated the facility had attempted to complete exercises with R23 in the past, however, FM-B was unsure if R23 was currently receiving services. FM-B stated he/she thought R23's feet and legs were becoming deformed.

On 3/21/18 at 3:10 p.m. PTA-A stated R23 had not been evaluated by physical therapy in order to determine if therapy or restorative services were needed.

On 3/22/18, at 7:05 a.m. NA-B and NA-C were observed to assist R23 with morning cares. R23 was in bed. While assisting R23 with donning a pair of pants, R23 attempted kick at the NA's with his right leg. R23 proceeded to grab his pants with his right hand and attempted to lift his buttocks to pull his pants up. R23 was unable to lift his buttocks off of the bed. R23 was noted to have full range of motion in his right arm as he attempted to strike out at the staff. As NA-B and NA-C assisted R23 to donne his shirt, R23's left arm/shoulder moved approximately 3-5 inches and was unable to fully extend. R23's elbows, hands, and feet were observed to be free from contractures.

- At 7:14 a.m. NA-C stated to her knowledge, R23 had never received ROM services and confirmed R23 had left sided limitation in ROM, however, had no change in ROM abilities.

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F 688	Continued From page 81 On 3/22/18, at 2:45 p.m. RN-E confirmed R23 had limitations in ROM and did not have a current restorative program. RN-E stated that facility had recently started with a new therapy provider and verified R23 had not been evaluated for services needed due to his left sided limitations. The Range of Motion Exercises policy dated 12/23/17, directed the staff to exercise the residents' joints and muscles. The policy also directed the staff to verify a physician order for ROM had been received and if there was no order, the staff were to contact the attending physician to obtain an order, as needed. In addition the staff were directed to record the following in the resident clinical record: - The date and time of the exercises. - The name of the person providing the exercise. - The type of ROM exercises. - Whether the exercise was active of passive. - How long the exercise was conducted. - If and how the resident participated in the procedures or any changes in the resident's ability to participate. - Any problems or complaint made by the residents related to the procedure. - If the resident refused the treatment and reason why along with interventions taken.	F 688		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. 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	F 689		5/6/18

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F 689	Continued From page 82 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: 1. Based on observation, interview and document review, the facility failed to identify, comprehensively assess, implement interventions and provide supervision for 1 of 1 resident (R226) with repeated exit seeking behavior and had eloped from the facility twice without the completion of an assessment or the implementation of interventions to ensure his safety. The facility's systematic failure resulted in the potential for serious harm, injury, impairment or death to residents with exit seeking behavior and risk for elopement. This failure resulted in an immediate jeopardy (IJ) for R226. The IJ for R226 began on 12/3/17, at 5:40 a.m. and was identified on 3/21/18, following an elopement from the facility where law enforcement returned R226 to the facility. R226 was admitted to the facility and began displaying exit seeking behaviors and eloped from the facility on two occasions without staff identifying, assessing and implementing immediate interventions. On 3/21/18, at 10:01 a.m. the administrator, director of nursing (DON), registered nurse (RN)-E, and the regional director of clinical services (RDCS) were informed of the IJ. The IJ was removed on 3/27/18, at 12:00 p.m. however, noncompliance remained at a scope and severity of D - isolated no actual harm with potential for more than minimal harm. 2. Based on observation, interview and document review, the facility failed to comprehensively assess and implement interventions in order to minimize the risk for serious injury, impairment or	F 689	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to assure residents are free of accident hazards. R226 was noted to have had multiple instances or exit-seeking and was successful eloping one night – staff did not promote safety by putting interventions in place to keep from elopement. This resulted in IJ which was reduced to SS=D and facility has now revised and educated on elopement policy and procedures and taking all resident statements seriously if they are exit seeking. Educated on care plans, assessments and safety devices. R226 had already been discharged and follow up was to teach staff about elopement policy. R14 had cervical fracture r/t fall and no comprehensive assessments were completed no interventions for safety were addressed and this resulted in an IJ which was reduced to SS=D on 3/27/2018. R14 had fall assessment completed, bed raised to level of safe transfers for resident to stand safely, mats removed, and resident walks twice a day for strengthening. Elopement assessment	

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F 689	Continued From page 83 death for 1 of 2 residents (R14) reviewed at risk for falls. R14 was admitted with a cervical (high neck) fracture and continued to fall at the facility without the completion of a comprehensive assessment and implementation of interventions. This failure resulted in an IJ for R14. The IJ began for R14 on 3/6/18, at 11:00 a.m. and identified on 3/22/18, when R14 sustained a fall. R14 was required to utilize a cervical collar which wrapped around R14's neck and was connected to a thoracic lumbar sacral orthosis (TLSO) stabilizing brace which wrapped around the back and abdomen due to a cervical fracturein 1/18. The facility failed to implement interventions to minimize/prevent further falls. On 3/22/18, at 1:10 p.m. the DON, administrator, RN-E, and the RDCS were informed of the IJ. The IJ was removed on 3/27/18, at 12:00 p.m. however, noncompliance remained at a scope and severity of D - isolated no actual harm with potential for more than minimal harm. 3. Based on observation, interview and document review, the facility failed to identify and comprehensively assess the use of a full body mechanical lift in order to minimize the risk for serious injury, impairment or death for 1of 1 resident (R2) who obtained repeated skin injuries when transferred with the lift and failed to implement interventions to prevent further injury. This resulted in an IJ for R2. R2's IJ began on 9/15/17, and identified on 3/22/18, when R2 sustained a skin tear while being transferred in a full body mechanical lift. The facility failed to comprehensively assess the risk for injury despite additional injuries sustained while being transferred in the lift, and implement	F 689	as well. R2 sustained s/t during transfer assumed to be caused by however, no report or investigation completed, no comprehensive assessments completed was completed and lift was not reviewed no safe lift technique which resulted in IJ and reduced on 3/27 to SS=D. R2 now uses a teddy bear to hold during transfers and helps hold arms in position from self-bruising during transfers, lift assessment in place, skin monitored weekly and skin assessment completed. R8 was noted to have syncopal type episodes and one was noted during use of sit to stand which potentially could have led to injury this was found to be an IJ which was reduced on 3/27 to SS=D. R8 was noted to not have been assessed for Hoyer sling size or safety, BP monitoring being monitored by physician and hypertensive medications have been reduced. PT also worked with R8 and did give her some exercises to do which she allows occasionally but since medication reduction has been stronger, lift assessment completed, fall assessment and medication review completed. R13 had no smoking assessment or comprehensive assessment to show safe smoking capabilities. R13 had smoking assessment and deemed safe to smoke independently. In this case, after the surveyors tagged the building and noted these deficiencies, immediate updates were made on abuse preventions, investigations, incident and accident, elopement procedures and safe cares with comprehensive assessments completed for all residents that residents	

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F 689	Continued From page 84 interventions in order to minimize the risk for further injures. The administrator and DON were notified of the IJ on 3/22/18, at 12:00 p.m.. The IJ was removed on 3/27/18, at 12:00 p.m. however, noncompliance remained at a scope and severity of D - isolated no actual harm with potential for more than minimal harm. 4. Based on observation, interview, and document review, the facility failed to complete a comprehensive standing mechanical lift assessment in order to determine it was safe and to minimize the risk for serious injury, impairment or death for 1 of 1 resident (R8) who had experienced syncopal episodes while utilizing a standing lift without the completion of an assessment and educate and assess staff competency on its use. This resulted in an IJ for R8. The IJ began for R8 on 3/9/18, when documentation revealed R8 had a syncopal episode while utilizing the standing mechanical lift. Subsequent interviews revealed R8 had previous syncopal episodes prior to 3/9/18, while utilizing the lift without the completion of a comprehensive assessment in order to determine syncopal episode etiology, to continue the safe use of the lift and educate staff on its use. On 3/22/18, at 12:08 p.m. the administrator, DON, and RDCS were notified of the IJ. The IJ was removed on 3/27/18, at 12:00 p.m. however, noncompliance remained at a scope and severity of D - isolated no actual harm with potential for more than minimal harm. Findings include:	F 689	in the facility. The policy on smoking assessments, mechanical lifts, falls, incidents and accidents were reviewed and updated. R8 care plan was updated with Hoyer assessment and sling information, R13 had smoking assessment completed, R14 has been assessed for falls, R2 has had Hoyer assessed and care planed. Staff have been educated on all situations and are aware of necessity follow up. 2. Because all residents live in this care community where accidents are possible and not always avoidable all are potentially affected by the cited deficiency. All residents that smoke will be assessed on admission, quarterly and annually or with significant change for smoking safety. All residents that require mechanical lifts have been assessed and appropriate slings chosen based on manufacturers recommendations. Care plans and care sheets are updated. All residents that have a fall, bruise or skin tear will have incident report and full investigation completed and reported to DON and state agency as necessary by regulations. A resident safety manual was developed; each staff will receive a copy for review. All residents that make statements of wanting to leave or are exit seeking have interventions in place and care planned accordingly. No other residents were affected. Currently all residents are current with assessments and follow up. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all staff will receive in-service training regarding state and	

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F 689	Continued From page 85 Elopement: R226's Admission Record form dated 3/21/18, indicated R226's diagnoses included gastrointestinal hemorrhage, wedge compression fracture of the lumbar vertebrae, muscle weakness, and chronic embolism and thrombosis of the deep veins in the left leg. R226's Clinic Health Status form dated 11/13/17, Section K, Risk For Elopement question #6 was check marked "yes" which indicated R226 had experienced a recent move in a room or facility. The directive for this section indicated for any questions marked "yes" the rater should consider a prevention plan of care for elopement. Section M indicated R226 had intermittent confusion. R226's clinical lacked a comprehensive elopement assessment. R226's admission Minimum Data Set (MDS) dated 11/20/17, indicated R226 had moderate cognitive impairment, had no behaviors including wandering, and required extensive assistance of one staff for bed mobility, transfers, dressing, locomotion off the unit, toileting, and personal hygiene. The MDS also indicated R226 required limited assistance of one staff for walking in room and corridor, and locomotion on the unit. In addition, the MDS indicated R226 and the staff believed he was capable of increased independence with some of the aforementioned activities of daily living (ADLs). R226's 14 day MDS dated 11/27/17, indicated R226 had moderate cognitive impairment, had no behaviors which included wandering, and required limited staff assistance for all ADLs.	F 689	federal requirements for incidents, accidents, elopement risks, mechanical lifts, smoking assessment needs and the need for an environment free of hazards. The training emphasizes the importance documentation, notification, assessing and care planning. 4. Effective 4/24/2018, a quality-assurance program was implemented under the supervision of the ED and DON to monitor residents with falls, bruises, Hoyer's, smoking, and any incident r/t the environment. The DON or designated quality-assurance representative will perform the following systematic changes: randomly checking residents who are approved to self-administer. The DON or designee will complete 2 audits per week x 4 weeks, then 1 audit weekly x2 months on all residents that smoke to ensure assessment complete and on Hoyer lifts to ensure assessed and care planned correctly. Safety checks on fall and elopement risks 4 residents per week x 4 weeks, then 2 residents weekly for 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting. 5. The ED and DON will be responsible for this POC.	

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R226's baseline care plan dated 11/13/17, indicated R226 had intermittent confusion, was able to communicate verbally, and had a history of falls. The behavior concerns section indicated R226 was unhappy at the facility but would be discharging in the future. The behavioral interventions section was blank. The alarms and restraints section indicated a wanderguard was initiated 12/3/17.

R226's care plan dated 12/8/17, indicated an ADL self care performance deficit related to activity intolerance, lumbar/thoracic compression fractures, and fatigue related to a recent gastrointestinal bleed, and deconditioning. The plan directed staff to assist R226 with ADL needs. Physical and occupational therapy was treating R226 with a goal to improve current level of function in ADLs including ambulation. The care plan also indicated R226 was at high risk for falls related to deconditioning, gait/balance problems and history of falls prior to admission. Acute pain related to the lumbar/thoracic fractures and directed staff to administer pain medication and to monitor the impact of the medication on R226's cognition. The care plan failed to identify R226's frequent elopement attempts and risk for elopement.

Review of R226's progress notes (PN) revealed the following:

-PN dated 11/13/17, at 12:30 p.m. indicated R226 was admitted to the facility and was alert and oriented with some confusion noted. An additional note at 10:10 p.m. indicated R226 was hollering out asking where he was and had been walking down the hallway, with a walker, several times during the evening.

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F 689	Continued From page 87 -PN dated 11/15/17, indicated R226 was alert and oriented to person, but was having periods of confusion, especially during the night shift. R226 required assistance of one staff for transfers and ambulation with a walker but had been doing this independently. -PN dated 11/17/18, indicated R226 had intermittent confusion in the evening not knowing where he was at. Needed occasional assistance from staff for transfers and had been up wheeling self independently in the wheelchair. -PN dated 11/18/17, indicated R226 was alert and oriented to self with some confusion which increased as the day progressed, -PN dated 11/19/17, at 4:24 a.m. R226 had started hollering out and was trying to leave the facility. -PN dated 11/21/17, indicated R226 had night time confusion and was independent with transfers, utilized a walker and propelled self long distances when using the wheelchair. -PN dated 11/26/18, indicated R226 continued to be more confused in the evening. Would come out of his room yelling and looking for people. R226 did not know where he was at. -PN dated 11/28/17, indicated R226 continued to have confusion early evening, would call out for family and did not know where he was at. Redirected easily. -PN dated 12/3/17, at 6:40 a.m. indicated between 5:00 a.m. - 5:10 a.m. R226 was talking about going home. Staff informed R226 he could go home when walking better. R226 also asked if there was a bus to take people home in which staff replied no, and R226 began wheeling himself to the dining room. At this time, the staff member left the area to assist another resident. At approximately 5:40 a.m. the staff member went to look for R226 and was unable to locate	F 689		

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him. A facility and ground search was conducted and staff were unable to locate R226. 911 was called to report the missing resident at which time the police department informed the facility they had an elderly gentleman at their department. R226 was returned to the facility at 6:30 a.m.. A temporary wanderguard was applied to R226 and every 15 minutes checks were initiated. R226 was scheduled to transfer to an assisted living the following Friday (12/8/17). A corresponding facility Minnesota Incident Report form dated 12/3/17, at 7:30 a.m. with a revision date of 12/5/17, was a copy of the above progress note and also indicated the registered nurse (RN) would update R226's care plan. However, R226's care plan was not updated to include the elopement risk or additional interventions to be implemented to prevent further elopements.
-PN dated 12/3/17, at 6:03 p.m. indicated R226 was very confused during the shift with noted hallucinations and paranoia. Family had been in to visit on and off all shift. Wanderguard was applied 9:30 a.m. to alert staff of attempts to elope.
-PN dated 12/3/17, at 10:00 p.m. indicated R226 was having increased bouts of confusion. Did not use call light anymore to summon staff assistance. Became more confused during the evening and roamed around the facility. Had a wanderguard placed tonight due to his elopement from the facility during earlier hours. R226 walked on his own and also used a wheelchair.
-PN dated 12/7/17, indicated some confusion during the evening, and would use call light to make needs known. Was wanting to go home. Daughter was called and was able to calm R226. Independent with walking and able to propel self long distances with the wheelchair.
-PN 12/8/18, indicated R226 was discharged from

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the facility to an assisted living.

On 3/20/18 at 1:41 p.m. when requested to review the facility abuse prevention policy and procedures related to elopement, the administrator and DON stated they were unable to locate it within the facility.
- At 1:49 p.m. the RDCS stated anytime a resident left the facility without a physician's order to leave, or unwitnessed, it would be assumed that is was an elopement. Therefore, the facility would notify family to see if the resident was with them, they would call the local policy/fire department to see if they had found anyone, and would also search the premises.

-At 4:25 p.m. the administrator, DON and the RDCS confirmed, based on the facility report, R226 had eloped from the facility, however, were unaware of any previous elopement attempts as R226's clinical record failed to identify any previous elopements or attempts to elope and due to their recent employment at the facility, they had no knowledge of these events. When asked about the facility's abuse prevention program related to elopement/abuse prevention, the RDCS stated the whole system needed to be "revamped." The administrator stated when her and the DON started at the facility, they became aware of the failure in the system and had begun educating the staff on the abuse prevention program policies and procedures which included elopement.

-At 5:58 p.m. licensed practical nurse (LPN)-A stated if a newly admitted resident attempted to elope from the facility, a wanderguard would be applied to the resident, an elopement assessment would be completed and a care plan

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would be developed.

-At 6:00 p.m. nursing assistant (NA)-A stated on more than one occasion prior to 12/3/17, R226 attempted to leave the facility, however, staff had "always caught him" by the door and redirected him. NA-A also stated his attempts to leave the facility had not only occurred on the night shift, rather on all shifts. When asked about the 12/3/17, elopement, NA-A stated she thought R226 had a wanderguard in place, however, it had not alarmed to alert staff of him leaving the facility.

-At 6:30 p.m. cook (C)-A stated R226 was not happy about being at the facility and had eloped from the facility a couple of times. C-A stated the incident with the police department was not the only time R226 had gotten away or attempted to leave the facility. C-A recalled another incident which occurred "way" before the police department incident, where he was going to go pick up R226 after he had left the facility and was down town at a gas station which was across the street from the police department. C-A stated "somebody" had called the facility and informed the staff that one of their residents was there, however, "somebody" had given R226 a ride back to the facility before he could go get him. C-A stated R226 used a wheelchair and would have had to get downtown by wheeling himself down the middle of the street as that was the only area of the road that had been plowed following the snow fall. C-A remembered R226 being appropriately dressed for the cold winter temperature.

On 3/21/18 at 8:31 a.m. NA-B confirmed R226 had not wanted to be there and stated he had

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always attempted to get out and leave the facility through any door that was in his site at the time. NA-B stated the wanderguard was not placed on R226 until after the incident where he had went to the police station even though he had attempted to leave the facility prior to that. However, NA-B stated she was not aware of any other incident where R226 actually eloped from the facility. NA-B stated if a resident attempted to leave the facility, the NAs could "highly" suggest to the nurse the need for a wanderguard, but they could not apply one without their direction.

-At 8:38 a.m. LPN-B stated she remembered a resident who had eloped from the facility and had made it to the police station and also the first incident where "somebody" had brought R226 back to the facility. She also stated R226 had dementia therefore could not leave unsupervised. LPN-B stated she did not complete any resident admission paperwork and did not do any resident care planning, however, if a resident needed a wanderguard due to exit seeking behaviors, she would go up the chain of command and get it taken care of to ensure a wanderguard was applied.

-At 10:01 a.m. the administrator, DON, RN-E and the RDCS were informed of R226's first elopement as described by C-A in which R226 had eloped from the building and was returned to the facility by an unidentified person. The administrator, DON, RN-E and the RDCS confirmed they were all unaware of this incident.

On 3/26/18, at 2:48 p.m. NA-B stated if resident voiced a desire and had also attempted to leave the facility unsupervised, the staff were to inform the charge nurse as well as all other staff,

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implement every five minute visual checks, and the nurse would apply a wanderguard to alert staff if the resident was attempting to leave the facility.

The IJ which began on 12/3/17, was removed on 3/27/18, at 12:00 p.m. when the facility completed the following:
- conducted an elopement risk assessment on all residents.
- developed and implemented improved policy and procedures related to resident elopement and safety which included the timely completion of comprehensive assessments, implementation of interventions and supervision, documentation requirements.
- staff education regarding the updated/revised policy and procedures.
- A quality assurance program was also implemented in order to monitor all incidents and accidents to ensure no safety hazards or safety risks are present.

Falls:

R14's Physician Nursing Home Admission Assessment dated 1/23/18, indicated R14 was admitted to the facility on 1/19/18, and had diagnoses which included a closed, nondisplaced fracture of the seventh cervical vertebra with routine healing, high blood pressure, type II diabetes, and late onset moderately advanced Alzheimer's disease with behavioral disturbance.

R14's admission MDS dated 1/26/18, indicated R14 had moderate cognitive impairment, had sustained a fracture as a result of a fall prior to admission, required limited assistance for bed mobility, transfers and ambulation of one person

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and required extensive assistance of one person for activities of daily living, was frequently incontinent of bowel and bladder, and had not displayed any inappropriate behavior symptoms. R14's Falls Care Area Assessment (CAA) had triggered for further assessment, however, it was not completed, as required. Therefore, a comprehensive fall risk assessment had not been completed.

On 3/20/18, at 12:48 p.m. R14 was observed resting in bed. R14 had a cervical collar around his neck connected to a thoracic lumbar sacral orthosis (TLSO) stabilizing brace which wrapped around the back and abdomen. R14's bed was low to the floor (approximately 12 inches off of the floor) and a one inch thick fall mat was on each side of the bed. R14 did not have a call light within reach in order to summon assistance, if needed. R14 was asked about the events which led to his admittance to the nursing home however, R14 was unable to articulate the sequence of events which led to his admission, and could not verbalize how long he had been in the nursing home or where he was living prior. R14 appeared to have difficulty hearing the surveyor and was not wearing hearing aids. R14's speech was difficult to hear and understand. R14 was continuously observed until 1:49 p.m. whereas he had slept off and on, in bed.

On 3/20/18, from 5:54 p.m. to 6:48 p.m. R14 was continuously observed to be remain in his room, seated in a wheelchair. R14 did not have a call light within reach. At no time throughout the observation, did the facility staff stop in R14's room to observe R14 for safety. During the observation, R14 had removed his tennis shoes, however, did not attempt to transfer

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independently. Throughout the observation, R14 slept off and on while seated in the wheelchair.

-At 7:18 p.m. R14 was provided evening cares and was assisted to bed. R14 continued to wear the TLSO, the bed was in a low position (approximately 12 inches from the floor) and a one inch thickness fall mat was placed next to the bed. R14 was not provided a call light in order to summon assistance, if needed, when cares were completed.

On 3/21/18, at 9:00 a.m. R14 was wheeled out of the dining room and assisted to his bedroom and positioned in front of the television where he actively watched a program. R14's hearing aids were on top of R14's bedside stand, and R14 was not provided a call light in order to summon assistance. R14 was wearing the TLSO, and tennis shoes.

On 3/22/18, at 8:02 a.m. NA-C assisted R14 to dress, however, did not insert his hearing aids. Following cares, NA-C wheeled R14 to the dining room.

-At 8:25 a.m. R14 propelled himself back to his room and sat in his wheelchair. R14 was observed to sleep off and on while in the chair.

Review of R14's medical record revealed the following information:

- admission note dated 1/19/18, indicated R14 was admitted to the facility for strengthening following a fall with C7 vertebrae injury. R14 wore a TLSO brace and had a history of falls and confusion. R14 required assistance of one person for transfers, had episodes of urinary

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F 689	Continued From page 95 incontinence. - PN dated 1/20/18, indicated the following information: R14 was alert and orientated to self and family only, had marked confusion, was very hard of hearing, and had difficulty expressing needs. R14 was not able to utilize call light, had urinary incontinence, wore incontinence briefs, and was assisted to the toilet every two hours. R14 required assistance of one for transfers, was not ambulating, and used the wheelchair for long distance travels. R14 required assistance of one for all activities of daily living and was able to feed himself independently after tray set-up. R14 had a history of wandering and a history of falls with injury. R14 had numerous bruises, abrasions, and skin tears from previous falls. R14's bed was placed in low position and fall mats were placed on both sides of bed. R14 denied pain or discomfort, and physical therapy and occupational therapy (PT&OT) services were started per MD order. - PN/Skin Assessment dated 1/20/18, described his injures as such: numerous bruises - right forearm, top of right hand, right elbow, right antecubital, large bruise to left outer thigh, top of left hand, right inner buttocks, bruising to both lateral and medial ankle, and yellowing bruising entire left side of face. R14 had scabbed areas to top of head, over 5th and 4th knuckles of left hand, and left lateral forearm. Lacerations were noted above left eye with steri strips intact, left ear, and skin tear to left elbow. R14's clinical record lacked a fall risk assessment. Review of R14's care plan for falls dated 1/24/18, directed the staff: - Be sure R14's call light is within reach and	F 689		

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encourage the resident to use it.
for assistance as needed.
- Needs prompt response to all requests for assistance.
- Educate the resident/family/caregivers about safety reminders and what to do if a fall occurs.
-Encourage [R14] to participate in activities that promote exercise, physical activity for strengthening and improved mobility.
- Ensure that [R14] is wearing appropriate footwear when ambulating or mobilizing in w/c.
-Follow facility fall protocol.
- Pt [physical therapy] evaluate and treat as ordered or PRN [as needed].

R14's fall incidents were reviewed from 1/19/18 - 3/22/18, during which it was noted R14 had two falls one on 3/6/18, and one on 3/11/18.

1. R14's PN dated 3/6/18, indicated "[R14] fell today while sitting in wheelchair. It appears he was reaching for something on his nightstand. He sustained skin tears to L [left] 2nd knuckle measuring 1 cm [centimeter]L [long] x 5 cm., R [right] 2nd knuckle 3 cm L, 3rd knuckle 1 cm L, R elbow 1 cm L , sl. below R elbow 2.5 cm L. Each of these were cleansed with wound solution, Bacitracin applied and covered. There was a red mark to his head that disappeared shortly after fall. VSS. neuros [neurologicals] are intact. D.O.N. [director of nursing] notified as well as family, Dr [doctor] and [administrator]... Patient denies pain at this time but will continue to monitor."

R14's Incident Report dated 3/6/18, indicated R14 had a fall at 11:00 a.m. when R14 appeared to have been leaning forward reaching for

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something from his nightstand. R14 fell forward out of the wheelchair hitting head. A comprehensive assessment of causal factors had not been completed. The incident report had not identified R14's behavior prior to the fall, glucose level, underlying illnesses, or what R14 was reaching for to assess for an environmental concern. The report indicated R14 had last been to the bathroom at 10:20 a.m.. The intervention indicated to minimize further falls included: R14 should not be left in room alone unless laying down, however, this intervention had not been added to R14's care plan, and as noted in the above observations, facility staff continued to leave R14 alone in his room when seated in his wheelchair.

2. R14's PN dated 3/11/18, at 8:45 a.m. indicated, "staff walking past room noted resident to be on his knees over the footrests of the legs of w/c [wheelchair] facing toward the bedside stand. Was unwitnessed. Noted that he had reopened an previous skin tear on the back of the left hand, middle knuckle area. Area was cleansed, non adherent dressing applied and wrapped with kerlix. DON notified via text. [Niece] was notified at 9:30 a.m." R14's clinical record lacked an incident report, no post fall assessment had been completed and there were no interventions implemented to minimize future fall incidents.

On 3/22/18, at 8:25 a.m. RN-D stated R14 was not to be left in his room unattended unless he was resting in bed otherwise he was to remain in common areas. RN-D stated she kept the medication cart close to R14's room to ensure she was able to check on R14 frequently. RN-D stated the facility falls policy directed for the completion of a Falls Form to report the fall,

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however, RN-D was not able to articulate any further interventions. RN-D looked for a facility policy for falls, however, she was unable to locate a policy.

On 3/22/18, at 8:25 a.m. NA-B and NA-C stated they were unaware of any type of fall interventions for R14. The NAs confirmed R14 was allowed to be in his room unattended and were unaware of any type of special monitoring schedule for R14.

On 3/22/18, at 8:29 a.m. the RDCS was interviewed regarding the facility's fall program, and policies/ procedures and stated upon her arrival at the facility on 3/20/18, she could not find a facility falls policy and procedure, therefore obtained a corporate policy and procedure for facility staff to use starting on 3/21/18. The RDCS confirmed the facility falls program was ineffective on keeping R14 safe from ongoing falls. The RDCS stated when R14 fell on 3/6/18, the fall had not been comprehensively assessed for causal factors, however, an intervention had been developed which included R14 should not have been left in his room alone. However, the RDCS confirmed the facility staff had not implemented the intervention, and it had not been added to R14's care plan. The RDCS also confirmed R14 had not been comprehensively assessed for fall risks after the fall that occurred on 3/11/18, in order to identify causal factors and implemented appropriate interventions.

On 3/22/18, at 1:10 p.m. the administrator and RDCS was notified that R14 was identified in immediate jeopardy to his health and safety due to the facility failure to comprehensively assess, monitor, and implement fall interventions to keep

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R14 safe from fall incidents. However, during the time the administrator and RDCS were developing a removal plan which addressed R14's safety related to falls R14 fell yet again on 3/22/18, at 1:10 p.m. while R14 was in his room unattended. R14 had not suffered a major injury as a result of the fall. On 3/22/18, at 2:01 p.m. the RDCS stated that R14 would be provided one to one staff supervision until appropriate interventions and plans for safety could be developed and implemented.

The immediate jeopardy that began on 3/6/18, was removed on 3/27/18, at 12:00 p.m. after the facility implemented a removal plan which included the following:

- Completed a comprehensive fall assessment for R14.
- Updated R14's care plan to direct the staff as to how to arrange the height of R14's bed.
- R14's bed was placed in a standard level bed height to allow R14 to enter/exit the bed safely.
- R14 received a physical therapy assessment.
- Developed an implemented a policy and procedure regarding falls and immediate interventions following a fall.
- Staff members were educated on the changes to R14's plan of care and revisions to the fall prevention policy.

Mechanical Lifts:

R2's annual MDS dated 11/2/17, indicated R2 had severe cognitive impairment and diagnoses which included Parkinson's disease, dementia and anxiety. The assessment indicated R2 required extensive staff assistance for all

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activities of daily living and required total assistance of two staff for all transfers.

R2's Lift Mobility Status form dated 12/31/17, indicated R2 did not have the ability to bear weight on his/her legs. R2 had the ability to tolerate a semi-reclined position and indicated R2 was to be transferred with a MaxiMove (brand name of a full body mechanical lift). The rest of the form was incomplete, as it was blank. R2 had not been assessed to identify the appropriate size sling or the number of staff members required to transfer R2 with the mechanical lift.

R2's care plan dated 12/28/17, identified R2 with impaired mobility related to Parkinson's disease progression. The plan directed the staff to transfer R2 with assistance of two staff and a full body mechanical lift. The plan also directed the staff to use caution during transfers and bed mobility in order to prevent R2 from striking their arms, legs and hands against sharp or hard surfaces.

On 3/20/18, at 7:44 p.m. NA-A stated the residents who required a mechanical lift for transfers could be transferred with the assistance of one or two staff depending upon how comfortable the staff member was in operating the lift.

On 3/21/18, at 12:00 p.m. R2 was observed resting in bed. NA-C positioned a full body lift sling under R2 and connected R2 to the full body lift. RN-C was present in the room, however, RN-C did not assist NA-C as R2 was lifted off of the bed via the full body lift. Once in the air, NA-C utilized the lift control pad and positioned R2 from a reclined to a seated position in the

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sling. When the lift sling was in a seated position, R2's feet repeatedly bumped the hydraulic support beam. NA-C did not ask RN-C for assistance in order to protect R2's legs from hitting the support beam as she proceeded to continue with the transfer. When NA-C had R2 positioned over her wheelchair, RN-C acknowledged R2's feet were repeatedly bumping the hydraulic beam and assisted by holding R2's feet away from the bar as NA-C lowered R2 into the wheelchair.

On 3/22/18, at 10:00 a.m. R2 was observed in her room, seated in a wheelchair. NA-B entered the room and proceeded to independently transfer R2 from the chair to the bed via a full body mechanical lift. During the transfer, R2's feet were observed to rub against the hydraulic lift. NA-B did not request assistance from another staff to assist with the transfer and proceeded to place R2 into bed.

Review of R2's incident reports revealed the following information:

- An incident report dated 9/15/17, read: "During transfer lift with hoyer [full body mechanical lift], Resident left forearm was pinched in lift as resident not grabbing handles. Superficial skin tear was received." The location of the injury was identified as left antecubital (inner elbow) and the area was cleaned and an "island dressing" was applied. The documentation did not indicate the size of the skin tear. The incident report lacked documentation related to follow up care or a root cause analysis of the injuries sustained from the lift. The report did not identify how many staff members were present at the time of the

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transfer which resulted in injury.

- An incident report dated 10/29/17, read: "Resident has very small skin tear to top of right hand from resident grabbing the lift used to transfer resident while in motion. Staff reminds resident not to grab lift but continues to do so during transfers. Just a little pink." The report indicated R2 sustained a skin tear of the back of the right hand. The area was cleansed, Bacitracin was applied and the area was covered with the dressing. The documentation did not indicate the size of the skin tear. Additional information on the report indicated R2 required the use of the mechanical lift to transfer from bed to chair and vice versa. When the lift was in motion, R2 would bang on the moving parts of the lift which resulted in skin tears. Staff members reassured R2 and reminded her not to grab the lift in those areas, but R2 continued to grab the lift. The lift was unable to be stopped to prevent "these parts" from moving during transfers. The documentation did not address the number of staff members present at the time of the injury and interventions implemented in order to prevent/ minimize further injuries was not completed.

- An incident report dated 11/15/17, read: "Nurse aide noted a 0.6 cm [centimeter] skin tear in the left hand webbing surrounded by a 2.0 cm x 2.0 cm bruise after using the mechanical lift. No bleeding noted. Resident has a tendency to grab the lift while mid transfer on the moving parts. It pinched." The wound was cleansed, Bacitracin and a dressing was applied. The location of the injury was noted to be on the back of the left hand. The report identified the cause of the injury, however, interventions implemented in

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order to prevent further injuries was not completed. The number of staff members present at the time of the injury was not identified.

Further review of R2's clinical record lacked documentation related to the aforementioned injuries. Nor was a comprehensive assessment related to transfers via a mechanical lift documented.

On 3/22/18, at 11:50 a.m. the RDCS confirmed the facility did not have any further documentation related to R2's injuries and the number of staff members present at the time of the injuries was unknown. RDCS confirmed no interventions were implemented to minimize R2's risk for additional injuries.

- At 12:08 p.m. the RDCS, administrator and DON were notified of the IJ related to R2's transfers with a fully body mechanical lift.

- At 2:46 p.m. RN-E confirmed R2's care plan directed the staff to transfer with assist of two staff members. RN-E verified the injuries were from the mechanical lift, however, upon further review of R2's clinical record, RN-E confirmed the record lacked any additional documentation related to the injuries.

On 3/24/18, at 8:21 a.m. R2 was observed in her room, seated in a wheelchair. NA-B was observed to connect R2 to a fully body mechanical lift and independently transferred R2 from the wheelchair to bed. During the transfer, R2 folded her hands as she was lifted into the air and her feet/shoes rubbed up against the hydraulic support beam during the transfer. No additional staff members were present at the time

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F 689	Continued From page 104 of the transfer. On 3/27/18, at 11:10 a.m. NA-B and NA-F were observed to transfer R2 with a mechanical lift from the bed to the wheelchair. NA-B placed a blanket under R2's right elbow and a small pillow under R2's left arm. NA-F guided R2's feet during the transfer to ensure R2 did not bump into the mechanical lift. The immediate jeopardy that began on 9/15/17, was removed on 3/27/18, at 12:00 p.m. after the facility implemented a removal plan which included the following: - Completed a comprehensive transfer/lift assessment for R2. - Updated R2's care plan to direct the care staff as to how to safely transfer R2 with a the full body mechanical lift. - Developed and implemented a policy and procedure regarding the safe handling of residents while utilizing a full body lift. - Staff were educated on the changes to the standing lift policy as well as changes to R2's care plan. R8's Admission Record dated 3/22/18, indicated R8 had diagnoses which included adult failure to thrive, diabetes, essential hypertension, muscle weakness, and non-compliance with medical treatment or regimen. R8's quarterly MDS dated 1/22/18, indicated R8 had intact cognition, required extensive assistance from one staff member for transfers, dressing, personal hygiene, and had impaired balance.	F 689		

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F 689	Continued From page 105 R8's care plan viewed and copied from R8's record on 3/21/18, indicated R8 required stand by assistance with four wheeled walker and stand by assist for toilet use. Care plan further indicated R8 had impaired cognitive function and was non-compliant with medical regimen. A care plan update dated 3/22/18, indicated R8 required the use of a sit to stand lift for toileting and transfers. R8's PN dated 1/26/18, indicated R8's leg buckled during a transfer and a referral was made to physical therapy to evaluate safe transfers using a mechanical lift as needed during periods of weakness. R8's Physical Therapy Evaluation and Plan of Treatment dated 2/9/18, indicated R8 was referred for evaluations of safe transfers. The evaluation included history and risk factors which included: failure to thrive, hypokalemia, falls, arthritis, seizures, diabetes, hypertension and muscle weakness. The evaluation indicated R8 had lower extremity weakness, and was not able to bear weight. The physical therapist (PT)recommended that R8 should perform all transfers with the use of the mechanical sit to stand lift. R8's clinical record lacked a mechanical lift evaluation which would identify an appropriate sling size and how many staff were needed to transfer R8 safely when using the sit to stand mechanical lift. The care plan also lacked revision to include the PT recommendation. The only Lift Mobility Status tool on record was dated 11/18/17, which indicated R8 did not require a mechanical lift. The tool read: "This is only a guide and cannot address all circumstances and medical	F 689		

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conditions. Only a team approach with nursing and therapy or qualified medical personnel involvement will create the safest situation of the patient and staff, while meeting the goal of increasing mobility and improving patient health."

R8's PN dated 3/9/18, indicated a NA reported R8 had "passed out" while in the stand-up lift after lunch. R8 complained of nausea at the time, had large amount of incontinent stool and the doctor would up updated. R8's record lacked evidence vital signs (heart rate, blood pressure, oxygen saturations) were obtained after the syncopal episode.

Historical blood pressures viewed and copied from R8's record on 3/21/18, revealed:

2/21/18-123/64
2/27/18-105/58
3/1/18-96/55
3/8/18- 89/55
3/12/18-86/48

R8's clinical record lacked documentation of notification of the physician regarding the low blood pressure readings until 3/12/18, and it was not evident any measures or ongoing assessments or monitoring were implemented to ensure safe transfers using the mechanical lift despite the hypotensive BP readings and "passing out" during transfers placing the resident at high risk for injury.

R8's Physical Therapy Evaluation and Plan of Treatment dated 3/12/18, indicated R8 was referred related to nursing reports of R8 "passing out" in the sit to stand lift. The evaluation indicated staff and R8 were interviewed and R8

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had reported, "passing out" two to three times per week for 15-20 seconds when in the sit to stand lift. The evaluation indicated nursing discussed having medications reviewed. The physical therapist recommended the use of the full body mechanical lift for all transfers to prevent injuries to R8 and staff. R8's clinical record lacked documentation of the syncopal events which occurred during mechanical lift transfers. However, this PT recommendation was never implemented.

Fax communication to the physician dated 3/12/18, at 11:30 a.m. indicated R8's blood pressure was 86/48. The note indicated over the last three weeks R8 had periods of passing out at least three times per week. The writer explained she had not been aware of the episodes until that morning and indicated an awareness of orthostatic hypotension at night. The writer further indicated R8 had lost 30 pounds in the past six months and perhaps not tolerating the doses of blood pressure medications. The physician responded, and gave orders to decrease both blood pressure medications and check blood pressure daily for seven days and to update her with blood pressure readings and symptoms.

R8's record lacked a completed comprehensive full body lift assessment after the PT recommendation, and the record further lacked documentation of monitoring for signs and symptoms related to the syncopal episodes and/or evaluation of the effectiveness of the lowered doses of blood pressure medications.

Blood pressures obtained after the decrease in blood pressure medications indicated the following results:

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F 689	Continued From page 108 3/13/18- 84/51 3/14/18-103/41 3/15/18-82/42 3/16/18-128/56 3/17/18-94/55 3/18/18-102/60 3/19/18-120/64 Late Entry PN created during the time of survey dated 3/14/18, indicated nursing discussed the PT recommendations for the use of full body mechanical lift for transfers. Per resident request, sit to stand lift would be utilized for transfers as resident wanted toileting independence and agreed that a full body mechanical lift would cause decrease in her dignity and ability to toilet therefore the physical therapy recommendations were discontinued. However, R8's clinical record lacked evidence of R8 being provided with the potential risks which included serious injury, impairment or death as well as the benefits if the mechanical lift was not used as recommended for safety by the PT. On 3/21/18, at 12:42 p.m. R8's call light was on and stated she had to use the restroom. RN-C obtained the sit to stand mechanical lift and explained it was her second day on the job at the facility and had not used a mechanical lift before. R8 directed RN-C how to put the lift harness around her and how to connect it to the mechanical lift. Once the harness was around R8, and connected to the lift, R8 instructed RN-C to tighten the harness, and to use the calf strap. R8 informed RN-C of her history of passing out during lift transfers. RN-C informed R8 that she would go slow and wait for R8's blood pressure to catch up. RN-C proceeded to raise R8 up from	F 689		

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her wheelchair. The harness became very loose around R8's chest, however, RN-C continued with the transfer and positioned R8 on a nearby commode.

-At 12:55 p.m. RN-C stated she had not received any training on the use of the mechanical lift and R8's transfer had been the first one she had ever completed. RN-C stated mechanical lifts could be used with one or two people and was dependent upon the resident. RN-C stated she did not know how tight the harness should be when using a sit to stand lift.
-At 1:30 p.m. physical therapy assistant (PTA)-A stated the therapy company he worked for was new to the building as of 1/26/18. PTA-A stated PT evaluated residents for safe transfers on admission, quarterly, and if nursing noticed a decline. PTA-A explained the evaluation to use mechanical lifts took into consideration the resident's muscle stability, muscle tone, past medical history, and limitations of range of motion. PTA-A explained to his knowledge no mechanical lift assessments had been completed since the company had started with the facility.
-At 1:45 p.m. NA-C stated awareness of two syncopal episodes for R8 which had occurred within the last three weeks. NA-C stated the first one had occurred on the evening shift and the second one happened during the day shift.
-At 1:46 p.m. NA-B indicated an awareness R8 had a syncopal episode while on the mechanical lift, however, was not aware of how many times it had occurred.
-At 2:06 p.m. during an interview with administrator, DON, and the RDCS, the RDCS stated staff would not fill out an incident report for a syncopal episode during a sit to stand mechanical lift transfer unless the resident

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received injuries, rather a recap of the medical documentation would be performed. RDCS stated if there was a second episode then therapy would be involved to evaluate transfers and the resident would be required to have two staff assist with a sit to stand mechanical lift instead of one. RDCS confirmed the care plan directed staff to perform transfers with stand by assist versus a mechanical lift.
-At 2:39 p.m. NA-E stated she had not seen R8 pass out while on the lift rather, R8 had informed her that she had passed out on the lift. NA-E stated she had only worked at the facility for a short time and had not been given any special instruction on what to do to if R8 "passed out."
-At 2:44 p.m. NA-D stated she had not seen R8 pass out. NA-D stated the only reason she was aware that R8 had passed out while on the lift was from other nursing assistants and R8 also told her. NA-D further stated to her knowledge there were no special instructions to ensure safety of R8 during the lift transfers or what to do if R8 "passed out."
-At 2:46 p.m. RN-E stated an unawareness of R8 passing out while on the lift and there were no new interventions.
-At 2:47 p.m. RDCS confirmed there was no other documentation of syncopal episodes other than on 3/9/18, and indicated since there was a lack of documented evidence of more than one episode, no further interventions were necessary because interventions of therapy evaluation, notification to the physician and lowering of the blood pressure medications were effective. RDCS further indicated if there was more than one documented episode, then for sure R8 would have been two staff assist with the mechanical lift. RDCS, acknowledged the reason for episodes were probably because of low blood

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pressures and weakness. RDCS indicated nursing did not agree with the PT recommendations to use the full body lift and thought the sit to stand lift was better for R8 to maintain her dignity and mobility based on a team decision. However, an assessment was not completed.

-At 3:24 p.m. PT-A verified he evaluated R8 for safe transfers on 2/9/18. PT-A indicated he was not able to help R8 stand and perhaps it was related to anxiety or other behavioral issues. PTA stated R8 was able to stand with the mechanical lift, however, PT only evaluated for the type of lift required to complete a safe transfer and not know how much assistance a resident would need once in the lift. PT-A further stated PT did not evaluate for the appropriate sling size or how many staff were needed to complete a transfer safely and expected nursing to determine that based on the resident behaviors, full medical history, participation level of resident, and resident's weight.

On 3/22/18, at 7:40 a.m. RN-D confirmed she had not received training on the mechanical lifts and stated the staff used mechanical lifts with one person unless the resident was combative, then two staff were used.
-At 7:45 a.m. LPN-B verified she had not received training on the mechanical lifts since hire date. LPN-B stated all mechanical lift transfers should be performed with two staff.
-At 9:50 a.m. RN-B stated she was the nurse who assessed R8 after the episode on 3/9/18, and stated she had notified the physician of the event and then got an order for a therapy evaluation because if she let go, or couldn't stand, the sit to stand lift would not be appropriate and would be

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dangerous for her to use. RN-B stated therapy recommended a full body lift for R8, but did not know why R8 continued to use the sit to stand lift.
-At 2:38 p.m. NA-F stated an awareness of the syncopal episodes because R8 had passed out on her four to five weeks ago, near the end of February, and she also witnessed another episode prior to 3/9/18. NA-F further stated, R8 passed out on a night person, and another day shift person. NA-F indicated she thought there was another episode which had happened after the 3/9/18, episode. NA-F stated she reported all the episodes to the nurse, but the NAs did not have access to nursing notes so we did not know if anything was documented or if anything got done about it. NA-F indicated she had brought it to the attention of one of the nurses, who at that time was not aware of the episodes and then the blood pressure medications were adjusted.

On 3/24/18, at 9:15 a.m. NA-G described the "passing out" episode on 3/9/18. She was assisting R8 to transfer and R8 stated she was going to faint and then "passed out." R8 went limp, she grabbed her waist and called for help. When help arrived they placed R8 in a chair. R8 did not come to until once in the chair. NA-G added she did not feel comfortable transferring R8 alone.

The immediate jeopardy that began on 3/9/17, was removed on 3/27/18, at 12:00 p.m. after the facility implemented a removal plan which included:

- Completed a comprehensive transfer/lift assessment for R8.
- Updated R8's care plan to direct the care staff as to how to safely transfer R8 with a the sit to

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stand or body mechanical lift when conditions warranted.
- Discussed risks and benefits with R8 and R8's power of attorney of the continued use of the sit to stand sift.
- Developed and implemented a policy and procedure regarding the safe handling of residents while in a full body lift.
- Staff were educated on the changes to the standing lift policy and changes to R8's care plan.

R18's Admission Record dated 3/22/18, included diagnosis of mild cognitive impairment, history of transient ischemic attacks, stroke, hemiplegia, and hemiparesis, abnormal involuntary movements, and epilepsy without status epilepticus.

R18's quarterly MDS dated 3/2/18, indicated R18 had severe cognitive impairment, required extensive assist from 2+ staff members for bed mobility and toilet use, was totally dependent on 2+ staff members for transfers and hygiene.

R18's current care plan printed on 3/22/18 indicated R18 required extensive assist of one staff for dressing, bathing, grooming and bed mobility, and two staff were required to transfer R18 with a full body mechanical lift due to R18's right sided hemiplegia and trunk weakness. The care plan also identified R18 had a seizure disorder and and history of stroke. The care plan failed to indicated which size mechanical lift sling the staff were to use while transferring R18 with the lift.

On 3/20/18, at 1:11 p.m. R18 was observed in her room, seated in her wheelchair. NA-B entered the

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room and informed R18 she was going to transfer her into bed. NA-B removed the wheelchair footrests, connected the lift sling to the mechanical lift, and proceeded to independently transfer R18 into her bed. No other staff members were present at the time of the transfer.

R18's Lift Mobility Status evaluation tool dated 12/20/17, indicated R18 weighed less than 500 pounds and could tolerate a semi-reclined position. The tool indicated R18 was a candidate for a full body lift. However, the evaluation lacked a comprehensive assessment/evaluation which included which lift to use, which lift sheet/sling to use, and how many staff members were required to safely transfer R18 using the mechanical lift. The tool indicated: "This is only a guide and cannot address all circumstances and medical conditions. Only a team approach with nursing and therapy or qualified personnel involvement will create the safest situation for the patient and staff, while meeting the goal of increasing mobility and improving patient health."

On 3/21/18, at 8:51 a.m. NA-B stated one staff person could transfer the residents using the full body lift and had always transferred R18 with only one staff person. NA-B stated if the NAs did not feel comfortable using the lift alone, another person could help. NA-B also stated at the time of performing a transfer with a mechanical lift the NA could decide if additional help was needed.

-At 12:42 p.m. RN-C stated she had not ever received any training on the use of mechanical lifts.

On 3/22/18, at 7:40 a.m. RN-D stated she had not received training on the mechanical lifts since hire

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date. RN-D indicated staff used mechanical lifts with one person unless the resident was combative, then two staff were used.
-At 7:45 a.m. LPN-B also stated she had not received training on how to use the mechanical lifts since hire date and that all mechanical lift transfers should be performed with two staff.

The Superior Healthcare Management Minnesota Region Mechanical Lifting Devices policy effective 12/23/17, did not address staff training requirements prior to the use of mechanical lifts, and did not direct staff to perform individualized comprehensive assessments for the appropriate lift type, sling, and number of staff to ensure safe transfers. The policy indicated the purpose of this procedure was to help lift residents using a lifting device to safely assist with transfers and directed staff to review the resident's care plan to assess for any special needs of the resident. The policy also indicated two nursing assistants were required to perform full body mechanical lift transfers, and one nursing assist could perform a sit to stand mechanical lift transfer.

The manufacturer's Instructions for Sara 3000 (sit to stand mechanical lift) indicated the intended use as: Sara 3000 is a mobile aide with a safe working load of 440 pounds intended to be used on a horizontal surface for raising to a standing position and short transfer of residents in hospitals, nursing homes or other health care facilities where the resident had been clinically assessed to correspond to the following categories: was able to partially bear weight on at least one leg, had some trunk stability, and stimulation of remaining abilities was important. The lift instructions and warnings to avoid injury to

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F 689	Continued From page 116 staff and residents included: -Before using the lift it was mandatory to read and fully understand the instructions. In addition, the operators needed to be trained on the lift's accessories, functions and controls. -Before using the lift a comprehensive assessment of the resident's condition and stability be performed by a qualified staff member and an individualized resident assessment by medically qualified person must be performed as to determine if the lower leg straps were required. Manufacturer's Maxi Move (full body lift) instructions for use indicated the lift was intended to be used under professional staff supervision where the patient has no capacity to support themselves, cannot stand unsupported and is not able to bear weight; not even partially, or is passive, might be almost or completely bedridden, is often stiff or has contracted joints is totally dependent on the caregiver. The lift instructions and warnings to avoid injury to staff and residents included: -Before using the lift it was mandatory to read and fully understand the instructions. In addition, the operators needed to be trained on the lift's accessories, functions and controls -The need for a second attendant to support the resident must be assessed for each individual resident by a medical professional to determine if a one or two person transfer was more appropriate based on the the resident's medical condition, behaviors, environment, and skill of staff members. -The manual further directed staff to ensure that the resident's hands and arms are kept inside the sling at all times to prevent injuries and ensure that the resident's legs and feet were well clear of any parts of the lift in order to avoid resident	F 689		

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

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F 689	Continued From page 117	F 689		

injuries and/or damage to the Maxi Move.

Smoking:

R13 routinely independently smoked cigarettes and the facility failed to complete a comprehensive smoking assessment to ensure R13's safety while smoking.

On 3/20/18, at 12:30 p.m. R13 was observed wheeling from dining room area and stated he was going outside to smoke soon.

-At 6:27 p.m. R13 was observed in his wheelchair, waiting for all the residents to leave the dining room area so he could go out the door to smoke.
-A 6:32 p.m. R13 was observed with his coat and hat on. Obtained his cigarettes and lighter which are stored at the nurse's station, from the nurse. He applied the smoking apron across his chest and lap and proceeded to wheel himself out the dining room door which lead to the patio. R13 lit and smoked his cigarette without difficulty followed by disposing of it in the appropriate receptacle.

On 3/21/18, at 2:01 p.m. R13 was observed outside on the back patio, smoking. He was dressed appropriately for the weather. A smoking apron was draped across chest area and lap. He smoked without difficulty and distinguished the cigarette in the appropriate receptacle.

On 3/22/18, at 2:00 p.m. R13 was observed outside on the back patio, smoking. A smoking apron was draped over his chest and lap area. No difficulties with smoking or distinguishing the cigarette noted.

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F 689	Continued From page 118 On 3/22/18, at 1:25 p.m. RN-E stated if a smoking assessment was not documented then it was not completed. On 3/23/18, at 3:09 p.m. RN-A confirmed a comprehensive smoking assessment was not completed as she could not find one. RN-A stated the previous therapy company completed the smoking assessments, however, since they no longer provide services at the facility, she is unsure who is responsible to complete them. On 3/26/18. at 10:38 a.m. the administrator and DON stated a comprehensive smoking assessment should have been completed quarterly and with any significant change in the residents condition. The undated Walker Rehabilitation & Healthcare Center Smoking Rules and Regulations for Grandfathered Residents form indicated residents who were grandfathered in to smoke, must have a smoking assessment completed by nursing, and must wear a smoking apron. All smoking materials must be kept at the nursing station.	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.	F 690		5/6/18

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F 690	Continued From page 119 §483.25(e)(2)For a resident with urinary 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 complete a comprehensive bladder assessment to determine the continued need for an indwelling catheter for 1 of 2 residents (R5) who utilized an indwelling catheter. Findings include: R5's quarterly Minimum Data Set (MDS) dated 1/10/18, indicated R5 had moderate cognitive	F 690	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to provide bowel/bladder incontinence care or	

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F 690	Continued From page 120 impairment and diagnoses included Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff members for bed mobility, transfers and all activities of daily living. The MDS also indicated R5 utilized an indwelling urinary catheter. R5's admission MDS dated 9/1/17, identified R5 as dependent upon staff for all activities of daily living and utilization of the catheter. R5's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 9/6/17, indicated R5 utilized an indwelling Foley catheter. The CAA did not include a comprehensive assessment of the catheter. R5's Bladder Assessment Form dated 11/22/17, indicated R5 had urinary retention which was unable to be treated or corrected medically or surgically. The assessment indicated R5 had an indwelling catheter. However, the assessment was not comprehensive as it did not identify when the catheter was placed, attempts to remove the catheter, bladder infection history or past bladder function history. R5's care plan dated 9/6/17, indicated R5 had an indwelling catheter and directed the staff how to care for the catheter and to monitor for signs and symptoms of infection. R5's physician order dated 11/15/17, indicated R5 had been started on Macrobid (an antibiotic) for 7 days for the treatment of a urinary tract infection. R5's clinical record did not contain a copy of the urinalysis. On 3/20/18, at 1:45 p.m. R5 was assisted to bed	F 690	catheter maintenance care to all residents based on appropriate diagnosis and assessment. One of the many ways that this has been achieved for resident #5 is completing comprehensive assessment of catheter and updating diagnosis based on use and medical symptoms. After survey noted that information was missing regarding catheter immediately the diagnosis was determined, and orders were reviewed. R5 was noted to have urinary retention and had been present since injury that left him impaired. During an accidental catheter removal noted resident did not have output and was not emptying urine – was determined could monitor output overnight. Resident had no significant output catheter reinserted and noted good output. In summary bladder unable to empty on own and catheter was necessary. Care sheets and care plans updated. 2. Because all residents are required to have proper diagnosis for catheter use all that have catheters are potentially affected by the cited deficiency. DON reviewed with staff appropriate diagnosis, monitoring, risks of infection and replacement of catheters. All current residents assessed for continence via bowel and bladder assessments and appropriate interventions for toileting or check and changing have been put in place and catheters have been reviewed. Care sheets updated and care plan. No other residents were affected. The policy on catheters has been reviewed. 3. To enhance currently compliant operations and under the direction of the	

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F 690	Continued From page 121 by nursing assistants (NA)-B and NA-F. NA-B was observed to hang R5's catheter drainage bag on the side of R5's bed frame. NA-B then emptied the catheter drainage bag. On 3/21/18, at 1:10 p.m. the director of nurses (DON) reviewed R5's record and indicated R5 had a diagnosis of urinary retention upon admission to the facility and R5 was admitted with the catheter. The DON confirmed R5 had been treated for a urinary tract infection while at the facility, however, the clinical record did not indicate if R5 had been evaluated for medical need of the catheter or if the catheter had been attempted to be removed. The DON confirmed the facility had not completed a comprehensive assessment for the continued need of the indwelling catheter. A policy related to indwelling catheters was requested and none was provided.	F 690	director of nurses, on 5/1/2018 all staff received in-service training for appropriate toileting, incontinent care, check and change programs, and catheter usage. The training emphasizes the importance of following a plan of care, reviewing diagnosis, catheters and appropriate monitoring. Also educated on appropriately assessing toileting needs and appropriate interventions. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents with catheters and updating MD, family and care plans with any changes to ensure appropriate follow through. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will audit residents with catheters in conjunction with assessment and interventions for first week, then 3 residents weekly for 5 weeks to ensure catheters maintained, have orders, are changed and documented if any infections in infection control log. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON will be responsible for this POC.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including	F 695		5/6/18

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F 695	Continued From page 122 tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a continuous positive airway pressure (CPAP) machine as ordered for 1 of 1 resident (R5) who was to utilize a CPAP machine. In addition, the facility failed to ensure a system was in place for changing and/or disinfecting oxygen therapy equipment for 1 of 3 (R3) resident reviewed for oxygen therapy. Findings include: R5's Essentia Health Nursing Home Note dated 11/24/17, (admission history and physical) identified R5 as having a diagnosis of obstructive sleep apnea. R5's primary physican indicated R5 was to utilize a CPAP machine (used to treat sleep apnea) every night "indefinitely." R5's quarterly Minimum Data Set (MDS) dated 1/10/18, indicated R5 had moderate cognitive impairments and diagnoses included Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff members for bed mobility, transfers and all activities of daily living. The MDS did not indicate R5 utilized a CPAP machine. R5's clinical record lacked a comprehensive assessment related to the use of a CPAP	F 695	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to provide respiratory care to all residents based on appropriate diagnosis and assessment. One of the many ways that this has been achieved for R5 is determining actual need for cpap machine and getting order accordingly. R3 has had oxygen machine tubing, humidifier container all replaced. The TAR has been updated to change out all tubing and containers weekly on nights and labeled accordingly. After survey noted that faulty system for o2 that was immediately addressed and the cpap was reviewed with MD. Care sheets and care plans updated. 2. Because all residents are required to have proper access and assistance with respiratory equipment all are potentially affected by the cited deficiency. DON reviewed with MD the need for cpap and	

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F 695	Continued From page 123 machine. R5's care plan dated 9/29/17, did not address the use of a CPAP. On 3/20/18, at 1:45 p.m. R5 was assisted to bed by nursing assistants (NA)-B and NA-F. A CPAP machine was not observed in R5's room, nor were the staff observed to locate a machine to apply. - At 7:45 p.m. R5 was assisted to bed for the night by NA-A and NA-D. After completing cares, the NAs were not observed to assist R5 with a CPAP machine. On 3/21/18, at 1:00 p.m. the regional director of clinical services (RDCS) reviewed R5's clinical record. The RDCS confirmed R5 had an order to utilize a CPAP machine each night as directed, however, it was not addressed on the care plan and a machine had not been provided. On 3/22/18, at 2:40 p.m. registered nurse (RN)-E reviewed R5's clinical record and confirmed R5 had an order for a CPAP machine, however, no further information regarding the CPAP was in the record. In addition, RN-E could not recall R5 ever utilizing a CPAP machine. On 3/23/18, at 10:00 a.m. family member (FM)-A stated R5 had received a CPAP machine prior to his accident which left him as a quadriplegic. FM-A stated that R5 was not comfortable with the CPAP machine and did not like it. FM-A stated the facility staff had never questioned use of the CPAP machine and it had not been utilized since R5 was admitted to the facility.	F 695	reviewed treatment sheets to ensure staff updated on when to change out and monitor equipment. All current residents assessed for dated tubing, proper containers clean and full for proper humidity. No other residents were affected. The policy on oxygen has been reviewed. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all staff will receive in-service training for appropriate oxygen use and monitoring of the system. Residents with cpap machines have been reviewed to ensure equipment available and documented. The training emphasizes the importance of following a plan of care, reviewing diagnosis, and appropriate monitoring. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the DON to monitor residents with cpap□s and oxygen. The DON or designated quality-assurance representative will perform the following systematic changes: the DON or designee will audit all residents for 3 weeks than 1 resident for 5 weeks to ensure oxygen tanks and equipment properly dated and humidifiers sanitized and clean. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON will be responsible for this POC.	

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F 695	Continued From page 124	F 695		

The CPAP/BiPAP Support policy dated 12/17, directed the staff to supply CPAP assistance as directed by the physician. If the resident refused the device, staff was to notify the physician.

R3's Treatment administration record (TAR) for March 2018, revealed a physician's order for 2 liters of oxygen as needed for dyspnea with a start date of 10/28/18. The TAR did not reflect when the oxygen tubing should be replaced or how the oxygen humidifier bottle should be maintained.

R3's care plan lacked identification of care and maintence of oxygen equipment.

On 03/19/18, 9:29 a.m. R3's oxygen tubing with nasal cannula was observed on the oxygen concentrator; the tubing was not dated and contained condensation bubbles. The humidifier bottle connected to the concentrator also was not dated. R3 stated she used oxygen mainly at night, had her own sterile water to use in the humidifier bottle, and was not aware of when the last time the tubing had been changed. R3 stated sometimes the tubing ends up on the floor where it wasn't supposed to be.

On 3/20/18, at 12:35 p.m. R3's humidifier bottle and the oxygen tubing was not dated. The tubing contained condensation bubbles.

On 3/21/18, at 9:20 a.m. R3's humidifier bottle and oxygen tubing observed was not dated. The tubing contained condensation bubbles.

On 3/24/18, at 8:19 a.m. R3's humidifier bottle and oxygen tubing observed was not dated. The

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F 695	Continued From page 125 tubing contained condensation bubbles. -At 8:20 a.m. registered nurse (RN)-B indicated oxygen tubing was supposed to be dated and changed weekly and thought the tubing changes were indicated on the TAR. RN-B stated if the tubing was not dated, there would not be a way to determine when the tubing was last changed. -At 8:53 a.m. licensed practical nurse (LPN)-B stated oxygen tubing should be marked with a date they were last changed and thought the tubing was supposed to be changed weekly. LPN-B verified the lack of the date on the tubing and the amount of condensation in the tubing. LPN-B then replaced the tubing. LPN-B was not aware if the humidifier bottle was to be replaced or disinfected. On 3/26/18, at 10:27 a.m. the administrator stated the oxygen tubing should be dated of when it was last changed and would provide a policy. Undated facility policy Oxygen Therapy included: General Infection Control Guidelines, 6) Dispose of disposable equipment appropriately and 7)Thoroughly clean all equipment used and return to appropriate storage area. The policy lacked a procedural system to ensure oxygen equipment would cleaned, disinfected, stored, and disposed of. The manufacturer's recommendations were requested and not received.	F 695		
F 725 SS=F	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to	F 725		5/6/18

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F 725	Continued From page 126 provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to provide timely assistance with incontinence cares, provide range of motion services, and timely assistance with turning and repositioning according to the residents' assessed need and as directed by the care plan. This lack of sufficient staff had the potential to affect all 23 residents who resided in the facility. Findings include:	F 725	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure sufficient nursing staff to provide basic care needs to residents based on the residents plan of care. It was	

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F 725	Continued From page 127 Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 2 of 2 residents (R2, R23) who were totally dependent on staff for incontinence cares and failed to provide grooming assistance for 1 of 2 male residents (R23) who required staff assistance to shave. See F677. Based on observation, interview and document review, the facility failed to provide timely repositioning as directed by the care plan for 4 of 4 residents ((R5, R18, R2, R23) who currently had a pressure ulcers or were at risk for the development of pressure ulcers. See F686. Based on observation, interview and document review, the facility failed to provide range of motion services as directed in order to prevent a decline on range of motion abilities for 2 of 5 residents (R5, R2) observed for range of motions services. The failure to provide the services resulted in actual harm for R5 and R2 who had sustained a decline in range of motion abilities. See 688. Residents: On 3/19/18, at 10:59 a.m. R3 an alert and orientated resident who received hospice services, stated she had to sometimes wait long periods of time (more than 10 minutes) for staff assistance. R3 stated she took a diuretic so she could not always wait for staff assistance to help her to get onto the bedside commode. R3 stated once assisted onto the commode, she would often times have to just transfer herself back off the commode because of her legs going numb, pain, and/or shortness of breath from sitting on	F 725	determined from survey team that residents did not get the cares they needed for activities of daily living as evidenced by R2 and R23 did not have timely assistance with incontinent cares who required total dependence, R 23 did not have grooming assistance with shaving and was dependent on staff to provide; R5, R18, R2 and R23 did not have timely repositioning as directed by the plan of care and are at risk for the impaired skin integrity. R2 and R5 did not have range of motion provided as directed by therapy recommendations. R3, R 21, FM B and R 18 all expressed concerns with providing necessary services due to not having sufficient staff to meet resident needs. NA-C, NA-A, RN-A, NA-B, LPN-B, RN-B expressed ongoing concerns with staffing that affected their ability to complete expected duties. Nurses identified management aware of concerns and had put in place mandating policy, a few staff hours have changed to cover meal times which was an area many staff felt lacked adequate coverage as expressed by NA□s. Since survey, 2 NAR□s have been brought in through contract, recruitment has been high priority, increased wages put in place,distributed within 30 miles and corporate recruiter posted on all active recruitment sites. The facility determined that no admissions will be accepted until all present staff are current on training requirements, deemed competent in skills, and until appropriate staffing is in place. 2. All residents are affected by the	

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F 725	Continued From page 128 the commode too long waiting for help. R3 stated there were only two aides on during the day and evening shifts and the nurses seemed to just walk by without offering to help while the NAs were running around. R3 stated the longest wait periods were in the morning, before and after meals, and at bedtime, but stated night shift was when she had to wait the longest because there was only one aide. R3 stated she was concerned about the safety for other residents in case of an emergency situation like a fall, because the emergency would consume the available staff and questioned what would happen if there were two emergencies at one time. At 9:14 a.m. R21, an alert and oriented resident, stated the facility did not have enough staff members to provide resident cares. R21 stated there were only two nursing assistants and a nurse on most weekends therefore R21 knew if he/she had turned his/her call light on to summon for assistance, he/she would have to wait a long time for the staff to come because they are so busy. At 10:45 a.m. family member (FM)-B stated his/her loved one could go 3-4 days without receiving assistance with personal shaving needs. FM-B stated she was unsure why her loved one was not receiving the assistance and was unsure if the if the facility had enough staff or not. At 11:48 a.m. R18 stated, she didn't think there was enough staff available, and seemed to have to wait longer for assistance on the overnight shift. R18 further stated staff did not always reposition her timely and they could probably offer more often.	F 725	deficient practice of insufficient staffing, which ultimately affects timely assistance with incontinent cares, range of motion services being provided and timely assistance with turning and repositioning. Regarding staffing; shifts were changed to add increased support during needed times, two-way radios initiated to increase communication for assistance needed between CNAs and nursing department, agency staffing assistance contacted for additional support. SSC initiated a staff recruitment campaign to increase marketing areas for recruiting potential new hires, as well as reaching out to staffing agency support until vacant positions have been filled, reached out to potential candidates through social media to inform of openings, sign on and referral bonuses and have reached out internally to other facilities for additional hands on support for CNA, LPN, and RN management support which has been provided to facility. 3. To enhance current recruitment efforts and overall operations and under the direction of the DON and ED, on 5/1/2018 all staff will discuss incentives and bonuses to help facility reach out to employment candidates. The training will emphasize the importance of all staff addressing resident needs, including importance of response to call lights, assistance with ADLs and expectations of licensed staff and non-licensed staff to aid residents as needed. 4. Effective 4/18/2018, a quality-assurance program was implemented under the supervision of the	

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F 725	Continued From page 129 Staff: On 3/19/18, at 12:40 p.m. nursing assistant (NA)-C stated the facility had 23 residents and only two NA's to provide direct care during the day and evening shifts. The night shift only had one NA. NA-A stated the NA's were able to just get the residents' basic cares done. NA-C also stated the NAs were responsible to provide range of motions exercises with morning cares, however, this was not being provided because there was not enough time to. On 3/22/18, at 6:34 a.m. registered nurse (RN)-A stated didn't feel like there was enough nursing assistants to take care of the residents. RN-A stated management was aware of the concerns and had put a mandating policy into place and temporary staff was contracted for a few weeks which seemed to help, and then a couple of staff had been hired. Stated staff was told staff scheduling was based on census and not acuity of the residents. RN-A stated the facility used to have three aides during the day and on evening shifts and one aide on during the overnight shift, and that seemed a lot more sufficient. RN-A indicated concerns pertaining to emergent situations during the night shift with only two staff around and the level of acuity, stated often times when only one nurse was scheduled or worked short handed, staff were not able to take breaks. RN-A further indicated meal times were challenging because there wasn't enough staff available to help feed the residents who required assistance. On 3/22/18, at 7:15 a.m. NA-B stated the NAs did not have time to complete documentation of	F 725	ED, DON and SSC to boost staffing and continue supporting current staff during this restructuring to appropriately care for the residents. 5. The DON and ED along with corporate recruitment team will be responsible for the POC.	

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resident cares because they were too busy providing cares. NA-B stated the NAs provided toileting and repositioning assistance to the residents, however, they were unable to complete those care tasks timely, as directed. NA-B also stated the NAs did not have time to provide range of motions exercises with morning cares because there was not enough time to.

- At 9:32 a.m. licensed practical nurse (LPN)-B stated the NAs were busy all day long. Between answering call lights and providing cares, they did not have the time to provide assistance with every two hour cares as directed by the care plans. LPN-B stated "they can not do it, there is not enough time in the day to get it done." LPN-B stated when a NA did not show up for their assigned day shift, one of the wing nurses would work as a NA which left only one nurse to complete all the nursing duties. LPN-B stated the meal times were the most difficult because of the number of staff required to assist the residents. LPN-B stated the staff did the very best they could and confirmed the residents' did not always receive assistance, exercises, shaving or oral cares due to a lack of staff.

On 3/23/18, at 10:40 a.m. RN-B stated the staffing at the facility was a challenge. At this time, the facility had many dependent residents. RN-B stated 10 of the 23 current residents required mechanical lifts (either standing or full body) to transfer and 18 of the 23 required assistance of at least one staff to complete cares. In the past, the facility had two nurses and three NAs during the day and evening shifts and the staff were able to timely assist the residents with personal care needs and exercises. RN-B stated due to a lower census the staffing had been

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reduced, however, when it was reduced from three to two aids, the resident care acuity was not taken into consideration.

On 3/24/18, at 8:40 a.m. NA-B stated the staffing was the worst she had seen in many years and was very frustrated with the current staff to resident ratio.

-At 10:00 a.m LPN-B stated in the past, the facility had utilized a supplemental nursing agency who provided pool staff to work in the facility, however, the pool staff had quit working at the facility several weeks ago, and the facility had not replaced them. LPN-B stated the staff members were tired.

On 3/27/18, at 8:34 a.m. the administrator and director of nursing (DON) were interviewed about facility staffing. The administrator stated she was hired on 1/17/18, and was told by the previous administrator that his main focus had been on staff recruitment and staffing. The administrator stated immediately upon hire, she had recognized the ineffective dissemination of the licensed staff and was currently in the process of reorganization and implementation of new job roles according to the staff members scope of practice. The administrator stated the current DON was appointed on 2/5/18, and immediately started on staff recruitment and scheduling activities. The administrator acknowledged the need for more nursing assistant hours during the day and evening shifts and was in the process of creating new scheduled positions. However, until those positions were filled, she expected licensed staff to help the nursing assistants with resident cares and to also assist the residents at meal times. Additionally, the administrator stated she had

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requested assistance from the corporate office to obtain staff, however, her request was not honored.

The facility quality assurance and performance improvement (QAPI) log dated 1/16/17, identified a prioritization plan for increasing staffing needs. The plan identified what staffing levels were needed based on census and acuity with the staffing goal as:
-three nursing assistants for morning shift, two staff with a ward assistant on the evening shifts, one to two aides on the overnight (depending on census and acuity of residents), one 12 hour RN, one 8 hour LPN, and one 12 hour RN and one 8 hour LPN for day/evening shifts. The staffing plan for the facility included social services marketing at local hospitals for appropriate residents, running advertisements for staff, signed contract on 1/15/18, for two temporary nursing assistants, and requesting assistance from the corporate office.

The facility assessment last revised 3/19/18, indicated the average daily census of 20-25 residents. The assessment indicated care and services the facility could provide included diseases/conditions and cognitive disabilities and identified the acuity of the current residents by identifying them by level of assistance required and resource utilization group (RUG) categories and percentages. The facility assessment identified number of nursing assistant hours needed was between 48-72 hours per day and 32 hours for licensed staff per day with a total number of direct care hours per day as 80-104. The assessment also included the nursing home compare staffing report which indicated nursing assistant hours per resident day were less than

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state and national averages.

Facility daily census reports for February and March 2018 reflected the following:

From 2/1/18-2/17/18, average daily resident census was 18. Average nursing assistant hours per day was 43.02. The daily census sheets in this time period reflected an average of three nursing assistants worked on the day and evening shifts (2.39 nursing assistant direct care hours per resident per day).

From 2/17/18-2/28/18, average daily resident census was 18. Average nursing assistant hours per day was 39.13. The daily census sheets in this time period reflected an average of two nursing assistants worked on the day and evening shifts (2.17 nursing assistant direct care hours per resident day).

From 3/1/18-3/19/18, average daily resident census was 22. Average nursing assistant hours per day was 39.52 hours. The daily census sheets in this time period reflected an average of two nursing assistants worked on the day and evening shifts (1.79 nursing assistant direct care hours per resident day).

Superior Healthcare Management Minnesota Region's undated Staffing policy included the following:

Our facility provides adequate staffing to meet needed care and services for our resident population.

1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and

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F 725	Continued From page 134 services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services 2. Certified nursing assistants are available on each shift to provide the needed care and services of each resident as outlined on the resident's comprehensive care plan. 6. Staffing will be based on resident census and facility needs.	F 725		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able	F 726		5/6/18

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F 726	Continued From page 135 to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff were trained and deemed competent in the identification of potential abuse and the investigation and reporting requirements for 3 of 3 (R226, R13, R5) residents with actual and potential abuse mistreatment incidences; knowledge of developing and implementing discharge planning needs for 1 of 1 resident (R24) who was discharged without a plan developed; knowledge of cardiac pacemaker care needs for 1 of 1 resident (R6) who had a pacemaker without staff knowledge of monitoring needs; knowledge of the identification of and need to complete a comprehensive assessment and ongoing monitoring and documentation requirements of pressure ulcers in order to prevent the worsening of a pressure related ulcers for 2 of 2 residents (R5, R18) who had developed pressure ulcers which had worsened; had been educated and were knowledgeable on the use mechanical resident lifts to ensure safe resident transfers for 2 of 2 residents (R2, R8) observed to have safety concerns during the use of mechanical lifts; and failed to ensure staff were knowledgeable of the identification of infectious outbreaks and how/when to implement infection control precautions in order to prevent the spread of infection. These failures also had the potential to affect all 23 residents residing in the facility. Findings include:	F 726	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure that there are sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and highest practicable physical, mental, psychosocial well-being of each resident. Since survey findings, all staff have been educated and are competent in identification of potential abuse and the investigation and reporting requirements for all residents resulting in findings on R226, R13 and R5. Education and knowledge for use of mechanical lifts was immediately provided to all staff to ensure safe transfers for R2, R8. Systems in place for identification of infectious outbreaks and how to implement infection control precautions to prevent spread of infections. R6□s pacemaker checks have been clearly identified and DON and facility educated on proper identification and complete assessments, monitoring and documentation for pressure ulcers to	

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F 726	Continued From page 136 Abuse reporting: F609/F610 R226, R13, and R5 had incidences of resident to resident abuse, elopements or injury of unknown origin and the staff failed to identify the incidences as potential abuse which required investigation and immediate reporting to the administrator and/or State agency. R13 stated during interview on 3/19/18, at 9:24 a.m. that R21 used to be his roommate and currently lived a couple doors from him, however, he could not get along with R21. R13 stated R21 would threaten to "beat him up" most recently being just two days ago. R13 stated about two months ago, when he was by the nursing station with staff present, R21 had "rolled up and punched him in the left shoulder." R13 denied being injured. R13 stated the staff who had witnessed the incident told R21 he had to "settle down." R13 denied being afraid of R21 and stated "all he is, is one big mouth" and that he tried to stay away from R21 as much as he could. Staff interviews confirmed the incident had occurred and verified R13's clinical record lacked documentation of the incident, investigation and interventions implemented to ensure R13's safety, and lack of reporting to the adminstrator and State agency. R226 had eloped from the facility according to the facility's computerized Risk Management Incident list. The note indicated R226 could not be located within the facility so a building and grounds search was conducted which was unsuccessful in locating R226 and 911 was called. When 911 was called, they informed the facility their missing resident was at the local police department. The police returned the resident to the facility,	F 726	prevent the worsening of pressure ulcers for all residents after findings on R5 and R18. Resident R24 no longer resides at facility to correct appropriate discharge planning needs however discharge planning process has been developed for any current residents discharging. On 3/26/18 it was determined by DON and ED that competency training lacked documentation to support how staff were effectively trained. It was determined training needed to be completed on all employees to address proper orientation to policies and procedures as well as annual requirements. In addition, licensed nurses and nursing assistance have additional requirements specific to their title and were determined to need proper competency testing of all areas as determined based on resident population, their job title, and areas identified through survey, staff, residents, families and the quality assurance committee. The facility determined that no admissions will be accepted until all present staff are current on training requirements, deemed competent in skills, and until appropriate staffing is in place. DON and designee immediately began proper competency trainings for all staff and new staff will be orientated through proper orientations system. 2. All residents can be affected by incompetent nursing staff. All employee files and training records were reviewed from Relias Learning, current orientation for new hires after 2/8/2018 and other individualized education provided since survey. The DON along with HR and ED	

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F 726	Continued From page 137 unharmed. The facility provided a copy of their facility Minnesota Incident Report from the Risk Management List which was dated 12/3/17, at 7:30 a.m. and revised on 12/5/17, which indicated R226 had eloped from the facility and a temporary wanderguard was placed, and every 15 minute checks were initiated. However, it lacked evidence the Stage agency was notified. However, further staff interview revealed another elopement whereas R226 had exited the building, wheeled self down the snow covered road, and crossed the main highway and was at a gas station. The interviews also revealed R226 had been returned to the facility by an unidentified person. R226's clinical record lacked any evidence of this elopement having had occurred, was investigated or reported. R5's Progress Note dated 3/13/18, at 11:20 p.m. indicated R5 had a 6.0 centimeter (cm) by 3.0 cm bruise which was yellow/green in color with some pinkness surrounding the bruise. The documentation did not identify where the bruise was located on R5. The quarterly Minimum Data Set (MDS) dated 1/10/18, indicated severe cognitive impairment, total assistance with activities of daily living and no resistance to cares. A Resident Bruise/Skin Tear/ Injury Report dated 3/13/18, indicated R5 had a 6.0 cm by 3.0 cm bruise on the right forearm which may have been caused by an arm brace. R5's physician, family and director of nurses were notified of the bruise. However, the State Agency was not notified within 24 hours as required of the bruise of unknown source. On 3/20/18 at 1:41 p.m. when requested to review the facility abuse prevention policy and	F 726	determined a series of trainings, in-services, 1:1 trainings, return demonstrations, Relias Learning and packets for review for all staff based on their individualized training requirements. 3. Upon review and completion of all competencies, re-orientation and annual training requirements, the DON will complete a 1:1 performance evaluation with each nursing employee to ensure competent staff, and review what other training and education needs should also be included for quality assurance purposes. All new hires will have completion of orientation and training consistent with facility policy. All casual employees unable to complete necessary training will not be allowed to work at facility until after completion and 1:1 review with DON. 4. Beginning 4/24/18 the DON, mentor DON and RN will provide all RNs with above educational training and will review, monitor and assist staff to ensure completion. Ongoing monthly in-services will be provided and tracked by DON (or designee) to assure continued compliance. Education programs will identify areas of weakness determined from performance reviews, resident needs and areas identified in the monthly QAPI reviews. All nursing staff's individual competencies will be completed by 5-6-2018, as well as being current on compliance training. All new hires will have completed competencies during orientation. Monthly for 6 months the facility will continue to monitor that assigned annual and deemed appropriate	

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F 726	Continued From page 138 procedures, the administrator and director of nursing (DON) stated they were unable to locate it within the facility. -At 1:49 p.m. the administrator and the DON confirmed R13's and R21's dislike for each other. The administrator, the DON and the regional director of clinical services (RDCS) were informed of the altercation and all stated they were unaware the altercation had occurred and confirmed it should have been reported to the administrator as well as the State agency, as required. On 3/20/18, at 4:25 p.m. the administrator, RDCS, and the DON confirmed R225 had eloped from the facility and the incident was not reported. When asked about the facility's abuse prevention program related to reporting, the RDCS stated the whole system needed to be "revamped." The administrator stated when her and the DON started at the facility, they became aware of the failure in the system and had begun educating the staff on the abuse prevention program policies and procedures. When notified of the IJ situation, they were informed of R226's additional elopement and stated they were unaware of this occurrence and confirmed it too should have been reported, as required. On 3/21/18, at 8:40 a.m. the RDCS stated she had only been with the facility's management company for three weeks and this was her first time at the facility. At this time, the RDCS called the Superior Healthcare Management (SHM) executive who overseen this facility. The executive stated the company took over operation of the facility on 2/1/17, whereas there was a former employee who continued to work at the	F 726	trainings are completed monthly. Any deficiencies will be immediately corrected, and findings will be documented and reviewed at the monthly quality assurance committee meeting. 5. The DON will be responsible for the POC.	

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facility through the ownership transition phase which ended June 2017, at which time a RDCS started working at the facility and was responsible for overseeing the clinical nursing operation until November 2017. Following this employee's departure, there was no specific regional director assigned to this "property" therefore a clinical supervisor was not present on site, rather was available for consultation via the phone. The RDCS verified and acknowledged the lack of facility systems and stated she would create a binder to place the facility abuse prevention program policy and procedures in and provide staff education.

On 3/26/18, at 3:26 p.m. licensed practical nurse (LPN)-A stated she was shown the newly created facility abuse prevention program binder last "Tuesday" (six days prior) and verified the binder was kept at the nurses station and contained the facility's policy and procedures related to abuse prohibition in which staff were to refer to when needed. However, LPN-A stated she did not know if any changes had been made to the facility's abuse protocol because she had not reviewed the information yet.

Discharge Planning: F660

R24 was discharged to home and the staff failed to identify the need to develop and implement a discharge plan prior to R24 leaving the facility in order to ensure R24's safe and successful transition back to home.

R24 was admitted to the facility on 12/15/17, with diagnoses that included but were not limited to: infection following a procedure, cerebrospinal fluid (CSF) leak, generalized muscle weakness,

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and headache. Review of the hospital dismissal summary dated 12/14/17, indicated R24 underwent a dural repair for a CSF leak following a lumbar fusion with a resulting infection. R24 was given IV antibiotics and sent to the nursing home to receive IV antibiotics until 12/21/17. R24 was admitted with a PICC (peripherally inserted central catheter) line.

Review of R24's discharge planning revealed a progress note dated 12/20/17, indicating R24 was going to discharge on 12/21/17, or 12/22/17, via driving herself in her personal car. The note indicated R24 wanted her medications to be sent to a Walgreens close to where she lived. The note also identified R24 would would be working with her primary care physician to set up home health care and follow-up appointments. The next discharge planning note was dated 12/22/17, which indicated R24 discharged home via personal car at 10:00 a.m. R24 wore a back brace and was able to perform activities of daily living (ADL's) independently. There was no indication if R24 was able to independently don and doff the back brace, who would care for the PICC, if R24 could independently change the dressing on the lower spine or if R24 had dressing supplies to change the dressing. Additionally, there was no evidence of teaching of signs and symptoms of infection or when to call the primary care provider. There was no indication R24 received medications, what those medications were, and if R24 had been educated on those medications. Although R24 indicated a need for home care, there was no indication a referral to a home health agency had been completed and if R24 was accepted for admission. The document Discharge Summary and Post-Discharge Plan of Care dated 12/22/17,

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was found in R24's closed record. The summary was incomplete. The summary indicated R24 wanted home health agency recommendations and the names of two agencies and their telephone numbers were listed. However, there was no indication if the agencies were contacted.

On 3/23/18, at 11:04 a.m. the director of nursing (DON) stated the facility did not have a system for discharging residents. The DON stated patient teaching should have been documented and indicated if R24 was able to don and doff the back brace, if R24 was able to independently change the dressing on the lower spine, if she had discharge medications and what they were, the PICC line should have been pulled or home care should have been set-up to ensure it's care, and a referral to a home health agency should have been initiated and set-up. Additionally, the signs and symptoms of infection should have been reviewed, and the surgeon and primary care physician phone numbers should have been provided. The DON stated the facility did not have a discharge policy and procedure which would have included training of staff on discharge planning at the time of R24's discharge. the DON provided a new discharge policy and procedure dated 12/23/17.

Cardiac pacemaker care: F684

R6 had a cardiac pacemaker and the staff failed to acknowledge the need for routine monitoring of the pacemaker to ensure proper functioning.

R6's quarterly MDS dated 1/17/18, identified R6 with moderate cognitive impairment and diagnoses including chronic atrial fibrillation and mitral valve disease. The MDS also indicated R6

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required limited assistance of one staff for all activities of daily living. R6's Hospital Discharge Summary dated 6/19/17, indicated R6 was to complete a pacemaker check over the telephone using a remote home monitor on 7/18/17. R6's care plan dated 6/28/17, identified R6 had a pacemaker due to atrial fibrillation and directed the staff to monitor for signs and symptoms of altered cardiac output or pacemaker malfunction such as dizziness, syncope, difficult breathing, pulse rate lower than programmed rate or lower than baseline blood pressures. However, the care plan did not direct the staff to assist to monitor the pacemaker via telephonic monitoring.

R6's clinical record lacked documentation related to the pacemaker monitoring.

On 3/22/18, at 1:05 p.m. licensed practical nurse (LPN)-B confirmed R6 had a pacemaker and stated the scheduled telephonic monitoring was to be completed by the nursing staff. LPN-B stated the scheduled times were to be identified on the electronic Medication Administration Records (EMAR). LPN-B reviewed R6's EMAR and stated the EMAR did not include the directive to complete pacemaker monitoring. At 1:17 p.m. LPN-B entered the medication room and located a pacemaker telephonic monitoring device and confirmed she had no idea the last time R6 had utilized the machine. At 3:00 p.m. registered nurse (RN)-E reviewed R6's clinical record and stated the clinical record lacked documentation as to the last time the pacemaker had been checked and she would have to look into the concern.

On 3/23/18, at 11:50 a.m. RN-E confirmed R6's medical record lacked documentation related to

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the pacemaker evaluations.

On 3/27/18, at 9:30 a.m. RN-D stated she had completed R6's pacemaker check via the telephone in February 2018, however, she had not documented the monitoring in the medical record. RN-D stated at the time of the monitoring, an additional appointment had not been made. RN-D stated the facility had not received any type of documentation from the pacemaker clinic which would indicate any concerns with the pacemaker. RN-D stated she would expect the clinic to contact the facility if there was a problem. RN-D did not voice awareness of the need to ensure routine monitoring/scheduled checks or the importance of follow up in order to ensure R6's pacemaker was functioning properly.

Pressure Ulcers: F686

R5 and R18 were identified at risk for the development of pressure related ulcers and was observed to have current ulcers which had worsened and the licensed staff failed to identify the change and/or complete a comprehensive assessment of the ulcer and implement routine monitoring of the ulcers in order to determine efficacy of the treatment, and ensure interventions were implemented which resulted in harm to R5 and R8.

R5's quarterly Minimum Data Set (MDS) dated 1/10/18, indicated R5 had moderate cognitive impairment and diagnoses included Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff members for bed mobility, transfers and all activities of daily living. The MDS also identified

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R5 at risk for the development of pressure ulcers.

R5's Pressure Ulcer Care Area Assessment (CAA) dated 9/6/17, identified R5 at risk for the development of pressure ulcers due to dependence upon staff for repositioning and bowel incontinence. The assessment directed staff to complete weekly skin assessments and to monitor R5's skin while assisting with personal cares. R5's care plan dated 8/28/17, directed the staff to assist R5 with repositioning at least every two hours.

R5's physician's order dated 11/29/17, directed staff to apply a DermFilm Thick Sacral Dressing to the coccyx every three days, and as needed. In addition, R5's Order Summary also included an order for the same wound dated 10/3/17, which directed the staff to apply an Allevyn Dressing (foam dressing) to the left buttock wound and to change every three days until healed.

R5's PNs' from 2/2/18, through 3/20/18, were reviewed and revealed R5 had buttock, coccyx and sacral pressure ulcers which had worsened. R5's clinical record lacked a weekly assessment of the wound/s which would include measurements of the wound, (length, width and depth), color of the wound and surrounding wound bed and current interventions. R5's clinical record also lacked evidence that R5's primary physician had been notified of the newly opened areas. In addition, R5's Electronic Treatment Administration Record (ETAR), dated 3/18, revealed duplicative orders to apply Allevyn and DermFilm dressings every three days to the same wound areas. The documentation revealed the nurses had initialed both dressings every three days which indicated they both dressings been

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applied to the wound, even though only one dressing was actually applied.

On 3/20/18, at 5:00 p.m. R5 was observed seated in a wheelchair in the main dining room waiting for supper.
-At 5:05 p.m. registered nurse (RN)-D fed R5 the evening meal.
-At 5:20 p.m. RN-D wheeled R5 back to his room, turned the television on and exited the room.
-At 5:55 p.m. R5 remained in his wheelchair. Nursing assistant (NA)-D entered R5's room and assisted R5 to wash his hands and face and change into a hospital gown. R5 was not repositioned.
-At 6:06 p.m. NA-D exited the room. R5 remained in the chair and continued to watch television.
-At 7:50 p.m. NA-D and NA-A returned to the room and transferred R5 from the wheelchair to bed. R5's wheelchair had a pressure redistribution seat cushion in place. R5's coccyx was covered with an intact thin Tegaderm hydrocolloid dressing. The skin along the edge of the wound was deep pink in color.
- At 7:55 p.m. NA-A stated R5 was assisted out of bed at 4:00 p.m. and confirmed R5 was not repositioned for 3 hours and 50 minutes. NA-A stated with only two NAs on staff, the staff were doing the best they could, however, they were unable to provide assistance with timely repositioning for all of the residents.

On 3/21/19, at 1:10 p.m. the DON and RDCS confirmed R5 was to receive assistance with repositioning every two hours as directed by the care plan. Upon review of the medical record, the DON stated she was unable to identify the exact date R5's buttocks began to show signs of breakdown and based on the lack of

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documentation, she was unable to determine the size of the pressure ulcer. The RDCS stated the facility should have completed a comprehensive skin assessment when the breakdown began.

- At 2:05 p.m. RN-D was observed to remove a Duoderm dressing from R5's sacrum. Upon removal of the dressing, RN-D identified two newly opened areas under the dressing. RN-D measured the first open area on the left buttocks to be 1.0 cm x 0.3 cm. The second open area on the lower left buttocks measured 2.0 cm by 2.0 cm. In addition, under the dressing there were three deep red approximately one inch non blanchable areas. RN-D stated the wound had changed appearance since the last time she had observed it. RN-D stated the open areas were new and the wound looked worse.

- At 2:10 p.m. the DON observed R5's sacrum. The DON stated the last time she had observed R5's sacrum, the skin was dry and flaky but intact. The DON confirmed R5 had newly developed stage 2 ulcers (pressure ulcer in which partial thickness skin loss involving epidermis, dermis, or both). RN-D applied a Duoderm dressing over the ulcers.

Review of R5's clinical record on 3/23/18, (two days later) revealed a lack of documentation related to the newly developed pressure ulcer's wound care and measurements from 3/21/18.

On 3/23/18, at 9:30 a.m. RN-E reviewed R5's record and confirmed R5 had developed a pressure ulcer and the facility failed to complete any type of documentation or comprehensive assessment related to the new pressure ulcers identified on 3/21/18. RN-E verified R5 had two

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treatment orders for the same sacral wound and the ETAR indicated both dressings were being applied even though only one dressing had been applied to the wound. RN-E also verified R5's care plan had not been followed as directed and R5 had not received wound care in accordance with the facility policy.

R18's Admission Record dated 3/22/18, indicated R18 had diagnoses which included mild cognitive impairment, stroke, hemiplegia, and hemiparesis, muscle weakness, fatigue, venous insufficiency, and obesity. R18's quarterly MDS dated 3/2/18, indicated R18 had severe cognitive impairment, required extensive assist from 2+ staff for bed mobility and toilet use, and was totally dependent on 2+ staff for transfers and hygiene. The MDS indicated at the time of assessment, R18 had one stage 2 pressure ulcer and two stage 3 pressure ulcers (Stage 3- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) which measured 2.0 x 6.0 x 0.4 cm. Ulcer treatments included pressure ulcer care, and pressure reducing device for bed and wheelchair.

R18's care plan printed on 3/22/18, indicated R18 required extensive assist of one staff for dressing, bathing, grooming and bed mobility, and extensive assist of two staff for transfers with a mechanical lift. The care plan also indicated R18 "has pressure ulcers development" related to pressure ulcer areas to the coccyx, and had a potential impairment to skin integrity related to fragile skin, immobility, weakness, and history of pressure ulcers. The care plan directed the staff

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F 726	Continued From page 148 to implement the following interventions: follow facility policies for the prevention/treatment of skin breakdown, monitor dressing, if needed, every shift to ensure if remains intact and adhering, to monitor/document/report, as needed, any changes in skin status such as appearance, color, wound healing, signs and symptoms of infection wound size, and stage, reposition R18 every two hours or more often, if needed and to perform weekly skin observation. If open area identified, treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue exudate (drainage). Although the care plan addressed pressure ulcers, the care plan did not address the newly developed pressure ulcers and/or was not revised to reflect the pressure ulcers identified on the 3/2/18, MDS assessment. R18's physician orders included: complete weekly skin assessment on Mondays (start date 2/13/17) -wound evaluation on left upper buttock every Monday per MD order (start date 2/20/17) -Change Tegaderm hydrocolloid (maintains a moist wound bed) thin 4x4 dressing every three days in the morning and as needed; apply skin prep to coccyx before applying new dressing to prevent skin tears. (start date 8/23/17, stop date 3/20/18) -Monitor Tegaderm hydrocolloid thin dressing to upper buttocks every shift to make sure dressing is in place, dressing is dry and intact every shift. Dressing to remain on until healed. (start date 9/30/17) -Comfort foam (for medium to heavy drainage) with border dressing 4x4 to sacral and buttock wounds change every 3 days until healed (start date 3/21/18)	F 726		

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F 726	Continued From page 149 -Roho cushion for wheelchair (start date 3/20/18) Weekly Skin Reviews (WSR) and PNs reviewed from 1/1/18, through 3/20/18, revealed worsening pressure ulcers, however lacked completed comprehensive evaluations and consistent documentation in order to ascertain locations, worsening, and or healing stages and lacked evidence of pressure relieving device efficacy. On 3/19/18, at 11:48 a.m. R18 was observed in her room, seated in the wheelchair. R18 stated she had pressure ulcers on her bottom, had them for a long time, and experienced discomfort when she sat too long. R18 stated she did not think her wheelchair cushion had been changed/replaced. R18 further stated staff did not always reposition her timely and felt they could probably offer to reposition her more often. On 3/20/17, at 1:17 p.m. NA-B was observed to transfer R18 from her wheelchair into bed using a full body mechanical lift. NA-B confirmed R18 had wounds on her bottom but had not seen R18's bottom since 3/16/18, and stated somebody had told her R18 had additional areas of skin breakdown. NA-B pulled down R18's pants, which exposed two hydrocolloid dressings positioned over the left buttock and sacral/coccyx region, and the mid right buttock. NA-B stated the wound on the left was new since last week. -At 1:39 p.m. medical doctor (MD)-B and health unit coordinator (HUC) entered R18's room. MD-B asked R18 if she had experienced pain from the sores, to which R18 responded she had some discomfort. As MD-B removed the tacky dressings, MD-B remarked she did not like this type of dressing because it rips the skin. MD-B	F 726		

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assessed the wounds and verified/documented the wound description, treatment and intervention efficacies.

-At 8:48 a.m. RN-D stated there was no designated RN to perform pressure ulcer/wound assessments, therefore were completed by whichever nurse was assigned to work that day. RN-D stated skin assessments were performed weekly, wound documentation should always include measurements, and if the wound was a pressure ulcer the nurse should indicate the stage of the ulcer. RN-D further stated the assessing nurse needed to determine possible causal factors of the breakdown and evaluate and implement appropriate interventions. RN-D stated if the pressure wounds were not healing, the interventions should be reassessed for effectiveness and the pressure relieving devices and surfaces should also be assessed for effectiveness.

-At 12:49 p.m. RN-E verified the Weekly Skin Observations were not complete nor comprehensive. RN-E stated all the evaluations should have been completed to identify: measurements including depth, if pressure ulcer then staged, a complete description of the wound, drainage, odor, current treatment, progress toward healing, and if worsening then reassessment of interventions, implementation of new interventions, and notification to physician. RN-E stated the facility nurses were very inconsistent with their documentation and it was difficult to ascertain exactly what was going on with the skin.

Mechanical lifts: F689

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R2 and R8 required staff assistance with transferring via a mechanical full body or sit to stand lift and the facility failed to ensure staff were trained and deemed competent on its use.

R2's annual MDS dated 11/2/17, indicated R2 had severe cognitive impairment and diagnoses which included Parkinson's disease, dementia and anxiety. The assessment indicated R2 required extensive staff assistance for all activities of daily living and required total assistance of two staff for all transfers. R2's Lift Mobility Status form dated 12/31/17, indicated R2 did not have the ability to bear weight on his/her legs. R2 had the ability to tolerate a semi-reclined position and indicated R2 was to be transferred with a MaxiMove (brand name of a full body mechanical lift). The rest of the form was incomplete, as it was blank. R2 had not been assessed to identify the appropriate size sling or the number of staff members required to safety transfer R2 with the mechanical lift.

On 3/21/18, at 12:00 p.m. R2 was observed resting in bed. NA-C positioned a full body lift sling under R2 and connected R2 to the full body lift. RN-C was present in the room, however, RN-C did not assist NA-C as R2 was lifted off of the bed via the full body lift. Once in the air, NA-C utilized the lift control pad and positioned R2 from a reclined to a seated position in the sling. When the lift sling was in a seated position, R2's feet repeatedly bumped the hydraulic support beam. NA-C did not ask RN-C for assistance in order to protect R2's legs from hitting the support beam as she proceeded to continue with the transfer. When NA-C had R2 positioned over her wheelchair, RN-C acknowledged R2's feet were repeatedly bumping

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the hydraulic beam and assisted by holding R2's feet away from the bar as NA-C lowered R2 into the wheelchair.

On 3/22/18, at 10:00 a.m. R2 was observed in her room, seated in a wheelchair. NA-B entered the room and proceeded to independently transfer R2 from the chair to the bed via a full body mechanical lift. During the transfer, R2's feet were observed to rub against the hydraulic lift. NA-B did not request assistance from another staff to assist with the transfer and proceeded to place R2 into bed.

On 3/20/18, at 7:44 p.m. NA-A stated the residents who required a mechanical lift for transfers could be transferred with the assistance of one or two staff depending upon how comfortable the staff member was in operating the lift.

R8's Admission Record dated 3/22/18, indicated R8 had diagnoses which included adult failure to thrive, diabetes, essential hypertension, muscle weakness, and non-compliance with medical treatment or regimen. R8's quarterly MDS dated 1/22/18, indicated R8 had intact cognition, required extensive assistance from one staff member for transfers, dressing, personal hygiene, and had impaired balance. R8's Progress notes (PN) dated 1/26/18, indicated R8's leg buckled during a transfer and a referral was made to physical therapy to evaluate safe transfers using a mechanical lift as needed during periods of weakness. R8's Physical Therapy Evaluation and Plan of Treatment dated 2/9/18, indicated R8 was referred for evaluations of safe transfers. The evaluation indicated R8 had lower extremity weakness, and was not able to bear

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weight. The physical therapist (PT) recommended that R8 should perform all transfers with the use of the mechanical sit to stand lift.

However, R8's clinical record lacked a mechanical lift evaluation which would identify an appropriate sling size and how many staff were needed to transfer R8 safely when using the sit to stand mechanical lift. The care plan also lacked revision to include the PT recommendation. The only Lift Mobility Status tool on record was dated 11/18/17, which indicated R8 did not require a mechanical lift. The tool read: "This is only a guide and cannot address all circumstances and medical conditions. Only a team approach with nursing and therapy or qualified medical personnel involvement will create the safest situation of the patient and staff, while meeting the goal of increasing mobility and improving patient health."

R8's dated 3/9/18, indicated a NA reported R8 had "passed out" while in the stand-up lift after lunch. R8 complained of nausea at the time, had large amount of incontinent stool and the doctor would up updated. R8's record lacked evidence vital signs (heart rate, blood pressure, oxygen saturations) were obtained after the syncopal episode.

R8's Physical Therapy Evaluation and Plan of Treatment dated 3/12/18, indicated R8 was referred related to nursing reports of R8 "passing out" in the sit to stand lift. The physical therapist recommended the use of the full body mechanical lift for all transfers to prevent injuries to R8 and staff. R8's clinical record lacked documentation of the syncopal events which

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occurred during mechanical lift transfers. However, this PT recommendation was never implemented.

On 3/21/18, at 12:42 p.m. R8's call light was on and stated she had to use the restroom. RN-C obtained the sit to stand mechanical lift and explained it was her second day on the job at the facility and had not used a mechanical lift before. R8 directed RN-C how to put the lift harness around her and how to connect it to the mechanical lift. Once the harness was around R8, and connected to the lift, R8 instructed RN-C to tighten the harness, and to use the calf strap. R8 informed RN-C of her history of passing out during lift transfers. RN-C informed R8 that she would go slow and wait for R8's blood pressure to catch up. RN-C proceeded to raise R8 up from her wheelchair. The harness became very loose around R8's chest, however, RN-C continued with the transfer and positioned R8 onto a nearby commode.

-At 12:55 p.m. RN-C stated she had not received any training on the use of the mechanical lift and R8's transfer had been the first one she had ever completed. RN-C stated mechanical lifts could be used with one or two people and was dependent upon the resident. RN-C stated she did not know how tight the harness should be when using a sit to stand lift. RN-C's competency evaluation check list was not available at the time of the survey.

On 3/22/18, at 7:40 a.m. RN-D confirmed she had not received training on the mechanical lifts and stated the staff used mechanical lifts with one person unless the resident was combative, then two staff were used.
-At 7:45 a.m. LPN-B verified she had not received

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training on the use of the mechanical lifts since hire date. LPN-B stated all mechanical lift transfers should be performed with two staff. In addition, LPN-B stated she had received two days of orientation.

Oxygen/Respiratory care: F695

R5 had an order for the use of a continuous positive airway pressure (CPAP) machine and the staff failed to acknowledge and implement the order nor ensure R5 had the machine in order to use.

R5's Essentia Health Nursing Home Note dated 11/24/17, (admission history and physical) identified R5 as having a diagnosis of obstructive sleep apnea. R5's primary physican indicated R5 was to utilize a CPAP machine (used to treat sleep apnea) every night "indefinitely." R5's quarterly MDS dated 1/10/18, indicated R5 had moderate cognitive impairments and required total assistance of two staff members for bed mobility, transfers and all activities of daily living. The MDS did not indicate R5 utilized a CPAP machine. R5's clinical record lacked identification of the need to use and also a comprehensive assessment related to the use of a CPAP machine. R5's care plan dated 9/29/17, did not address the use of a CPAP.

Observation on 3/20/18, revealed R5 did not have nor did the staff offer to assist with or look for a CPAP machine in R5's room.

On 3/21/18, at 1:00 p.m. the RDCS reviewed R5's clinical record and confirmed R5 had an order to utilize a CPAP machine each night, however, the order was not identified, addressed

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on the care plan and a machine had not been provided.

On 3/22/18, at 2:40 p.m. RN-E reviewed R5's clinical record and confirmed R5 had an order for a CPAP machine, however, no further information regarding the CPAP was noted in the record. In addition, RN-E could not recall R5 ever utilizing a CPAP machine.

On 3/23/18, at 10:00 a.m. family member (FM)-A stated R5 had received a CPAP machine prior to his accident which left him as a quadriplegic. FM-A stated R5 was not comfortable with the CPAP machine and did not like it, however the staff had never questioned R5's family on the use of the CPAP machine and confirmed his personal machine had not been utilized since R5 was admitted to the facility.

Infection control: F880

An outbreak of Influenza had occurred at the facility and the staff failed to identify the need to implement isolation precautions and/or infection control practices to prevent the spread of infection.

The facility's Influenza-like Illness Line List form initiated on 1/5/18, indicated R12 had tested positive for Influenza A (highly contagious disease which is spread through air droplets) on 1/5/18. The form identified three additional residents (R125, R124, and R6) who also tested positive for Influenza A between 1/5/18, and 1/15/18. Eight additional residents were also identified as displaying flu like symptoms (including but not limited to fever, cough, muscle pain, headache or chills) during the identified dates as indicated

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F 726	Continued From page 157 below: -R21 displayed symptoms on 1/5/18, which included sore throat, cough, and sinus congestion. -R10 displayed symptoms on 1/6/18, which included vomiting, temperature of 101.8, and headache and on 1/7 and 1/8/18, symptoms included non-productive cough, productive cough with yellow phlegm and increased chest congestion. - R9 displayed symptoms on 1/10/18, which included a temperature of 101.2 degrees along with symptoms of sore throat, cough and sinus congestion. - R4 displayed symptoms on 1/10/18, which included a temperature of 101.1 degrees along with symptoms of sore throat, cough and sinus congestion. -R1 displayed symptoms on 1/15/18, which included a temperature of 100.5 degrees along with, sinus congestion -R8 displayed symptoms on 1/15/18, which included temperature of 100.8 degrees along with sore throat, cough, chills, and sinus congestion. - R227 displayed symptoms on 1/15/18, which included a temperature of 100.8 degrees along with muscle aches, head ache, cough, chills, and sinus congestion. - R2 displayed symptoms on 1/17/18, which included a cough chills and sinus congestions. Additional review of the infection control logs and resident clinical records revealed a lack of evidence that the aforementioned residents had isolation precautions initiated at the time of the symptom onset and/or as well as the implementation of personal protective equipment such as masks, gloves, gowns when caring for	F 726		

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residents with symptoms in order to prevent cross contamination from resident to resident during the provision of cares. The facility also lacked evidence the licensed staff had been trained and deemed competent on the identification of infectious outbreaks and when and how to initiate infection control precautions including the utilization of PPE as well as isolation measure to initiate.

The Superior Healthcare Management Minnesota Region Influenza, Prevention and Control of Seasonal (influenza) policy dated 12/27/17, directed the staff to initiate standard and droplet precautions for all residents identified with influenza.

During the monitoring visit on 3/25/18, RN-B, who was working as a floor nurse, was observed passing resident medications out. RN-B stated a new binder which contained staff education on the use of mechanical lifts and infection control policies and procedures was placed and the nurses station and all staff were instructed to review and sign indicating they had read and understood its contents. Time was not set up for this training rather, staff were to independently read and learn the information during their work shift, when time allowed. RN-B stated she was also instructed to perform staff competency tests for the staff that were working today (Sunday) in which she had not started, and was not sure if staff were tested yesterday or not because she had not had a chance to check into it.

-At 9:20 a.m. NA-B stated she had been "enlightened" regarding the need to use two people to transfer just one of the residents' who required the use of a mechanical lift and all the

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F 726	Continued From page 159 others could still be transferred with one staff person only. Employee Record Review: On 3/26/18, at 9:05 a.m employee personnel records were reviewed with the business office manager which revealed the following: Registered nurse (RN)-D was hired on 1/3/18. RN-D's personnel record contained a Job Description/Competency/Evaluation dated 1/29/18, which indicated the purpose of this position was to monitor the performance of non-licensed personnel and to also assist in modifying the treatment regiment to meet the physical need of the resident in accordance with established medical practices and the requirements of the policies and procedures of the facility. The Duties and Responsibilities section included but was not limited to the duty of: -observing resident skin and documentation per facilty policy -consult with the resident's physician in providing resident care and treatment, as necessary -routinely assess the total needs of the resident and adjust care plans as needed -is responsible for accurate observations, evaluation, and reporting of resident symptoms, sudden changes in condition reactions and progress to the physician and shift supervisor -is responsible for competent adminsitration of care and treatments according the physician orders and facility policy and procedure -implementation, progress and documention of restorative nursing program -review care plans daily to ensure that appropriate care is being rendered	F 726		

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F 726	Continued From page 160 -attends mandatory in-services. The form also indicated RN-D was competent with the provision of sterile wound care and followed proper procedure for hand washing, isolation, PPE, universal precautions, use of PPE when performing procedures that may involve exposure to to blood or body fluids, utilized appropriate lifting devices to ensure resident and staff safety, and would use only the equipment trained on how to use. However, the form included 157 competency requirement areas which were all dated as trained/completed on 1/29/18. The form was signed by the employee and the previous DON on 1/29/18, verifying all areas were reviewed, tested and completed on that day. The Certified Nursing Assistant Job Description/Evaluation annual and probationary from indicated the NA's were trained and competent in the following non inclusive areas: -report all changes in resident condition to the charge nurse -performed all assigned tasks in accordance with established policies and procedures -follow established polices concerning exposure to blood/body fluids -perform restorative and rehabilitative procedures as instructed -observe and report presence of pressure areas and skin breakdowns to prevent pressure ulcers -provide daily range of motion exercises, record data as instructed -maintained competency and is tested to be competent in hand washing, resident transfers, range of motion -follows proper procedure on hand washing, isolation, PPE, universal precautions and the safe	F 726		

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operations of equipment, and uses appropriate lifting devices to ensure resident and staff safety
-reports accidents to the manager/supervisor on duty
-uses PPE when performing procedures that may involve exposure to blood or body fluids
- will use only the equipment you have been trained to use and operate the equipment in a safe manner
The form had a total of 174 competency areas to be reviewed and deemed competent.

NA-C was hired on 12/10/14, NA-C's personnel record contained a Certified Nursing Assistant Job Description/Compentency/Evaluation dated 11/22/17. The form indicated NA-C was competent on all 174 identified aspects of the duties of the NA. NA-C's competency evaluation was completed in its entirety on 11/22/18, by the former DON.

NA-B was hired on 9/27/93. NA-B's personnel record contained a Certified Nursing Assistant Job Description/Competency/Evaluation form dated 11/21/17. The form indicated NA-B was competent on all 174 identified aspects of duty. NA-B's competency evaluation was completed in its entirety on 11/21/17, by the former DON.

NA-D was hired on 11/13/17. NA-D's personnel record contained a Certified Nursing Assistant Job Description/Competency/Evaluation form dated 11/28/17. The form indicated NA-D was competent on all 174 identified aspects of duty. NA-D's competency evaluation was completed in its entirety on 11/12/17, by the former DON.

NA-G was hired on 3/6/18. NA-G's personnel record lacked an orientation competency form.

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F 726	Continued From page 162 NA-H was hired on 6/8/17. NA-H's personnel record contained a Nurse Aide Training Inventory (orientation) form dated 6/10/18, in which a former NA had indicated NA-H had been instructed on all areas of employment/duties. However, NA-H's training form had not been revewed by a nurse. - At 9:42 a.m. the business office manager stated she did not know how the staff competency testing and training had been completed. - At 9:42 a.m. the administrator stated she had started at the facility on 1/18/18 and was unaware how the former DON had completed the competency training. However, verified it was not possible to train and test all staff on all aspects of their assigned job in a single day. The administrator stated true competency testing required the staff to complete return demonstrations of their knowledge. The administrator stated all staff would require retraining. - At 9:58 a.m. the business office manager stated to her knowledge, the facility staff had not received training on the abuse policy, falls, mechanical lifts or infection control. - At 10:10 a.m. the DON stated new employees received computerized training on basic practices along with on the job training with a co-worker. The DON stated she was unaware how competency testing had been done in the past, but stated she had not completed competency training for staff since assuming the DON role six weeks ago. The DON stated she would be working on a training program.	F 726		

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F 726	Continued From page 163 - At 10:13 p.m. LPN-A stated she could not recall any type of training on abuse, falls, mechanical lifts or infection control in the past year. On 3/24/18, at 9:15 a.m. NA-G stated after she was hired other nursing assistants showed her how to use the mechanical lifts however, she never watched a video or took a test. NA-G stated she didn't really feel comfortable when she used the mechanical lifts by herself and usually asked for help. NA-G stated she would like more training. NA-G stated she had received five days of orientation, which consisted of working on different shifts in order to get to know the residents' routines. The Facility assessment last revised on 3/19/18, included: Staff training is routinely completed upon hire and annually. The forms such as orientation checklist, skill checklists/competencies can be found on the shared T drive as well as individual employees files, and Relias learning. Employees train on their annual requirements identified by regulatory guidelines and the facility, in a classroom setting which occurred in the corresponding month of their birthday. Training took place immediately as identified. NAs and licensed staff had skill competency checklists that were reviewed upon hire along with their orientation training as well as reviewed periodically with their DON. Training topics included some of the following: -Communication -Resident rights -Abuse, neglect, exploitation and reporting requirements	F 726		

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F 726	Continued From page 164 -Infection control -Identification of changes in condition -Required in-service training for nurse aides. Inservice training must be sufficient to ensure the continuing competence of nurse aides, but also must be no less than 12 hours per year. Include dementia training and resident abuse prevention training. Competencies included: -Person-centered care: care planning, documentation of treatments and medications -Activities of daily: dressing, feeding, nail and hair care, perineal care, range of motion, transfers using gait belt and mechanical lift. -Infection control: hand hygiene, isolation, standard universal precautions including the use of personal protective equipment, MRSA/VRE/CDI precautions and environmental cleaning -Medication administration -Resident assessments and examinations: skin assessment, pressure injury assessment, observations in response to treatment -specialized care-diabetic glucose testing, oxygen adminsitration, wound care/dressings -Caring for residents with mental and psychosocial disorders, implementing nonpharmacological interventions. A policy related to staff competencies was requested and none was provided.	F 726		

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F 726	Continued From page 165	F 726		

On 3/21/18, at 12:42 p.m., registered nurse (RN)-C stated today was her second day of orientation and she had not received training on mechanical lifts since hire date.

RN-C's competency checklist was not available at the time of survey.

On 3/22/18, at 7:40 a.m. RN-D indicated she had not received training on the mechanical lifts since hire date.

-At 7:45 a.m. licensed practical nurse (LPN)-B indicated she had not received training on the mechanical lifts since hire date. LPN-B stated she had received two days of orientation.

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F 726	Continued From page 166	F 726		

On 3/24/18, at 9:15 a.m. nursing assistant (NA)-G stated after she was hired other nursing assistants showed her how to use the mechanical lifts however, she never watched a video or took a test. NA-G stated she didn't really feel comfortable when she used the mechanical lifts by herself and usually asked for help. NA-G stated she would like more training. NA-G stated she had received five days of orientation, which consisted of working on different shifts to get to know the resident's routines.

The Facility assessment last revised on 3/19/18, included:
Staff training is completed upon hire and annually routinely. Forms such as orientation checklist, skill checklists/competencies can be found on the shared T drive as well as individual employees files, and Relias learning. Employees train on their annual requirements identified by regulatory guidelines and facility need in a classroom setting that occurs in the corresponding month of their birthday. Training takes place immediately as identified.
CNA's and licensed staff have skill competency checklists that are reviewed upon hire along with their orientation training as well as reviewed periodically with their director of nursing.

Training topics included:
-Communication
-Resident rights
-Abuse, neglect, exploitation and reporting requirements
-Infection control
-Identification of changes in condition
-Required in-service training for nurse aides.
Inservice training must be sufficient to ensure the

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F 726	Continued From page 167 continuing competence of nurse aides, but also must be no less than 12 hours per year. Include dementia training and resident abuse prevention training. Competencies included: -Person-centered care: care planning, documentation of treatments and medications -Activities of daily: dressing, feeding, nail and hair care, perineal care, range of motion, transfers using gait belt and mechanical lift. -Infection control: hand hygiene, isolation, standard universal precautions including the use of personal protective equipment, MRSA/VRE/CDI precautions and environmental cleaning -Medication administration -Resident assessments and examinations: skin assessment, pressure injury assessment, observations in response to treatment -specialized care-diabetic glucose testing, oxygen adminsitration, wound care/dressings -Caring for residents with mental and psychosocial disorders, implementing nonpharmacological interventions.	F 726		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the	F 730	This Plan of Correction constitutes my	5/6/18

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F 730	Continued From page 168 facility failed to ensure 12 hours of annual inservice training was completed by 2 of 5 nursing assistants (NA-B, NA-C) whose personnel records were reviewed. Findings include: NA-B was hired on 9/27/93. NA-B's employee record indicated she had completed zero of the 12 required training hours from 9/27/16 to 3/26/18. NA-C was hired on 12/10/14. NA-C's employee record indicated she had completed 2.75 of the 12 required training hours from 12/16/16 to 3/26/18. On 3/26/18, at 10:09 a.m. the director of nurses (DON) stated all NA's were to received 12 hours of NA training per year. The undated Certified Nursing Assistant Job Description/Competency/Evaluations form indicated all NA's were to complete 23 hours of in-service training annually tracked from hire date not calendar year.	F 730	written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure 12 hours of annual in-service education training is completed by all nursing assistants. NA-B and NA-C were given the complete in-service requirements and they will have scheduled times to complete 12-hour trainings prior to 5-6-2018. 2. The facility has determined that all residents have to potential to be affected by this deficient practice if staff are not adequately trained to provide safe cares. 3. A tracking log of all annual in-service training has been created and provided to assure annual education requirements have been met for all Nursing Assistants. The DON (or designee) will provide 12 hours of annual in-service education for all nurse aids to include information based on performance reviews, resident needs and areas identified in QAPI and completion will be by 5-6-2018. 4. Beginning 4/24/18 the DON (or designee) has provided all NAs with assigned courses through Relias Learning for 12 hours of annual in-service trainings. DON (or designee) will monitor and assist staff to ensure completion by 5-6-2018. All new hires will begin completion in orientation before beginning to provide direct resident cares. In addition, monthly	

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F 730	Continued From page 169	F 730	in-services will be provided and tracked by DON (or designee) to assure ongoing compliance and education as determined by quality assurance committee. Education programs will identify areas of weakness determined from performance reviews, resident needs and areas identified in the monthly QAPI reviews. Audits of NA trainings will continue monthly for 6 months to assure that completion of assigned monthly education is occurring. Any deficiencies will be immediately corrected, and findings will be documented and reviewed at the monthly quality assurance committee meeting. 5. The DON (or designee) will be responsible for the POC.	
F 745 SS=G	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance and/or arrangements to obtain legal council, and provide therapeutic conversation for 1 of 1 resident (R21) who had urgent legal matters pending in court. Findings include: R21's admission record indicated R21 had diagnoses which included end stage renal disease (kidney failure) with dependence on renal	F 745	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure there is an organized social services department or program to provide	5/6/18

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F 745	Continued From page 170 dialysis, status post heart transplant, diabetes type II, major depressive disorder, heart failure, insomnia, and anemia. R21's annual Minimum Data Set (MDS) dated 12/20/17, indicated R21 had moderate cognitive impairment, had mood symptoms which included having little interest or pleasure in doing things, feeling tired or having little energy, and had trouble falling asleep or staying asleep, and displayed no inappropriate behavior symptoms. Review of R21's daily preferences revealed it was very important for R21 to take care of his personal belongings, use a telephone in private, and have a place to lock personal belonging to keep them safe. The MDS indicated R21 required extensive assistance of more than two persons for bed mobility, transfers, and dressing. R21 did not ambulate, and used a wheelchair as a mode of transportation. R21 was interviewed on 3/20/18, at 2:11 p.m. and stated he was frustrated because he was going through a divorce and the attorney he had retained to represent him had sent a letter at the end of February 2018, which indicated his attorney would no longer be representing him. R21 went on to say that he owned a home, and had many assets including having part ownership of a business. R21 stated he had not received any income from the business since living in the nursing home and was worried the business partners were taking his share of the profits. R21 stated he would call attorneys to represent him with the aforementioned legal matters if he had a cell phone but could not find anyone to purchase a phone for him. R21 stated he had told many of the staff including the current social service designee (SSD) as well as the previous SSD, he	F 745	medically related social services to each resident. If additional mental health, financial services or substance abuse is needed, the facility must ensure to make referrals to or collaborate with outside resources for the resident. The facility failed to provide arrangement or assistance with legal counsel for R21, as well as failed to provide therapeutic conversation for this individual who had pending legal issues in court that were urgent. SSD reviewed with R21 and assisted him with receiving legal counsel, has completed a psychosocial assessment to identify any unmet needs, and has updated the care plan to reflect ongoing therapeutic meetings to assist in psychosocial and family issues. 2. All residents can be affected by this deficient practice due to the obligation of the facility to ensure that medically related social services are provided to all residents. SSC will complete a psychosocial assessment on all residents by 5/4/18 and will updated the care plan to reflect any changes made. All policies and procedures were reviewed and updated. 3. To enhance currently compliant operations and under the direction of the Administrator, the SSD has received education from a LSW on 4/23/18 in other facility to increase support, training and education in current SSC role. On 4/24/18 SSC attended presentation from Pathway Health focusing on recent regulatory changes for social workers in post-acute care. Also reviewed job description, and regulatory requirements	

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F 745	Continued From page 171 was worried due not having an attorney to represent him in the divorce hearing that was scheduled for April 10th, 2018. R21's medical record was reviewed including all progress notes and assessments completed 11/1/18 - 3/20/18, and there was no evidence R21 had been assessed for any psychosocial issues, and there were no progress notes which indicated R21 was having difficulty or frustration related to pending legal/personal matters. A psychosocial assessment on R21 was last completed on 10/18/17, but had not identified any psychosocial issues at that time. R21's care plan (undated) was reviewed and interventions for R21's psychosocial dysfunction and family discord had not been developed. The social services designee was interviewed on 3/21/18, at 1:03 p.m. during which she stated she was aware R21 was going through a divorce and currently did not have a divorce attorney retained. The SSD stated she had not asked R21 when the divorce case was scheduled, and had not assisted R21 with the tools necessary to retain an attorney (a phone, listing of attorneys in the area, number to legal aide etc...). The SSD confirmed R21 had not been assessed to determine if he had any unmet psychosocial needs since 10/18/17. The SSD confirmed she had not developed a care plan to visit with R21 periodically in order to provide ongoing therapeutic conversation related to R21's psychosocial and family discord issues. On 3/23/18, at 8:43 a.m. a follow up interview was conducted with the SSD who stated R21 retained	F 745	of medically-regulated social series to support ensuring services are provided, as well as situations that would be required but can be obtained from outside entities. Policies are procedures were reviewed and updated policies. 4. Effective 4/24/2018, a quality-assurance program was implemented under the supervision of the SSC that all residents will be reviewed at time of admission, quarterly and with notable change to ensure psychosocial assessments are being completed thoroughly and completely. All triggers will be care planned and communicated to staff via care sheets and communication book if new interventions in place. SSC has provided verbal education to all nursing staff on what to report regarding new psychosocial concerns. This form has been provided for licensed staff and CNAs in their respective communication logs to communicate to SSC. A psychosocial assessment will be completed for all residents by 5/4/18 by SSC. Following initial assessment, SSC will continue to audit 25% of resident population each week for 2 months on psychosocial assessments, identifying and aiding and/or arrangements for medically-related social services and ensure that services are provided, as well as assuring ongoing therapeutic meetings to effectively assist in all resident□s psychosocial and medical □ related issues. Re-education and reinforcement will happen immediately on any discrepancies noted between progress notes, resident statements, care sheets	

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F 745	Continued From page 172 an attorney to represent him in his divorce and she assisted him in getting a prepaid VISA card to pay for the attorney's retainer fee. The SSD also stated she had discussed the potential of financial exploitation with his wife with whom he had been estranged. The SSD stated she got R21 a personal cell phone and that they were having a conference call with his attorney today at 4:00 p.m.. The SSD stated she was in the process of making a care plan which indicated she would visit with R21 at least weekly, or more often as needed, to provide support during this difficult divorce. On 3/27/18, at approximately 9:25 a.m. R21 was interviewed again and stated that when his attorney quit him back in February, and he knew he did not have access to another attorney or even a phone to call one, he felt frustrated and could not sleep at night due to worrying about what was going to happen if he did not get representation. R21 also stated he had a hard time eating and would have to force himself to eat. R21 stated he was still having anxiety because when he last spoke to his attorney's office, they told him that they could no longer assist him. He stated the SSD had not stopped in to follow up with him on where he was at on this matter. R21 stated he did not know how to get an email account and was still having great anxiety and frustration because he still did not know if he had an attorney retained because he was told that he needed to have an email account in order to receive communication from the attorney and did not know how to get one. On 3/27/18, at 9:29 a.m. the SSD confirmed she had not followed up with R21 since Friday. She stated she was not aware R21 needed an email	F 745	etc. The findings of the quality-assurance checks will be documented, reviewed and continue appropriate monitoring at the monthly quality-assurance committee meeting for further review or corrective action. 5. ED will be responsible for this POC.	

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F 745	Continued From page 173 account in order to receive information from his attorney. In addition, the SSD confirmed she had not shown R21 how to use the cell phone and stated she would assist him in setting up an email account and also linking the email account to his cell phone for ease of access and would follow up with the email address to his attorneys office. A policy regarding psychosocial assessment and services was requested but not provided.	F 745		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756		5/6/18

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F 756	Continued From page 174 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to act upon recommendation from the consultant pharmacist for 3 of 6 residents (R2, R23, R1) who had received recommendations from the pharmacist. Findings include: R2's annual Minimum Data Set (MDS) dated 11/2/17, identified R2 with severe cognitive impairments and diagnoses including Parkinson's disease, dementia and anxiety. The assessment indicated R2 required extensive assistance with all activities of daily living and did not display mood or behavior problems. The assessment indicated R2 received daily antipsychotic and antidepressant medications. R2's physician orders dated 1/2/18, included Seroquel (antipsychotic) 25 milligrams (mg) twice a day, remeron (antidepressant) 7.5 mg at bedtime, Prozac (antidepressant) 30 mg daily, and Klonopin (mood stabilizer) 0.125 mg one tablet every 24 hours as needed for agitation and anxiety.	F 756	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to provide pharmacy consultation along with drug review and follow up with all pharmacy recommendations for MD review. R2, R23 and R1 all had pharmacy consultations and none of the recommendations had been followed and the medications were primarily for behaviors which documentation and care plans failed to show any of the behaviors existing. After survey noted these concerns immediately DON met with pharmacy to get a reprint of any recommendations for march and met together on 4/19/2018 to review recommendations and review potential	

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F 756	Continued From page 175 During observations of personal cares on 3/21/18, at 11:30 a.m. R2 was observed to receive total assistance with cares from nursing assistant (NA)-C. R2 displayed no behaviors. R2's electronic medication administration record (EMAR) for 1/2018- 3/2018, indicated R2 had received the schedule doses of Seroquel and Remeron as ordered. R2 had not utilized the PRN Klonopin order. The EMAR also included daily documentation related to potential side effects of antidepressant, antianxiety and antipsychotic medications. The EMAR indicated R2 had not displayed any type of side effects from the medications. The EMAR did not identify R2's behaviors associated with the medications. Review of R2's Consultant Pharmacist Medicaiton Review form dated 7/20/17, indicated the pharmacist had questioned if a the Seroquel, remeron, Prozac or Klonopin could be considered for a dose reduction. R2's primary physican indicated he/she agreed with the pharmacist recommendations, however, R2's family refused to allow a dose reduction. A Consultant Pharmacist Medication Review form dated 9/19/17, indicated the pharmacist had requested non pharmacological interventions to be attempted prior to the administration of the Klonopin PRN and to identify the specific target behaviors to guide the use of the medication. The physican indicated he/she was in agreement with the recommendation and directed the staff to attempt non pharmacological interventions and document the findings. A Consultant Pharmacist Medication Review form	F 756	outcomes or corrections. 2. Because all residents receive their medications from our facility pharmacy and many medications are overly prescribed and resident's conditions change, it has potential to affect all residents. A pharmacy consultant meeting has been held and pharmacy consultant very open to assisting with any questions and facility needs. Recommendations of all resident's medications were reviewed for all residents and plan in place to ensure all residents have proper follow through. All staff dispensing medications should ensure they are given and if utilizing prn for more than 14 days update MD to do face visit to determine necessity and that behavior meds have proper diagnosis and documentation of behaviors. The policy on pharmacy consultation has been updated along with pharmacy policy book provided at nursing station. No other residents were affected. 3. To enhance currently compliant operations and under the direction of the director of nurses, on 5/1/2018 all nursing staff will receive in-service training on pharmacy expectations, monitoring prn medications related to 14 day rule, behavioral medications and need for dose reductions and/or behavioral charting, and making sure consultation reports are sent to MD's for orders and that when orders are returned copy given to DON. 4. Effective 4/19/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor resident medications and pharmacy follow up. The	

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F 756	Continued From page 176 dated 11/21/17, indicated the pharmacist had requested the staff to identify the non pharmacological interventions utilized prior to the administration of the medication. The pharmacist indicated target behaviors were not identified in the record. The primary physican was in agreement with the pharmacist findings. A Consultant Pharmacist Medication Review for dated 2/23/18, indicated R2 had not utilized the PRN Klonopin in the past month and questioned if the medication could be discontinued. R2's primary physican indicated R2's family member refused to consider a dose reduction or discontinuation of the medication. Review of R2's clinical record did not identify what specific types of individualized behaviors R2 displayed. Nor did the record include any non-pharmacological interventions to attempt if the PRN Klonopin was to be used. R2's record lacked a quantitative and qualitative evaluation of her behaviors in relationship to the medications. On 3/22/18, at 2:50 p.m. registered nurse (RN)-E confirmed the consultant pharmacist had made recommendations for R2, however, the facility lacked documentation that they had been completed. RN-E confirmed the facility did not have a comprehensive system to monitor residents behaviors in relationship to their mood altering medications. R23 utilized a PRN antianxiety medication and did not receive a 14 day re-evaluation of the medication. In addition, R23 received an antidepressant medication without adequate monitoring for the continued use of the medication.	F 756	DON or designee will follow up on all pharmacy consultant recommendations immediately, meet with pharmacy consultant monthly to review all medication recommendation started 4/18/2018 then complete 4 audits per week x 4 weeks, then 2 audits weekly x2 months to ensure compliance with follow up on consultation requests. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. Pharmacy and DON will be responsible for this POC.	

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R23's quarterly MDS dated 3/9/18, identified R23 with severe cognitive impairments and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R2 required extensive assistance with all activity of daily living. R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7 day review period.

R23's annual MDS dated 10/13/17, also indicated R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7 day review period

R23's Psychotropic Drug Use Care Area Assessment (CAA) dated 10/19/17, indicated R23 utilized antidepressant and antianxiety medications daily. The CAA indicated R23's behaviors put himself and staff members at risk for injury.

R23's Order Summary Report dated 2/23/18, included an order for Trazodone 50 milligrams (mg) to be given daily at beditme for anxiousness and insomnia. The order had been received on 3/31/17. R23 had a second order for Ativan (antianxiety medication) 0.5 mg to be administered as needed for agitation prior to morning and evening cares with one additional dose. The order was received on 9/7/17.

R23's care plan dated 3/27/17, indicated R23 had a history of being physically aggressive due to dementia. the plan directed the staff to administer

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medication as order and monitor/document the side effects and effectiveness of the medication.

R23's clinical record did not identify specific target behaviors for the use of the PRN antianxiety medication. Nor were non-pharmacological interventions identified to be administered prior to the medication administration.

Review of R23's electronic medication administration record (EMAR) indicated R23 had received 32 dose of PRN Ativan in 1/18, 48 doses in 2/18, and 23 doses in 3/18 from 3/1/18 - 3/22/18.

Review of R23's medical record lacked indication of non- pharmacological interventions attempted prior to the use of the PRN medication.

R23's Consultant Pharmacist Medication Review form dated 1/20/18, indicated the consultant pharmacist had identified R23's frequent use of antianxiety medication. The pharmacist indicated a PRN antianxiety medication required a 14 day face to face evaluation by the ordering physican. If the medication was to be continued, the record required clinical documentation for the continued need.

R23's primary physician replied on 1/26/18, and indicated R23 had significant anxiety and required the occasional doses of Ativan.

On 3/20/18, at 5:15 p.m. nursing assistant (NA)-D warned registered nurse (RN)-E that while assisting R23 with a meal, if food was spilt on R23, he had a history to attempting to strike out at his caregivers.
R1 received multiple psychotropic medications

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without an appropriate diagnosis, without adequate monitoring, and there was no justification for their continued use.

R1's quarterly MDS dated 12/27/17, identified R1 with severe cognitive impairments and diagnoses including Alzheimer's disease, high blood pressure, and type II diabetes. The MDS indicated R1 required extensive assistance with all activity of daily living. R1 displayed no signs or symptoms of psychosis or delirium and had no verbal and physical aggressive behaviors towards others. The MDS indicated R1 utilized antipsychotic and antidepressant medications daily.

R1's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/3/17, indicated R1 utilized antipsychotic and antidepressant medications daily which included the medications risperdone, and trazodone. The CAA had not indicated R1 had any inappropriate behaviors.

R1's Order Summary Report was requested but not provided.

Review of R1's medication administration record for March 2018 indicated R1 received the antipsychotic medication risperdone 0.5 mg every day and 1 mg twice a day for dementia without behavioral disturbance since May of 2017 (the exact date could not be found in documentation or through interview with staff) and received Depakote Sprinkles 125 MG since 1/16/2018 for restlessness and agitation. R1 received the antidepressant Trazodone 25 milligrams (mg) to be given twice a day for dementia with behavioral disturbance since 4/28/17.

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R1's care plan dated last revised on 12/28/17, indicated R1 target behaviors included wandering, being uncooperative, and continuous pacing. The care plan directed the staff to administer medication as ordered, monitor/document the side effects and effectiveness of the medication, report behavior changes to the physician, and provide non pharmacological interventions with include 1 to 1 activity, redirecting, and removing resident from environment to decrease target behaviors, anxiety, or depression.

The progress notes for R1 were reviewed from 1/1/18-3/21/18, and there were no documented incidence of inappropriate behavior for R1.

R1 was observed periodically throughout the survey on 3/20/18, from 12:30 -8:00 p.m. on 3/21/18, from 9:00 a.m. to 3:30 p.m. 3/22/18, from 7:00 a.m.-3:00 p.m. during which it was noted that R1 did not move on her own, was not able to verbalize, and had absolutely no inappropriate behaviors.

R1's Consultant Pharmacist Medication Review form dated 8/25/17, indicated the consultant pharmacist had identified R1 had been on Risperdone 0.25 in the morning and 1 mg twice daily and requested the physician to attempt a dose reduction or write a justification providing clinical documentation regarding the risk vs benefit of the continued dose. The follow-up action section indicated the physician accepted the recommendation, however there is no evidence the reduction was attempted or clinical justification statement had been documented. There were no further pharmacy recommendations regarding the use of the

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F 756	Continued From page 181 risperdone, depakote, or trazodone. However the facility could not find the recommendations from February 2018, and March 2018 had not yet been completed. The consultant pharmacist was interviewed on 3/27/18, at 8:59 a.m. and stated that the pharmacy review in July 2017 indicated the use of rispersone was for end of life delirium, but did not know if that diagnosis had been added to R1 record by the prescribing physician. Additionally, the consultant phamacist did not know if R1 had been showing signs of delirium in the past three months. The consultant pharmacist confirmed R1 had no current behavior symptoms that would justify the need for trazodone, risperdone, and depakote and had not recommded a decrease in any of those medications since August 2017 pharmacy review where only risperdone was recommended for decrease. The consultant pharmacist stated that she had not made any recent recommendations to R1's drug regimen.	F 756		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		5/6/18

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F 758	Continued From page 182 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who received as needed (PRN) antianxiety medications had rational for utilization of the	F 758	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	

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F 758	Continued From page 183 medication longer than 14 days. This practice affected 3 of 3 residents (R23, R2, R3) with orders for antianxiety medications. In addition, the faciilty failed to adequately monitor psychoactive medications regarding efficacy and on-going need for 5 of 6 residents (R23, R2, R6, R1, R3) reviewed for psychotropic medications. Finding include: R23 utilized a PRN antianxiety medication and the record did not contain a rational or duration of use for utilization of the medications greater than 14 days. In addition, R23 received antidepressant medication without adequate monitoring for the continued use of the medication. R23's quarterly minimum data set (MDS) dated 3/9/18, identified R23 with severe cognitive impairments and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living. R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7 day review period. R23's annual MDS dated 10/13/17, also indicated R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7 days during the review period R23's Psychotropic Drug Use Care Area Assessment (CAA) dated 10/19/17, indicated R23	F 758	admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to follow guidelines regarding use of PRN psychotropic medications. For R2, R23, and R3 the facility failed to ensure these residents who received their prn antianxiety medications had rationale for utilization of the medication longer than the 14-day regulation. These medications have been reviewed with pharmacy consultant and recommendations sent to MD for follow up documentation. The facility also failed to adequately monitor psychoactive medications efficacy and need for R23, R2, R6, R1, and R3. All medications have been reviewed with consultant and discussed at QAPI in April. The framework has been set to ensure adequate follow up with dose reductions, proper diagnoses, target behaviors put in place on TAR and overall compliance with the 14-day regulation. MAR□s and TAR□s updated and care plans updated. 2. Because many residents have orders for PRN psychotropics, many are potentially affected by the cited deficiency, staff were reminded to ensure safe environments and necessary interventions to redirect behaviors before utilizing medications if medications are needed consistently MD to schedule if medications needed often or discontinued if not used. This will occur every 14 days. All residents have been reviewed for	

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F 758	Continued From page 184 utilized antidepressant and antianxiety medications daily. The CAA indicated R23's behaviors put himself and staff members at risk for injury. R23's Order Summary Report dated 2/23/18, included an order for Trazodone (antidepressant) 50 milligrams (mg) to be given daily at beditme for anxiousness and insomnia. The order had been received on 3/31/17. R23 had a second order for Ativan (antianxiety) 0.5 mg to be administered as needed for agitation prior to morning and evening cares with one additional dose as needed throughout the day. The order was received on 9/7/17. R23's care plan dated 3/27/17, indicated R23 had a history of being physically aggressive due to dementia. The plan directed staff to administer medication as ordered and monitor/document the side effects and effectiveness of the medication. R23's clinical record did not identify specific target behaviors for the use of the PRN antianxiety medication. Nor were non-pharmacological interventions identified to be attempted prior to the medication administration. Review of R23's electronic medication administration record (EMAR) indicated R23 had received 32 doses of PRN Ativan in 1/18, 48 doses in 2/18, and 23 doses in 3/18 from 3/1/18 - 3/22/18. Review of R23's medical record lacked indication of non- pharmacological interventions attempted prior to the use of the PRN medication. R23's Consultant Pharmacist Medication Review	F 758	current as needed psychotropic meds for appropriate use. No other residents were affected. The policy on PRN psychotropic and psychotropic medications has been reviewed and revised. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all nursing staff will receive in-service training on utilizing PRN psychotropic medications that are ordered PRN for more than 14 days and the importance of physician doing visit to order continued use or schedule if needed consistently, indicating target behaviors noted in documentation, and non-pharmacological approaches. Psychotropic medications will be reviewed at quarterly and annual reviews to determine need, effectiveness or dose reduction. 4. Effective 4/19/2018, a quality-assurance program was implemented under the supervision of the DON to monitor residents with prn orders for psychotropic meds. The DON or designated quality-assurance representative will perform the following systematic audits on residents with orders for prn psychotropic; 50 % of residents x 4 weeks, then 25% of residents weekly x 2 months to ensure compliance in this area of PRN use as well as residents on psychotropic medications to ensure diagnosis, target behaviors and reductions. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented, submitted and monitored at the monthly quality-assurance committee	

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F 758	Continued From page 185 form dated 1/20/18, indicated the consultant pharmacist had identified R23's frequent use of antianxiety medication. The pharmacist indicated a PRN antianxiety medication required the record required clinical documentation from the physican for the continued need. R23's primary physician replied on 1/26/18, and indicated R23 had significant anxiety and required the occasional doses of Ativan. The physician did not indicate what type of non pharmacological interventions were to be attempted prior to the administration of the medication. On 3/20/18, at 5:15 p.m. nursing assistant (NA)-D warned registered nurse (RN)-E that while assisting R23 with a meal, if food was spilled on R23, he had a history to attempting to strike out at his caregivers. On 3/21/18, at 1:30 p.m. the regional director of clinical services (RDCS) reviewed R23's clinical record and confirmed the facility had not identified R23's target behaviors for the continued use of the as needed antianxiety medication. R23's record did not contain a rational for the use of the PRN ativan for a time period of greater than 14 days. Non pharmacological interventions had not been identified and the antidepressant medication had not been evaluated on a quarterly basis. The RDCS stated the facility did not have a system to monitor behaviors in relationship to their prescribed medications. On 3/22/18, at 7:10 a.m. R23 was observed to receive assistance with personal cares by NA-B and NA-C. R23 attempted to hit and kick at the staff during cares.	F 758	meeting for further review or corrective action. 5. The Pharmacy, SSC and DON will be responsible for this POC.	

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F 758	Continued From page 186 On 3/23/18, at 10:33 a.m. RN-B stated R23's behaviors included yelling, kicking and pinching during cares. RN-B stated staff was to offer R23 a drink or reapproach him. At times, R23 required a PRN Ativan, however, the facility did not have a system to document non pharmacological interventions prior to the administration of the medication. R2 received antipsychotic medications without adequate monitoring for the continued use of the medication. In addition, R2 had PRN antianxiety medication and the clinical record did not contain a rational or duration of use for the antianxiety medication utilized greater than 14 days. R2's annual MDS dated 11/2/17, identified R2 with severe cognitive impairments and diagnoses including Parkinson's disease, dementia and anxiety. The assessment indicated R2 required extensive assistance with all activities of daily living and did not display mood or behavior problems. The assessment indicated R2 received daily antipsychotic and antidepressant medications. R2's Psychotropic Medicaiton Care Area Assessment (CAA) dated 11/3/17, indicated R2 received antipsychotic and antidepressant medications and the staff was to monitor for side effects of the medications. R2's physician orders dated 1/2/18, included an order for Seroquel (antipsychotic) 25 milligrams (mg) twice a day, remeron (antidepressant) 7.5 mg at bedtime, Prozac (antidepressant) 30 mg daily, and Klonopin (antianxiety) 0.125 mg one tablet every 24 hours as needed for agitation and anxiety.	F 758		

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F 758	Continued From page 187 R2's care plan dated 12/28/17, indicated R2 utilized psychotropic medication. The plan directed the staff to monitor for target behaviors and document, monitor R2's behaviors, provide non-pharmaceutical interventions that included one on one interventions, redirecting and changing position. The plan also directed the staff to evaluate for the effectiveness of the medications. During observations of personal cares on 3/21/18, at 11:30 a.m. R2 was observed to receive total assistance with cares from nursing assistant (NA)-C. At no time was R2 observed to display any type of behaviors. R2's electronic medication administration record (EMAR) for 1/18- 3/18, indicated R2 had received the schedule doses of Seroquel and Remeron as ordered. R2 had not utilized the PRN Klonopin order. The EMAR also included daily documentation related to potential side effects of antidepressant, antianxiety and antipsychotic medications. The EMAR indicated R2 had not displayed any type of side effects from the medications. The EMAR did not identify R2's behaviors for which she was receiving the medications. Review of R2's Consultant Pharmacist Medication Review form dated 7/20/17, indicated the pharmacist had quested if the Seroquel, remeron, Prozac or Klonopin could be considered for a dose reduction. R2's primary physican indicated he/she agreed with the pharmacist recommendations, however, R2's family refused to allow a dose reduction.	F 758		

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- A Consultant Pharmacist Medication Review form dated 9/19/17, indicated the pharmacist had requested non pharmacological interventions be attempted prior to administration of the PRN Klonopin and to identify the target behaviors to guide the use of the medication. The physican indicated he/she was in agreement with the recommendation and directed the staff to attempt non pharmacological interventions and document the findings.

- A Consultant Pharmacist Medication Review form dated 11/21/17, indicated the pharmacist had requested the staff to identify the non pharmacological interventions prior to the administration of the medication. The pharmacist indicated target behaviors were not identified in the record. The primary physican was in agreement with the pharmacist findings.

- A Consultant Pharmacist Medication Review form dated 2/23/18, indicated R2 had not utilized the PRN Klonopin in the past month and questioned if the medication could be discontinued. R2's primary physican indicated R2's family member refused to consider a dose reductions or discontinuation of the medication.

R2's record contained an order dated 1/15/18, in which the primary physican requested to have R2 evaluated by a mental health practitioner.

R2's Behavioral Health evaluation dated 3/15/18, indicated during the evaluation R2's family member was present and reported R2 displayed hallucinations in the past and had suffered severe distress during past attempts at medication reductions. Therefore, the medications were not adjusted per the family request.

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F 758	Continued From page 189 Review of R2's clinical record did not identify what specific types of behaviors R2 displayed. Nor did the record include any type of non-pharmacological interventions to attempt if the PRN Klonopin was to be used. R2's record lacked a quantitative and qualitative evaluation of her behaviors in relationship to the medications. On 3/22/18, at 2:50 p.m. registered nurse (RN)-E stated the facility staff was to identify R2's target behaviors, monitor the behaviors and complete a monthly evaluation of the behaviors in relationship to the medications. RN-E stated the facility did not have a system in place to monitor the behaviors and at this time no staff member was reviewing the efficacy of the medications. R2's PRN Klonopin had not been utilized, however, R2's power of attorney refused to allow the medication to be reduced. RN-E stated R2's clinical record did not include documentation in which the risks and benefits of the medications had been discussed with the family member. On 3/23/18, at 10:40 a.m. registered nurse (RN)-B stated R2 did not display any type of adverse behaviors. R6 received antianxiety medications, without adequate behavior monitoring. R6's quarterly MDS dated 1/17/18, identified R6 with moderate cognitive impairments and diagnoses including depressive disorder, chronic atrial fibrillation and mitral valve disease. The MDS also identified R6 as feeling down and having little energy 2-6 days during the assessment period. R6 did not display behaviors. R6 required limited assistance of one staff for all	F 758		

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activities of daily living.

R6's admission MDS dated 6/29/17, identified R6 as having little to no interest in doing things, feeling down and depressed and feeling bad about herself on 2-6 days during the assessment period. R6 did not display any type of adverse behaviors at the time of the assessment.

R6's Psychotropic Medication CAA dated 6/29/17, indicated R6 utilized Buspar (antianxiety) for anxiety and Zoloft (antidepressant) for depression. The CAA directed the staff to monitor for the efficacy and side effects of the medications

R6's Order Summary Report dated 3/5/18, included an order for Buspar 10 mg every day. The Buspar was stared on 10/17/17, for "major depressive disorder." R6 also had an order dated 1/18/18, for Celexa 20 mg daily for the treatment of major depressive disorder.

R6's care plan dated 12/1/17, directed the staff to administer medications as ordered and monitor for side effects. R6's care plan did not identify target behaviors for the continued use of the antianxiety medications.

During the survey conducted from 3/19/18, - 3/27/18, R6 was not observed to display any type of behaviors. For example, on 3/21/18, at 12:25 p.m. R6 was observed in the main dining room eating the noon meal. R6 sat with two other residents, conversed with the other residents and when she was through with the meal, wheeled herself out of the dining room.

Review of R6's EMAR's for January, February

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and March 2018, indicated staff monitored R6 for generic symptoms of depression including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statement, repetitive anxiety and tearfulness. The EMAR's indicated R6 never displayed any of the aforementioned concerns. The EMAR did not identify specific individualized target behaviors for R6.

R6's Behavioral Health Psychiatric Progress Report dated 3/15/18, indicated R6's antidepressant medications had been changed in 1/18, from Zoloft to Celexa. Due to the change, the psychiatric nurse practitioner had opted not to reduce R6's antianxiety medication and continue to monitor R6's antidepressant medications. R6 was not displaying behaviors at the time of the evaluation.

Review of R6's Progress Notes dated 1/8/18, - 3/21/18, revealed no documentation of an evaluation of R6's behaviors after the antidepressant medications were changed on 1/18/18. The notes also lacked a comprehensive analysis of R6's behaviors/symptoms being treated with of the antianxiety medication.

On 3/22/18, at 2:50 p.m. RN-E stated the facility staff was to identify R6's target behaviors, monitor the behaviors and complete a monthly evaluation of the behaviors in relationship to the medications. RN-E stated the facility did not have a system in place to monitor the behaviors and at this time no staff member was reviewing the efficacy of the medications.

On 3/23/18, at 10:40 a.m. RN-D stated R6 did not display any type of adverse behaviors.

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R1 received multiple psychotropic medications without an appropriate diagnosis, adequate monitoring, or justification for continued use.

R1's quarterly MDS dated 12/27/17, identified R1 with severe cognitive impairments and diagnoses including Alzheimer's disease, high blood pressure, and type II diabetes. The MDS indicated R1 required extensive assistance with all activities of daily living. R1 displayed no signs or symptoms of psychosis or delirium and had no verbal or physical aggressive behaviors towards others. The MDS indicated R1 utilized antipsychotic and antidepressant medications daily.

R1's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/3/17, indicated R1 utilized antipsychotic and antidepressant medications daily which included the medications risperdone, and trazodone. The CAA had not indicated R1 had any inappropriate behaviors.

R1's Order Summary Report was requested but not provided.

Review of R1's medication administration record for March 2018, indicated R1 received the antipsychotic medication risperdone 0.5 mg every day and 1 mg twice a day for dementia without behavioral disturbance since 5/17 (exact date was not found in the record or through interview with staff) and received Depakote Sprinkles (mood stabilizer) 125 mg since 1/16/18, for restlessness and agitation. R1 received Trazodone (antidepressant) 25 mg to be given twice a day for dementia with behavioral disturbance since 4/28/17.

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R1's care plan dated last revised 12/28/17, indicated R1 target behaviors included wandering, being uncooperative, and continuous pacing. The care plan directed staff to administer medication as ordered, monitor/document the side effects and effectiveness of the medication, report behavior changes to the physician, and provide non pharmacological interventions with include 1:1 activity, redirecting, and removing resident from environment to decrease target behaviors, anxiety, or depression.

R1's Consultant Pharmacist Medication Review form dated 8/25/17, indicated the consultant pharmacist had identified R1 had been on Risperdone 0.25 in the morning and 1 mg twice daily and requested the physician to attempt a dose reduction or write a justification providing clinical documentation regarding the risk vs benefit of the continued dose. The follow-up action section indicated the physician accepted the recommendation, however there was no evidence the reduction was attempted or clinical justification statement had been documented. There were no further pharmacy recommendations regarding the use of the risperdone, depakote, or trazodone. However the facility could not find the recommendations from 2/18, and 3/18, had not yet been completed.

The progress notes for R1 were reviewed from 1/1/18-3/21/18, and there were no documented incidences of inappropriate behavior for R1.

R1 was observed periodically throughout the survey on 3/20/18, from 12:30 -8:00 p.m. on 3/21/18, from 9:00 a.m. to 3:30 p.m. 3/22/18, from 7:00 a.m.-3:00 p.m. during which it was noted R1 did not move on her own, was not able

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to verbalize, and had no inappropriate behaviors.

On 3/26/18, at 9:54 a.m. the regional director of clinical services (RDCS) reviewed R1's medication record and progress notes and confirmed R1 did not have appropriate diagnoses for the use of risperdone and depakote. R1's progress notes had not indicated any inappropriate behavior symptoms R1 had displayed from 1/1/18-3/22/18, and wandering and pacing is not appropriate indications for the use of risperdone, trazodone, and depakote.

R3's as needed (PRN) Ativan lacked duration and documented physician rational for exceeding beyond a 14 day duration. R3's face sheet dated 3/23/18, included diagnoses of asthma and chronic respiratory failure.

A communication note from the hospice service to a physician dated 2/26/18, requested R3's scheduled Ativan (antianxiety) 0.5 mg every four hours be changed to 0.5 mg PRN every four hours because the scheduled dose caused increased drowsiness. The physician's response on the communication identified agreement and orders to change Ativan to 0.5 mg every for hours as needed for anxiety. The order lacked a duration for use. R3's record lacked evidence of a physician's evaluation to extend the duration for use of the Ativan beyond 14 days.

R3's medication administration record (MAR) indicated between 3/1/18, and 3/23/18, Ativan 0.5 mg was administered on 40 occasions.

On 3/23/18, at 10:12 a.m. registered nurse (RN)-E indicated the physician should have documented a rational and a duration for the PRN

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F 758	Continued From page 195 Ativan. RN-E stated she thought the hospice physician was responsible for ensuring appropriate documentation for PRN psychotropic medications. On 3/26/18, at 10:27 a.m. the administrator indicated PRN psychotropic medication beyond 14 days required a physician justification and duration for use. Superior Healthcare Management Minnesota Region policy and procedure dated 12/23/17, identified the facility will make every effort to comply with state and federal regulations related to the use of psychopharmacological medications to include regular review for continued need, appropriate dosage, side effect, risks and/or benefits. Additionally, the facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environment, medical, and/or behavioral interventions, as well as psychopharmacological medications can be utilized.	F 758		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adaptive equipment to promote independence with eating for 1 of 1 residents (R23) reviewed for nutrition	F 810	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	5/6/18

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F 810	Continued From page 196 observed to display difficulty eating and drinking. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/9/18, identified R23 with severe cognitive impairments and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living including eating. R23's annual MDS dated 10/13/17, also identified R23 as requiring extensive assistance with eating. R23's Nutritional Status Care Area Assessment (CAA) dated 10/20/17, indicated R23 displayed disruptive behaviors and threw food during meals. The CAA consisted of check marks for the identified items, but no compressive assessment of R23's nutritional needs. R23's Nutritional Data V2.1 form dated 12/21/17, indicated R23 did not require adaptive equipment during meals. R23's Care Plan dated 1/20/18, indicated R23 was to utilize a plate guard for meals to ensure R23 was able to eat greater than or equal to 75% of the meal. On 3/19/18, at 10:47 a.m. family member (FM)-B stated R23 seemed to be very thirsty when FM-B visited the facility. FM-B stated she had brought R23 a covered cup to use in his room but was unaware if the staff were allowing R23 to use the cup.	F 810	admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to provide adaptive equipment to all residents in conjunction with OT to ensure resident remains as independent and high functioning as they can. R23 was noted to have divided plate in his care plan but not on diet card as dietary manager stated it had been discontinued and R23 was also noted to have very difficult time reaching table and food due to chair and spilled most of his beverage. Although special covered cup is in his room a covered cup was not available for meal service. OT to evaluation for more appropriate cup and divided plate will be put back on diet slip and covered cup used in dining room. 2. Because all many residents need adaptive devices many are potentially affected by the cited deficiency. This was discussed with dietary manager and dietician and it is agreed the diet slip will be updated when appropriate cup is determined and in meantime staff to encourage with assisting and utilizing divided plate and finger food type items. All residents with adaptive devices have been reviewed for use and appropriateness. No other residents were affected. 3. To enhance currently compliant operations all staff will be updated at in-service 5/1/2018 about adaptive equipment and importance of offering it or alerting charge nurse if further follow up is	

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F 810	Continued From page 197 On 3/19/18, at 12:05 p.m. R23 was wheeled into the dining room in a tilt and space wheelchair. R23's wheelchair was in a reclined position. R23 was positioned perpendicular to the table as his wheelchair was too high to fit under the table. - At 12:07 p.m. R23 reached for a glass of thickened juice and attempted to drink from the glass. R23 was observed to spill the juice onto his shirt as he was not able to get the glass to his lips without spilling. - At 12:10 p.m. R23 continued to pick up his glass, attempt to drink and spilled onto his shirt. - At 12:12 p.m. family member (FM)-A asked an unidentified staff member if R23 was able to feed himself. FM-A stated "I have never seen him try to do that before." - At 12:15 p.m. R23 again picked up his glass and spilled the juice onto his shirt. - At 12:17 p.m. nursing assistant (NA)-C served R23 the noon meal consisting of ham, potatoes and fruit. R23's plate was not observed to be equipped with a plate guard as NA-C began to feed R23 with the meal. - At 12:32 p.m. R23 had eaten approximately 1/3 of the meal with the assistance of NA-C. R23 continued to independently pick up his glass, attempted to drink, causing the liquid to spill onto his shirt. On 3/20/18, at 12:50 p.m. R23 was observed in the dining room. R23 had a meal consisting of sloppy Joe (sandwich on a hamburger bun) green beans and fruit. R23 was observed to hold the sandwich in his hand and eat it independently. NA-B attempted to assist R23 with the other meal items but R23 refused the assitance. - At 12:57 a.m. R23 was assisted out of the dining	F 810	needed to find another option. Reviewed respect and dignity with and importance of giving residents the tools they need to be successful in their ADL's. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the dietary manager to monitor adaptive devices and residents needing assistance. The dietary manager or designated quality-assurance representative will perform the following systematic changes: the dietary manager or OT will complete audits on residents with adaptive devices or needing devices for all meals during first week then 3 audits per resident per week x 4 weeks, then 1 audit x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. All staff will be responsible for this POC.	

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room . R23 had eaten 100% of the sandwich and bites of the other meal items. R23's shirt was observed to have spilled juice on it.

- At 5:00 p.m. R23 was observed to be seated perpendicular to the dining room. A glass of thickened juice was observed on the table, which R23 picked up and began drinking. R23's wheelchair was in a semi-reclined position as he began to take sips from the glass. R23 was observed to spill a small portion of the juice onto his shirt.
- At 5:06 p.m. NA-D served R23 a meal consisting of tuna noodle casserole, peas and a bun. R23's plate was not observed to be equipped with a plate guard. NA-D was observed to turn R23's wheelchair so he was able to face the meal and repositioned the wheelchair into an upright position.
- At 5:08 p.m. R23 picked up his spoon and began to feed himself.
- At 5:13 p.m. R23 attempted to drink a glass of juice and spilled it down himself and onto the floor. Once the glass hit the floor, R23 began to eat the meal with his fingers. R23 was observed to have a significant amount (greater than 1/2 of the food) spill onto himself, the table and the floor while eating. NA-D was not observed to assist R23 with eating the meal.
- At 5:17 p.m. registered nurse (RN)-E asked NA-D if she could assist in the dining room. NA-D directed RN-E to assist R23 and warned RN-E that if the food was spilled on R23, he had a history of striking out at the staff. RN-E sat next to R23 and realized the table was too low for R23 to sit properly. RN-E then reached under the table and raised the level of the table by cranking a lever on the table pedestal stand. R23 was then positioned under the table to reach the meal

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without over extending his arms.

- At 5:30 p.m. R23 had finished approximately 25% of of his meal with a significant amount of spillage noted on the floor, R23 and the table. R23 was not receptive to RN-E's attempts to assist him with the meal.
On 3/21/18, at 12:15 p.m. R23 was observed in the dining room. NA-B served R23 the meal. R23's plate was not observed to have a plate guard. NA-B was observed to sit next to R23 and feed him the meal.
- At 12:29 p.m. the dietary manager (DM) stated any type of adaptive equipment required at meals was identified on the resident dietary card. Review of R23's dietary card did not identify any type of adaptive equipment. The DM stated R23 had an order for a plate guard in the past, but it was discontinued about six weeks ago because at the time, R23 was not attempting to feed himself. The DM stated the nurses should have documented the discontinuation of the plate guard. The DM confirmed R23 had been feeding himself the past few days and a lip plate was not provided. The DM also stated R23 had not utilized covered cups at meals, but did have a covered up in his room brought in by the family members. The DM stated she had not noticed R23's ability to drink and had not requested R23 to be evaluated for additional adaptive equipment at meals.
Review of R23's clinical record lacked documentation related to the discontinuation of the plate guard.

On 3/21/18, at 1:45 p.m. the director of nursing stated she was unaware of the type of adaptive equipment R23 was to be utilizing at meals. To her knowledge, no staff member or family

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F 810	Continued From page 200 member had requested R23 to be evaluated for the use of adaptive equipment. The DON stated she would review R23's record for further information related to the plate guard discontinuation, but to her knowledge, no documentation had been completed. A policy related to adaptive meal equipment was requested and not provided.	F 810		
F 835 SS=F	Administration CFR(s): 483.70 §483.70 Administration. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure adequate administrative oversite for all 23 residents residing in the facilty. The systematic lack of oversite resulted in immediate jeopardy's (IJs) for 5 resident related to accident prevention and all 28 residents residing in the facility during the influenza season identified for infection control prevention. The facility's systemic failure to comprehensively assess and effectively implement interventions to prevent accidents and infection control measures could have resulted in potential serious harm, injury, impairment or death. This had the potential to affect all 23 residents residing in the facility. Findings include:	F 835	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure adequate oversite for all 23 residents residing in the facility. Lack of systemic oversite resulted in immediate jeopardies for 5 residents related to accident prevention and 28 residents residing in the facility during the influenza season related to infection control. This deficient practice had the potential to result in	5/6/18

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F 835	Continued From page 201 On 3/26/18, at 11:00 a.m. the facility administrator stated she had assumed the responsibilities for the administrator role on 1/18/18. At that time, she had identified system failures within the facility. The adminstrator indicated she had contacted the regional director of clinical services (RDCS)-B and the corporate chief of operations officer (COO) regarding the identified concerns. The administrator stated the system failures had been communicated, however, corrective plans had not been established to achieve compliance. Multiple systemic and care related issues and immediate jeopardy's were identified during the recertification survey. The following were the immediate jeopardy's: F689 related to resident elopement for R226 and any other exit seeking residents. The IJ which began on 3/21/18, at 10:01 a.m, was removed on 3/27/18, at 12:00 p.m. when the facility completed an elopement risk assessment on all residents and developed and implemented improved policy and procedures related to resident elopement and safety. F689 related to a systematic failure to identify and comprehensively assess the use of full body mechanical lifts to ensure residents did not receive injuries while utilizing the lift which included R2. The IJ began on 9/15/17, and was removed on 3/27/18, at 12:00 p.m., after the facility implemented a removal plan including a comprehensive assessment with individualized interventions for transfer. F689 related to a systematic failure to identify and comprehensively assess the use of a full body mechanical lift to ensure the staff members were	F 835	serious harm, injury, impairment or death. The vacant position of RDCS has been filled and additional support and guidance has been established for facility. Administration communication to the COO of the present system failures, lack of systems and current support that would be needed. COO acknowledged and supported in getting additional needed resources and support to assist in areas that were identified to need support. Systemic failures were identified, corrective actions were taken to identify all residents at risk and steps taken to prevent reoccurrences. 2. This deficient practice can affect all residents who reside in the facility. 3. To enhance currently compliant operations and under the direction of the Administrator and RDCS, facility policies and procedures were reviewed, revised, systems implemented and monitored. On 4/18/2018 the Administrator, DON, mentor DON and RDCS reviewed expectations for DON to report and review all nursing related concerns and questions with RDCS or mentor DON as identified. Administrator to consult with RDCS and report identified areas to COO. RDCS overseeing facility on-site and off-site, providing increased assistance and monitoring to facility to ensure compliance with identified areas of concern. RDCS and COO have also provided ongoing support from other facilities within company to timely and efficiently review and update areas identified facility. Nurse management from other SNF was assigned to assist on-site and to provide	

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F 835	Continued From page 202 utilizing the appropriate number of staff members during transfers for R18 who was observed to be transferred with one staff member in the lift, resulting in the potential for serious harm, injury impairment or death. The immediate jeopardy began on 9/15/17, and was removed on 3/27/18, at 12:00 p.m. after the facility completed a comprehensive assessment with individualized interventions for lift transfers. F689 related to a systematic failure to comprehensively assess and effectively implement fall interventions in order to minimize the risk for serious injury or death for R14 who had repeated falls and a cervical fracture resulting in the potential for serious harm, injury, impairment or death. The immediate jeopardy was removed for R14 on 3/27/18, at 12:00 noon after the facility comprehensively assessed R14 for falls and developed appropriate interventions. F689 related to a systemic failure to comprehensively assess and effectively implement fall interventions in order to minimize the risk for serious injury or death for R8 who had syncope episodes while utilizing a standing lift resulting in the potential for serious harm, injury, impairment or death. The immediate jeopardy that began on 9/15/17, and was identified on 3/22/17, at 12:08 p.m. was removed on 3/27/18, at 12:00 p.m. after the facility implemented a removal plan that included a comprehensive assessment and individualized interventions. F880 related to a systemic failure to develop and maintain an ongoing infection control surveillance program to identify potential infectious outbreaks. This failure resulted in an immediate jeopardy (IJ) due to an influenza A outbreak. This practice had	F 835	mentoring to facilities current DON. She will assist in support with developing, implementing, maintaining and sustaining systems to meet requirements of compliance and resident needs. Stratis Health has been contacted to assist facility to review systems, help identify opportunities for improvement and support to assure systems are in place and functioning. COO approved for the DON to attend a DON training to assist her in her new role. Another SNF□s DON and MDS Coordinator also assisting with additional clinical support on and off-site. Through these additional services, the DON will be able to ensure residents needs are maintained at the highest practicable level. SSC also receiving consulting services through experienced individuals within company to assist and is attending off-site training and mentoring. RDCS presently overseeing nursing facility systems and in constant communication with DON and Administrator in reviewing systems, identifying and monitoring systems and support needed and then reviewing progress and findings with COO. COO is reviewing and communicating this information with governing board to assure compliance. 4. To assure proper administration of the facility, proper oversight needs to be maintained to allow the facility to use its resources effectively and to efficiently ensure the resident□s highest level of physical, mental and psychosocial well-being are attained or maintained. This will be monitored through direct	

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F 835	Continued From page 203 the potential to affect all 28 residents residing in the facility at the time of the outbreak. In addition, the facility failed to ensure appropriate isolation precautions were initiated for R5 and R24 who were infected with organisms which required contact precautions. The facility failed to maintain appropriate infection control practices in the main laundry. This practice had the potential to affect all 23 residents residing at the facility. The IJ related to infection control practices and the initiation of isolation precautions began on 1/5/18. The IJ was removed on 3/27/18, at 12:00 p.m. when facility policies and procedures were reviewed, revised, and implemented and all staff were educated on the changes. Additional systemic issues included: F867 related to the quality assurance performance improvement (QAPI) committee was ineffective from 9/2017 through 1/17/2018, in which it failed to identify opportunities for improvement and develop measurable action plans with goals and plans to monitor for compliance. The facility's PAST non-compliance lead to multiple system failures. F725/F726 related to the facility failed to ensure sufficient, competent staffing was available in order to implement activity programs, and provide timely assistance with personal cares according to the residents' assessed need and as directed by the care plan. This practice was systemic and had the potential to affect all 23 residents who resided in the facility. F600/F607 related to the facility failure to develop and implement policies procedures related to the prevention of abuse/neglect and exploitation of	F 835	communication from Administrator to COO, as well as DON to RDCS. An audit has been created to identify areas that the facility will be expected to report and review with RDCS and COO of, updating at the time of incident or determination to review, and submitted weekly for 16 weeks then monthly for 4 months. Minutes and supporting documentation of QAPI meetings, as well as any Ad Hocs will be sent for review to RDCS and COO, and will be monitored until such a time that shows consistent substantial compliance with the regulations and until it has been determined from a representative of the regional executive team feels it is no longer needed. At that time reporting and communication will continue based on company expectations. 5. The Administrator will be responsible for this POC.	

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residents and misappropriation of resident property. In addition, the facility lacked polices and procedures for identification, protection, reporting, and investigating resident to resident abuse, elopement, and injuries of unknown source.

Multiple harm level deficient practices were identified including:

F686 in which the facility failed to provide appropriate assessment, monitoring and interventions to prevent the development of pressure ulcers for 4 of 6 residents (R5, R18, R2, R23) in the sample who had current pressure ulcers. The facility's failure to adequately assess, monitor and/or implement interventions resulted in actual harm for R5 who developed pressure ulcers while at the facility and for R18 who had recurrent pressure ulcers.

F688 when the facility failed to provide range of motion services as directed in order to prevent the decline in range of motion (ROM) abilities for 2 of 5 residents (R5, R2) observed to have had a decline in ROM which was not identified nor assessed to be to be unavoidable.

F745 in which the facility failed to provide assistance and/or arrangements to obtain legal council, and provide therapeutic conversation for 1 of 1 resident (R21) who had urgent legal matters pending in court.

Review of the Summary of Email communications between the administrator and corporate staff indicated the following information:

- 1/18/18, email sent to RDCS-B and COO

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regarding general compliance concerns related to Phase 2 requirements of the updated CMS Federal regulations.

- 1/20/18, email sent to RDCS-B and COO regarding the facility's newly hired director of nursing (DON) in need of training for the electronic medical record system (Point Click Care/PCC). Requested additional training for the DON and nursing staff.

- 1/25/19, email sent to COO requesting support for the DON and Minimum Data Set (MDS) nurse for additional training and to assist with survey preparedness.

- 1/31/18, email to COO notifying him of the administrator's approved shared licenses between two facilities.

- 2/9/18, email to RDCS-C requesting additional support to the DON in training.

- 2/16/18, email to COO and RDCS-C requesting staff members from the administrator's second facility be allowed to assist with staff training regarding PCC. Also expressed concerns that the DON, business office manger, social service coordinator and activity director had not been exposed to the survey process. The administrator requested additional training for staff regarding falls, skin /wound documentation, treatments and general documentation.

On 3/26/18 at 1:00 p.m. the administrator stated the COO, RDCS-B and RDCS-C responded to the emails through discussions in which they acknowledged the concerns of the facility but did not allow the administrator to move forward with

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F 835	Continued From page 206 any plan for assistance. A policy related to administration was requested but none was provided.	F 835		
F 837 SS=F	Governing Body CFR(s): 483.70(d)(1)(2) §483.70(d) Governing body. §483.70(d)(1) The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and §483.70(d)(2) The governing body appoints the administrator who is- (i) Licensed by the State, where licensing is required; (ii) Responsible for management of the facility; and (iii) Reports to and is accountable to the governing body. This REQUIREMENT is not met as evidenced by: Based on interview, the facility failed to ensure the governing body acted on the administrator's report of the facility's systemic failures related to lack of facility systems and policy/procedures governing the facility's functioning to ensure quality of care and quality of life for the residents. This had the potential to affect all 23 residents which resided in the facility. Findings include: An attempt was made to reach the president of the governing body (PGB) via telephone prior to the survey exit on 3/27/18, which was	F 837	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure that a governing body is responsible for establishing and implement policies regarding operation and management of facility, as well as appointing an	5/6/18

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F 837	Continued From page 207 unsuccessful, however, a message was left for a return telephone call. The president of the governing body was telephoned again on 3/28/18, at 11:20 a.m.. At that time, he was asked if the governing body was aware of the multiple systems issues identified during the survey of the facility that included lack of: policy development and implementation, staffing, infection control systems, and lack of abuse and neglect policy implementation. The PGB stated when the facility was purchased in 2/17, there was a transition period that ended on 6/30/17. The PGB stated the company had purchased nine homes together and by 11/17, the PGB realized all nine of the homes had major systemic issues, and all nine of the homes were either unmanaged or mismanaged. The PGB stated the first steps that were taken to reestablish healthy working facilities were getting staff hired into management positions, front line positions, and consultant positions. At the same time staff was being hired, policies and procedures were being developed consistent with the regulations. They were currently working on implementation of those policies and procedures. The PGB stated the governing body was aware of the total systemic failures, but there were so many issues they could not come into compliance by the time the recertification survey had taken place. They were working hard to rebuild the facility's management and operations to be in compliance with the federal and state regulations. Review of the Governing Board Meeting minutes dated 11/3/17, revealed the board was notified of the lack of sufficient staffing, quality assurance, and process improvement initiatives. Action plans needed included: Quality Metrics, Staffing, Review of previous state survey results, Resident	F 837	administrator who is licensed, responsible for management and expected to report and be accountable to the governing body. The facility failed to ensure the governing body acted on the administrator□s report of the systemic failures related to lack of facility systems, policy/procedures that governed the facility□s functioning to ensure quality of care and quality of life for all residents. During survey, the areas identified by Administrator were reported and reviewed with the Governing Body, who acted immediately upon these and plans were implemented to support facility to ensure quality of care and quality of life for the residents. The systemic failures were identified, corrective actions were taken to identify all residents at risk and steps taken to prevent reoccurrences. 2. This has the potential to affect all residents□ who reside at the facility. 3. To enhance currently compliant operations and under the direction of the Administrator, facility policies and procedures were reviewed, revised, systems implemented and monitored. On 4/23/18 a process was implemented for quality assurance; the Administrator is to directly report to the governing body monthly via email of QAPI minutes and supporting documentation. The Administrator is to report indirectly to the governing body through email notification to COO immediately with presence of MDH at facility, survey results, allegations of abuse or neglect, complaints, reportable events, upon identifying a systemic failure, identified concerns such	

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F 837	Continued From page 208 Council Review, Phase 2 requirements, and Unplanned Hospitalizations. Additionally, the governing board asked all locations to report, train and reinforce infection control practices across all departments.	F 837	as staffing, and update status of these instances for quality assurance purposes monthly at a minimum. The Administrator is also responsible and held accountable to report information indirectly to the governing body through the COO of audits, open staffing positions and recruitment and retention plan, supplies needed for facility to meet resident needs which is done as determined when systems fall outside of budgeted expectations or deemed necessary for meeting resident needs for quality of life purposes and updating of changes made to facility assessment at time of change. COO is reviewing and communicating this information with governing board to assure compliance. 4. To assure proper administration of the facility, proper oversight needs to be maintained to allow the facility to use its resources effectively and to efficiently to ensure the resident□s highest level of physical, mental and psychosocial well-being are attained or maintained. This will be monitored to ensure direct communication of identified areas occur from Administrator to Governing Board, as well as expected items communicated indirectly to Governing Board through notification to COO, including responses to assure facility has an active governing body. An audit has been created to identify areas that Administrator will be expected to report to the Governing Board, and submitted to the COO for review weekly for 16 weeks then monthly for 2 months. Minutes and supporting documentation of QAPI meetings, as well	

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F 837	Continued From page 209	F 837	as any Ad Hocs will be directly emailed to COO and governing board, and will be monitored until such a time that shows consistent substantial compliance with the regulations and until it has been determined from a representative of the regional executive team that it is no longer needed. At that time reporting and communication will continue based on company expectations. 5. The Administrator will be responsible for this POC.	
F 841 SS=F	Responsibilities of Medical Director CFR(s): 483.70(h)(1)(2) §483.70(h) Medical director. §483.70(h)(1) The facility must designate a physician to serve as medical director. §483.70(h)(2) The medical director is responsible for- (i) Implementation of resident care policies; and (ii) The coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the medical director failed to ensure facility policies and procedures had been developed and implemented to ensure quality of resident care. This deficient practice had the potential to affect all 23 residents who resided in the facility. Findings include: The facility medical director (MD) was interviewed on 3/26/18, at 11:43 a.m. during which she stated she made rounds at the facility a minimum of once a week, she was available by telephone at	F 841	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure that the facility has a medical director who is responsible for implementation and helping evaluate resident care policies	5/6/18

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F 841	Continued From page 210 any time, and attended the quality assurance meetings at least every three months. The MD stated she was involved with developing and implementing quality action plans for sufficient staffing, and stated a large portion of the issues in the facility were related to the rapid turn over in both front line staff and management staff. The MD stated she was very involved in the influenza outbreak that had occurred in January, but was not aware staff was not wearing proper personal protective equipment (PPE) to minimize the spread of infection to other residents. The MD was not aware if the facility had proper infection control policies developed and implemented. The MD stated falls were reviewed at every QAPI meeting, however was not aware if the facility had proper policies and procedures to follow so fall risks were minimized. Review of all the facility policies for infection control, abuse prohibition, falls, use of mechanical lifts, pressure ulcers, psychotropic medication monitoring, resident rights, admission transfer & discharge, and dignity, revealed none had been signed indicating approval by the medical director. The regional director of clinical services was interviewed on 3/26/18, at 1:26 p.m. and confirmed the medical director had not reviewed and approved any of the aforementioned policies.	F 841	and coordination of medical care in the facility. The facility failed to meet this requirement by the medical director□s failure to ensure the facility policies and procedures had been developed and implemented to ensure quality of resident care. QAPI met on 2/20/18 where it was identified by Administrator that present system was not reviewing operations, identifying OFIs, prioritizing OFIs, determining the root cause and implementing PIPs. In discussion with Medical Director and QAPI members, it was determined and reviewed that QAPI had previously been ineffective. Administrator educated everyone on the QAPI program, the guidelines, processes and how to analyze data, etc. to begin to effectively address systemic failures to improve quality at facility. On 4/17/18 it was identified by Administrator via plan of correction that Medical director review of policies, for infection control, abuse prohibition, falls, use of mechanical lifts, pressure ulcers, psychotropic medication monitoring, resident rights, admission transfer and discharge, and dignity had not occurred and an Ad Hoc was initiated on 4/17/18 to assure that the medical director is involved in development, review and approval of resident care policies by including their input specific to our resident population and facility needs. Specific review of these policies also includes quality assurance members and will be brought for further discussion and review at next QAPI scheduled on 5/15/2018. 2. This has the potential to affect all	

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F 841	Continued From page 211	F 841	residents who reside at the facility. 3. To enhance currently compliant operations and under the direction of the Administrator, facility policies and procedures were reviewed, revised, systems implemented and monitored. After identification of ineffective QAPI program, education was provided and reviewed by the Administrator during the 2/20/18 QAPI. Areas reviewed were how to identify the elements and goals of the QAPI program, assistance and tools for accurate data review, and proper identification of root cause while assuring goals are SMART (specific, measurable, attainable, realistic and time oriented). Medical Director contract was reviewed by Administrator and Medical Director on 4/17/2018; discussed expectation that Administrator must ensure all responsibilities of the Medical Director are effectively performed to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being in accordance with regulatory guidelines and responsibilities outlined for Medical Director on the agreed contract. 4. To assure the facility has a medical director who is helping to evaluate resident care policies, implementation of, and coordination of medical care in the facility; the Administrator or designee will conduct weekly audits to assure that the facility is effectively communicating and properly notifying the Medical Director of resident events, collaborating on areas of concern and timely responses from Medical Director are occurring. Audits to include monthly participation of QAPI from	

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F 841	Continued From page 212	F 841	Medical Director, responsibilities of the Medical Director to facility are being completed accurately and in accordance with contract and Administrator to ensure effective performance of responsibilities of medical director until such a time that shows consistent substantial compliance with the regulations and until it has been determined by Administrator and COO that it is no longer needed. 5. The Administrator or designee will be responsible for this POC.	
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F 842		5/6/18

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records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and

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F 842	Continued From page 214 (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure clinical records were complete and accurate for 7 of 20 resident (R5, R2, R23, R6, R13, R21, R225) records reviewed. This had the potential to affect all 23 residents residing in the facility. Findings include: R5's medical record did not accurately reflect wound care. On 3/21/19, at 2:05 p.m. registered nurse (RN)-D was observed to remove a Duoderm dressing from R5's sacrum. Upon removal of the dressing RN-D identified two newly opened areas under the dressing. RN-D measured the first open area on the left buttocks to be 1 cm x 0.3 cm. The second open area noted on the lower left buttocks measured 2 cm by 2 cm. The three areas under the dressing approximately 1 inch in diameter were observed to be deep red/purple in color and were not blanchable. RN-D stated the wound had changed appearance since the last time she had observed it. RN-D stated the open areas were new and the wound looked worse. Review of R5's clinical record on 3/23/18, lacked documentation related to the wound care and measurements from 3/21/18. On 3/23/18, at 9:30 a.m. RN-E reviewed R5's record and confirmed the facility had not completed any type of documentation related to the newly identified open areas identified on	F 842	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure that the medical records are maintained medical records on each resident that are complete, accurately documented, readily accessible and systematically organized. The facility failed to assure that clinical records were accurate and complete for R5, R6, R13, R21, R2, R23, R225. All licensed nurses were retrained on 4/25/18 and 5/1/18 by DON and other facility Nurse management on requirements of accurate medical record documentation and processes and Ad Hoc implemented regarding this. 2. All resident can be affected by the deficient practice. The policy on has been reviewed and revised. 3. To enhance currently compliant operations and under the direction of the DON, on 5/1/2018 all nursing staff will receive in-service training on complete, accurate, readily accessible and systematically organized medical record requirements for all residents. Documentation will be reviewed and monitored by director of nursing to assure	

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F 842	Continued From page 215 3/21/18. On 3/27/18, at 9:30 a.m. RN-D confirmed she had not completed any type of documentation regarding R5's wounds treated on 3/21/18. RN-D stated she "spaced it." R5's Progress Note dated 3/13/18, at 11:20 p.m. indicated R5 had a 6 cm by 3 cm bruise which was yellow/green in color with some pinkness surrounding the bruise. The documentation did not identify where the bruise was located or the origin of the bruise. No further documentation related to the bruise was noted in R5's record. Review of R2's clinical record revealed the following information: R2's Lift Mobility Status form dated 12/31/17, indicated R2 did not have the ability to bear weight on his/her legs. R2 did have the ability tolerate a semi-reclined position and indicated R2 was to be transferred with a MaxiMove (brand name of a full body mechanical lift). The rest of the form was incomplete, as it was blank. R2 had not been assessed to identify the appropriate size sling nor did it identify the number of staff memebers required to transfer R2. An incident report dated 9/15/17, indicated R2 had sustained a skin tear on her left inner elbow while being transferred with a mechanical lift which required first aid. The documentation did not identify the root cause of the injury, the number of staff members present at the time of the injury or interventions to minimize further injuries. An incident report dated 10/29/17, indicated R2	F 842	the policies are being enforced. 4. Effective 4/24/2018, a quality-assurance program was implemented under the supervision of the DON to monitor resident for accurate and complete documentation, assuring electronic documentation and proper organization of information is followed. The DON or designee will perform the following systematic audits on residents; 50 % of residents per week x 4 weeks, then 25% of residents weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. The DON will be responsible for this POC.	

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had sustained a skin tear on the back of the right hand while being transferred via a full body mechanical lift. The documentation did not identify the root cause of the injury, the number of staff members preset at the time of the injury or interventions to minimize further injuries.

An incident report dated 11/15/17, indicated R2 had sustained a skin tear and bruise on her left hand while being transferred via a full body mechanical lift. The documentation did not identify the root cause of the injury, the number of staff members present at the time or interventions to minimize further injuries.

Further review of R2's clinical record lacked documentation related to the identified injuries.

On 3/22/18, at 11:50 a.m. the regional director of clinical services (RDCS) confirmed the facility did not have any further documentation related to R2's injuries and the number of staff members present at the time of the injuries was unknown.

On 3/27/18, at 10:05 a.m. the administrator stated she had identified a concern with documentation in the facility and had been attempting to train staff members on how to improve documentation. The administrator stated the facility would be developing an action plan to ensure complete and accurate documentation.

R23's Care Plan dated 1/20/17, indicated R23 was to utilize a plate guard for meals to ensure R23 was able to eat greater than or equal to 75% of the meal.

On 3/19/18, at 12:05 p.m. R23 was observed to

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be served the noon meal. R23's plate was not equipped with a plate guard.

On 3/20/18, at 12:05 p.m. R23 was observed to be served the noon meal. R23's plate was not equipped with a plate guard

On 3/20/18, at 5:05 p.m. R23 was served the evening meal. R23's plate was not equipped with a plate guard.

On 3/21/18, at 12:15 p.m. R23 was served the noon meal. R23's plate was not observed to have a plate guard.

- At 12:29 p.m. the dietary manager (DM) stated any type of adaptive equipment required at meals was identified on the resident dietary card. Review of R23's dietary card did not identify any type of adaptive equipment. The DM stated R23 had an order for a plate guard in the past, but it was discontinued about six weeks ago because at the time, R23 was not attempting to feed himself. The DM stated the nurses should have documented the discontinuation of the plate guard.

Review of R23's clinical record lacked documentation related to the discontinuation of the plate guard.

On 3/21/18, at 1:45 p.m. the DON stated she was unaware of the type of adaptive equipment R23 was to be utilizing at meals. The DON stated she would review R23's record for further information related to the plate guard discontinuation, but to her knowledge, no documentation had been completed. No further information was provided regarding R23's plate

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guard.

R6's clinical record lacked documentation related to the pacemaker monitoring.

R6's Care Plan dated 6/28/17, identified R6 as having a pacemaker due to atrial fibrillation. The care plan did not direct the staff to assist to monitor the pacemaker via telephonic monitoring.

R6's clinical record lacked documentation related to the pacemaker monitoring.

- At 1:05 p.m. licensed practical nurse (LPN)-B confirmed R6 had a pacemaker and stated the scheduled telephonic monitoring were to be completed by the nursing staff. LPN-A stated the scheduled times were to be identified on the electronic medication administration records (EMAR). LPN-B reviewed R6's EMAR and stated the EMAR did not include pacemaker monitoring.

- At 1:17 p.m. LPN-B entered the medication room and located a pacemaker telephonic monitoring device. LPN-B confirmed she had no idea the last time R6 utilized the machine.

On 3/23/18, at 11:50 a.m. RN-E confirmed R6's medical record lacked documentation related to the pacemaker evaluations.

On 3/27/18, at 9:25 a.m. LPN-A stated the pacemaker monitoring was scheduled in the nurse's appointment book at the desk. LPN-A then identified R6 had a pacemaker check on 2/13/18. LPN-A stated she had not completed the pacemaker check. LPN-A stated that upon completion of the pacemaker monitoring, the clinic staff directed the staff as to when the next

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monitoring was to take place. Upon review of the calendar, LPN-A stated R6 did not have a scheduled pacemaker check in the next six months.

- At 9:30 a.m. RN-D stated she had completed the pacemaker check via telephone in February 2018, however, she had not documented the monitoring in the medical record.
During interview on 3/19/18, at 9:24 a.m. R13 stated R21 used to be his roommate and currently lived a couple doors from him, however, he could not get along with R21. R13 stated R21 would threaten to "beat him up" most recently being just two days ago. R13 stated about two months ago, when he was by the nursing station with staff present, R21 had "rolled up and punched him in the left shoulder." R13 denied being injured. R13 stated the staff who had witnessed the incident told R21 he had to "settle down." R13 denied being afraid of R21 and stated "all he is, is one big mouth" and that he tried to stay away from R21 as much as he could.

On 3/20/18, at 1:10 p.m. nursing assistant (NA)-B stated R21 and R13 used to be roommates who did not get along and would swear at each other so they got separate rooms. NA-B stated currently, when R13 would wheel past R21's room, R21 would call R13 names and had also witnessed the aforementioned altercation between R13 and R21. However, R13's and R21's clinical records lacked evidence of the resident to resident altercation.

During review of the facility's computerized risk management incident list, an incident whereby R225 had eloped from the facility was noted and the police had returned R225 to the facility,

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unharmed. On 3/20/18, at 6:30 p.m. Cook (C)-A stated R225 was not happy about being at the facilty and had eloped from the facilty a couple of times. C-A stated the incident with the police department was not the only time R225 had gotten away or attempted to leave the facility. C-A recalled another incident which occurred "way" before the police department incident, where he was going to go pick up R225 after he had left the facility and was downtown at a gas station which was across from the police department. C-A stated "somebody" had called the facility and informed the staff that one of their residents was there, however, that "somebody" had given R225 a ride back to the facility before he could go get him. C-A stated R225 used a wheelchair and would have had to get downtown by wheeling himself down the middle of the street as that was the only area of the road that had been plowed open following the snow fall. C-A remembered R225 being appropriately dressed for the cold winter temperature. R225's clinical record lacked evidence of this elopement and frequent, daily attempts to elope.

On 3/20/18, at 1:49 p.m. the administrator and the DON and the regional director of clinical services (RDCS) were informed of the altercation and all stated they were unaware the altercation had occurred and was not noted in the clinical records. At 4:25 p.m. the RDCS, administrator and the DON confirmed R225 had eloped from the facility on one occasion, however was not aware of the previous elopement which occurred prior to employment at the facility.

The Superior Healthcare Management Minnesota Region Medical Records Safeguarding policy and procedure dated 12/23/17, did not address the

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F 842	Continued From page 221 required contents of a resident's medical record.	F 842		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the Quality Assurance Performance Improvement (QAPI) committee failed to identify and develop action plans related to multiple system failures which included areas of elopement, falls, safe use of mechanical resident, staffing and staff competencies, infection control, range of motion services, pressure ulcers, social services, abuse prohibition in order to ensure quality care. This had the potential to affect all 23 residents residing at the facility. Findings include: On 3/27/18, at 8:34 a.m. the administrator and director of nursing (DON) were interviewed about the facility's current QAPI program activities. The administrator stated she had started at the facility on 1/17/18, which had been previous executive director's (ED) last day. The administrator stated she had reviewed the facility's QAPI minutes and identified they had lacked content and identification of system issues, had no corresponding data or action plans, and the facility had not implemented the newly developed phase II nursing home requirements federally	F 867	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure that the Quality Assurance Performance Improvement committee identifies and develops appropriate action plans related to system failures. The facility failed to have appropriate action plans related to system failures including elopement, falls, safe use of mechanical lift for residents, sufficient staffing and competent staff, infection control, range of motion services, pressure ulcers, social services and abuse prohibition to ensure quality of care. QAPI met on 2/20/18 where it was identified by Administrator that present system was not reviewing operations, identifying OFIs, prioritizing OFIs, determining the root cause and	5/6/18

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F 867	Continued From page 222 implemented 11/27/18, which included the completion of a facility assessment. The administrator stated upon identification of the lack of systems, she had requested assistance from the facility's corporate office in order to help to train the new director of nursing and assist with fixing the system problems identified however, her requests were denied. The DON stated she had identified system issues related to documentation, reporting, and fall incident completion, however, her primary focus had been on staffing, recruitment, scheduling, and identifying root cause of system breakdowns in order to develop and implement specific action plans for compliance. The administrator stated the quality assurance committee met monthly and the first one she conducted was on 2/20/18. She stated the committee members were unaware of how to gather specific quality data as well as any facility statistical information. She also stated the facilty's Point Right computer based tool used to gather the facility's quality indicator information was incorrect and not up to date and had to educate all of the facilty managers on how access it and how to revise the information so statistics were valid. The administrator explained the tool had not reflected actual facility statistics and there had been no evidence in QAPI minutes which had reflected where or how Point Right statistics of the quality indicators had been assessed or identified. Adminstrator indicated she had to explain to the members of the QAPI committee the expectations of data collection including how it was collected, analysis of the data collected, evidence of action plan completion areas, and monitoring for compliance.	F 867	implementing PIPs. In discussion with Medical Director and QAPI members, it was determined and reviewed that QAPI had previously been ineffective. Administrator educated everyone on the QAPI program, the guidelines, processes and how to analyze data, etc. to begin to effectively address systemic failures to improve quality at facility. 2. Lack of appropriate action plans for system failures can affect all residents at the facility. After identifying system failures from survey, ad hocs were identified and implemented, and brought to following scheduled QAPI on 4/17/2018. At this meeting, opportunities for improvement were identified, prioritized, root cause was determined, and performance improvement plans were initiated, reviewed and continue to be monitored. 3. To enhance currently compliant operations and under the direction of the Administrator, education was provided by Administrator to the quality assurance committee on 2/20/2018 when it was determined that previous meetings were ineffectively being conducted. Education reviewed the elements and goals of the QAPI program, assistance and tools for accurate data review, and proper identification of root cause while assuring goals are SMART (specific, measurable, attainable, realistic and time oriented). On 5/1/2018 all staff will receive in-service training regarding QAPI program, who is on the committee and their roles, what is discussed, frequency of meetings, who to report suggestions to bring to QAPI,	

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F 867	Continued From page 223 QAPI committee action plans were reviewed from 9/2017 through 2/2018. QAPI plans dated 2/5/18, included the following opportunities for improvement: implement phase II requirements, general compliance concerns, nursing department not at level where they need to be operating, facility assessment, abuse prevention program, reporting abuse neglect, clinical protocols, and decision tree. The areas identified had an action plan and notes indicated they would be reviewed at the next QAPI meeting and plan to identify more specific opportunities for focus. The QAPI committee log dated 2/20/18, indicated presentation of plans dated 2/5/18, and identified a concern with the way QAPI data had been gathered. The notes included, medical director and team stated the information in the past meetings didn't contain quality information and members of the committee were not sure where to gather data. Specific measures for improvement to ensure the deficient practice did not reoccur and monitoring system were identified. The forms used for QAPI logs from 9/1/17 through 1/16/18, were printed on forms belonging to the previous corporate owner. The logs lacked ongoing quality assurance activities in order to maintain compliance with identified areas of deficient practice. The logs further lacked identification of specific areas/systems that required performance improvement for compliance. QAPI logs further lacked evidence of root cause analysis with supporting evidence, and identification of comprehensive action plans that included specific goals and time frames for	F 867	where monthly posting of review of prior months QAPI are, etc. 4. The QA committee will meet monthly to discuss action plans related to deficiencies noted during survey, review and analyze audits and determine appropriate continued monitoring or system changes in addition to other items already identified on the QAPI plan agenda. The medical director will be present monthly and pharmacy consultant will be present at a minimum quarterly; if not present minutes will have submitted to them prior to meeting to allow for input during meeting, then will be reviewed and signed monthly. Audits are in place and reviewed monthly to assure that all supporting documentation from each department head is submitted to the Administrator the Monday prior to meeting for adequate time to review. After QAPI the minutes and supporting documentation will then be sent to RDCS and COO for review. This plan of correction will be monitored at the monthly QAPI meeting and audits to continue until such a time that shows consistent substantial compliance with the regulations and the facilities QAPI plan has been met, as determined by a representative of the regional executive team. 5. The Administrator or designee will be responsible for this POC.	

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implementation and completion. The logs also lacked evidence action plans were implemented, analyzed and revised as necessary to ensure successful completion. The logs had no monitoring systems to assist in ascertaining areas in need of improvement. The logs identified reported areas were carried over from month to month with no change.

QAPI committee logs for 9/19/17 included:
-Elopement identified staff response to wander guard alerts needed improvement and maintenance monitored the wonder guard system. There was no evidence of root cause analysis of staff response time or evidence of an action plan to improve response time.
-Falls number of falls reported could not definitively be determined based on how the report was completed however, indicated three of which occurred all on evening shift; root cause minimally identified residents not using their call lights or asking for help. The plan indicated "working on getting more staff". The plan lacked an analysis of what other areas impacted residents related to the need for more staff on evening shift and lacked identification of interim interventions until more staff were hired. In addition there was no evidence of a monitoring plan.
-Mechanical Lift- new policy: "lift policy of two staff members"
-Infection control identified the number of infections and type, indicated no action was needed because most residents admitted with infections from hospital. Lacked action plan to prevent the spread of infection and monitoring to maintain compliance, and root cause analysis of infections that were facility acquired (nosocomial).
-Pressure ulcers identified number of impaired

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F 867	Continued From page 225 skin integrity including identification of reoccurring pressure ulcers. The root cause analysis only indicated that most wounds were present upon resident admission. There was no evidence of root cause analysis of ulcers that were reoccurring, no evidence of an action plan to improve, or prevent worsening. Furthermore there was no indication monitoring systems had been developed and implemented. -Nurse competency status none completed waiting for forms from corporate. QAPI committee logs dated 10/17/17, included: -Elopement continued to repeat information in previous month. -Infection control remained unchanged from previous month. Although the influenza season began on 10/1/17, there were no influenza prevention activities identified. -Mechanical lift identified an injury to one resident during a lift transfer related to resident getting scared and grabbing onto the bars. There was no further review. -Falls PIP for personal alarms indicated all personal alarms were removed on 10/6/17, with the exception of one resident. The plan only identified "get all alarms removed". Fall tracking indicated eight falls, twice as many as the previous month, with reasons that included not using call light, not asking for assistance, and under-staffed during the evening shift. No further action plan discussion noted. -Pressure ulcers identified the number of pressure ulcers with reoccurrence. Root cause identified as, "Most are residents admitted with G-tubes (gastrointestinal tubes utilized for feeding/medications when unable to swallow) /sores/surgical wounds. Some residents who are incontinent have reoccurring abrasions/open area	F 867		

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on buttocks". The plan further lacked an action plan and there was no evidence a monitoring system was developed and/or implemented.
-Nurse competency status same as previous month.

QAPI committee logs 11/21/17, included:
-Elopement same as previous two months.
-Infection control same as previous two months. No influenza prevention activities were identified.
-Mechanical lift injuries identified one resident (same resident from previous month) with two incidents that resulted in skin tears on hands and arms from grabbing onto the bars. The action plan lacked a root cause analysis, evidence of actions taken, or a plan to monitor for efficacy.
-Falls report indicated a total of 16 falls, which was doubled from the previous month. No further action plan discussion.
-Nurse competency status identified as in progress, and forms were just received from corporate.
-Pressure ulcers the report indicated an increase in pressure areas .and indicated the facility was working with corporate and the brief company.

QAPI committee logs dated 12/19/17, included:
-Elopement continues to be a concern related to staff response time as in 3 previous months.
-Infection control identified number of infections and type. No further analysis or discussion. Indicated hand washing competencies had been completed.
-Mechanical lifts for third consecutive month the same resident was identified. Plan remained unchanged.
-Falls indicated there were 4 fall occurrences during the month; 3 falls related to slipping out of recliners and one for lower extremity weakness.

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F 867	Continued From page 227 No analysis was available. -Pressure ulcers identified an increase in pressure ulcers, however all information including action plan was the same as the two previous months. -Staffing This first month PIP identified "increasing staff while increasing census". The plan did not identify minimum staffing levels or if current needs were being met. There was no evidence of how the planned staffing ratios were determined. There had not been a facility assessment developed which included staffing ratios. -Nurse competency status identified to be in progress. No further information provided. QAPI committee logs dated 1/16/18, included: - Elopement of a resident who went to the police station. The root cause was identified as resident confusion and staff response was slow to wander guard alarm. Staff slow response to wander guard system had been identified every month since September. The plan lacked any further analysis or planning. -Infection control infections included bronchitis/respiratory and cellulitis. Notes identified "influenza in house" and Minnesota Department of Health Infection Control Assessment and Response Program's (ICAR) scheduled visit had to be rescheduled due to Influenza A. The report did not identify outbreaks, patterns/trends of influenza, infection control prevention measures taken, if the infections had been reported to the state agency, or ongoing monitoring systems. The analysis for the identified infections concluded that hand washing competencies needed to be completed. -Pressure ulcers reflected an overall decrease in the amount of pressure ulcers. The root cause	F 867		

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analysis and plan were unchanged. "Due to pressure areas/wetness working with corporate and brief company to remedy situation."
-Falls a performance improvement project (PIP) for falls indicated the facility had a goal to remove all personal safety alarms to align with the corporate goal. All of the alarms had been removed on 10/6/18, with the exception of one resident. The report further indicated the facilities progress to meet the goal had been not obtained related to nursing replacing alarms on residents, however, indicated the last alarm was removed on 1/11/18. The fall report indicated a total more than a two fold increase since September, however it is unclear if the data was accurate. There was no evidence of how the fall data had been collected, root cause analysis, or development/implementation of an action plan to minimize the risk of falls.
-Nurse competency indicated competencies were in progress. No other information was recorded.
-Staffing Second month of PIP and indicated same concerns with staffing and resident census. The plan did not identify minimum staffing levels, did not identify services that were impacted, or an analysis on impact of resident quality of care/quality of life. In addition, the facility did not evaluate and develop a plan for the provision of care and services when enough staff was not available based on the outlined goal. A facility assessment had not been completed.

QAPI Committee Guideline last revised 2/17, included the QAPI committee monitors and sustains living center operational performance in clinical and non-clinical systems through self-identification and improvement in areas where opportunities for improvement (OFI's) have been identified.

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F 867	Continued From page 229 The facility conducts performance improvement projects (PIPs) to examine and improve care or services identified in OFi's. System chart included; Review of operations, identify OFI's through data review, trends observation, prioritization of OFI's, determine root causes using fish bone, 5 whys, and process steps, implement PIP smart goals, approach, development, learning, integration (ADLI), sustain outcome. QAPI PIP LOG: conduct PIPs to examine and improve care or services in areas that are identified as needing attention. A PIP is a concentrated effort on a particular problem in one area of the facility or facility wide; it involve gathering information systemically to clarify issues or problems, and intervening for improvements. PIPs are selected in areas important and meaningful for the specific type and scope of services unique to the facility. The guidelines directed to review quality measures (QM)'s and directed on how to summarize and analyze data including reviewing trends, determining root cause, identify education opportunities, and need for education. The guidelines then directed to determine an action plan based on collected data.	F 867		
F 880 SS=L	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.	F 880		5/6/18

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F 880	Continued From page 230 §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 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	F 880		

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F 880	Continued From page 231 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 develop and maintain an ongoing infection control surveillance program to identify potential infectious outbreaks. This failure resulted in an immediate jeopardy (IJ) due to an influenza A outbreak from 1/5/2018 - 1/18/2018, in which droplet precautions were not initiated for 4 residents (R12, R124, R125, and R6) who tested positive for influenza A, and for 8 additional residents (R21, R10, R9, R4, R1, R8, R227, and R2) who displayed signs and symptoms of influenza. In addition, policies and procedures related to infection control had not been developed and implemented. This practice had the potential to affect all 23 residents residing in the facility at the time of the outbreak. In addition, the facility failed to ensure contact precautions were initiated for 2 of 2 residents (R5, R24) who were infected with organisms which required contact precautions. Additionally, the	F 880	1. The goal of the facility is to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease. During the survey, it was noted 5 residents were confirmed to have influenza, 3 received treatment HS, MY, CS. HG refused treatment, and unsure of why 5th E.S. did not receive treatment. It was then noted per infection control log that 8 other residents showed signs and symptoms of influenza but were not confirmed. No documentation as to why they were not tested to confirm diagnosis. Carts were not supplied in halls, signage was not on individual doors and in interviewing staff they were unsure of where to find PPE and what different type of precautions there were. Staff interviewed by regional director on 3/25/18	

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F 880	Continued From page 232 facility failed to ensure appropriate hand hygiene was completed for 3 of 8 residents (R8, R18 and R2) observed to receive medications. This practice had the potential to affect all 23 residents residing at the facility. Findings include: The IJ related to infection control practices and the lack of initiation of isolation precautions began on 1/5/18, when R12 was diagnosed with influenza A and the facility failed to initiate standard and droplet precautions to prevent the transmission of influenza to other residents. Three additional residents (R125, R124 and R6) tested positive for influenza and 8 other residents developed flu like symptoms. Influenza A is a highly contagious disease which is spread through air droplets. The administrator and the director of nursing (DON) were notified on 3/23/18, at 4:05 p.m. of the IJ. The IJ was removed on 3/27/18, at 12:00 p.m., however, non-compliance remained at a scope and severity level of F, which indicated a widespread systemic failure which had the potential to affect all residents residing in the facility. According to the Centers for Disease Control (CDC) an outbreak of influenza in a long term care facility is identified as two or more residents testing positive for influenza. Individuals with influenza are encouraged not to mingle with others and standard and droplet precautions are to be initiated. (reference: www.CDC.gov). Most people who get influenza will recover in a few days to less than two weeks, but some people will develop complications (such as pneumonia) as a result of the flu, some of which can be life-threatening and result in death. Pneumonia,	F 880	(2 nurses and one aide) that all residents that had symptoms did stay in their room while not feeling well, staff had access to masks and if residents did come out they wore them as well, but only residents without symptoms could go to dining room. Signs were up for notification and sanitizer and masks were available at entrance. In another situation, a resident TL was diagnosed with MRSA in his g-tube site and no precautions were in place to prevent transmission. The facility failed to initiate, monitor and implement an infection control program. Basic infection control precautions were not taken, and the program failed to prevent further cross contamination from residents and staff. The facility was not adequately educated on standard, contact and droplet precautions nor where adequate signs available to ensure staff knew who was on isolation or where isolation carts were located. No negative outcome was identified to be caused by the alleged deficient practice. 2. Corrective action taken for those residents having the potential to be affected by the alleged deficient practice: Residents that require special isolation precautions have been reviewed and identified and the procedure for putting those precautions has been put into place. Residents receiving antibiotics currently have had their orders reviewed to ensure no cross-contaminating pathogens or viruses have gone unnoticed. The director of nursing along with pharmacy consultant have reviewed antibiotic list. To prevent any potential	

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F 880	Continued From page 233 bronchitis, sinus and ear infections are examples of complications from flu. The flu can make chronic health problems worse. On 3/23/18, at 8:00 a.m. the regional director of clinical services (RDCS) stated the facility did not have a nurse identified to act as the facility's infection control preventionist. The RDCS stated all infection control surveillance and concerns were to be directed to the director of nursing. - At 8:30 a.m. the administrator and the DON were interviewed regarding the infection control practices of the facility. The DON stated she had assumed the responsibilities of the DON in January 2018, and the only infection control log she was able to locate was for an influenza outbreak in January 2018, which had been completed by the former DON. The DON stated she had completed the infection control surveillance logs the week of 3/12/18, for the months of January, February and March 2018, after having reviewed resident records and identifying there were residents who had been treated with antibiotics. The DON confirmed the logs did not include the tracking or trending of illnesses which were not treated with antibiotics. The Influenza-like Illness Line List form initiated on 1/5/18, indicated R12 had tested positive for Influenza A on 1/5/18. The form identified three additional residents (R125, R124, and R6) who also tested positive for Influenza A between 1/5/18 and 1/15/18. Eight additional residents were identified as displaying flu like symptoms (including but not limited to fever, cough, muscle pain, headache or chills) during the identified dates.	F 880	spread of infection, appropriate infection control practices will be implemented, including isolation, the use of standard precautions, and utilization of personal protective equipment. 3. Measures/Systemic changes put in place to assure the alleged deficient practice does not re occur: All staff were immediately educated regarding findings to include infection prevention program which were put into effect immediately. All staff (nursing, housekeeping and leadership team) in building 3/24 and 3/25 have been educated on where isolation carts are (more have been ordered), what the different precautions are and when to ensure isolation precautions are put in place to reduce further transmission. All staff will be educated on their next shift prior to working. Ensuring staff also understand indirect vs. direct transmission. Infection Control Program will be led by the director of nursing and discussed quarterly at QAPI the program goals are to: 1. Investigate, control, and prevent infections in the facility; 2. Decides what procedures, such as isolation should be applied to an individual resident according to pathogen determined; 3. Maintain a record of incidents (outbreaks or trends) and corrective actions related to infections. All residents determined to need isolation will be monitored and isolation precautions utilized immediately. 4. Corrective actions will be monitored	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 234 According to the facility information printed off of the Minnesota Department of Health website dated 9/21/16, influenza transmission occurred predominately by large respiratory droplets that are expelled from the respiratory tract during coughing or sneezing. The droplet particles usually did not remain suspended in the air, and close contact (usually less then three feet) was required for transmission. Infectiousness begins 24 hours prior to the onset of the illness. Adults were usually contagious until five days after the onset of illness. The incubation period for influenza was identified as one to four days. The website directed the facility to control an influenza outbreak by the implementation of standard and droplet precautions for all residents with suspected or confirmed influenza. The precautions were to remain in place for seven days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever was longer. Examples of Standard Precautions were identified as: - wear gloves - wear gowns if clothes may be soiled with respiratory secretions - change gloves and gowns after each resident encounter - perform hand hygiene before wearing gloves and after removing gloves Examples of Droplet Precautions were identified as: - private rooms if possible - cohorting ill residents if private rooms were unavailable - wear a facemask upon entering the resident	F 880	to ensure the alleged deficient practice will not re occur: • Infection Control Program – The director of nursing or designee will review all orders taken daily to monitor for residents needing isolation precautions. This will be done daily for one month, and then reviewed by QAPI to determine if further monitoring needed. • Preventing Spread of Infection – New easy to disinfect carts have been ordered, supplies to pre-stock as well as signage have been put together. These carts will be inventoried and stocked every night shift as new nightly process to ensure carts are ready and available at any time. • Education – Staff will be in-serviced immediately to infection control practices and educated on where supplies are located, new resource binder at nursing station, education will be put into new hire packet, infection control will be reviewed at annual in-service. Infection control audits will be completed by director of nursing or designee on employees randomly selected but to ensure all employees are reviewed once a week over next 3 months and then randomly for next 3 months, so every employee will be reviewed during that time frame and then results will be discussed at QAPI to determine if further monitoring needed. These audits will ask staff where carts are located, can staff identify each different type of precaution, where is the infection plan located and indirect vs indirect contamination. Completed 3/25/2018 Further review since survey all residents	

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F 880	Continued From page 235 room - have the resident wear a facemask if movement or transportation is necessary. The Superior Healthcare Management Minnesota Region Influenza, Prevention and Control of Seasonal (influenza) policy dated 12/27/17, directed the staff to initiate standard and droplet precautions for all residents identified with influenza. R12's quarterly Minimum Data Set dated 1/26/18, indicated R12 had intact cognition, required limited to supervision/set up for activities of daily living, did not walk, and was independent with locomotion on and off the unit. The MDS also indicated R13 was offered but declined the influenza seasonal vaccine. R12's Doctor's Order Sheet indicated on 1/8/18, R12 had been sent to the emergency room on 1/5/18, due to an increased temperature, cough, yellow mucous, and lethargy. R12 was diagnosed with influenza A and treated with Tamiflu (an anti-viral medication to treat influenza). Although R12's clinical record reflects staff had instructed R12 to remain in his room during his illness, there is no evidence droplet precautions had been implemented. R124's admission MDS indicated R124 had severely impaired cognition, required extensive assistance of one to two staff for all activities of daily living, and had received the influenza vaccine prior to admission to the facility. R124's Progress Note (PN) dated 1/7/18, indicated at 7:20 a.m. R124 had a low grade temperature, non productive cough with wheezing	F 880	admitted with pathogen which needs isolation have been reviewed. Infection control measures in place, pre-set up carts ready with signage and no further residents have been identified. One resident did present with MRSA and proper procedure was followed. Handwashing audits done on all staff during first week. Then 4 staff per week x2 weeks and 2 staff per week x2 months. Facility remains in compliance.	

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noted and was treated with Tylenol. At 11:20 a.m. no further wheezing was noted, however, R124 stated she was coughing up yellow phlegm. R124 stated she felt better than she had the night before.
-A PN dated 1/8/18, at 2:10 a.m. indicated R124 continued with a low grade temperature, wheezing, and a non productive cough. R124 had remained in her room in order to prevent the spread of infection.
-A PN dated 1/8/18, at 10:51 p.m. indicated R124 had vomited, was restless and her skin was warm to touch. Temp 101.6, has loose productive cough, increased wheezing, and oxygen saturation was at 80%. R124 was sent to the emergency room for an evaluation.
-A PN dated 1/8/18, at 2:52 a.m. indicated R124 was admitted to the hospital for treatment of influenza A and pneumonia.
Although R124's clinical record reflected isolation to her room, the record lacked evidence of the implementation of droplet precautions.

R125's admission MDS dated 1/9/18, indicated R125 had moderate cognitive impairment and extensive to limited assistance from one staff person for all activities of daily living. The MDS also indicated R125 was offered but declined the influenza seasonal vaccination.

R125's PN dated 1/11/18, indicated the resident had fallen and was sent to the emergency room. A subsequent note indicated R125 was transferred to another hospital for neurological care.
-A PN dated 1/16/18, indicated R125 remained in the hospital and was diagnosed with and treated for influenza.
-A PN dated 1/17/18, indicated R125 returned to

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the facility with diagnoses including influenza A, and urinary tract infection, required oxygen use and assistance of one staff of all activities of daily living.
-A PN dated 1/18/18, indicated R125 had attempted self transfers several times, therefore the staff member assisted R125 up and took her down to the nurse's station which was directly located in the main corridor of resident and visitor traffic flow.
-A PN dated 1/18/18, at 3:35 p.m. indicated R125 continued to have adventitious lung sounds and would be getting up for supper.
-A PN dated 1/19/18, at 2:58 a.m. indicated R125 had expired.
-R125's clinical record lacked evidence of the implementation of infection control precautions.

R6's clinical record contained a Status Change Notification dated 1/8/18, which indicated the facility had been notified R6 had tested positive for influenza A. R6 received an order for Tamiflu and an antibiotic for the treatment of pneumonia.

Review of R6's progress notes from 1/8/18 - 1/17/18, revealed from 1/8/18 - 1/14/18, R6 remained in her room. However, on 1/14/18, R6 was noted to have a temperature of 99.0 degrees Fahrenheit, an occasional cough, and raspy voice. On 1/15/18, R6 ambulated to and from the dining room for meals. On 1/16/18, R6 remained her her room as she was not feeling well.

Further review of the Infection control log for January 2018, revealed eight additional residents who had displayed symptoms of influenza.

-R21 displayed symptoms on 1/5/18, which included sore throat, cough, and sinus

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congestion.

-R10 displayed symptoms on 1/6/18, which included vomiting, temperature of 101.8, and headache. On 1/7 and 1/8/18, symptoms included non-productive cough, productive cough with yellow phlegm and increased chest congestion.

- R9 displayed symptoms on 1/10/18, which included a temperature of 101.2 degrees along with symptoms of sore throat, cough and sinus congestion.

- R4 displayed symptoms on 1/10/18, which included a temperature of 101.1 degrees along with symptoms of sore throat, cough and sinus congestion.

-R1 displayed symptoms on 1/15/18, which included a temperature of 100.5 degrees along with, sinus congestion

-R8 displayed symptoms on 1/15/18, which included temperature of 100.8 degrees along with sore throat, cough, chills, and sinus congestion.

- R227 displayed symptoms on 1/15/18, which included a temperature of 100.8 degrees along with muscle aches, head ache, cough, chills, and sinus congestion.

- R2 displayed symptoms on 1/17/18, which included a cough chills and sinus congestions.

Additional review of the infection control logs lacked indications that the aforementioned residents had isolation precautions initiated at the time of the symptom onset.

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Review of the quality assurance performance improvement (QAPI) committee meeting log dated 1/16/18, identified infections of bronchitis/respiratory and cellulitis. Notes identified "influenza in house" and Minnesota Department of Health Infection Control Assessment and Response Program's (ICAR) scheduled visit had to be rescheduled due to influenza A. The report did not identify outbreaks, patterns/trends of influenza, infection control prevention measures taken such as initiation of transmission based precautions (isolation), if the infections had been reported to the health department, or ongoing monitoring systems. The analysis for the identified infections concluded that hand washing competencies needed to be completed. In addition, the QAPI logs did not address any quality assurance activities for influenza preparations or prevention measures for the influenza season that began on 10/1/17.

On 3/23/18, at 8:15 a.m. licensed practical nurse (LPN)-B stated she could not recall utilizing any type of isolation precautions in the facility. LPN-B confirmed the facility had an outbreak of influenza, yet isolation precautions had not been utilized.

-At 8:20 a.m. NA-A stated she could not recall utilizing infection control isolation gowns in the past six months.

- At 8:52 a.m. the DON confirmed the facility had four residents who tested positive with influenza A and 9 additional residents who displayed flu-like symptoms. The DON confirmed the facility had not implemented droplet precautions as directed.

- At 10:21 a.m. NA-C opened the supply closet

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and was able to locate all PPE supplies. NA-C stated the facility had not utilized PPE in the past six months. NA-F joined the conversation and NA-F also confirmed the facility had not utilized PPE in the past six months.

- At 10:42 a.m. RN-B stated the facility had not utilized PPE in the past year. RN-B stated gloves and masks were utilized during the influenza outbreak by some staff, but at no time were gowns utilized.

- At 1:55 p.m. the HUC stated during the influenza outbreak in 1/2018, the former DON printed a sign off of the CDC website and posted it on the front door. The HUC stated the facility did not have any type of signs in the facility to notify staff, resident or visitors, when/if a resident had a potential contagious infection. The HUC stated the facility had signs in the past but she had not seen them for many years. The HUC stated she could not recall the last time PPE was utilized at the facility.

During the monitoring visit on 3/25/18, at 8:54 a.m. RN-B stated infection control education binders had been placed at the nurses station for all to review and sign off, however, she stated she had not had time to review them yet.

-At 9:16 a.m. NA-G stated the only training she had been provided was related to the use of the mechanical resident lift and neck brace.

The IJ that began on 1/5/18, was removed on 3/27/18, at 12:00 p.m. when the facility completed the following interventions were verified through observation, staff interviews and record review:

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F 880	Continued From page 241 - Infection control policies and procedures were reviewed and updated. - Additional personal protective equipment (PPE) was ordered for the facility. - All staff members were educated on where the PPE was located. - Infection control signs were ordered for future use. - All staff were educated on the facility infection control polices and procedures, including when to initiate transmission based precautions in order to prevent the spread of influenza. Contact Precautions: R5's PN dated 12/21/17, indicated R5 had a gastrostomy tube site which was pink and had discharge (color not identified). The documentation indicated a culture of the gastrostomy tube site was obtained and R5 was started on an antibiotic for Methicillin Resistant Staph Aureus (MRSA) which is a type of staph bacteria that is resistant to several antibiotics. R5's Essentia Health laboratory results collected on 12/13/17, indicated R5 had Methicillin Resistant Staphylococcus at the gastrostomy tube site. Daily PNs from 12/22/17 - 12/30/17, included daily "infection notes." The notes indicated R5 was receiving an antibiotic for the gastrostomy tube site infection with drainage, however, the documentation did not indicate if isolation	F 880		

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F 880	Continued From page 242 precautions had been initiated. An Infection Surveillance Data Collection Form dated 12/20/17, indicated R5 had been identified with MRSA and treated with antibiotics. The staff were to implement contact isolation precautions. R24 was admitted to the facility on 12/15/17, with diagnoses that included but were not limited to: infection following a procedure, cerebrospinal fluid (CSF) leak, generalized muscle weakness, and headache. Review of the hospital dismissal summary dated 12/14/17, indicated R24 underwent a dural repair for a CSF leak following a lumbar fusion. The spinal incision was cultured and was infected with staphylococcus epidermis and candida albicans. R24 was given IV antibiotics and sent to the nursing home to receive IV antibiotics until 12/21/17. Review of R24's medical record including all assessments and progress notes for the entire stay in the facility (12/15/17 - 12/22/17), revealed R24 had not been placed into isolation precautions as identified by the facility's policy for infection control. The policy Isolation- Categories of Transmission Based Precautions dated 12/23/17, revealed R24 should have been placed in contact precautions for the draining spinal wound infected with staphylococcus epidermis and candida albicans. During interview with the DON on 3/23/18, at 11:04 a.m. she confirmed there was no indication in R24's record contact precautions were implemented as the infection control policy for isolation precautions indicated.	F 880		

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The Superior Healthcare Management Minnesota Region MRSA policy dated 12/27/17, directed the staff to implement contact precautions if resident had draining fluids.

On 3/23/18, at 8:52 a.m. the DON confirmed R5 had been diagnosed and treated for MRSA, yet contact isolation precautions had not been implemented.

- At 8:15 a.m. licensed practical nurse (LPN)-B stated she could not recall utilizing any type of isolation precautions in the facility. LPN-B confirmed R5 had been treated for MRSA in the past three months and the facility had an outbreak of influenza, yet isolation precautions had not been utilized

- At 8:20 a.m. NA-A stated she could not recall utilizing infection control isolation gowns in the past six months. NA-A stated she had utilized the gowns in the past for residents who had tested positive for MRSA or C-Diff.

- At 9:10 a.m. the administrator stated the facility had isolation precaution supplies in the facility, however, she would have to ask the health unit coordinator (HUC) where the supplies were located.
When queried if when the infection control practices of the facility had last been reviewed, the administrator stated she had started at the facility on 1/18/18, and had no records of when the infection control policies and procedures had been reviewed for the facility. The administrator

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stated the corporate level policies were reviewed annually but she did not have access to proof of the policy review.

- At 9:20 a.m. the administrator stated going forward the staff were to be trained on infection control practices and how to implement the facility procedures, however, the staff had not received the education at the time and it was a work in progress.

- At 10:15 a.m. LPN-B stated that if resident required droplet or isolation precautions, she would have to find the supplies for personal protective equipment (PPE), however, she could not state where the PPE was located in the facility. LPN-B asked nursing assistant (NA)-C where the supplies were located. NA-C directed LPN-B to the supply closet in the social service designees office.

- At 10:21 a.m. NA-C opened the supply closet and was able to locate all PPE supplies. NA-C stated the facility had not utilized PPE in the past six months. NA-F joined the conversation and NA-F also confirmed the facility had not utilized PPE in the past six months.

- At 10:42 a.m. RN-B stated the facility had not utilized PPE in the past year. RN-B stated gowns and isolation carts were to be utilized if a resident had something contagious like MRSA. RN-B confirmed R5 had MRSA in the past four months yet PPE was not utilized.

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Superior Healthcare Management Govern Board Meeting dated 11/3/17, indicated the following: "The Governing board has asked all locations to report, train and reinforce infection control practices across all departments."

On 3/23/18, at 8:52 a.m. the DON stated she was unaware of any type of infection control training that had been completed in the past year. However, infection control training was scheduled to be completed in April 2018.

Medication administration:

On 3/20/18, at 7:19 p.m. RN-C was observed preparing medication for R8. On three different occasions, RN-C was observed to remove a bottle of medications from the medication cart, open the bottle and dispense one pill out of the bottle directly into his/her hand before adding it to a soufflé cup. RN-C then recapped the bottle and returned the bottle to the cart. RN-C then carried the soufflé cup of medications into R8's room and assist R8 to take the medications.

- At 7:31 p.m. RN-C returned to the medication cart, he/she was not observed to wash his/her hands as he began dispensing medications for R18. RN-C dispensed six tablets from individualized bubble cards, directly into a soufflé cup. He/she then opened a drawer, picked up a bottle of calcium and dumped one tablet from the bottle directly into his/her hand before adding it to the soufflé cup. RN-C then reviewed the electronic Medication Administration Record and

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F 880	Continued From page 246 reported the calcium had recently been discontinued at which time he/she removed the calcium tablet from the medication cup by picking it out with his/her fingers and discarding the medication in the trash. RN-C then administered the medications to R18. - At 8:27 p.m. RN-C returned to the medication cart and began dishing medications for R2. RN-C was not observed to wash his/her hand prior to opening a bottle of Tylenol 325 milligrams and placing two tablets directly from the bottle into his hand and adding them to a soufflé cup. RN-C added three addition medications (carbidopa-levadopa, remeron and quetipine furmaratate) to the soufflé cup from individualized bubble cards. RN-C then crushed all of the medications and administered them to R2. - At 8:38 p.m. RN-C confirmed he had dispensed all medications from the bottles into his/her hand prior to adding them into the resident soufflé cups. RN-C stated he/she normally dished the medications from the bottles into his hands. The undated Administering Medication policy, directed the staff to follow established infection control procedures during the administration of medications as applicable. On 3/26/18, at 11:30 a.m. the administrator confirmed medications were not to be dispensed directly from a bottle into the staff members hand. The staff were to dispense the medication from the bottle into the cap of the medication bottle, or directly into a soufflé cup.	F 880		
F 943 SS=E	Abuse, Neglect, and Exploitation Training CFR(s): 483.95(c)(1)-(3)	F 943		5/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING _____ B. WING _____	03/27/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 943	Continued From page 247 §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required annual training on resident abuse prevention for 4 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-I) reviewed for abuse/ vulnerable adult (VA) training. POLICY 2X Findings include: The Walker Rehabilitation and Healthcare facility assessment dated November 2017, indicated all staff would be educated on the facility's Vulnerable Adult policy. On 3/26/18, at 9:30 a.m. the business office manager stated all nursing assistant (NA) training was to be completed on the Relias computerized training system/modules. - At 9:35 a.m. review of employee records	F 943	F943 SS=E This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure trainings on abuse, neglect and exploitation requirements are completed upon hire and annually. The facility failed to train on these requirements for NA B, NA C, NA D, NA 1. Training has been assigned by HR to these staff through Relias learning to be completed by 5-6-18. 2. The facility has determined that all residents have the potential to be affected	

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F 943	Continued From page 248 revealed the following: NA-B was hired on 9/27/93. NA-B's Relias transcript indicated NA-B had not completed a VA training course. NA-C was hired on 12/10/14. NA-C's Relias transcript indicated NA-C had not completed a VA training course. NA-D was hired on 11/13/17. NA-D's Relias transcript indicated NA-D had not completed a VA training course. NA-I was hired on 6/8/17. NA-I"s Relias transcript indicated NA-I had not completed a VA training course. - At 10:00 a.m. the business office manager stated she was unaware of how the staff were to receive abuse training. On 3/27/18, at 10:00 a.m. the director of nursing stated all staff members were to complete abuse training annually which was to be recorded in the Relias computerized training program. The undated Superior Healthcare Management, Minnesota Region Abuse Prevention Program policy and implementation form indicated comprehensive policies had been developed to aid the facility in preventing abuse, neglect, or mistreatment to their residents. The program would include policy and procedures which governed, at a minimum: mandated staff training/orientation program which included such topics as abuse prevention, identification, abuse reporting, dealing with violent behaviors and catastrophic resident reactions etc.. A policy	F 943	by this deficient practice if staff are not adequately trained on abuse, neglect and exploitation upon hire and annually. All staff must complete training requirements through Relias of abuse and neglect by 5-6-2018. 3. Beginning 4/24/2018 HR provided Relias training modules for all staff to complete abuse, neglect and exploitation requirements by May 8th 2018. On 5/1/18 the DON (or designee) will provide all staff with the resident safety manual to reinforce information. A procedure has been implemented for HR to set up all staff with new hires and annually to assure enrollment, monitoring and completion being reviewed. 4. Audits will be completed weekly on all staff to assure compliance, and with new employees during that time frame to assure compliance and any deficiencies noted will be corrected on the spot. The educational status of employees has been added to review indefinitely and ongoing at every QAPI to assure monthly the HR or Designee is monitoring all staff including contracted services and volunteers to ensure that compliance is occurring. 5. The DON (or designee) will be responsible for the POC.	

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F 943	Continued From page 249 specific to abuse training was requested and not provided. The undated Superior Healthcare Management Minnesota Region, Abuse Prevention Program Policy Interpretation and Implementation form indicated comprehensive policies and procedures had been developed to aid their facility in preventing abuse, neglect or mistreatment of their residents. The abuse prevention program provides policies and procedures that governed, as a minimum: mandated staff training/orientation programs which included topics such as abuse preventions, identification and reporting of abuse, stress management, dealing with violent behaviors or catastrophic reactions etc. However, the policy provided by the facility did not identify the frequency of the mandated staff abuse training.	F 943		

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	245323	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/20/2018**

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

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/26/2018

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

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K 000	Continued From page 1 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency This facility was surveyed as a single building. Golden Living Center of Walker is a 1-story building with a partial basement. The building was constructed at two different times. The original building was constructed in 1967 and was determined to be of Type II(222) construction. In 1994, an addition was constructed to the east side of the building that was determined to be of Type II(111) construction and separated with a 2 hour fire barrier. The main level is divided into 3 smoke zones. The building is protected by a complete automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system and in common areas that is monitored for automatic fire department notification. The facility has a capacity of 35 beds and had a census of 24 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101	K 291		4/18/18

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K 291	Continued From page 2 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on observations and an interview with staff, the facility has failed to ensure that emergency lighting has been tested and maintained in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.9.3. This deficient practice could affect 35 of 35 residents, as well as an undetermined number of staff, and visitors in the event of an emergency evacuation during a power outage. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 03/20/2018, observation during a review of all available testing and maintenance documentation and an interview with the Maintenance Supervisor revealed that the facility had not conduct 3 of 12 30 second monthly test of the battery operated emergency lights found within the facility. This deficient condition was verified by a member of the Maintenance staff.	K 291	1. The deficient practice occurred prior to the current Maintenance Supervisor's employment. Since identification of deficient practice, the Administrator initiated an Ad Hoc on 4-18-2018 to monitor emergency lighting testing bi-monthly to assure tests are completed monthly and brought to the quality assurance committee for review and continued monitoring until determined resolved. 2. 4/18/2018 3. Administrator is responsible for monitoring audit, and Maintenance Supervisor is responsible for completed audit bi-monthly. Current temporary Administrator is Brooke Slaughter, and current Maintenance Supervisor is Jackie Foster.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at	K 712		4/18/18

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K 712	Continued From page 3 least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 35 of 35 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:30 a.m. to 3:30 p.m. on 03/20/2018, during the review of all available fire drill documentation and interview with a maintenance staff member the following deficient conditions were found: 1. It was revealed that the facility did not conduct 1 overnight shift fire drill in the third quarter. 2. It was revealed that the facility did not conduct 1 evening overnight shift fire drill in the fourth quarter. 3. It was revealed that the facility did not conduct 1 of 12 tests of the DACT ensuring that the fire alarm signal was received by the monitoring company.	K 712	1. Since identification of deficient practice, the Administrator initiated an Ad Hoc on 4-18-2018 to monitor Maintenance Supervisor's fire drill testing bi-monthly to assure tests are completed on correct shift monthly, as well as verification that fire alarm signal as received by the monitoring company. This will be brought to the quality assurance committee for review and continued monitoring until determined resolved. 2. 4/18/2018 3. Administrator is responsible for monitoring audit, and Maintenance Supervisor is responsible for completed audit bi-monthly. Current temporary Administrator is Brooke Slaughter, and current Maintenance Supervisor is Jackie Foster.	

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K 712	Continued From page 4 This deficient condition was confirmed by a Maintenance Supervisor.	K 712		

Electronically delivered
April 17, 2018

Ms. Brooke Slaughter, Administrator
Walker Rehabilitation & Healthcare Center
209 Birchwood Avenue West PO Box 700
Walker, MN 56484

Re: State Nursing Home Licensing Orders - Project Number S5323027

Dear Ms. Dillon:

The above facility was surveyed on March 19, 2018 through March 27, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman, Unit Supervisor at (218) 308-2104 or lyla.burkman@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

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
	00995	A. BUILDING: _____ B. WING _____	03/27/2018

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

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 3/19/18 - 3/27/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure 12 hours of annual inservice training was completed by 2 of 5 nursing assistants (NA-B, NA-C) whose personnel records were reviewed. Findings include: NA-B was hired on 9/27/93. NA-B's employee record indicated she had completed zero of the 12 required training hours from 9/27/16 to 3/26/18.	2 285	corrected	5/8/18

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	00995	A. BUILDING: _____ B. WING _____	03/27/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 285	Continued From page 3 NA-C was hired on 12/10/14. NA-C's employee record indicated she had completed 2.75 of the 12 required training hours from 12/16/16 to 3/26/18. On 3/26/18, at 10:09 a.m. the director of nurses (DON) stated all NA's were to received 12 hours of NA training per year. The undated Certified Nursing Assistant Job Description/Competency/Evaluations form indicated all NA's were to complete 23 hours of in-service training annually tracked from hire date not calendar year. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all nursing assistants receive 12 hours of continuing education annually. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 285		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct	2 302		5/8/18

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2 302	Continued From page 4 care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to provide an annual required training on resident Alzheimers Training / Dementia Training for 4 of 5 nursing assistants (NA-B, NA-C, NA-K, NA-I) reviewed for Alzheimer's training. Findings include: The facility assessment entitled Walker Rehabilitation Healthcare last revised on 3/19/18, indicated all staff members would be educated on Alzheimers / dementia care. On 3/26/18, at 9:30 a.m. the business office manager stated all NA training was to be completed on the Relias computerized training system/modules.	2 302	corrected	

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2 302	Continued From page 5 - At 9:35 a.m. the employee record were reviewed and revealed the following information: NA-B was haired on 9/27/93. NA-B's Relias transcript indicated NA-B had not completed a Alzheimers training course. NA-C was hired on 12/10/14. NA-C's Relias transcript indicated NA-C had not completed a Alzheimers training course. NA-K was hired on 6/8/17. NA-K's Relias transcript indicated NA-K had not completed a Alzheimers training course NA-I was hired on 6./8/17. NA-I"s Relias transcript indicated NA-I had not completed a Alzheimers training course. - At 10:00 a.m. the business office manager stated she was unaware if staff had received any other form of Alzheimers training. On 3/27/18, at 10:00 a.m. the director of nursing stated all staff members were to complete Alzheimers/Dementia training annually. The training was recorded in the Relias computerized training program. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure all direct care staff and their supervisors receive training on Alzheimers/dementia care. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.	2 302		

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2 302	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced	2 540		5/8/18

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2 540	Continued From page 7 by: Based on interview and document review, the facility failed to ensure Care Area Assessments were completed for 2 of 12 residents (R13, R14) when their annual and/or significant change Minimum Data Set was completed. Findings include: R13's annual Minimum Data Set (MDS) dated 7/24/17, indicated R13 had moderate cognitive impairment, required limited to physical staff assistance for activities of daily living, urinary incontinence, no natural or fragmented teeth and was at risk for pressure ulcers. The Care Area Assessment Summary (CAA) indicated the following CAAs were identified as needing further comprehensive assessment/investigation to determine if R13 required interventions and care planning: Cognitive/Loss Function Activity of Daily Living/Rehabilitation Potential Urinary Incontinence Falls Nutritional Status Dental Care Pressure Ulcer However, R13's medical record lacked evidence of the completion of the identified CAAs. On 3/22/18, at 1:25 p.m. registered nurse (RN)-E stated she was responsible to complete the MDS assessments and the corresponding CAAs. RN-E confirmed R13's 7/24/17, triggered CAAs were not completed, as required. During interview with the administrator and director of nursing (DON) on 3/26/18, at 10:38	2 540	corrected	

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2 540	Continued From page 8 a.m. the administrator stated it would be expected that the CAAs be completed when triggered. The Superior Healthcare Management Minnesota Region MDS/CAA Policy effective 3/22/18, indicated would comply with all applicable federal and stated requirements related to the completion of the MDS and CAAs and directed each team member to complete their designated assessments and MDS sections along with the CAAs and care plan for the items that are triggered on their section of the MDS for which they completed. Review of the Long Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI) indicated: The RAI consisted of three basic components: Minimum Data Set (MDS) Version 3.0, Care Area Assessment (CAA) process and RAI Utilization Guidelines. The Care Areas triggered identified residents who had been or were at risk for developing specific functional problems and required further assessment. The completion of a CAA was the further investigation of the triggered areas in order to determine if the care area required interventions and care planning. The RAI manual further indicated that CAAs must be completed in conjunction with the completion of the resident's admission, annual, and significant change MDS. R14's admission MDS dated 1/26/18, indicated R14 had moderate cognitive impairment, suffered a fracture as a result of a fall prior to admission, no inappropriate behavior symptoms, required limited assistance of one person when ambulating in room, required extensive assistance of one person for transfers, and required extensive assistance of one person for	2 540		

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2 540	Continued From page 9 dressing and toilet use. The MDS indicated having books or newspapers to read, being around animals or pet visits, and participating in religious activities were somewhat important to R14. Review of R14's undated CAA for activities revealed the CAA had not been completed. There was no assessment of current activity interests, activity interests prior to admission, environmental or staffing issues that hindered participation, unique skills or knowledge the resident has that could be passed onto others, or issues that result in reduced activity participation. Review of R14's undated CAA for falls revealed the CAA had not been completed. There was no CAA assessment of physical limitations, medications, diagnoses, history of falls, laboratory findings, or environmental factors. Additionally, there was no analysis of the findings of the CAA. The regional director of clinical services was interviewed on 3/22/18, at 8:29 a.m. during which she confirmed R14's CAA's for activities and falls had not been fully completed. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure care area assessments are completed in accordance to the Resident Instrument Manual. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations.	2 540		

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2 540	Continued From page 10 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners;	2 625		5/8/18

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2 625	Continued From page 11 L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure clinical records were complete and accurate for 7 of 20 resident (R5, R2, R23, R6, R13, R21, R225) records reviewed. This had the potential to affect all 23 residents residing in the facility. Findings include: R5's medical record did not accurately reflect wound care. On 3/21/19, at 2:05 p.m. registered nurse (RN)-D was observed to remove a Duoderm dressing from R5's sacrum. Upon removal of the dressing RN-D identified two newly opened areas under the dressing. RN-D measured the first open area on the left buttocks to be 1 cm x 0.3 cm. The second open area noted on the lower left buttocks measured 2 cm by 2 cm. The three areas under the dressing approximately 1 inch in diameter were observed to be deep red/purple in color and were not blanchable. RN-D stated the wound had changed appearance since the last	2 625	corrected	

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2 625	Continued From page 12	2 625		

time she had observed it. RN-D stated the open areas were new and the wound looked worse.

Review of R5's clinical record on 3/23/18, lacked documentation related to the wound care and measurements from 3/21/18.

On 3/23/18, at 9:30 a.m. RN-E reviewed R5's record and confirmed the facility had not completed any type of documentation related to the newly identified open areas identified on 3/21/18.

On 3/27/18, at 9:30 a.m. RN-D confirmed she had not completed any type of documentation regarding R5's wounds treated on 3/21/18. RN-D stated she "spaced it."

R5's Progress Note dated 3/13/18, at 11:20 p.m. indicated R5 had a 6 cm by 3 cm bruise which was yellow/green in color with some pinkness surrounding the bruise. The documentation did not identify where the bruise was located or the origin of the bruise. No further documentation related to the bruise was noted in R5's record.

Review of R2's clinical record revealed the following information:

R2's Lift Mobility Status form dated 12/31/17, indicated R2 did not have the ability to bear weight on his/her legs. R2 did have the ability tolerate a semi-reclined position and indicated R2 was to be transferred with a MaxiMove (brand name of a full body mechanical lift). The rest of the form was incomplete, as it was blank. R2 had not been assessed to identify the appropriate size sling nor did it identify the number of staff memebers required to transfer R2.

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2 625	Continued From page 13 An incident report dated 9/15/17, indicated R2 had sustained a skin tear on her left inner elbow while being transferred with a mechanical lift which required first aid. The documentation did not identify the root cause of the injury, the number of staff members present at the time of the injury or interventions to minimize further injuries. An incident report dated 10/29/17, indicated R2 had sustained a skin tear on the back of the right hand while being transferred via a full body mechanical lift. The documentation did not identify the root cause of the injury, the number of staff members preset at the time of the injury or interventions to minimize further injuries. An incident report dated 11/15/17, indicated R2 had sustained a skin tear and bruise on her left hand while being transferred via a full body mechanical lift. The documentation did not identify the root cause of the injury, the number of staff members present at the time or interventions to minimize further injuries. Further review of R2's clinical record lacked documentation related to the identified injuries. On 3/22/18, at 11:50 a.m. the regional director of clinical services (RDCS) confirmed the facility did not have any further documentation related to R2's injuries and the number of staff members present at the time of the injuries was unknown. On 3/27/18, at 10:05 a.m. the administrator stated she had identified a concern with documentation in the facility and had been attempting to train staff members on how to improve documentation. The administrator stated the facility would be developing an action	2 625		

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2 625	Continued From page 14 plan to ensure complete and accurate documentation. R23's Care Plan dated 1/20/17, indicated R23 was to utilize a plate guard for meals to ensure R23 was able to eat greater than or equal to 75% of the meal. On 3/19/18, at 12:05 p.m. R23 was observed to be served the noon meal. R23's plate was not equipped with a plate guard. On 3/20/18, at 12:05 p.m. R23 was observed to be served the noon meal. R23's plate was not equipped with a plate guard On 3/20/18, at 5:05 p.m. R23 was served the evening meal. R23's plate was not equipped with a plate guard. On 3/21/18, at 12:15 p.m. R23 was served the noon meal. R23's plate was not observed to have a plate guard. - At 12:29 p.m. the dietary manager (DM) stated any type of adaptive equipment required at meals was identified on the resident dietary card. Review of R23's dietary card did not identify any type of adaptive equipment. The DM stated R23 had an order for a plate guard in the past, but it was discontinued about six weeks ago because at the time, R23 was not attempting to feed himself. The DM stated the nurses should have documented the discontinuation of the plate guard. Review of R23's clinical record lacked documentation related to the discontinuation of the plate guard.	2 625		

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2 625	Continued From page 15 On 3/21/18, at 1:45 p.m. the DON stated she was unaware of the type of adaptive equipment R23 was to be utilizing at meals. The DON stated she would review R23's record for further information related to the plate guard discontinuation, but to her knowledge, no documentation had been completed. No further information was provided regarding R23's plate guard. R6's clinical record lacked documentation related to the pacemaker monitoring. R6's Care Plan dated 6/28/17, identified R6 as having a pacemaker due to atrial fibrillation. The care plan did not direct the staff to assist to monitor the pacemaker via telephonic monitoring. R6's clinical record lacked documentation related to the pacemaker monitoring. - At 1:05 p.m. licensed practical nurse (LPN)-B confirmed R6 had a pacemaker and stated the scheduled telephonic monitoring were to be completed by the nursing staff. LPN-A stated the scheduled times were to be identified on the electronic medication administration records (EMAR). LPN-B reviewed R6's EMAR and stated the EMAR did not include pacemaker monitoring. - At 1:17 p.m. LPN-B entered the medication room and located a pacemaker telephonic monitoring device. LPN-B confirmed she had no idea the last time R6 utilized the machine. On 3/23/18, at 11:50 a.m. RN-E confirmed R6's medical record lacked documentation related to the pacemaker evaluations. On 3/27/18, at 9:25 a.m. LPN-A stated the	2 625		

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2 625	Continued From page 16	2 625		

pacemaker monitoring was scheduled in the nurse's appointment book at the desk. LPN-A then identified R6 had a pacemaker check on 2/13/18. LPN-A stated she had not completed the pacemaker check. LPN-A stated that upon completion of the pacemaker monitoring, the clinic staff directed the staff as to when the next monitoring was to take place. Upon review of the calendar, LPN-A stated R6 did not have a scheduled pacemaker check in the next six months.

- At 9:30 a.m. RN-D stated she had completed the pacemaker check via telephone in February 2018, however, she had not documented the monitoring in the medical record. During interview on 3/19/18, at 9:24 a.m. R13 stated R21 used to be his roommate and currently lived a couple doors from him, however, he could not get along with R21. R13 stated R21 would threaten to "beat him up" most recently being just two days ago. R13 stated about two months ago, when he was by the nursing station with staff present, R21 had "rolled up and punched him in the left shoulder." R13 denied being injured. R13 stated the staff who had witnessed the incident told R21 he had to "settle down." R13 denied being afraid of R21 and stated "all he is, is one big mouth" and that he tried to stay away from R21 as much as he could.

On 3/20/18, at 1:10 p.m. NA-B stated R21 and R13 used to be roommates who did not get along and would swear at each other so they got separate rooms. NA-B stated currently, when R13 would wheel past R21's room, R21 would call R13 names and had also witnessed the aforementioned altercation between R13 and R21. However, R13's and R21's clinical records lacked evidence of the resident to resident

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

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2 625	Continued From page 17 altercation. During review of the facility's computerized risk management incident list, an incident whereby R225 had eloped from the facility was noted and the police had returned R225 to the facility, unharmed. On 3/20/18, at 6:30 p.m. Cook (C)-A stated R225 was not happy about being at the facilty and had eloped from the facilty a couple of times. C-A stated the incident with the police department was not the only time R225 had gotten away or attempted to leave the facility. C-A recalled another incident which occurred "way" before the police department incident, where he was going to go pick up R225 after he had left the facility and was downtown at a gas station which was across from the police department. C-A stated "somebody" had called the facility and informed the staff that one of their residents was there, however, that "somebody" had given R225 a ride back to the facility before he could go get him. C-A stated R225 used a wheelchair and would have had to get downtown by wheeling himself down the middle of the street as that was the only area of the road that had been plowed open following the snow fall. C-A remembered R225 being appropriately dressed for the cold winter temperature. R225's clinical record lacked evidence of this elopement and frequent, daily attempts to elope. On 3/20/18, at 1:49 p.m. the administrator and the DON and the regional director of clinical services (RDCS) were informed of the altercation and all stated they were unaware the altercation had occurred and was not noted in the clinical records. At 4:25 p.m. the RDCS, administrator and the DON confirmed R225 had eloped from the facility on one occasion, however was not aware of the previous elopement which occurred	2 625		

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2 625	Continued From page 18 prior to employment at the facility. The Superior Healthcare Management Minnesota Region Medical Records Safeguarding policy and procedure dated 12/23/17, did not address the required contents of a resident's medical record. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure complete, timely, and accurate documentation was kept current for all residents. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the monitoring results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure an appropriate discharge plan was developed and implemented for 1 of 1 resident (R24) who was discharged to home.	2 685	corrected	5/8/18

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2 685	Continued From page 19 Findings include: R24 was admitted to the facility on 12/15/17, with diagnoses that included but were not limited to: infection following a procedure, cerebrospinal fluid (CSF) leak, generalized muscle weakness, and headache. Review of the hospital dismissal summary dated 12/14/17, indicated R24 underwent a dural repair for a CSF leak following a lumbar fusion with a resulting infection. R24 was given IV antibiotics and sent to the nursing home to receive IV antibiotics until 12/21/17. R24 was admitted with a PICC (peripherally inserted central catheter) line. Review of R24's discharge planning revealed a progress note dated 12/20/17, indicating R24 was going to discharge on 12/21/17, or 12/22/17, via driving herself in her personal car. The note indicated R24 wanted her medications to be sent to a Walgreens close to where she lived. The note also identified R24 would would be working with her primary care physician to set up home health care and follow-up appointments. The next discharge planning note was dated 12/22/17, which indicated R24 discharged home via personal car at 10:00 a.m. R24 wore a back brace and was able to perform activities of daily living (ADL's) independently. There was no indication if R24 was able to independently don and doff the back brace, who would care for the PICC, if R24 could independently change the dressing on the lower spine or if R24 had dressing supplies to change the dressing. Additionally, there was no evidence of teaching of signs and symptoms of infection or when to call the primary care provider. There was no	2 685		

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2 685	Continued From page 20	2 685		

indication R24 received medications, what those medications were, and if R24 had been educated on those medications. Although R24 indicated a need for home care, there was no indication a referral to a home health agency had been completed and if R24 was accepted for admission.

The document Discharge Summary and Post-Discharge Plan of Care dated 12/22/17, was found in R24's closed record. The summary was incomplete. The summary indicated R24 wanted home health agency recommendations and the names of two agencies and their telephone numbers were listed. However, there was no indication if the agencies were contacted.

On 3/23/18, at 11:04 a.m. the director of nursing (DON) stated the facility did not have a system for discharging residents. The DON stated patient teaching should have been documented and indicated if R24 was able to don and doff the back brace, if R24 was able to independently change the dressing on the lower spine, if she had discharge medications and what they were, the PICC line should have been pulled or home care should have been set-up to ensure it's care, and a referral to a home health agency should have been initiated and set-up. Additionally, the signs and symptoms of infection should have been reviewed, and the surgeon and primary care physician phone numbers should have been provided. The DON stated the facility did not have a discharge policy and procedure at the time of R24's discharge, and provided a discharge policy and procedure dated 12/23/17.

SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could

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2 685	Continued From page 21 develop, review, and /or revise policies and procedures to ensure recapitulations were completed for all discharged residents. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 685		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to provide timely assistance with incontinence cares, provide range of motion services, and timely assistance with turning and repositioning according to the residents' assessed need and as directed by the care plan. This lack of sufficient staff had the potential to affect all 23 residents who resided in the facility.	2 800	corrected	5/8/18

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2 800	Continued From page 22 Findings include: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 2 of 2 residents (R2, R23) who were totally dependent on staff for incontinence cares and failed to provide grooming assistance for 1 of 2 male residents (R23) who required staff assistance to shave. See F677. Based on observation, interview and document review, the facility failed to provide timely repositioning as directed by the care plan for 4 of 4 residents ((R5, R18, R2, R23) who currently had a pressure ulcers or were at risk for the development of pressure ulcers. See F686. Based on observation, interview and document review, the facility failed to provide range of motion services as directed in order to prevent a decline on range of motion abilities for 2 of 5 residents (R5, R2) observed for range of motions services. The failure to provide the services resulted in actual harm for R5 and R2 who had sustained a decline in range of motion abilities. See 688. Residents: On 3/19/18, at 10:59 a.m. R3 an alert and orientated resident who received hospice services, stated she had to sometimes wait long periods of time (more than 10 minutes) for staff assistance. R3 stated she took a diuretic so she could not always wait for staff assistance to help her to get onto the bedside commode. R3 stated once assisted onto the commode, she would often times have to just transfer herself back off the commode because of her legs going numb,	2 800		

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2 800	Continued From page 23	2 800		

pain, and/or shortness of breath from sitting on the commode too long waiting for help. R3 stated there were only two aides on during the day and evening shifts and the nurses seemed to just walk by without offering to help while the NAs were running around. R3 stated the longest wait periods were in the morning, before and after meals, and at bedtime, but stated night shift was when she had to wait the longest because there was only one aide. R3 stated she was concerned about the safety for other residents in case of an emergency situation like a fall, because the emergency would consume the available staff and questioned what would happen if there were two emergencies at one time.

At 9:14 a.m. R21, an alert and oriented resident, stated the facility did not have enough staff members to provide resident cares. R21 stated there were only two nursing assistants and a nurse on most weekends therefore R21 knew if he/she had turned his/her call light on to summon for assistance, he/she would have to wait a long time for the staff to come because they are so busy.

At 10:45 a.m. family member (FM)-B stated his/her loved one could go 3-4 days without receiving assistance with personal shaving needs. FM-B stated she was unsure why her loved one was not receiving the assistance and was unsure if the if the facility had enough staff or not.

At 11:48 a.m. R18 stated, she didn't think there was enough staff available, and seemed to have to wait longer for assistance on the overnight shift. R18 further stated staff did not always reposition her timely and they could probably offer more often.

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2 800	Continued From page 24 Staff: On 3/19/18, at 12:40 p.m. nursing assistant (NA)-C stated the facility had 23 residents and only two NA's to provide direct care during the day and evening shifts. The night shift only had one NA. NA-A stated the NA's were able to just get the residents' basic cares done. NA-C also stated the NAs were responsible to provide range of motions exercises with morning cares, however, this was not being provided because there was not enough time to. On 3/22/18, at 6:34 a.m. registered nurse (RN)-A stated didn't feel like there was enough nursing assistants to take care of the residents. RN-A stated management was aware of the concerns and had put a mandating policy into place and temporary staff was contracted for a few weeks which seemed to help, and then a couple of staff had been hired. Stated staff was told staff scheduling was based on census and not acuity of the residents. RN-A stated the facility used to have three aides during the day and on evening shifts and one aide on during the overnight shift, and that seemed a lot more sufficient. RN-A indicated concerns pertaining to emergent situations during the night shift with only two staff around and the level of acuity, stated often times when only one nurse was scheduled or worked short handed, staff were not able to take breaks. RN-A further indicated meal times were challenging because there wasn't enough staff available to help feed the residents who required assistance. On 3/22/18, at 7:15 a.m. NA-B stated the NAs did not have time to complete documentation of resident cares because they were too busy	2 800		

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2 800	Continued From page 25	2 800		

providing cares. NA-B stated the NAs provided toileting and repositioning assistance to the residents, however, they were unable to complete those care tasks timely, as directed. NA-B also stated the NAs did not have time to provide range of motions exercises with morning cares because there was not enough time to.

- At 9:32 a.m. licensed practical nurse (LPN)-B stated the NAs were busy all day long. Between answering call lights and providing cares, they did not have the time to provide assistance with every two hour cares as directed by the care plans. LPN-B stated "they can not do it, there is not enough time in the day to get it done." LPN-B stated when a NA did not show up for their assigned day shift, one of the wing nurses would work as a NA which left only one nurse to complete all the nursing duties. LPN-B stated the meal times were the most difficult because of the number of staff required to assist the residents. LPN-B stated the staff did the very best they could and confirmed the residents' did not always receive assistance, exercises, shaving or oral cares due to a lack of staff.

On 3/23/18, at 10:40 a.m. RN-B stated the staffing at the facility was a challenge. At this time, the facility had many dependent residents. RN-B stated 10 of the 23 current residents required mechanical lifts (either standing or full body) to transfer and 18 of the 23 required assistance of at least one staff to complete cares. In the past, the facility had two nurses and three NAs during the day and evening shifts and the staff were able to timely assist the residents with personal care needs and exercises. RN-B stated due to a lower census the staffing had been reduced, however, when it was reduced from three to two aids, the resident care acuity was not

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2 800	Continued From page 26 taken into consideration. On 3/24/18, at 8:40 a.m. NA-B stated the staffing was the worst she had seen in many years and was very frustrated with the current staff to resident ratio. -At 10:00 a.m LPN-B stated in the past, the facility had utilized a supplemental nursing agency who provided pool staff to work in the facility, however, the pool staff had quit working at the facility several weeks ago, and the facility had not replaced them. LPN-B stated the staff members were tired. On 3/27/18, at 8:34 a.m. the administrator and director of nursing (DON) were interviewed about facility staffing. The administrator stated she was hired on 1/17/18, and was told by the previous administrator that his main focus had been on staff recruitment and staffing. The administrator stated immediately upon hire, she had recognized the ineffective dissemination of the licensed staff and was currently in the process of reorganization and implementation of new job roles according to the staff members scope of practice. The administrator stated the current DON was appointed on 2/5/18, and immediately started on staff recruitment and scheduling activities. The administrator acknowledged the need for more nursing assistant hours during the day and evening shifts and was in the process of creating new scheduled positions. However, until those positions were filled, she expected licensed staff to help the nursing assistants with resident cares and to also assist the residents at meal times. Additionally, the administrator stated she had requested assistance from the corporate office to obtain staff, however, her request was not honored.	2 800		

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2 800	Continued From page 27 The facility quality assurance and performance improvement (QAPI) log dated 1/16/17, identified a prioritization plan for increasing staffing needs. The plan identified what staffing levels were needed based on census and acuity with the staffing goal as: -three nursing assistants for morning shift, two staff with a ward assistant on the evening shifts, one to two aides on the overnight (depending on census and acuity of residents), one 12 hour RN, one 8 hour LPN, and one 12 hour RN and one 8 hour LPN for day/evening shifts. The staffing plan for the facility included social services marketing at local hospitals for appropriate residents, running advertisements for staff, signed contract on 1/15/18, for two temporary nursing assistants, and requesting assistance from the corporate office. The facility assessment last revised 3/19/18, indicated the average daily census of 20-25 residents. The assessment indicated care and services the facility could provide included diseases/conditions and cognitive disabilities and identified the acuity of the current residents by identifying them by level of assistance required and resource utilization group (RUG) categories and percentages. The facility assessment identified number of nursing assistant hours needed was between 48-72 hours per day and 32 hours for licensed staff per day with a total number of direct care hours per day as 80-104. The assessment also included the nursing home compare staffing report which indicated nursing assistant hours per resident day were less than state and national averages. Facility daily census reports for February and March 2018 reflected the following:	2 800		

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2 800	Continued From page 28 From 2/1/18-2/17/18, average daily resident census was 18. Average nursing assistant hours per day was 43.02. The daily census sheets in this time period reflected an average of three nursing assistants worked on the day and evening shifts (2.39 nursing assistant direct care hours per resident per day). From 2/17/18-2/28/18, average daily resident census was 18. Average nursing assistant hours per day was 39.13. The daily census sheets in this time period reflected an average of two nursing assistants worked on the day and evening shifts (2.17 nursing assistant direct care hours per resident day). From 3/1/18-3/19/18, average daily resident census was 22. Average nursing assistant hours per day was 39.52 hours. The daily census sheets in this time period reflected an average of two nursing assistants worked on the day and evening shifts (1.79 nursing assistant direct care hours per resident day). Superior Healthcare Management Minnesota Region's undated Staffing policy included the following: Our facility provides adequate staffing to meet needed care and services for our resident population. 1. Our facility maintains adequate staffing on each shift to ensure that our resident's needs and services are met. Licensed registered nursing and licensed nursing staff are available to provide and monitor the delivery of resident care services 2. Certified nursing assistants are available on each shift to provide the needed care and	2 800		

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2 800	Continued From page 29 services of each resident as outlined on the resident's comprehensive care plan. 6. Staffing will be based on resident census and facility needs. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure sufficient, competent nursing staff were available to care for the residents. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by:	2 830		5/8/18

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2 830	Continued From page 30 Based on observation, interview, and record review, the facility failed to ensure routine pacemaker functionality checks had been performed for 1 of 1 resident (R6) reviewed who utilized a cardiac pacemaker. Findings include: R6's quarterly Minimum Data Set (MDS) dated 1/17/18, identified R6 with moderate cognitive impairment and diagnoses including: depressive disorder, chronic atrial fibrillation and mitral valve disease. The MDS also indicated R6 required limited assistance of one staff for all activities of daily living. R6's Hospital Discharge Summary dated 6/19/17, indicated R6 was to complete a pacemaker check over the telephone using a remote home monitor on 7/18/17. R6's care plan dated 6/28/17, identified R6 had a pacemaker due to atrial fibrillation and directed the staff to monitor for signs and symptoms of altered cardiac output or pacemaker malfunction such as dizziness, syncope, difficult breathing, pulse rate lower than programmed rate or lower than baseline blood pressures. The care plan did not direct the staff to assist to monitor the pacemaker via telephonic monitoring. R6's clinical record lacked documentation related to the pacemaker monitoring. On 3/22/18, at 9:30 a.m. R6 was observed to ambulate approximately 125 feet with stand by assistance of one staff member. R6 was not observed to display shortness of breath, dizziness or fatigue while walking.	2 830	corrected	

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2 830	Continued From page 31 - At 1:05 p.m. licensed practical nurse (LPN)-B confirmed R6 had a pacemaker and stated the scheduled telephonic monitoring was to be completed by the nursing staff. LPN-A stated the scheduled times were to be identified on the electronic Medication Administration Records (EMAR). LPN-B reviewed R6's EMAR and stated the EMAR did not include pacemaker monitoring. - At 1:17 p.m. LPN-B entered the medication room and located a pacemaker telephonic monitoring device. LPN-B confirmed she had no idea the last time R6 utilized the machine. - At 3:00 p.m. registered nurse (RN)-E reviewed R6's clinical record and stated the clinical record lacked documentation as to the last time it was checked. RN-E stated she would have to look into the concern. On 3/23/18, at 11:50 a.m. RN-E confirmed R6's medical record lacked documentation related to the pacemaker evaluations. On 3/27/18, at 9:25 a.m. LPN-A stated the pacemaker monitoring was scheduled in the nurse's appointment book at the desk. LPN-A then identified R6 had a pacemaker checked on 2/13/18. LPN-A stated she had not completed the pacemaker check. LPN-A stated that upon completion of the pacemaker monitoring, the clinic staff directed the staff as to when the next monitoring was to take place. Upon review of the calendar, LPN-A stated R6 did not have a scheduled pacemaker check in the next six months. - At 9:30 a.m. RN-D stated she had completed the pacemaker check via the telephone in February 2018, however, she had not	2 830		

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2 830	Continued From page 32 documented the monitoring in the medical record. RN-D stated at the time of the monitoring, an additional appointment had not been made. RN-D stated the facility had not received any type of documentation from the pacemaker clinic which would indicate any concerns with the pacemaker. RN-D stated she would expect the clinic to contact the facility if there was a problem. - At 9:50 a.m. the Sanford Pacemaker Clinic staff was interviewed via telephone. The clinic staff stated R6's pacemaker check was completed on 2/13/18, and R6 was due for a cardiologist evaluation. R6 would be scheduled an appointment in the next two months for further review. - At 10:51 a.m. RN-D stated he/she had spoken to R6's family member who was aware R6 was to be seen in the clinic for a cardiac evaluations. RN-D confirmed the facility was not aware of the upcoming appointment. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure appropriate care of residents with special clinical needs was provided. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 895	Continued From page 33	2 895		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services as directed in order to prevent the decline in range of motion (ROM) abilities for 2 of 5 residents (R5, R2) observed to have had a decline in ROM. The lack of the provision of the services resulted in actual harm for R5 due to the development of upper extremity contractures; and actual harm for R2 due to the development of contractures in the lower extremities. Lastly, the facility failed to assess the need for ROM services for 1 of 5 residents (R23) observed with limitations in ROM without the assessment and development of a ROM program in order to prevent a decline or maintain current ROM abilities. Findings include R5's quarterly Minimum Data Set (MDS) dated	2 895	corrected	5/8/18

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2 895	Continued From page 34 1/10/18, indicated R5 had moderate cognitive impairment and diagnoses which included Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff for bed mobility, transfers and all activities of daily living, and had bilateral functional limitation in range of motion of the upper and lower extremities. R5's admission MDS dated 9/1/17, indicated R5 was dependent upon staff for all activities of daily living and had bilateral functional limitation in ROM of the upper and lower extremities. R5's Activities of Daily Living Care Area Assessment (CAA) dated 9/6/17, indicated R5 required total staff assistance all activities of daily living related to encephalopathy (brain disease, damage or malfunction), spinal fusion and weakness. The CAA indicated R5 was participating in therapy. R5's Therapist Progress and Discharge Summary dated 9/14/17, indicated R5 had bilateral contractures of the upper and lower extremities. The physical therapist directed the nursing staff to complete upper and lower extremity range of motion exercises in order to maintain mobility. R5's care plan dated 8/25/17, indicated R5 had limited physical mobility and directed the staff to provide gentle range of motion with daily cares. On 3/19/18, at 10:15 a.m. family member (FM)-A stated she was not aware of R5 receiving any type of range of motion services. FM-A stated R5's arms began to contract one year ago after an accident which resulted in R5's quadriplegia. FM-A stated R5 had received therapy right after the accident, however, had not received any therapy services since that time. FM-A stated R5	2 895		

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2 895	Continued From page 35	2 895		

was to wear his braces daily, but felt R5's arms were getting worse. At this time, R5 was observed seated in a wheelchair with bilateral elbow braces on. The braces were applied to the inner aspect of the left and right elbows and extended to the mid upper and lower arms and were covered with a soft cloth padding and secured with velcro straps. The braces prevented further flexion of the elbows. R5's elbows were in a fixed position, and his hands rested in a fisted position.

- At 12:40 p.m. NA-C stated the facility had 23 residents and only two NAs to provide direct care to all the residents during the day and evening shifts. One NA worked on the night shift. NA-A stated the NAs were able to provide the residents with basic cares but did not provide ROM services. NA-C stated ROM exercises were to be provided during the provision of morning caress, however, they [NAs] did not have to time complete the exercises.

On 3/20/18, at 12:37 p.m. R5 was observed in his room, seated in a wheelchair, with bilateral elbow braces on. NA-B stated R5 was not able to fully straighten/extend his arms rather was only able to move them a few inches. R5 was observed to move his shoulders which also moved his arms approximately 1-2 inches.

- At 5:55 p.m. NA-D was observed to assist R5 with evening cares. When NA-D removed the bilateral arm braces, R5's arms curled tightly to his chest and his hands remained in a fisted position. NA-D proceeded to lift up R5's right elbow moving it slightly in order to remove R5's shirt sleeve. While lifting the elbow, his arm was unable to extend and his shoulder moved less than two inches away from R5's body resulting in

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2 895	Continued From page 36	2 895		

NA-D maneuvering his shirt sleeve off his arm. NA-A slipped the shirt over R5's head and slid it off of the left arm. R5's left arm was not observed to move while the shirt was removed. NA-D proceeded to wash R5's hands and arms. When washing the hands, R5 was noted to extend his right fingers to an approximately 90 degree angle. R5's right hand fingers appeared fixed with NA-D only washing between his fingers. NA-D again washed R5's left hand as his hand was open with his fingers extended to a 45 degree angle and were unable to extend any further. NA-D completed the cares by dressing R5 in a hospital gown and applying lotion to R5's arms, elbows and shoulders. NA-D was not observed to provide R5 any upper extremity ROM exercises.

- At 6:16 p.m. NA-D stated the evening shift staff did not provide the residents' any ROM exercises because the day shift staff completed the ROM programs/exercises.

On 3/21/18, at 9:19 a.m. NA-C stated she had been the NA assigned to provide the residents' functional maintenance programs as established by the physical therapist. However, in February 2018, she was removed from rehab services and reassigned to provide resident personal cares. NA-C stated R5 had had a functional maintenance program in the past, however, now that there is not a specific employee assigned to provide the rehab services, the NAs were directed to provide the ROM services during the provision of personal cares. NA-C stated the staff simply did not have the time to provide ROM services in addition to routine personal cares.

On 3/21/18, at 9:21 p.m. licensed practical nurse (LPN)-B confirmed R5 had not been receiving

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2 895	Continued From page 37 ROM services and stated due to this, it had been getting more difficult to apply R5's elbow braces because his arms were more stiff and his contractures were getting tighter. -At 9:30 a.m. registered nurse (RN)-D stated she could not recall R5 ever having received range of motion services and confirmed the braces were more difficult to apply due R5's increased stiffness of his upper extremities. Review of R5's electronic Medication and Treatment Administration Record dated 3/2018, indicated the nursing staff were to apply hand braces at night and elbow braces during the day. The records did not direct the staff to perform range of motion services for R5. - At 1:05 p.m. the director of nursing (DON) stated range of motion services was to be completed with personal cares. The DON stated she was not aware the exercises were not being completed as directed. - At 1:10 p.m. the regional director of clinical services (RDCS) stated the facility did not have a restorative program, however, they had recently hired a new company to provide physical therapy to the residents. The RDCS stated she was unaware R5's braces were more difficult to apply due to decreased movement. The RDCS stated R5 would need to be re-evaluated by physical therapy. On 3/21/18, at 3:10 p.m. the contracted physical therapy assistant (PTA)-A stated R5 had not been evaluated by physical therapy, therefore his ROM abilities had not been assessed. On 3/22/18, at 2:46 p.m. RN-E confirmed NA-C	2 895		

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2 895	Continued From page 38	2 895		

had provided the residents' restorative services in the past and stated NA-C would be the most knowledgeable staff member who could identify if a resident had a decline in ROM ability.

R2's annual MDS dated 11/2/17, indicated R2 had severe cognitive impairment and diagnoses which included Parkinson's disease, dementia and anxiety. The MDS also indicated R2 required extensive staff assistance for all activities of daily living, total staff assist for transfers, and had no functional limitations in ROM. The Activities of Daily Living CAA did not trigger at the time of the annual assessment, therefore an assessment of R2's ROM abilities was not conducted. R2's quarterly MDS dated 12/27/17, indicated R2 had functional limitations in bilateral upper and lower extremities.

R2's Assessment of Functional Range of Motion dated 1/13/18, indicated R2 had bilateral limitations of ROM in the upper and lower extremities.

R2's care plan dated 12/28/17, directed the staff to monitor and report changes in ROM ability, provide physical therapy referrals as order and as needed, and to monitor/document/report any signs or symptoms of immobility such as contractures forming or worsening.

R2's clinical record did not include a physical or occupational therapy discharge summary.

R2's Restorative Record dated 1/2018, indicated R2 had received passive range of motion (PROM) to the bilateral lower extremities five times per week, and PROM to upper extremities five times a week.
The February 2018, Restorative Record indicated

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R2 had received ROM to the upper and lower extremities on 11 days, however, the documentation ended on 2/14/18. The record was blank from 2/15/18 - 2/28/18, and the March 2018, documentation was blank.

On 3/21/18, at 11:30 a.m. NA-C was observed to assist R2 with changing an incontinent brief. During the cares, R2's colostomy bag disconnected requiring R2's clothing to be changed. While changing R2's pants, R2 was noted to be unable to straighten her legs at the knees. NA-C stated she had previously been assigned to assist R2 with ROM exercises but in the middle of February 2018, she had been reassigned to assist with residents' with routine cares instead of completing ROM services. NA-C stated R2 used to be able to straighten her knees to about 50% full extension, but since she was no longer being provided ROM exercises, R2's knees had become tighter/more contracted. NA-C proceeded to assist R2 with applying a pair of pants.

-At 11:35 a.m. NA-C removed R2's shirt. R2's hands were held in a fisted position. R2 moved her left shoulder and extended her elbow, however, the right shoulder did not move more than two inches and she was unable to extend her arm at the elbow. NA-C stated R2 had had the ability to fully open both of her hands. NA-C manually opened R2's right hand to approximately a 90 degree angle and the left hand opened to approximately a 75 degree angle. NA-C confirmed R2 had limitations in her upper extremities, however, stated R2's upper extremity ROM ability had not changed since the ROM had stopped. NA-C stated the staff were to complete ROM exercises during morning cares, however, since the facility had only two NAs to provide care

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2 895	Continued From page 40 for the 23 residents, the staff did not have the time to complete ROM exercises, as directed. - At 3:10 p.m. PTA-A stated R2 had not been evaluated by physical therapy in order to determine if services were needed. R2's clinical record lacked any type of documentation related to R2's ability to participate in ROM exercises. On 3/22/18, at 2:45 p.m. RN-E confirmed R2 was to be receive assistance with PROM exercises as directed by the care plan. RN-E stated NA-C had completed the ROM services in the past, therefore she would be the only staff member in the facility who could truly identify if a change in ROM had occurred. RN-E confirmed none of the licensed nurses had been monitoring or evaluating the ROM program in order to determine if the residents were receiving the services, evaluating their progress, or monitoring for a change in a residents' ROM ability. RN-E stated the NAs were to complete ROM exercises with morning cares and were directed to report any pertinent charge in a residents' ability to the charge nurse and the nurses were directed to document the ROM on the treatment administration records. Review of R2's electronic Treatment Record did not include documentation related to range of motion services having been provided. RN-E confirmed R2's record did not reflect a ROM program and verified R2 range of motion in her lower extremities had declined. R23's quarterly MDS dated 3/9/18, indicated R23 had severe cognitive impairment and diagnoses which included dementia, history of stroke and aphasia (inability to speak). The MDS indicated	2 895		

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2 895	Continued From page 41 R2 required extensive assistance with all activities of daily living. R23's annual MDS dated 10/13/17, indicated R23 required total staff assistance for all activities of daily living. R23's care plan dated 7/19/17, directed the staff to have physical therapy and occupational therapy evaluate and treat R23 as directed by the physician. The care plan also directed the staff to report signs and symptoms of immobility, or contractures forming or worsening. The care plan did not direct the staff to assist R23 with ROM exercises. R23's Therapist Progress and Discharge Summary dated 4/13/17, indicated R23 had lower extremity limitations in ROM. The physical therapist indicated nursing staff was to provide R23 ROM with manual stretches including bilateral hamstrings. The frequency of the exercises was not indicated. R23's Therapist Progress and Discharge summary dated 4/14/17, indicated R23 had limitation in ROM in the upper extremities. The occupational therapist indicated R23 was to receive ROM exercises however, the frequency of the services was not identified. Review of the facility's Restorative nursing documentation did not include a restorative nursing program for R23. Review of R23's electronic medication record did not direct the staff to assist with ROM. On 3/19/18, at 10:55 a.m. FM-B stated the facility had attempted to complete exercises with R23 in the past, however, FM-B was unsure if R23 was currently receiving services. FM-B stated he/she	2 895		

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2 895	Continued From page 42 thought R23's feet and legs were becoming deformed. On 3/21/18 at 3:10 p.m. PTA-A stated R23 had not been evaluated by physical therapy in order to determine if therapy or restorative services were needed. On 3/22/18, at 7:05 a.m. NA-B and NA-C were observed to assist R23 with morning cares. R23 was in bed. While assisting R23 with donning a pair of pants, R23 attempted kick at the NA's with his right leg. R23 proceeded to grab his pants with his right hand and attempted to lift his buttocks to pull his pants up. R23 was unable to lift his buttocks off of the bed. R23 was noted to have full range of motion in his right arm as he attempted to strike out at the staff. As NA-B and NA-C assisted R23 to donne his shirt, R23's left arm/shoulder moved approximately 3-5 inches and was unable to fully extend. R23's elbows, hands, and feet were observed to be free from contractures. - At 7:14 a.m. NA-C stated to her knowledge, R23 had never received ROM services and confirmed R23 had left sided limitation in ROM, however, had no change in ROM abilities. On 3/22/18, at 2:45 p.m. RN-E confirmed R23 had limitations in ROM and did not have a current restorative program. RN-E stated that facility had recently started with a new therapy provider and verified R23 had not been evaluated for services needed due to his left sided limitations. The Range of Motion Exercises policy dated 12/23/17, directed the staff to exercise the residents' joints and muscles. The policy also directed the staff to verify a physician order for	2 895		

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2 895	Continued From page 43 ROM had been received and if there was no order, the staff were to contact the attending physician to obtain an order, as needed. In addition the staff were directed to record the following in the resident clinical record: - The date and time of the exercises. - The name of the person providing the exercise. - The type of ROM exercises. - Whether the exercise was active of passive. - How long the exercise was conducted. - If and how the resident participated in the procedures or any changes in the resident's ability to participate. - Any problems or complaint made by the residents related to the procedure. - If the resident refused the treatment and reason why along with interventions taken. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure residents received range of motion services as directed. The DON or designee could educate all appropriate staff on the systems. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the	2 900		5/8/18

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2 900	Continued From page 44 development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate assessment, monitoring and interventions to prevent the development of pressure ulcers and promote healing of current pressure ulcers for 4 of 6 residents (R5, R18, R2, R23) in the sample who had current pressure ulcers. The facility's failure to adequately assess, monitor and/or implement interventions resulted in actual harm for R5 who developed pressure ulcers while at the facility and for R18 who had recurrent pressure ulcers. Findings Include: R5 was identified at risk for the development of pressure ulcers and did not receive timely assistance with repositioning and developed two pressure ulcers resulting in actual harm. R5's quarterly Minimum Data Set (MDS) dated 1/10/18, indicated R5 had moderate cognitive impairment and diagnoses included Parkinson's	2 900	corrected	

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disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff members for bed mobility, transfers and all activities of daily living. The MDS also identified R5 at risk for the development of pressure ulcers.

R5's admission MDS dated 9/1/17, identified R5 as dependent upon staff for all activities of daily living and at risk for the development of pressure ulcers.

R5's Pressure Ulcer Care Area Assessment (CAA) dated 9/6/17, identified R5 at risk for the development of pressure ulcers due to dependence upon staff for repositioning and bowel incontinence. The assessment directed staff to complete weekly skin assessments and to monitor R5's skin while assisting with personal cares.

The Braden Scale (a tool utilized to predict pressure ulcer development) dated 11/22/17, identified R5 at risk for the development of pressure ulcers.

R5's Tissue Tolerance Observation form dated 11/22/17, indicated R5 displayed a "pink, blanchable" area over boney prominences. The form did not identify which boney prominences had skin change/susceptibility to pressure nor any skin care directives for the staff to implement.

R5's care plan dated 8/28/17, directed the staff to assist R5 with repositioning at least every two hours.

R5's physician's order dated 11/29/17, directed staff to apply a DermFilm Thick Sacral Dressing to the coccyx every three days, and as needed. In addition, R5's Order Summary also included an

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order for the same wound dated 10/3/17, which directed the staff to apply an Allevyn Dressing (foam dressing) to the left buttock wound and to change every three days until healed.

Review of R5's Progress Notes (nurses notes) revealed the following information:

- 2/2/18, R5's upper buttocks, coccyx and sacral area was red, barrier cream applied.
- 2/3/18, redness to upper buttocks, coccyx and sacral area, barrier cream applied.
- 2/4/18, redness to upper buttocks, coccyx, and sacral area, barrier cream applied.
- 2/6/18, small superficial excoriated areas to upper buttocks and sacral areas. Barrier cream applied and repositioning every two hours provided.
- 2/7/18, small excoriated area and redness to upper buttocks, coccyx and sacral area, barrier cream applied.
- 2/12/18, scabbed area to left buttocks and small scabbed area to sacrum, barrier cream applied.
-2/16/18, scabbed area to left buttocks and sacrum, barrier cream applied.
-2/17/18, scabbed area to left buttocks and sacrum, barrier cream applied.
-2/20/18, two superficial excoriated areas. Right buttocks measures 3.0 centimeters (cm) by 1.5 cm. The left buttocks measured 1.0 cm by 0.7 cm covered with hydrocolloid thin dressing (a stretchy dressing which adheres to the skin.)
- 2/24/18, dressing changed, area is very dry. Presents as superficial sheer area, small amount of blood noted. Applied Duoderm (hydrocolloid) dressing.
- 2/26/18, friction shear to bilateral upper buttocks and sacral region, barrier cream applied, reposition every two hours.
- 3/3/18, dry areas to upper buttocks and sacral

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2 900	Continued From page 47 region, barrier cream applied. - 3/4/18, dry areas to upper buttocks and sacral region, foam dressing (a foam pad to cover the wound with an adhesive edge to adhere to the skin) applied. - 3/6/18, dry areas to bilateral buttocks foam dressing applied. A Weekly Skin Review dated 3/10/18, indicated R5 had "superficial open area on sacral areas" and "excoriation on the buttocks." - 3/12/18, excoriated areas to bilateral buttocks, Tegaderm hydrocolloid placed - 3/16/18, continues with dry area to bilateral buttocks and sacral region, foam dressing applied. - 3/20/18, excoriated areas to upper bilateral buttocks, applying Tegaderm hydrocolloid dressing. Review of R5's clinical record lacked a weekly assessment of the wound which would include measurements of the wound, (length, width and depth), color of the wound and surrounding wound bed and current interventions. Review of R5's clinical record lacked indication R5's primary physician had been notified of the newly opened areas. Review of R5's Electronic Treatment Administration Record (ETAR), dated 3/18, revealed duplicative orders to apply Allevyn and DermFilm dressings every three days to the same wound. The documentation revealed the nurses had initialed both dressings every three days which indicated they had both been applied to the wound, even though only one dressing was actually applied.	2 900		

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2 900	Continued From page 48 On 3/20/18, at 5:00 p.m. R5 was observed seated in a wheelchair in the main dining room waiting for supper. -At 5:05 p.m. registered nurse (RN)-D fed R5 the evening meal. -At 5:20 p.m. RN-D wheeled R5 back to his room, turned the television on and exited the room. -At 5:55 p.m. R5 remained in his wheelchair. Nursing assistant (NA)-D entered R5's room and assisted R5 to wash his hands and face and change into a hospital gown. R5 was not repositioned. -At 6:06 p.m. NA-D exited the room. R5 remained in the chair and continued to watch television. -At 7:50 p.m. NA-D and NA-A returned to the room and transferred R5 from the wheelchair to bed. R5's wheelchair had a pressure redistribution seat cushion in place. R5's coccyx was covered with an intact thin Tegaderm hydrocolloid dressing. The skin along the edge of the wound was deep pink in color. - At 7:55 p.m. NA-A stated R5 was assisted out of bed at 4:00 p.m. and confirmed R5 was not repositioned for 3 hours and 50 minutes. NA-A stated with only two NAs on staff, the staff were doing the best they could, however, they were unable to provide assistance with timely repositioning for all of the residents. On 3/21/19, at 1:10 p.m. the director of nurses (DON) and the regional director of clinical services (RDCS) stated R5 was to receive assistance with repositioning every two hours as directed by the care plan. Upon review of the medical record, the DON stated she was unaware of the exact date R5's buttocks began to show signs of breakdown. The RDCS stated the facility should have completed a comprehensive skin assessment when the breakdown began. The	2 900		

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2 900	Continued From page 49 DON stated she was unable to determine the size of the wound based on the facility documentation. - At 2:05 p.m. RN-D was observed to remove a Duoderm dressing from R5's sacrum. Upon removal of the dressing, RN-D identified two newly opened areas under the dressing. RN-D measured the first open area on the left buttocks to be 1.0 cm x 0.3 cm. The second open area on the lower left buttocks measured 2.0 cm by 2.0 cm. In addition, under the dressing there were three deep red approximately one inch non blanchable areas. RN-D stated the wound had changed appearance since the last time she had observed it. RN-D stated the open areas were new and the wound looked worse. - At 2:10 p.m. the DON observed R5's sacrum. The DON stated the last time she had observed R5's sacrum, the skin was dry and flaky but intact. The DON confirmed R5 had newly developed stage 2 ulcers (pressure ulcer in which partial thickness skin loss involving epidermis, dermis, or both). RN-D applied a Duoderm dressing over the ulcers. Review of R5's clinical record on 3/23/18, (two days later) revealed a lack of documentation related to the newly developed pressure ulcer's wound care and measurements from 3/21/18. On 3/23/18, at 9:30 a.m. RN-E reviewed R5's record and confirmed R5 had developed a pressure ulcer and the facility failed to complete any type of documentation or comprehensive assessment related to the new pressure ulcers identified on 3/21/18. RN-E verified R5 had two treatment orders for the same sacral wound and the ETAR indicated both dressings were being applied even though only one dressing had been	2 900		

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applied to the wound. RN-E also verified R5's care plan had not been followed as directed and R5 had not received wound care in accordance with the facility policy.

R18 had developed a pressure related ulcer which had worsened and the staff failed to complete a comprehensive wound assessment to determine efficacy of current interventions, and failed to update the care plan.

R18's Admission Record dated 3/22/18, indicated R18 had diagnoses which included mild cognitive impairment, stroke, hemiplegia, and hemiparesis, muscle weakness, fatigue, venous insufficiency, and obesity.

R18's quarterly MDS dated 3/2/18, indicated R18 had severe cognitive impairment, required extensive assist from 2+ staff for bed mobility and toilet use, and was totally dependent on 2+ staff for transfers and hygiene. The MDS indicated at the time of assessment, R18 had one stage 2 pressure ulcer and two stage 3 pressure ulcers (Stage 3- Full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss. May include undermining or tunneling) which measured 2.0 x 6.0 x 0.4 cm. Ulcer treatments included pressure ulcer care, and pressure reducing device for bed and wheelchair.

R18's Pressure Ulcer CAA dated 8/22/17, indicated R18 was at high risk for pressure ulcers, and had a history of pressure ulcers. The CAA further indicated R18 required a special mattress or seat cushion to reduce or relieve pressure. The CAA did not identify which type of

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2 900	Continued From page 51 special mattress and/or seat cushion R18 required. R18's care plan printed on 3/22/18, indicated R18 required extensive assist of one staff for dressing, bathing, grooming and bed mobility, and extensive assist of two staff for transfers with a mechanical lift. The care plan also indicated R18 "has pressure ulcers development" related to pressure ulcer areas to the coccyx, and had a potential impairment to skin integrity related to fragile skin, immobility, weakness, and history of pressure ulcers. The care plan directed the staff to implement the following interventions: -keep skin clean and dry, apply lotion on dry skin -report abnormalities, failure of skin to heal, maceration and sign/symptoms of infection to the physician -identify/document potential causal factors and eliminate/resolve where possible -use a draw sheet or lifting device to move the resident. -administer treatments as ordered and to monitor for effectiveness -apply barrier cream to buttocks twice a day and as needed -educate the resident/family/caregivers as to causes of skin breakdown including transfer/positioning requirements, importance of taking care during ambulating/mobility, good nutrition and frequent repositioning. -follow facility policies for the prevention/treatment of skin breakdown -if the resident refused treatment, confer with the resident, interdisciplinary team and family to determine why and try alternative methods to gain compliance. Document the alternative methods. -inform the res/family/caregivers of any new skin breakdown	2 900		

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2 900	Continued From page 52 -lift sling to be removed when in bed -monitor dressing, if needed, every shift to ensure if remains intact and adhering. Report loose dressing to treatment nurse -monitor nutritional status. serve diet as ordered, monitor intake and record -monitor/document/report, as needed, any changes in skin status: appearance, color, wound healing, signs and symptoms of infection wound size, and stage. - obtain and monitor lab work -teach resident/family importance of changing positions for the prevention of pressure ulcers and encourage small frequent position changes -turn and reposition R18 at least every two hours, more often if needed or requested -provide a pressure relieving/reducing device on bed/chair, however, does not identify which type of cushion to be used. - use fracture bed pan in bed. encourage R18 to be on bedpan ten minutes, observe skin and report any redness or open areas to nurse -weekly skin observation. If open area, treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue exudate (drainage). Although the care plan addressed pressure ulcers, the care plan did not address the newly developed pressure ulcers and/or was not revised to reflect the pressure ulcers identified on the 3/2/18, MDS assessment. In addition, the care plan lacked identification of the type of pressure reducing mattress required for R18's needs. R18's Tissue Tolerance Observation dated 2/24/18, indicated R18 was at high risk for pressure ulcers with risk factors that included current or history of pressure ulcers, history of stroke, and was not cooperative with positioning.	2 900		

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2 900	Continued From page 53 The evaluation indicated skin over bony prominences was pink and blanchable after sitting for one and two hour time frames. The evaluation also identified when R18 was in a lying position after 1/2 hour, one hour, and two hours the skin over bony prominences was pink and blanchable. The evaluation did not identify where the pink areas were and did not identify a repositioning schedule. R18's physician orders included: -Complete weekly skin assessment on Mondays (start date 2/13/17) -wound evaluation on left upper buttock every Monday per MD order (start date 2/20/17) -Change Tegaderm hydrocolloid (maintains a moist wound bed) thin 4x4 dressing every three days in the morning and as needed; apply skin prep to coccyx before applying new dressing to prevent skin tears. (start date 8/23/17, stop date 3/20/18) -Monitor Tegaderm hydrocolloid thin dressing to upper buttocks every shift to make sure dressing is in place, dressing is dry and intact every shift. Dressing to remain on until healed. (start date 9/30/17) -Comfort foam (for medium to heavy drainage) with border dressing 4x4 to sacral and buttock wounds change every 3 days until healed (start date 3/21/18) -Roho cushion for wheelchair (start date 3/20/18) Weekly Skin Reviews (WSR) and progress notes (PN) reviewed form 1/1/18, through 3/20/18, lacked completed comprehensive evaluations and consistency of documentation in order to ascertain locations, worsening, and or healing stages. The record further lacked evidence of pressure relieving device efficacy.	2 900		

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2 900	Continued From page 54 -WSR dated 1/1/18, Small pinpoint open area in mid coccyx slit, rest of area appears macerated, and a patch was applied per MD (medical doctor) orders. -WSR dated 1/8/18, Open area, had areas of maceration, applied patch per MD order to coccyx, had a small pinpoint area that is open. -PN note dated 1/14/18, included a hydrocolloid dressing placed to buttocks. Slit in coccyx was superficial, still very fragile. One open area to left buttock 1.0 cm x 1.0 cm and two small reddened areas on right buttock. -WSR dated 1/15/18, Continues to have maceration on coccyx, has on upper right buttock 1.0 centimeter (cm) open area. Red around wound. Applied dressing per MD orders. The record lacked evidence of any further wound evaluation or ongoing treatment. -WSR dated 1/22/18, Has maceration in gluteal fold, skin wet and white in color. Has 2.0 x 0.3 cm open area. On the right buttock has 2 open wounds. Proximal measures 1.0 x 0.9 cm. Distal measures 0.5 x 0.5. No drainage. Cleansed and applied Mepilex dressing. -PN dated 1/23/18, indicated the MD was contacted related to open areas on buttocks and coccyx not healing related to urinary incontinence. MD ordered placement of an indwelling catheter for wound healing. -WSR dated 1/29/18, continues to have on coccyx 1.0 cm x 0.6 millimeter (mm) open area on coccyx, noted maceration to area. Dressing applied after coccyx dried off. Will continue to monitor. -Corresponding PN dated 1/29/18, indicated coccyx was healing post indwelling catheter placement and to refer to the weekly evaluation for full description. -PN dated 1/30/18, indicated the coccyx wound	2 900		

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

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2 900	Continued From page 55 was stage III pressure ulcer and measured 1.0 cm by 0.7 cm with depth of 0.5 cm with questionable tunneling in the center of the wound bed. -PN dated 2/3/18 indicated the coccyx wound appeared smaller, and appeared to be a stage II. No odor, redness, or warmth. -WSR dated 2/5/18, coccyx 1.0 x 1.0 cm with 0.4 cm depth. Moisture associated. Able to visualize wound bed. Dermallevyn thin to be applied and changed every 3 days. -PN dated 2/6/18, MD made aware of the measurements of coccyx wound. -WSR dated 2/12/18, Coccyx very macerated and left open to air for one hour and turned to scabs. Upper left coccyx thin pink skin area measures 3.0 x 1.0 cm, no depth superficial. Rest of coccyx and upper bilateral buttocks have 0.04 to 0.03 to 0.02 cm with brown dry scabs. With dry skin attached around scabbed areas. -WSR dated 2/19/18, coccyx 1.0 x 0.4 cm purple area on coccyx. Not open at this time and left buttock small pinpoint 0.1 by 0.1 cm purple area. Not open but surrounding dry skin. -WSR dated 2/26/18, center of coccyx measures 2.0 cm by 0.6 mm wound bed depth 0.4 mm, areas of eschar 0.5 mm and slough (defined as yellow devitalized tissue, that can be stringy or thick and adherent on the tissue bed) was present. Scant amount brown drainage with slight odor present on dressing and skin around the wound. Other areas on lower right buttock measure 2.0 cm x 0.5 cm with no drainage. -Corresponding PN dated 2/26/18, indicated director of nursing (DON), MD, and family were notified of the changes. -PN dated 3/2/18, included: skin assessment was completed related to skin breakdown. Stage 3 noted on coccyx 2.0 x 6.0 x 0.4 centimeters (cm). Stage 2 left of coccyx area approximately 1.0 x	2 900		

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2 900	Continued From page 56 1.0 x 0.2 cm skin sloughing off of the wound. Stage 2 right below coccyx area, small 0.5 x 0.5 x 0.1 cm area. Slough skin on top. Dressing to coccyx changed every three days and as needed. Offload side to side positioning while in bed. The note indicated the director of nursing was updated and an air mattress would be placed on 3/2/18. The note also indicated R18 had historically refused to offload (relieve pressure to an area to allow reperfusion to the skin) and repositioning and staff would monitor. -WSR dated 3/5/18, 2.0 cm x 1 cm healing stage 3, no drainage appears macerated. Left buttock 0.2 x 0.2 cm scabbed area, skin around scab reddened. Left buttock 2.0 cm x 2 cm scabbed area, surrounding skin white. Also included resident non-compliant with turning and repositioning from side to side. Larger areas cleansed and applied Dermallevyn. -WSR dated 3/12/18, coccyx area 0.5 mm circular, 0.03 mm depth. Wound bed is deep purple, other areas that were open healed. -PN dated 3/16/18, included 2.0 x 2.0 red raised, painful area to right ischium. Question if may be some type of boil or beginning of a pressure ulcer. Foam dressing was applied, and MD would be notified. -WSR dated 3/19/18, coccyx 1.5 x 1.0 cm. Wound bed 100% granulation tissue. Wound cleansed and Dermallevyn applied. Right buttock 1.0 cm x 1.0 cm presents as deep tissue injury (Suspected deep tissue injury-purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear. The area may be preceded by tissue that is painful, firm, mush, boggy, warmer or cooler as compared to adjacent tissue. Evolution may include a thin blister over a dark wound bed). Not open bruise like appearance. Area covered with Dermallevyn.	2 900		

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2 900	Continued From page 57 Left buttock has two wounds- each measuring 1.0 x 0.2 cm. Present as possible skin tears. Cleansed and applied Dermallevyn. On 3/19/18, at 11:48 a.m. R18 was observed in her room, seated in the wheelchair. The seat cushion in the wheelchair was identified to be a standard pommel cushion (designed to stabilize seating position and support hip alignment which is made of dense foam to keep the resident from sliding out of the wheelchair). The mattress on the bed was standard foam perimeter mattress. R18 stated she had pressure ulcers on her bottom, had them for a long time, and experienced discomfort when she sat too long. R18 stated when staff changed her wound dressings she experienced discomfort, however, indicated pain medication was administered prior to the dressing changes. R18 stated she had wanted an air mattress on her bed but had never received one. R18 stated did not think her wheelchair cushion had been changed/replaced. R18 further stated staff did not always reposition her timely and felt they could probably offer to reposition her more often. On 3/20/17, at 1:17 p.m. NA-B was observed to transfer R18 from her wheelchair into bed using a full body mechanical lift. NA-B confirmed R18 had wounds on her bottom but had not seen R18's bottom since 3/16/18, and stated somebody had told her R18 had additional areas of skin breakdown. NA-B pulled down R18's pants, which exposed two hydrocolloid dressings positioned over the left buttock and sacral/coccyx region, and the mid right buttock. NA-B stated the wound on the left was new since last week. -At 1:39 p.m. medical doctor (MD)-B and health unit coordinator (HUC) entered R18's room.	2 900		

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2 900	Continued From page 58 MD-B asked R18 if she had experienced pain from the sores, to which R18 responded she had some discomfort. As MD-B removed the tacky dressings, MD-B remarked she did not like this type of dressing because it rips the skin. MD-B assessed the wounds and verified the following: -upper coccyx sacral region stage 2, (healing stage 3) -left buttock open stage 2; the other wound below the open wound was superficial and "covered" and because of that was hard to stage. -left buttock above the stage 2 ulcer were two small superficial areas and stated those were probably caused from removing the adhesive bandage and were not considered pressure related. -Right buttock over ischium a small raised dark purple area with surrounding redness. MD-B stated the purple area was necrotic tissue (non-viable tissue due to reduced blood supply) and would be a stage 2 when it opened. -small stage 2 on the inner right buttock MD-B stated the sacral wound had shown improvement since the insertion of an indwelling catheter. MD-B asked R18 how repositioning had been going to which R18 responded, not very well. MD-B reinforced importance of repositioning to R18. R18 agreed to go to the wound clinic for further evaluation. MD-B verified the wheelchair cushion was firm and flat and did not provide enough support and should be changed to something more pressure relieving. MD-B also stated R18 should have had an air mattress on her bed in order to provide more pressure relief support while in bed. HUC stated nursing staff had talked about putting an air mattress on the bed and was unaware why it had not been implemented.	2 900		

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2 900	Continued From page 59 On 3/22/18, at 7:57 a.m. NA-B stated R18 had a pretty set routine and was supposed to be repositioned every two hours from side to side, but often refused. NA-B stated if R18 refused repositioning, staff were to remind her of the risks of refusing such as skin breakdown. NA-B also stated she did not think there was enough staff because the residents were sometimes repositioned 10-30 minutes late. NA-B confirmed R18's mattress and chair cushion had never been changed and had always been the same as what she currently used. -At 8:48 a.m. RN-D stated there was no designated RN to perform pressure ulcer/wound assessments, therefore were completed by whichever nurse was assigned to work that day. RN-D stated skin assessments were performed weekly, wound documentation should always include measurements, and if the wound was a pressure ulcer the nurse should indicate the stage of the ulcer. RN-D further stated the assessing nurse needed to determine possible causal factors of the breakdown and evaluate and implement appropriate interventions. RN-D stated if the pressure wounds were not healing, the interventions should be reassessed for effectiveness and the pressure relieving devices and surfaces should also be assessed for effectiveness. -Continuous observation from 11:30 a.m. until 1:44 p.m. revealed the following: -At 11:30 a.m. R18 was in her room, seated in the wheelchair, watching television. -At 12:04 p.m. NA-B wheeled R18 to the dining room for lunch -At 1:03 p.m. an unidentified staff member returned R18 to her room.	2 900		

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2 900	Continued From page 60 -At 1:08 p.m. R18 stated the staff member had not repositioned when returned to her room. -At 12:49 p.m. RN-E verified the Weekly Skin Observations were not complete nor comprehensive. RN-E stated all the evaluations should have been completed to identify: measurements including depth, if pressure ulcer then staged, a complete description of the wound, drainage, odor, current treatment, progress toward healing, and if worsening then reassessment of interventions, implementation of new interventions, and notification to physician. RN-E stated the facility nurses were very inconsistent with their documentation and it was difficult to ascertain exactly what was going on with the skin. RN-E confirmed she had asked the maintenance director to put the air mattress on the bed on 3/2/18, and thought it had been implemented that same day. -At 12:54 p.m. RN-E observed R18's bed and verified the mattress on R18's bed was not the air mattress she had requested to be put on the bed. RN-E confirmed R18's mattress was a standard foam mattress which all the residents in the facility used, and was not provided based on her pressure ulcer/pressure relief needs. RN-E indicated the only difference on R18's mattress was it had the edge perimeters. -At 1:44 p.m. R18 remained seated in her wheelchair. R18 stated her routine was to stay up in the wheelchair until her television program was over at 2:00 p.m. R18 stated when the program was over she would call for staff to get laid down into bed. On 3/22/18, at 3:10 p.m. the maintenance director confirmed she had not put the air mattress on R18's bed as requested because she was waiting for a doctor's order. But, the director stated she had not requested or asked the	2 900		

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2 900	Continued From page 61 nursing staff for the specific order documentation so that she could place the air mattress on the bed. Although staff identified refusal of cares, the quarterly interdisciplinary review dated 12/30/17, identified no behaviors which included refusal of cares. Additionally, the care plan printed as current on 3/22/18, failed to identify refusal of care or individualized interventions related to refusal of cares. R2's annual MDS dated 11/2/17, indicated R2 had severe cognitive impairment and diagnoses which included Parkinson's disease, dementia and anxiety. The assessment indicated R2 required total assistance with bed mobility and transfers, and was at risk for the development of pressure ulcers. The Pressure Ulcer CAA dated 11/3/17, identified R2 at risk for the development of pressure ulcers due to the inability to reposition herself. The CAA directed staff to provide a redistribution cushion in her wheelchair and bed. R2's Tissue Tolerance Observation form dated 10/31/17, indicated a Braden Scale had been completed and identified R2 at high risk for the development of pressure ulcers, however, R2's clinical record did not contain a copy of the Braden Scale. The observation indicated R2 had not developed reddened areas during the observation time. The observation tool did not identify the frequency of repositioning needs for R2. R2's care plan dated 12/28/17, identified R2 at	2 900		

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2 900	Continued From page 62 risk for the development of pressure ulcers and directed the staff to assist R2 with a repositioning every two hours. On 3/22/18, during continuous observations from 7:05 a.m. to 10:00 a.m. R2 was not observed to be assisted with reposition. - At 7:05 a.m. R2 was observed seated in a wheelchair in her room. - At 7:37 a.m. the HUC wheeled R2 from her room to the dining room. - At 7:41 a.m. the HUC served and assisted R2 with breakfast. - At 8:07 a.m. R2 had finished the meal. The HUC wheeled R2 out of the dining room. - At 8:12 a.m. R2 was wheeled back to her room. - At 8:57 a.m. R2 was wheeled into the activity room by the activity director. - At 9:53 a.m. NA-B stated R2 was assisted out of bed at 6:30 a.m. and she had not had time to assist/reposition her since that time. - At 10:00 a.m. NA-B wheeled R2 to her room and assisted R2 to transfer from the wheelchair to the bed via a full body mechanical lift. A pressure redistribution cushion was noted on the seat of her wheelchair. Once in bed, NA-B changed R2's incontinence brief. R2's skin was pink and intact. -At 10:05 a.m. NA-B confirmed R2 had last been assisted with repositioning at 6:30 a.m. a total of 2 hours and 30 minutes earlier. On 3/22/18, at 2:58 p.m. RN-E confirmed R2 was to be assisted with repositioning every two hours as directed by the care plan. R23's quarterly MDS dated 3/9/18, indicated R23 had severe cognitive impairment and diagnoses which included dementia, history of stroke and	2 900		

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2 900	Continued From page 63 aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all bed mobility and transfers and was at risk for the development of pressure ulcers. R23's annual MDS dated 10/13/17, also identified R23 as being totally dependent upon staff for bed mobility, transfers and at risk for the development of pressure ulcer. R23's Pressure Ulcer CAA dated 10/9/17, identified R23 at risk for the development of pressure ulcers and directed the staff to utilize a pressure reducing mattress, chair cushion, and to assist R23 with offloading every two hours and as needed. R23's Braden Scale for Prediction of Pressure Sore Risk dated 3/9/18, identified R23 at moderate risk for the development of pressure ulcers. The Tissue Tolerance Observation Tool dated 3/9/18, indicated R23 did not develop reddened areas after two hours in one position. R23's care plan dated 7/19/17, directed staff to assist with repositioning every two hours. During continuous observation on 3/22/18, from 7:13 a.m. to 10:07 p.m. R23 was not observed to receive assistance with repositioning. - At 7:13 a.m. NA-B and NA-C were observed to transfer R23 from bed to a wheelchair via a full body mechanical lift. - At 8:46 a.m. R23 was wheeled into the dining room. - At 8:48 a.m. R23 was assisted with the breakfast meal. - At 9:16 a.m. R23 was wheeled to the activity room for church.	2 900		

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2 900	Continued From page 64 - At 9:35 a.m. R23 was wheeled from the activity room to the nurses station. - At 10:00 a.m. R23 was wheeled to his room. - At 10: 05 a.m. NA-B and NA-C were observed to transfer R23 from the wheelchair to the bed via a full body mechanical lift. A pressure redistribution cushion was noted on R23's wheelchair seat. R23's skin was clear and intact. - At 10:10 a.m. NA-B and NA-C confirmed R23 had not received assistance with repositioning since 7:13 a.m. a total of 2 hours and 50 minutes earlier. On 3/23/18, at 10:35 a.m. RN-B stated R23 was to receive assistance with repositioning every two hours as directed by the care plan. Superior Healthcare Management Minnesota Region policy and procedure, Pressure Ulcer Risk Assessment dated 12/23/17, indicated the following: -pressure ulcers are usually formed when a resident remained in the same position for an extended period of time causing increased pressure or decrease of circulation -if pressure ulcers are not treated when discovered, they can become larger, painful, and infected -pressure ulcers are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (feces, urine, soap, discharge), decline in nutrition, and hydration status, acute illness or decline in the resident's physical and/or mental condition -pressure ulcers are a serious skin condition for the resident -routinely assess and document the condition of the resident's skin per facility wound and skin care program for any signs and symptoms of irritation or breakdown.	2 900		

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2 900	Continued From page 65 -Skin would be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. Superior Healthcare Management Minnesota Region policy and procedure, Pressure Ulcer Treatment dated 12/23/17, included general guidelines and strategies for stage I, stage II, and stage III pressure ulcers which directed consistent assessment and documentation, implementation of appropriate interventions, and monitoring for efficacy of interventions, and making revisions in interventions based on assessment. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure resident with pressure ulcers receive appropriate cares. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:	2 910		5/8/18

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2 910	Continued From page 66 A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete a comprehensive bladder assessment to determine the continued need for an indwelling catheter for 1 of 2 residents (R5) who utilized an indwelling catheter. Findings include: R5's quarterly Minimum Data Set (MDS) dated 1/10/18, indicated R5 had moderate cognitive impairment and diagnoses included Parkinson's disease, quadriplegia and depression. The MDS indicated R5 required total assistance of two staff members for bed mobility, transfers and all activities of daily living. The MDS also indicated R5 utilized an indwelling urinary catheter. R5's admission MDS dated 9/1/17, identified R5 as dependent upon staff for all activities of daily living and utilization of the catheter. R5's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 9/6/17, indicated R5 utilized an indwelling Foley catheter. The CAA did not include a	2 910	corrected	

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2 910	Continued From page 67 comprehensive assessment of the catheter. R5's Bladder Assessment Form dated 11/22/17, indicated R5 had urinary retention which was unable to be treated or corrected medically or surgically. The assessment indicated R5 had an indwelling catheter. However, the assessment was not comprehensive as it did not identify when the catheter was placed, attempts to remove the catheter, bladder infection history or past bladder function history. R5's care plan dated 9/6/17, indicated R5 had an indwelling catheter and directed the staff how to care for the catheter and to monitor for signs and symptoms of infection. R5's physician order dated 11/15/17, indicated R5 had been started on Macrobid (an antibiotic) for 7 days for the treatment of a urinary tract infection. R5's clinical record did not contain a copy of the urinalysis. On 3/20/18, at 1:45 p.m. R5 was assisted to bed by nursing assistants (NA)-B and NA-F. NA-B was observed to hang R5's catheter drainage bag on the side of R5's bed frame. NA-B then emptied the catheter drainage bag. On 3/21/18, at 1:10 p.m. the director of nurses (DON) reviewed R5's record and indicated R5 had a diagnosis of urinary retention upon admission to the facility and R5 was admitted with the catheter. The DON confirmed R5 had been treated for a urinary tract infection while at the facility, however, the clinical record did not indicate if R5 had been evaluated for medical need of the catheter or if the catheter had been attempted to be removed. The DON confirmed the facility had not completed a comprehensive	2 910		

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2 910	Continued From page 68 assessment for the continued need of the indwelling catheter. A policy related to indwelling catheters was requested and none was provided. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure residents with catheters received appropriate care and services. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 945	MN Rule 4658.0530 Subp. 1 Assistance with Eating - Nursing Personnel Subpart 1. Nursing personnel. Nursing personnel must determine that residents are served diets as prescribed. Residents needing help in eating must be promptly assisted upon receipt of the meals and the assistance must be unhurried and in a manner that maintains or enhances each resident's dignity and respect. Adaptive self-help devices must be provided to contribute to the resident's independence in eating. Food and fluid intake of residents must be observed and deviations from normal reported to the nurse responsible for the resident's care during the work period the observation of a deviation was made. Persistent unresolved problems must be reported to the	2 945		5/8/18

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2 945	Continued From page 69 attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adaptive equipment to promote independence with eating for 1 of 1 residents (R23) reviewed for nutrition observed to display difficulty eating and drinking. Findings include: R23's quarterly Minimum Data Set (MDS) dated 3/9/18, identified R23 with severe cognitive impairments and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living including eating. R23's annual MDS dated 10/13/17, also identified R23 as requiring extensive assistance with eating. R23's Nutritional Status Care Area Assessment (CAA) dated 10/20/17, indicated R23 displayed disruptive behaviors and threw food during meals. The CAA consisted of check marks for the identified items, but no compressive assessment of R23's nutritional needs. R23's Nutritional Data V2.1 form dated 12/21/17, indicated R23 did not require adaptive equipment during meals. R23's Care Plan dated 1/20/18, indicated R23	2 945	corrected	

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2 945	Continued From page 70 was to utilize a plate guard for meals to ensure R23 was able to eat greater than or equal to 75% of the meal. On 3/19/18, at 10:47 a.m. family member (FM)-B stated R23 seemed to be very thirsty when FM-B visited the facility. FM-B stated she had brought R23 a covered cup to use in his room but was unaware if the staff were allowing R23 to use the cup. On 3/19/18, at 12:05 p.m. R23 was wheeled into the dining room in a tilt and space wheelchair. R23's wheelchair was in a reclined position. R23 was positioned perpendicular to the table as his wheelchair was too high to fit under the table. - At 12:07 p.m. R23 reached for a glass of thickened juice and attempted to drink from the glass. R23 was observed to spill the juice onto his shirt as he was not able to get the glass to his lips without spilling. - At 12:10 p.m. R23 continued to pick up his glass, attempt to drink and spilled onto his shirt. - At 12:12 p.m. family member (FM)-A asked an unidentified staff member if R23 was able to feed himself. FM-A stated "I have never seen him try to do that before." - At 12:15 p.m. R23 again picked up his glass and spilled the juice onto his shirt. - At 12:17 p.m. nursing assistant (NA)-C served R23 the noon meal consisting of ham, potatoes and fruit. R23's plate was not observed to be equipped with a plate guard as NA-C began to feed R23 with the meal. - At 12:32 p.m. R23 had eaten approximately 1/3 of the meal with the assistance of NA-C. R23 continued to independently pick up his glass, attempted to drink, causing the liquid to spill onto his shirt.	2 945		

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2 945	Continued From page 71 On 3/20/18, at 12:50 p.m. R23 was observed in the dining room. R23 had a meal consisting of sloppy Joe (sandwich on a hamburger bun) green beans and fruit. R23 was observed to hold the sandwich in his hand and eat it independently. NA-B attempted to assist R23 with the other meal items but R23 refused the assitance. - At 12:57 a.m. R23 was assisted out of the dining room . R23 had eaten 100% of the sandwich and bites of the other meal items. R23's shirt was observed to have spilled juice on it. - At 5:00 p.m. R23 was observed to be seated perpendicular to the dining room. A glass of thickened juice was observed on the table, which R23 picked up and began drinking. R23's wheelchair was in a semi-reclined position as he began to take sips from the glass. R23 was observed to spill a small portion of the juice onto his shirt. - At 5:06 p.m. NA-D served R23 a meal consisting of tuna noodle casserole, peas and a bun. R23's plate was not observed to be equipped with a plate guard. NA-D was observed to turn R23's wheelchair so he was able to face the meal and repositioned the wheelchair into an upright position. - At 5:08 p.m. R23 picked up his spoon and began to feed himself. - At 5:13 p.m. R23 attempted to drink a glass of juice and spilled it down himself and onto the floor. Once the glass hit the floor, R23 began to eat the meal with his fingers. R23 was observed to have a significant amount (greater than 1/2 of the food) spill onto himself, the table and the floor while eating. NA-D was not observed to assist R23 with eating the meal. - At 5:17 p.m. registered nurse (RN)-E asked	2 945		

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2 945	Continued From page 72 NA-D if she could assist in the dining room. NA-D directed RN-E to assist R23 and warned RN-E that if the food was spilled on R23, he had a history of striking out at the staff. RN-E sat next to R23 and realized the table was too low for R23 to sit properly. RN-E then reached under the table and raised the level of the table by cranking a lever on the table pedestal stand. R23 was then positioned under the table to reach the meal without over extending his arms. - At 5:30 p.m. R23 had finished approximately 25% of of his meal with a significant amount of spillage noted on the floor, R23 and the table. R23 was not receptive to RN-E's attempts to assist him with the meal. On 3/21/18, at 12:15 p.m. R23 was observed in the dining room. NA-B served R23 the meal. R23's plate was not observed to have a plate guard. NA-B was observed to sit next to R23 and feed him the meal. - At 12:29 p.m. the dietary manager (DM) stated any type of adaptive equipment required at meals was identified on the resident dietary card. Review of R23's dietary card did not identify any type of adaptive equipment. The DM stated R23 had an order for a plate guard in the past, but it was discontinued about six weeks ago because at the time, R23 was not attempting to feed himself. The DM stated the nurses should have documented the discontinuation of the plate guard. The DM confirmed R23 had been feeding himself the past few days and a lip plate was not provided. The DM also stated R23 had not utilized covered cups at meals, but did have a covered up in his room brought in by the family members. The DM stated she had not noticed R23's ability to drink and had not requested R23 to be evaluated for additional adaptive equipment at meals.	2 945		

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2 945	Continued From page 73 Review of R23's clinical record lacked documentation related to the discontinuation of the plate guard. On 3/21/18, at 1:45 p.m. the director of nursing stated she was unaware of the type of adaptive equipment R23 was to be utilizing at meals. To her knowledge, no staff member or family member had requested R23 to be evaluated for the use of adaptive equipment. The DON stated she would review R23's record for further information related to the plate guard discontinuation, but to her knowledge, no documentation had been completed. A policy related to adaptive meal equipment was requested and not provided. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents received the appropriate adaptive equipment at meals. The DON or designee could could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 945		
21225	MN Rule 4658.0700 Subp. 2 A Medical Director; Duties Develop res care P&P Subp. 2. Duties. The medical director, in conjunction with the administrator and the	21225		5/8/18

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21225	Continued From page 74 director of nursing services, must be responsible for: A. the development of resident care policies and procedures that are to be approved by the licensee; This MN Requirement is not met as evidenced by: Based on interview and document review, the medical director failed to ensure facility policies and procedures had been developed and implemented to ensure quality of resident care. This deficient practice had the potential to affect all 23 residents who resided in the facility. Findings include: The facility medical director (MD) was interviewed on 3/26/18, at 11:43 a.m. during which she stated she made rounds at the facility a minimum of once a week, she was available by telephone at any time, and attended the quality assurance meetings at least every three months. The MD stated she was involved with developing and implementing quality action plans for sufficient staffing, and stated a large portion of the issues in the facility were related to the rapid turn over in both front line staff and management staff. The MD stated she was very involved in the influenza outbreak that had occurred in January, but was not aware staff was not wearing proper personal protective equipment (PPE) to minimize the spread of infection to other residents. The MD was not aware if the facility had proper infection control policies developed and implemented. The MD stated falls were reviewed at every QAPI meeting, however was not aware if the facility had proper policies and procedures to follow so fall risks were minimized.	21225	corrected	

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21225	Continued From page 75 Review of all the facility policies for infection control, abuse prohibition, falls, use of mechanical lifts, pressure ulcers, psychotropic medication monitoring, resident rights, admission transfer & discharge, and dignity, revealed none had been signed indicating approval by the medical director. The regional director of clinical services was interviewed on 3/26/18, at 1:26 p.m. and confirmed the medical director had not reviewed and approved any of the aforementioned policies. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure the medical director was active in the review, development and implementation of facility practices. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21225		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced	21375		5/8/18

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21375	Continued From page 76 by: Based on observation, interview and document review, the facility failed to develop and maintain an ongoing infection control surveillance program to identify potential infectious outbreaks. This failure resulted in an immediate jeopardy (IJ) due to an influenza A outbreak from 1/5/2018 - 1/18/2018, in which droplet precautions were not initiated for 4 residents (R12, R124, R125, and R6) who tested positive for influenza A, and for 8 additional residents (R21, R10, R9, R4, R1, R8, R227, and R2) who displayed signs and symptoms of influenza. In addition, policies and procedures related to infection control had not been developed and implemented. This practice had the potential to affect all 23 residents residing in the facility at the time of the outbreak. In addition, the facility failed to ensure contact precautions were initiated for 2 of 2 residents (R5, R24) who were infected with organisms which required contact precautions. Additionally, the facility failed to ensure appropriate hand hygiene was completed for 3 of 8 residents (R8, R18 and R2) observed to receive medications. This practice had the potential to affect all 23 residents residing at the facility. Findings include: The IJ related to infection control practices and the lack of initiation of isolation precautions began on 1/5/18, when R12 was diagnosed with influenza A and the facility failed to initiate standard and droplet precautions to prevent the transmission of influenza to other residents. Three additional residents (R125, R124 and R6) tested positive for influenza and 8 other residents developed flu like symptoms. Influenza A is a highly contagious disease which is spread through air droplets. The administrator and the	21375	corrected	

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director of nursing (DON) were notified on 3/23/18, at 4:05 p.m. of the IJ. The IJ was removed on 3/27/18, at 12:00 p.m., however, non-compliance remained at a scope and severity level of F, which indicated a widespread systemic failure which had the potential to affect all residents residing in the facility.

According to the Centers for Disease Control (CDC) an outbreak of influenza in a long term care facility is identified as two or more residents testing positive for influenza. Individuals with influenza are encouraged not to mingle with others and standard and droplet precautions are to be initiated. (reference: www.CDC.gov). Most people who get influenza will recover in a few days to less than two weeks, but some people will develop complications (such as pneumonia) as a result of the flu, some of which can be life-threatening and result in death. Pneumonia, bronchitis, sinus and ear infections are examples of complications from flu. The flu can make chronic health problems worse.

On 3/23/18, at 8:00 a.m. the regional director of clinical services (RDCS) stated the facility did not have a nurse identified to act as the facility's infection control preventionist. The RDCS stated all infection control surveillance and concerns were to be directed to the director of nursing.

- At 8:30 a.m. the administrator and the DON were interviewed regarding the infection control practices of the facility. The DON stated she had assumed the responsibilities of the DON in January 2018, and the only infection control log she was able to locate was for an influenza outbreak in January 2018, which had been completed by the former DON. The DON stated she had completed the infection control

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surveillance logs the week of 3/12/18, for the months of January, February and March 2018, after having reviewed resident records and identifying there were residents who had been treated with antibiotics. The DON confirmed the logs did not include the tracking or trending of illnesses which were not treated with antibiotics.

The Influenza-like Illness Line List form initiated on 1/5/18, indicated R12 had tested positive for Influenza A on 1/5/18. The form identified three additional residents (R125, R124, and R6) who also tested positive for Influenza A between 1/5/18 and 1/15/18. Eight additional residents were identified as displaying flu like symptoms (including but not limited to fever, cough, muscle pain, headache or chills) during the identified dates.

According to the facility information printed off of the Minnesota Department of Health website dated 9/21/16, influenza transmission occurred predominately by large respiratory droplets that are expelled from the respiratory tract during coughing or sneezing. The droplet particles usually did not remain suspended in the air, and close contact (usually less then three feet) was required for transmission. Infectiousness begins 24 hours prior to the onset of the illness. Adults were usually contagious until five days after the onset of illness. The incubation period for influenza was identified as one to four days. The website directed the facility to control an influenza outbreak by the implementation of standard and droplet precautions for all residents with suspected or confirmed influenza. The precautions were to remain in place for seven days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever was longer.

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21375	Continued From page 79 Examples of Standard Precautions were identified as: - wear gloves - wear gowns if clothes may be soiled with respiratory secretions - change gloves and gowns after each resident encounter - perform hand hygiene before wearing gloves and after removing gloves Examples of Droplet Precautions were identified as: - private rooms if possible - cohorting ill residents if private rooms were unavailable - wear a facemask upon entering the resident room - have the resident wear a facemask if movement or transportation is necessary. The Superior Healthcare Management Minnesota Region Influenza, Prevention and Control of Seasonal (influenza) policy dated 12/27/17, directed the staff to initiate standard and droplet precautions for all residents identified with influenza. R12's quarterly Minimum Data Set dated 1/26/18, indicated R12 had intact cognition, required limited to supervision/set up for activities of daily living, did not walk, and was independent with locomotion on and off the unit. The MDS also indicated R13 was offered but declined the influenza seasonal vaccine. R12's Doctor's Order Sheet indicated on 1/8/18, R12 had been sent to the emergency room on 1/5/18, due to an increased temperature, cough,	21375		

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yellow mucous, and lethargy. R12 was diagnosed with influenza A and treated with Tamiflu (an anti-viral medication to treat influenza). Although R12's clinical record reflects staff had instructed R12 to remain in his room during his illness, there is no evidence droplet precautions had been implemented.

R124's admission MDS indicated R124 had severely impaired cognition, required extensive assistance of one to two staff for all activities of daily living, and had received the influenza vaccine prior to admission to the facility.

R124's Progress Note (PN) dated 1/7/18, indicated at 7:20 a.m. R124 had a low grade temperature, non productive cough with wheezing noted and was treated with Tylenol. At 11:20 a.m. no further wheezing was noted, however, R124 stated she was coughing up yellow phlegm. R124 stated she felt better than she had the night before.
-A PN dated 1/8/18, at 2:10 a.m. indicated R124 continued with a low grade temperature, wheezing, and a non productive cough. R124 had remained in her room in order to prevent the spread of infection.
-A PN dated 1/8/18, at 10:51 p.m. indicated R124 had vomited, was restless and her skin was warm to touch. Temp 101.6, has loose productive cough, increased wheezing, and oxygen saturation was at 80%. R124 was sent to the emergency room for an evaluation.
-A PN dated 1/8/18, at 2:52 a.m. indicated R124 was admitted to the hospital for treatment of influenza A and pneumonia.
Although R124's clinical record reflected isolation to her room, the record lacked evidence of the implementation of droplet precautions.

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R125's admission MDS dated 1/9/18, indicated R125 had moderate cognitive impairment and extensive to limited assistance from one staff person for all activities of daily living. The MDS also indicated R125 was offered but declined the influenza seasonal vaccination.

R125's PN dated 1/11/18, indicated the resident had fallen and was sent to the emergency room. A subsequent note indicated R125 was transferred to another hospital for neurological care.
-A PN dated 1/16/18, indicated R125 remained in the hospital and was diagnosed with and treated for influenza.
-A PN dated 1/17/18, indicated R125 returned to the facility with diagnoses including influenza A, and urinary tract infection, required oxygen use and assistance of one staff of all activities of daily living.
-A PN dated 1/18/18, indicated R125 had attempted self transfers several times, therefore the staff member assisted R125 up and took her down to the nurse's station which was directly located in the main corridor of resident and visitor traffic flow.
-A PN dated 1/18/18, at 3:35 p.m. indicated R125 continued to have adventitious lung sounds and would be getting up for supper.
-A PN dated 1/19/18, at 2:58 a.m. indicated R125 had expired.
-R125's clinical record lacked evidence of the implementation of infection control precautions.

R6's clinical record contained a Status Change Notification dated 1/8/18, which indicated the facility had been notified R6 had tested positive for influenza A. R6 received an order for Tamiflu and an antibiotic for the treatment of pneumonia.

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21375	Continued From page 82 Review of R6's progress notes from 1/8/18 - 1/17/18, revealed from 1/8/18 - 1/14/18, R6 remained in her room. However, on 1/14/18, R6 was noted to have a temperature of 99.0 degrees Fahrenheit, an occasional cough, and raspy voice. On 1/15/18, R6 ambulated to and from the dining room for meals. On 1/16/18, R6 remained her her room as she was not feeling well. Further review of the Infection control log for January 2018, revealed eight additional residents who had displayed symptoms of influenza. -R21 displayed symptoms on 1/5/18, which included sore throat, cough, and sinus congestion. -R10 displayed symptoms on 1/6/18, which included vomiting, temperature of 101.8, and headache. On 1/7 and 1/8/18, symptoms included non-productive cough, productive cough with yellow phlegm and increased chest congestion. - R9 displayed symptoms on 1/10/18, which included a temperature of 101.2 degrees along with symptoms of sore throat, cough and sinus congestion. - R4 displayed symptoms on 1/10/18, which included a temperature of 101.1 degrees along with symptoms of sore throat, cough and sinus congestion. -R1 displayed symptoms on 1/15/18, which included a temperature of 100.5 degrees along with, sinus congestion -R8 displayed symptoms on 1/15/18, which included temperature of 100.8 degrees along with sore throat, cough, chills, and sinus congestion.	21375		

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21375	Continued From page 83 - R227 displayed symptoms on 1/15/18, which included a temperature of 100.8 degrees along with muscle aches, head ache, cough, chills, and sinus congestion. - R2 displayed symptoms on 1/17/18, which included a cough chills and sinus congestions. Additional review of the infection control logs lacked indications that the aforementioned residents had isolation precautions initiated at the time of the symptom onset. Review of the quality assurance performance improvement (QAPI) committee meeting log dated 1/16/18, identified infections of bronchitis/respiratory and cellulitis. Notes identified "influenza in house" and Minnesota Department of Health Infection Control Assessment and Response Program's (ICAR) scheduled visit had to be rescheduled due to influenza A. The report did not identify outbreaks, patterns/trends of influenza, infection control prevention measures taken such as initiation of transmission based precautions (isolation), if the infections had been reported to the health department, or ongoing monitoring systems. The analysis for the identified infections concluded that hand washing competencies needed to be completed. In addition, the QAPI logs did not address any quality assurance activities for influenza preparations or prevention measures for the influenza season that began on 10/1/17. On 3/23/18, at 8:15 a.m. licensed practical nurse (LPN)-B stated she could not recall utilizing any type of isolation precautions in the facility. LPN-B confirmed the facility had an outbreak of influenza, yet isolation precautions had not been	21375		

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21375	Continued From page 84 utilized. -At 8:20 a.m. NA-A stated she could not recall utilizing infection control isolation gowns in the past six months. - At 8:52 a.m. the DON confirmed the facility had four residents who tested positive with influenza A and 9 additional residents who displayed flu-like symptoms. The DON confirmed the facility had not implemented droplet precautions as directed. - At 10:21 a.m. NA-C opened the supply closet and was able to locate all PPE supplies. NA-C stated the facility had not utilized PPE in the past six months. NA-F joined the conversation and NA-F also confirmed the facility had not utilized PPE in the past six months. - At 10:42 a.m. RN-B stated the facility had not utilized PPE in the past year. RN-B stated gloves and masks were utilized during the influenza outbreak by some staff, but at no time were gowns utilized. - At 1:55 p.m. the HUC stated during the influenza outbreak in 1/2018, the former DON printed a sign off of the CDC website and posted it on the front door. The HUC stated the facility did not have any type of signs in the facility to notify staff, resident or visitors, when/if a resident had a potential contagious infection. The HUC stated the facility had signs in the past but she had not seen them for many years. The HUC stated she could not recall the last time PPE was utilized at the facility. During the monitoring visit on 3/25/18, at 8:54 a.m. RN-B stated infection control education binders had been placed at the nurses station for	21375		

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21375	Continued From page 85 all to review and sign off, however, she stated she had not had time to review them yet. -At 9:16 a.m. NA-G stated the only training she had been provided was related to the use of the mechanical resident lift and neck brace. The IJ that began on 1/5/18, was removed on 3/27/18, at 12:00 p.m. when the facility completed the following interventions were verified through observation, staff interviews and record review: - Infection control policies and procedures were reviewed and updated. - Additional personal protective equipment (PPE) was ordered for the facility. - All staff members were educated on where the PPE was located. - Infection control signs were ordered for future use. - All staff were educated on the facility infection control polices and procedures, including when to initiate transmission based precautions in order to prevent the spread of influenza. Contact Precautions: R5's PN dated 12/21/17, indicated R5 had a gastrostomy tube site which was pink and had discharge (color not identified). The documentation indicated a culture of the gastrostomy tube site was obtained and R5 was started on an antibiotic for Methicillin Resistant Staph Aureus (MRSA) which is a type of staph bacteria that is resistant to several antibiotics.	21375		

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R5's Essentia Health laboratory results collected on 12/13/17, indicated R5 had Methicillin Resistant Staphylococcus at the gastrostomy tube site.

Daily PNs from 12/22/17 - 12/30/17, included daily "infection notes." The notes indicated R5 was receiving an antibiotic for the gastrostomy tube site infection with drainage, however, the documentation did not indicate if isolation precautions had been initiated.

An Infection Surveillance Data Collection Form dated 12/20/17, indicated R5 had been identified with MRSA and treated with antibiotics. The staff were to implement contact isolation precautions.

R24 was admitted to the facility on 12/15/17, with diagnoses that included but were not limited to: infection following a procedure, cerebrospinal fluid (CSF) leak, generalized muscle weakness, and headache.

Review of the hospital dismissal summary dated 12/14/17, indicated R24 underwent a dural repair for a CSF leak following a lumbar fusion. The spinal incision was cultured and was infected with staphylococcus epidermis and candida albicans. R24 was given IV antibiotics and sent to the nursing home to receive IV antibiotics until 12/21/17.

Review of R24's medical record including all assessments and progress notes for the entire stay in the facility (12/15/17 - 12/22/17), revealed R24 had not been placed into isolation precautions as identified by the facility's policy for infection control. The policy Isolation- Categories of Transmission Based Precautions dated

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21375	Continued From page 87 12/23/17, revealed R24 should have been placed in contact precautions for the draining spinal wound infected with staphylococcus epidermis and candida albicans. During interview with the DON on 3/23/18, at 11:04 a.m. she confirmed there was no indication in R24's record contact precautions were implemented as the infection control policy for isolation precautions indicated. The Superior Healthcare Management Minnesota Region MRSA policy dated 12/27/17, directed the staff to implement contact precautions if resident had draining fluids. On 3/23/18, at 8:52 a.m. the DON confirmed R5 had been diagnosed and treated for MRSA, yet contact isolation precautions had not been implemented. - At 8:15 a.m. licensed practical nurse (LPN)-B stated she could not recall utilizing any type of isolation precautions in the facility. LPN-B confirmed R5 had been treated for MRSA in the past three months and the facility had an outbreak of influenza, yet isolation precautions had not been utilized - At 8:20 a.m. NA-A stated she could not recall utilizing infection control isolation gowns in the past six months. NA-A stated she had utilized the gowns in the past for residents who had tested positive for MRSA or C-Diff. - At 9:10 a.m. the administrator stated the facility had isolation precaution supplies in the facility,	21375		

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however, she would have to ask the health unit coordinator (HUC) where the supplies were located.
When queried if when the infection control practices of the facility had last been reviewed, the administrator stated she had started at the facility on 1/18/18, and had no records of when the infection control policies and procedures had been reviewed for the facility. The administrator stated the corporate level policies were reviewed annually but she did not have access to proof of the policy review.

- At 9:20 a.m. the administrator stated going forward the staff were to be trained on infection control practices and how to implement the facility procedures, however, the staff had not received the education at the time and it was a work in progress.

- At 10:15 a.m. LPN-B stated that if resident required droplet or isolation precautions, she would have to find the supplies for personal protective equipment (PPE), however, she could not state where the PPE was located in the facility. LPN-B asked nursing assistant (NA)-C where the supplies were located. NA-C directed LPN-B to the supply closet in the social service designees office.

- At 10:21 a.m. NA-C opened the supply closet and was able to locate all PPE supplies. NA-C stated the facility had not utilized PPE in the past six months. NA-F joined the conversation and NA-F also confirmed the facility had not utilized PPE in the past six months.

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- At 10:42 a.m. RN-B stated the facility had not utilized PPE in the past year. RN-B stated gowns and isolation carts were to be utilized if a resident had something contagious like MRSA. RN-B confirmed R5 had MRSA in the past four months yet PPE was not utilized.

Superior Healthcare Management Govern Board Meeting dated 11/3/17, indicated the following: "The Governing board has asked all locations to report, train and reinforce infection control practices across all departments."

On 3/23/18, at 8:52 a.m. the DON stated she was unaware of any type of infection control training that had been completed in the past year. However, infection control training was scheduled to be completed in April 2018.

Medication administration:

On 3/20/18, at 7:19 p.m. RN-C was observed preparing medication for R8. On three different occasions, RN-C was observed to remove a bottle of medications from the medication cart, open the bottle and dispense one pill out of the bottle directly into his/her hand before adding it to a soufflé cup. RN-C then recapped the bottle and returned the bottle to the cart. RN-C then carried the soufflé cup of medications into R8's room and assist R8 to take the medications.

- At 7:31 p.m. RN-C returned to the medication cart, he/she was not observed to wash his/her hands as he began dispensing medications for

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R18. RN-C dispensed six tablets from individualized bubble cards, directly into a soufflé cup. He/she then opened a drawer, picked up a bottle of calcium and dumped one tablet from the bottle directly into his/her hand before adding it to the soufflé cup. RN-C then reviewed the electronic Medication Administration Record and reported the calcium had recently been discontinued at which time he/she removed the calcium tablet from the medication cup by picking it out with his/her fingers and discarding the medication in the trash. RN-C then administered the medications to R18.

- At 8:27 p.m. RN-C returned to the medication cart and began dishing medications for R2. RN-C was not observed to wash his/her hand prior to opening a bottle of Tylenol 325 milligrams and placing two tablets directly from the bottle into his hand and adding them to a soufflé cup. RN-C added three addition medications (carbidopa-levadopa, remeron and quetipine furmaratate) to the soufflé cup from individualized bubble cards. RN-C then crushed all of the medications and administered them to R2.

- At 8:38 p.m. RN-C confirmed he had dispensed all medications from the bottles into his/her hand prior to adding them into the resident soufflé cups. RN-C stated he/she normally dished the medications from the bottles into his hands.

The undated Administering Medication policy, directed the staff to follow established infection control procedures during the administration of medications as applicable.

On 3/26/18, at 11:30 a.m. the administrator confirmed medications were not to be dispensed

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21375	Continued From page 91 directly from a bottle into the staff members hand. The staff were to dispense the medication from the bottle into the cap of the medication bottle, or directly into a soufflé cup. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure infection control policies and procedures are developed and implemented based on current standards of practice. The DON or designee could educate all staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those monitoring results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines.	21426		5/8/18

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21426	Continued From page 92 (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 4 residents (R10) received a two step tuberculin skin test (TST) in accordance to the Centers for Disease Control and Prevention (CDC) guidelines. In addition, the facility failed to ensure 1 of 1 resident (R17) who had a history of tuberculosis had received additional testing for tuberculosis. The facility failed to ensure 2 of 5 employees/ nursing assistants (NA-E and NA-G) had received a two step TST. The facility failed to complete a comprehensive TB risk assessment for the facility. Findings include: The CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Setting, 2005, directed that all residents must receive a baseline TB screening. The baseline TB screening should consist of assessment for TB risk factors and history; assessment for current symptoms of active TB; and testing for the presence of infection with mycobacterium tuberculosis. In addition to screenings, the residents and employees were to receive a two step tuberculin skin test (TST) or a laboratory screening for the presence of TB. If an employee or resident tested positive for any of aforementioned tests, a chest x-ray and/or	21426	corrected	

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medical examination by a medical practitioner was to be completed to rule out active disease.

Residents:

R10 was admitted to the facility on 6/20/17. R10's Baseline TB screening Tool for Nursing Home and Boarding Care Home Residents dated 6/20/17, indicated R10 had received a single step TST on 6/30/17. R10's medical record lacked documentation related to a second step TST.

R17 was admitted to the facility on 2/5/18. R17's undated Baseline TB screening Tool for Nursing Home and Boarding Care Home Residents indicated R17 had a history of TB and had been treated for TB in the past. R17's clinical record lacked a chest x-ray or other documentation which would indicate if he/she was free of TB.

On 3/23/18, at 11:00 a.m. registered nurse (RN)-B confirmed R10 had not received a second step TST and R17's medical record did not identify additional information related to TB testing.

Employees:

Review of the employee records revealed the following information.

NA-E was hired on 3/5/18. NA-E's employee record did not include a screening for TB or a TST test.

NA-G was hired on 3/6/18. NA-G's employee record did not include a screening for TB or a TST test.

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21426	Continued From page 94 On 3/26/18, at 10:15 a.m. the director of nursing stated the employee TB screenings and test should be at the nurses station. Upon review of the nurses station, the DON reported she was unable to locate the TB screenings or TSTs. Facility Risk Assessment: The undated Annual Tuberculosis (TB) Risk Assessment indicated the facilty was located in a low risk community. The form indicated the DON and RN-B would complete the form in April 2018. On 11/23/18, at 8:30 a.m. the administrator stated the facility risk assessment was not complete. The administrator stated the regional director of clinical services (RDCS) had completed the form upon arrival to the facility on 3/20/18. The administrator confirmed the assessment was not comprehensive or complete. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure the facility, residents and staff were properly screened for TB and that the TST was administered appropriately. The DON or designee could develop monitoring systems to ensure ongoing compliance and report the results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General	21435		5/8/18

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21435	Continued From page 95 Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess resident centered activities preferences and develop individualized interventions for 1 of 2 residents (R14) reviewed for activities. Findings include: R14's physician nursing home admission assessment dated 1/23/18, indicated R14 had been admitted to the facility on 1/19/18, and had diagnoses that included, but were not limited to: closed nondisplaced fracture of the seventh cervical vertebra with routine healing, high blood pressure, type II diabetes, late onset moderately advanced Alzheimer's disease with behavioral disturbance. The admission Minimum Data Set (MDS) dated 1/26/18, indicated R14 had moderate cognitive impairment, suffered a fracture as a result of a fall prior to admission, had not displayed any inappropriate behavior symptoms, required	21435	corrected	

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limited assistance of one person when ambulating in room, required extensive assistance of one person for transfers, and required extensive assistance of one person for dressing and toilet use. The MDS indicated having books or newspapers to read, being around animals or pet visits, and participating in religious activities were somewhat important to R14.

R14 was observed on 3/20/18, from 12:48 p.m. to 7:18 p.m., 3/21/18, from 9:00 a.m. to 1:00 p.m., and 3/22/18, from 8:02 a.m. to 2:30 p.m.. R14 was not provided activities and did not attend any activities during these times.

R14's medical record was reviewed and there was no assessment of leisure pursuits or activities of interest completed. R14's undated Care Area Assessment (CAA) for activities revealed it had not been completed. There was no assessment of current activity interests, activity interests prior to admission, environmental or staffing issues that hindered participation, unique skills or knowledge the resident had that could be passed onto others, or issues that result in reduced activity participation.

Review of R14's activities care plan dated 1/29/18, indicated the following: "Invite the resident to activity programs that encourage physical activity, physical mobility, such as exercise group, walking activities to promote mobility." A copy of R14's activity participation log was requested but not provided.

On 3/22/18, at 8:29 a.m. the regional director of clinical services (RDCS) was interviewed and confirmed R14 had not been comprehensively assessed for activities of interest and a

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21435	Continued From page 97 comprehensive care plan with individualized interventions including activities of interest had not been developed. The Superior Healthcare Management Minnesota Region policy for Activities dated 12/23/17, indicated that within 14 day of a residents admission to the facility a residents activities would be assessed for and an activity plan based on the residents choices and preferences would be developed. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure all residents received a comprehensive activity assessment to assist with developing individualized, resident centered interventions. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services.	21475		5/8/18

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21475	Continued From page 98 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance and/or arrangements to obtain legal council, and provide therapeutic conversation for 1 of 1 resident (R21) who had urgent legal matters pending in court. Findings include: R21's admission record indicated R21 had diagnoses which included end stage renal disease (kidney failure) with dependence on renal dialysis, status post heart transplant, diabetes type II, major depressive disorder, heart failure, insomnia, and anemia. R21's annual Minimum Data Set (MDS) dated 12/20/17, indicated R21 had moderate cognitive impairment, had mood symptoms which included having little interest or pleasure in doing things, feeling tired or having little energy, and had trouble falling asleep or staying asleep, and displayed no inappropriate behavior symptoms. Review of R21's daily preferences revealed it was very important for R21 to take care of his personal belongings, use a telephone in private, and have a place to lock personal belonging to keep them safe. The MDS indicated R21 required extensive assistance of more than two persons for bed mobility, transfers, and dressing. R21 did not ambulate, and used a wheelchair as a mode of transportation. R21 was interviewed on 3/20/18, at 2:11 p.m. and stated he was frustrated because he was going through a divorce and the attorney he had	21475	corrected	

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retained to represent him had sent a letter at the end of February 2018, which indicated his attorney would no longer be representing him. R21 went on to say that he owned a home, and had many assets including having part ownership of a business. R21 stated he had not received any income from the business since living in the nursing home and was worried the business partners were taking his share of the profits. R21 stated he would call attorneys to represent him with the aforementioned legal matters if he had a cell phone but could not find anyone to purchase a phone for him. R21 stated he had told many of the staff including the current social service designee (SSD) as well as the previous SSD, he was worried due not having an attorney to represent him in the divorce hearing that was scheduled for April 10th, 2018.

R21's medical record was reviewed including all progress notes and assessments completed 11/1/18 - 3/20/18, and there was no evidence R21 had been assessed for any psychosocial issues, and there were no progress notes which indicated R21 was having difficulty or frustration related to pending legal/personal matters.

A psychosocial assessment on R21 was last completed on 10/18/17, but had not identified any psychosocial issues at that time.

R21's care plan (undated) was reviewed and interventions for R21's psychosocial dysfunction and family discord had not been developed.

The social services designee was interviewed on 3/21/18, at 1:03 p.m. during which she stated she was aware R21 was going through a divorce and currently did not have a divorce attorney retained. The SSD stated she had not asked R21 when the

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divorce case was scheduled, and had not assisted R21 with the tools necessary to retain an attorney (a phone, listing of attorneys in the area, number to legal aide etc...). The SSD confirmed R21 had not been assessed to determine if he had any unmet psychosocial needs since 10/18/17. The SSD confirmed she had not developed a care plan to visit with R21 periodically in order to provide ongoing therapeutic conversation related to R21's psychosocial and family discord issues.

On 3/23/18, at 8:43 a.m. a follow up interview was conducted with the SSD who stated R21 retained an attorney to represent him in his divorce and she assisted him in getting a prepaid VISA card to pay for the attorney's retainer fee. The SSD also stated she had discussed the potential of financial exploitation with his wife with whom he had been estranged. The SSD stated she got R21 a personal cell phone and that they were having a conference call with his attorney today at 4:00 p.m.. The SSD stated she was in the process of making a care plan which indicated she would visit with R21 at least weekly, or more often as needed, to provide support during this difficult divorce.

On 3/27/18, at approximately 9:25 a.m. R21 was interviewed again and stated that when his attorney quit him back in February, and he knew he did not have access to another attorney or even a phone to call one, he felt frustrated and could not sleep at night due to worrying about what was going to happen if he did not get representation. R21 also stated he had a hard time eating and would have to force himself to eat. R21 stated he was still having anxiety because when he last spoke to his attorney's office, they told him that they could no longer

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21475	Continued From page 101 assist him. He stated the SSD had not stopped in to follow up with him on where he was at on this matter. R21 stated he did not know how to get an email account and was still having great anxiety and frustration because he still did not know if he had an attorney retained because he was told that he needed to have an email account in order to receive communication from the attorney and did not know how to get one. On 3/27/18, at 9:29 a.m. the SSD confirmed she had not followed up with R21 since Friday. She stated she was not aware R21 needed an email account in order to receive information from his attorney. In addition, the SSD confirmed she had not shown R21 how to use the cell phone and stated she would assist him in setting up an email account and also linking the email account to his cell phone for ease of access and would follow up with the email address to his attorneys office. A policy regarding psychosocial assessment and services was requested but not provided. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure social service needs are identified and addressed for each resident. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21475		

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21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to act upon recommendations from the consultant pharmacist for 3 of 6 residents (R2, R23, R1) who had received recommendations from the pharmacist. Findings include: R2's annual Minimum Data Set (MDS) dated 11/2/17, identified R2 with severe cognitive	21535	corrected	5/8/18

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impairments and diagnoses including Parkinson's disease, dementia and anxiety. The assessment indicated R2 required extensive assistance with all activities of daily living and did not display mood or behavior problems. The assessment indicated R2 received daily antipsychotic and antidepressant medications.

R2's physician orders dated 1/2/18, included Seroquel (antipsychotic) 25 milligrams (mg) twice a day, remeron (antidepressant) 7.5 mg at bedtime, Prozac (antidepressant) 30 mg daily, and Klonopin (mood stabilizer) 0.125 mg one tablet every 24 hours as needed for agitation and anxiety.

During observations of personal cares on 3/21/18, at 11:30 a.m. R2 was observed to receive total assistance with cares from nursing assistant (NA)-C. R2 displayed no behaviors.

R2's electronic medication administration record (EMAR) for 1/2018- 3/2018, indicated R2 had received the schedule doses of Seroquel and Remeron as ordered. R2 had not utilized the PRN Klonopin order. The EMAR also included daily documentation related to potential side effects of antidepressant, antianxiety and antipsychotic medications. The EMAR indicated R2 had not displayed any type of side effects from the medications. The EMAR did not identify R2's behaviors associated with the medications.

Review of R2's Consultant Pharmacist Medicaiton Review form dated 7/20/17, indicated the pharmacist had questioned if a the Seroquel, remeron, Prozac or Klonopin could be considered for a dose reduction. R2's primary physican indicated he/she agreed with the pharmacist recommendations, however, R2's family refused

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21535	Continued From page 104 to allow a dose reduction. A Consultant Pharmacist Medication Review form dated 9/19/17, indicated the pharmacist had requested non pharmacological interventions to be attempted prior to the administration of the Klonopin PRN and to identify the specific target behaviors to guide the use of the medication. The physican indicated he/she was in agreement with the recommendation and directed the staff to attempt non pharmacological interventions and document the findings. A Consultant Pharmacist Medication Review form dated 11/21/17, indicated the pharmacist had requested the staff to identify the non pharmacological interventions utilized prior to the administration of the medication. The pharmacist indicated target behaviors were not identified in the record. The primary physican was in agreement with the pharmacist findings. A Consultant Pharmacist Medication Review for dated 2/23/18, indicated R2 had not utilized the PRN Klonopin in the past month and questioned if the medication could be discontinued. R2's primary physican indicated R2's family member refused to consider a dose reduction or discontinuation of the medication. Review of R2's clinical record did not identify what specific types of individualized behaviors R2 displayed. Nor did the record include any non-pharmacological interventions to attempt if the PRN Klonopin was to be used. R2's record lacked a quantitative and qualitative evaluation of her behaviors in relationship to the medications. On 3/22/18, at 2:50 p.m. registered nurse (RN)-E confirmed the consultant pharmacist had made	21535		

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recommendations for R2, however, the facility lacked documentation that they had been completed. RN-E confirmed the facility did not have a comprehensive system to monitor residents behaviors in relationship to their mood altering medications.

R23 utilized a PRN antianxiety medication and did not receive a 14 day re-evaluation of the medication. In addition, R23 received an antidepressant medication without adequate monitoring for the continued use of the medication.

R23's quarterly MDS dated 3/9/18, identified R23 with severe cognitive impairments and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R2 required extensive assistance with all activity of daily living. R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7 day review period.

R23's annual MDS dated 10/13/17, also indicated R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7 day review period

R23's Psychotropic Drug Use Care Area Assessment (CAA) dated 10/19/17, indicated R23 utilized antidepressant and antianxiety medications daily. The CAA indicated R23's behaviors put himself and staff members at risk for injury.

R23's Order Summary Report dated 2/23/18,

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included an order for Trazodone 50 milligrams (mg) to be given daily at beditme for anxiousness and insomnia. The order had been received on 3/31/17. R23 had a second order for Ativan (antianxiety medication) 0.5 mg to be administered as needed for agitation prior to morning and evening cares with one additional dose. The order was received on 9/7/17.

R23's care plan dated 3/27/17, indicated R23 had a history of being physically aggressive due to dementia. the plan directed the staff to administer medication as order and monitor/document the side effects and effectiveness of the medication.

R23's clinical record did not identify specific target behaviors for the use of the PRN antianxiety medication. Nor were non-pharmacological interventions identified to be administered prior to the medication administration.

Review of R23's electronic medication administration record (EMAR) indicated R23 had received 32 dose of PRN Ativan in 1/18, 48 doses in 2/18, and 23 doses in 3/18 from 3/1/18 - 3/22/18.

Review of R23's medical record lacked indication of non- pharmacological interventions attempted prior to the use of the PRN medication.

R23's Consultant Pharmacist Medication Review form dated 1/20/18, indicated the consultant pharmacist had identified R23's frequent use of antianxiety medication. The pharmacist indicated a PRN antianxiety medication required a 14 day face to face evaluation by the ordering physican. If the medication was to be continued, the record required clinical documentation for the continued need.

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21535	Continued From page 107 R23's primary physician replied on 1/26/18, and indicated R23 had significant anxiety and required the occasional doses of Ativan. On 3/20/18, at 5:15 p.m. nursing assistant (NA)-D warned registered nurse (RN)-E that while assisting R23 with a meal, if food was spilt on R23, he had a history to attempting to strike out at his caregivers. R1 received multiple psychotropic medications without an appropriate diagnosis, without adequate monitoring, and there was no justification for their continued use. R1's quarterly MDS dated 12/27/17, identified R1 with severe cognitive impairments and diagnoses including Alzheimer's disease, high blood pressure, and type II diabetes. The MDS indicated R1 required extensive assistance with all activity of daily living. R1 displayed no signs or symptoms of psychosis or delirium and had no verbal and physical aggressive behaviors towards others. The MDS indicated R1 utilized antipsychotic and antidepressant medications daily. R1's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/3/17, indicated R1 utilized antipsychotic and antidepressant medications daily which included the medications risperdone, and trazodone. The CAA had not indicated R1 had any inappropriate behaviors. R1's Order Summary Report was requested but not provided. Review of R1's medication administration record for March 2018 indicated R1 received the	21535		

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antipsychotic medication risperdone 0.5 mg every day and 1 mg twice a day for dementia without behavioral disturbance since May of 2017 (the exact date could not be found in documentation or through interview with staff) and received Depakote Sprinkles 125 MG since 1/16/2018 for restlessness and agitation. R1 received the antidepressant Trazodone 25 milligrams (mg) to be given twice a day for dementia with behavioral disturbance since 4/28/17.

R1's care plan dated last revised on 12/28/17, indicated R1 target behaviors included wandering, being uncooperative, and continuous pacing. The care plan directed the staff to administer medication as ordered, monitor/document the side effects and effectiveness of the medication, report behavior changes to the physician, and provide non pharmacological interventions with include 1 to 1 activity, redirecting, and removing resident from environment to decrease target behaviors, anxiety, or depression.

The progress notes for R1 were reviewed from 1/1/18-3/21/18, and there were no documented incidence of inappropriate behavior for R1.

R1 was observed periodically throughout the survey on 3/20/18, from 12:30 -8:00 p.m. on 3/21/18, from 9:00 a.m. to 3:30 p.m. 3/22/18, from 7:00 a.m.-3:00 p.m. during which it was noted that R1 did not move on her own, was not able to verbalize, and had absolutely no inappropriate behaviors.

R1's Consultant Pharmacist Medication Review form dated 8/25/17, indicated the consultant pharmacist had identified R1 had been on Risperdone 0.25 in the morning and 1 mg twice

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daily and requested the physician to attempt a dose reduction or write a justification providing clinical documentation regarding the risk vs benefit of the continued dose. The follow-up action section indicated the physician accepted the recommendation, however there is no evidence the reduction was attempted or clinical justification statement had been documented. There were no further pharmacy recommendations regarding the use of the risperdone, depakote, or trazodone. However the facility could not find the recommendations from February 2018, and March 2018 had not yet been completed.

The consultant pharmacist was interviewed on 3/27/18, at 8:59 a.m. and stated that the pharmacy review in July 2017 indicated the use of rispersone was for end of life delirium, but did not know if that diagnosis had been added to R1 record by the prescribing physician. Additionally, the consultant phamacist did not know if R1 had been showing signs of delirium in the past three months. The consultant pharmacist confirmed R1 had no current behavior symptoms that would justify the need for trazodone, risperdone, and depakote and had not recommded a decrease in any of those medications since August 2017 pharmacy review where only risperdone was recommended for decrease. The consultant pharmacist stated that she had not made any recent recommendations to R1's drug regimen.

SUGGESTED METHODS OF CORRECTION:

The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all recommendations provided by the pharmacist were reviewed and

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21535	Continued From page 110 acted upon. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who received as needed (PRN) antianxiety	21540	corrected	5/8/18

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medications had rational for utilization of the medication longer than 14 days. This practice affected 3 of 3 residents (R23, R2, R3) with orders for antianxiety medications. In addition, the faciilty failed to adequately monitor psychoactive medications regarding efficacy and on-going need for 5 of 6 residents (R23, R2, R6, R1, R3) reviewed for psychotropic medications.

Finding include:

R23 utilized a PRN antianxiety medication and the record did not contain a rational or duration of use for utilization of the medications greater than 14 days. In addition, R23 received antidepressant medication without adequate monitoring for the continued use of the medication.

R23's quarterly minimum data set (MDS) dated 3/9/18, identified R23 with severe cognitive impairments and diagnoses including dementia, history of stroke and aphasia (inability to speak). The MDS indicated R23 required extensive assistance with all activities of daily living. R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7 day review period.

R23's annual MDS dated 10/13/17, also indicated R23 displayed daily verbal and physical aggressive behaviors towards others. The MDS indicated R23 utilized antidepressant medications daily and utilized antianxiety medication 6 of a 7 days during the review period

R23's Psychotropic Drug Use Care Area Assessment (CAA) dated 10/19/17, indicated R23

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utilized antidepressant and antianxiety medications daily. The CAA indicated R23's behaviors put himself and staff members at risk for injury.

R23's Order Summary Report dated 2/23/18, included an order for Trazodone (antidepressant) 50 milligrams (mg) to be given daily at beditme for anxiousness and insomnia. The order had been received on 3/31/17. R23 had a second order for Ativan (antianxiety) 0.5 mg to be administered as needed for agitation prior to morning and evening cares with one additional dose as needed throughout the day. The order was received on 9/7/17.

R23's care plan dated 3/27/17, indicated R23 had a history of being physically aggressive due to dementia. The plan directed staff to administer medication as ordered and monitor/document the side effects and effectiveness of the medication.

R23's clinical record did not identify specific target behaviors for the use of the PRN antianxiety medication. Nor were non-pharmacological interventions identified to be attempted prior to the medication administration.

Review of R23's electronic medication administration record (EMAR) indicated R23 had received 32 doses of PRN Ativan in 1/18, 48 doses in 2/18, and 23 doses in 3/18 from 3/1/18 - 3/22/18.

Review of R23's medical record lacked indication of non- pharmacological interventions attempted prior to the use of the PRN medication.

R23's Consultant Pharmacist Medication Review form dated 1/20/18, indicated the consultant

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pharmacist had identified R23's frequent use of antianxiety medication. The pharmacist indicated a PRN antianxiety medication required the record required clinical documentation from the physican for the continued need.

R23's primary physician replied on 1/26/18, and indicated R23 had significant anxiety and required the occasional doses of Ativan. The physician did not indicate what type of non pharmacological interventions were to be attempted prior to the administration of the medication.

On 3/20/18, at 5:15 p.m. nursing assistant (NA)-D warned registered nurse (RN)-E that while assisting R23 with a meal, if food was spilled on R23, he had a history to attempting to strike out at his caregivers.

On 3/21/18, at 1:30 p.m. the regional director of clinical services (RDCS) reviewed R23's clinical record and confirmed the facility had not identified R23's target behaviors for the continued use of the as needed antianxiety medication. R23's record did not contain a rational for the use of the PRN ativan for a time period of greater than 14 days. Non pharmacological interventions had not been identified and the antidepressant medication had not been evaluated on a quarterly basis. The RDCS stated the facility did not have a system to monitor behaviors in relationship to their prescribed medications.

On 3/22/18, at 7:10 a.m. R23 was observed to receive assistance with personal cares by NA-B and NA-C. R23 attempted to hit and kick at the staff during cares.

On 3/23/18, at 10:33 a.m. RN-B stated R23's behaviors included yelling, kicking and pinching

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during cares. RN-B stated staff was to offer R23 a drink or reapproach him. At times, R23 required a PRN Ativan, however, the facility did not have a system to document non pharmacological interventions prior to the administration of the medication.

R2 received antipsychotic medications without adequate monitoring for the continued use of the medication. In addition, R2 had PRN antianxiety medication and the clinical record did not contain a rational or duration of use for the antianxiety medication utilized greater than 14 days.

R2's annual MDS dated 11/2/17, identified R2 with severe cognitive impairments and diagnoses including Parkinson's disease, dementia and anxiety. The assessment indicated R2 required extensive assistance with all activities of daily living and did not display mood or behavior problems. The assessment indicated R2 received daily antipsychotic and antidepressant medications.

R2's Psychotropic Medicaiton Care Area Assessment (CAA) dated 11/3/17, indicated R2 received antipsychotic and antidepressant medications and the staff was to monitor for side effects of the medications.

R2's physician orders dated 1/2/18, included an order for Seroquel (antipsychotic) 25 milligrams (mg) twice a day, remeron (antidepressant) 7.5 mg at bedtime, Prozac (antidepressant) 30 mg daily, and Klonopin (antianxiety) 0.125 mg one tablet every 24 hours as needed for agitation and anxiety.

R2's care plan dated 12/28/17, indicated R2 utilized psychotropic medication. The plan

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directed the staff to monitor for target behaviors and document, monitor R2's behaviors, provide non-pharmaceutical interventions that included one on one interventions, redirecting and changing position. The plan also directed the staff to evaluate for the effectiveness of the medications.

During observations of personal cares on 3/21/18, at 11:30 a.m. R2 was observed to receive total assistance with cares from nursing assistant (NA)-C. At no time was R2 observed to display any type of behaviors.

R2's electronic medication administration record (EMAR) for 1/18- 3/18, indicated R2 had received the schedule doses of Seroquel and Remeron as ordered. R2 had not utilized the PRN Klonopin order. The EMAR also included daily documentation related to potential side effects of antidepressant, antianxiety and antipsychotic medications. The EMAR indicated R2 had not displayed any type of side effects from the medications. The EMAR did not identify R2's behaviors for which she was receiving the medications.

Review of R2's Consultant Pharmacist Medication Review form dated 7/20/17, indicated the pharmacist had quested if the Seroquel, remeron, Prozac or Klonopin could be considered for a dose reduction. R2's primary physican indicated he/she agreed with the pharmacist recommendations, however, R2's family refused to allow a dose reduction.

- A Consultant Pharmacist Medication Review form dated 9/19/17, indicated the pharmacist had requested non pharmacological interventions be attempted prior to administration of the PRN

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Klonopin and to identify the target behaviors to guide the use of the medication. The physican indicated he/she was in agreement with the recommendation and directed the staff to attempt non pharmacological interventions and document the findings.

- A Consultant Pharmacist Medication Review form dated 11/21/17, indicated the pharmacist had requested the staff to identify the non pharmacological interventions prior to the administration of the medication. The pharmacist indicated target behaviors were not identified in the record. The primary physican was in agreement with the pharmacist findings.

- A Consultant Pharmacist Medication Review form dated 2/23/18, indicated R2 had not utilized the PRN Klonopin in the past month and questioned if the medication could be discontinued. R2's primary physican indicated R2's family member refused to consider a dose reductions or discontinuation of the medication.

R2's record contained an order dated 1/15/18, in which the primary physican requested to have R2 evaluated by a mental health practitioner.

R2's Behavioral Health evaluation dated 3/15/18, indicated during the evaluation R2's family member was present and reported R2 displayed hallucinations in the past and had suffered severe distress during past attempts at medication reductions. Therefore, the medications were not adjusted per the family request.

Review of R2's clinical record did not identify what specific types of behaviors R2 displayed. Nor did the record include any type of non-pharmacological interventions to attempt if

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the PRN Klonopin was to be used. R2's record lacked a quantitative and qualitative evaluation of her behaviors in relationship to the medications.

On 3/22/18, at 2:50 p.m. registered nurse (RN)-E stated the facility staff was to identify R2's target behaviors, monitor the behaviors and complete a monthly evaluation of the behaviors in relationship to the medications. RN-E stated the facility did not have a system in place to monitor the behaviors and at this time no staff member was reviewing the efficacy of the medications. R2's PRN Klonopin had not been utilized, however, R2's power of attorney refused to allow the medication to be reduced. RN-E stated R2's clinical record did not include documentation in which the risks and benefits of the medications had been discussed with the family member.

On 3/23/18, at 10:40 a.m. registered nurse (RN)-B stated R2 did not display any type of adverse behaviors.

R6 received antianxiety medications, without adequate behavior monitoring.

R6's quarterly MDS dated 1/17/18, identified R6 with moderate cognitive impairments and diagnoses including depressive disorder, chronic atrial fibrillation and mitral valve disease. The MDS also identified R6 as feeling down and having little energy 2-6 days during the assessment period. R6 did not display behaviors. R6 required limited assistance of one staff for all activities of daily living.

R6's admission MDS dated 6/29/17, identified R6 as having little to no interest in doing things, feeling down and depressed and feeling bad about herself on 2-6 days during the assessment

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period. R6 did not display any type of adverse behaviors at the time of the assessment.

R6's Psychotropic Medication CAA dated 6/29/17, indicated R6 utilized Buspar (antianxiety) for anxiety and Zoloft (antidepressant) for depression. The CAA directed the staff to monitor for the efficacy and side effects of the medications

R6's Order Summary Report dated 3/5/18, included an order for Buspar 10 mg every day. The Buspar was stared on 10/17/17, for "major depressive disorder." R6 also had an order dated 1/18/18, for Celexa 20 mg daily for the treatment of major depressive disorder.

R6's care plan dated 12/1/17, directed the staff to administer medications as ordered and monitor for side effects. R6's care plan did not identify target behaviors for the continued use of the antianxiety medications.

During the survey conducted from 3/19/18, - 3/27/18, R6 was not observed to display any type of behaviors. For example, on 3/21/18, at 12:25 p.m. R6 was observed in the main dining room eating the noon meal. R6 sat with two other residents, conversed with the other residents and when she was through with the meal, wheeled herself out of the dining room.

Review of R6's EMAR's for January, February and March 2018, indicated staff monitored R6 for generic symptoms of depression including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statement, repetitive anxiety and tearfulness. The EMAR's indicated R6 never displayed any of the aforementioned concerns. The EMAR did not

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 119 identify specific individualized target behaviors for R6. R6's Behavioral Health Psychiatric Progress Report dated 3/15/18, indicated R6's antidepressant medications had been changed in 1/18, from Zoloft to Celexa. Due to the change, the psychiatric nurse practitioner had opted not to reduce R6's antianxiety medication and continue to monitor R6's antidepressant medications. R6 was not displaying behaviors at the time of the evaluation. Review of R6's Progress Notes dated 1/8/18, - 3/21/18, revealed no documentation of an evaluation of R6's behaviors after the antidepressant medications were changed on 1/18/18. The notes also lacked a comprehensive analysis of R6's behaviors/symptoms being treated with of the antianxiety medication. On 3/22/18, at 2:50 p.m. RN-E stated the facility staff was to identify R6's target behaviors, monitor the behaviors and complete a monthly evaluation of the behaviors in relationship to the medications. RN-E stated the facility did not have a system in place to monitor the behaviors and at this time no staff member was reviewing the efficacy of the medications. R1 received multiple psychotropic medications without an appropriate diagnosis, adequate monitoring, or justification for continued use. R1's quarterly MDS dated 12/27/17, identified R1 with severe cognitive impairments and diagnoses including Alzheimer's disease, high blood pressure, and type II diabetes. The MDS indicated R1 required extensive assistance with all activities of daily living. R1 displayed no signs	21540		

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21540	Continued From page 120	21540		

or symptoms of psychosis or delirium and had no verbal or physical aggressive behaviors towards others. The MDS indicated R1 utilized antipsychotic and antidepressant medications daily.

R1's Psychotropic Drug Use Care Area Assessment (CAA) dated 11/3/17, indicated R1 utilized antipsychotic and antidepressant medications daily which included the medications risperdone, and trazodone. The CAA had not indicated R1 had any inappropriate behaviors.

R1's Order Summary Report was requested but not provided.

Review of R1's medication administration record for March 2018, indicated R1 received the antipsychotic medication risperdone 0.5 mg every day and 1 mg twice a day for dementia without behavioral disturbance since 5/17 (exact date was not found in the record or through interview with staff) and received Depakote Sprinkles (mood stabilizer) 125 mg since 1/16/18, for restlessness and agitation. R1 received Trazodone (antidepressant) 25 mg to be given twice a day for dementia with behavioral disturbance since 4/28/17.

R1's care plan dated last revised 12/28/17, indicated R1 target behaviors included wandering, being uncooperative, and continuous pacing. The care plan directed staff to administer medication as ordered, monitor/document the side effects and effectiveness of the medication, report behavior changes to the physician, and provide non pharmacological interventions with include 1:1 activity, redirecting, and removing resident from environment to decrease target behaviors, anxiety, or depression.

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21540	Continued From page 121 R1's Consultant Pharmacist Medication Review form dated 8/25/17, indicated the consultant pharmacist had identified R1 had been on Risperdone 0.25 in the morning and 1 mg twice daily and requested the physician to attempt a dose reduction or write a justification providing clinical documentation regarding the risk vs benefit of the continued dose. The follow-up action section indicated the physician accepted the recommendation, however there was no evidence the reduction was attempted or clinical justification statement had been documented. There were no further pharmacy recommendations regarding the use of the risperdone, depakote, or trazodone. However the facility could not find the recommendations from 2/18, and 3/18, had not yet been completed. The progress notes for R1 were reviewed from 1/1/18-3/21/18, and there were no documented incidences of inappropriate behavior for R1. R1 was observed periodically throughout the survey on 3/20/18, from 12:30 -8:00 p.m. on 3/21/18, from 9:00 a.m. to 3:30 p.m. 3/22/18, from 7:00 a.m.-3:00 p.m. during which it was noted R1 did not move on her own, was not able to verbalize, and had no inappropriate behaviors. On 3/26/18, at 9:54 a.m. the regional director of clinical services (RDCS) reviewed R1's medication record and progress notes and confirmed R1 did not have appropriate diagnoses for the use of risperdone and depakote. R1's progress notes had not indicated any inappropriate behavior symptoms R1 had displayed from 1/1/18-3/22/18, and wandering and pacing is not appropriate indications for the use of risperdone, trazodone, and depakote.	21540		

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21540	Continued From page 122	21540		

R3's as needed (PRN) Ativan lacked duration and documented physician rational for exceeding beyond a 14 day duration. R3's face sheet dated 3/23/18, included diagnoses of asthma and chronic respiratory failure.

A communication note from the hospice service to a physician dated 2/26/18, requested R3's scheduled Ativan (antianxiety) 0.5 mg every four hours be changed to 0.5 mg PRN every four hours because the scheduled dose caused increased drowsiness. The physician's response on the communication identified agreement and orders to change Ativan to 0.5 mg every for hours as needed for anxiety. The order lacked a duration for use. R3's record lacked evidence of a physician's evaluation to extend the duration for use of the Ativan beyond 14 days.

R3's medication administration record (MAR) indicated between 3/1/18, and 3/23/18, Ativan 0.5 mg was administered on 40 occasions.

On 3/23/18, at 10:12 a.m. registered nurse (RN)-E indicated the physician should have documented a rational and a duration for the PRN Ativan. RN-E stated she thought the hospice physician was responsible for ensuring appropriate documentation for PRN psychotropic medications.

On 3/26/18, at 10:27 a.m. the administrator indicated PRN psychotropic medication beyond 14 days required a physician justification and duration for use.

Superior Healthcare Management Minnesota Region policy and procedure dated 12/23/17, identified the facility will make every effort to

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21540	Continued From page 123 comply with state and federal regulations related to the use of psychopharmacological medications to include regular review for continued need, appropriate dosage, side effect, risks and/or benefits. Additionally, the facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of environment, medical, and/or behavioral interventions, as well as psychopharmacological medications can be utilized. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents medications regimes were free from unnecessary medications. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced	21810		5/8/18

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21810	Continued From page 124 by: Based on observation, interview and document review, the facility failed to ensure reasonable accommodation of need related to call lights within reach for 1 of 2 residents (R14) with repeated falls. Findings include: R14's physician nursing home admission assessment dated 1/23/18, indicated R14 had been admitted to the facility on 1/19/18, and had diagnoses that included, but were not limited to: closed nondisplaced fracture of the seventh cervical vertebra with routine healing, high blood pressure, type II diabetes, late onset moderately advanced Alzheimer's disease with behavioral disturbance. The admission Minimum Data Set (MDS) dated 1/26/18, indicated R14 had moderate cognitive impairment, suffered a fracture as a result of a fall prior to admission, not displayed any inappropriate behavior symptoms, required limited assistance of one person when ambulating in room, required extensive assistance of one person for transfers, required extensive assistance of one person for dressing and toilet use, and was frequently incontinent of bowel and bladder. R14 was observed on 3/20/18, at 12:48 p.m. laying in bed in his bedroom. It was noted R14 had a cervical collar around the neck connected to a thoracic lumbar sacral orthosis (TLSO) stabilizing brace that wrapped around the back and abdomen. R14's bed was low to the floor (approximately 12 inches from the floor) and there was fall mat placed next to the bed. R14 had not been provided the call light to summon	21810	corrected	

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21810	Continued From page 125 assistance. R14 was again observed on 3/20/18, from 5:54 p.m. to 6:48 p.m. while seated up in the wheelchair in his bedroom. At no time did any facility staff stop into R14's room to check on R14 for safety. R14 did not have access to the call light to summon assistance. R14 was observed on 3/20/18, at 7:18 p.m. during which it was noted R14 was provided evening care and assisted to bed. R14 continued to wear the TLSO, was in a low bed with a fall mat next to the bed. R14 had not been provided a call light to summon assistance at the end of observations. On 3/21/18, at 9:00 a.m. R14 was removed from the dining room and assisted to his bedroom via a wheelchair and placed in front of the television where he actively watched a television program. R14 was not provided a call light to summon assistance. Review of R14's care plan for falls dated 1/24/18, the following interventions were developed: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. The regional director of clinical services (RDCS) was interviewed regarding R14's fall incidents during which she confirmed R14 should have been provided the call light to summon assistance and minimize fall incidents. The Superior Healthcare Management Minnesota Region policy for Answering the Call light (undated) indicated in step 5. When a resident is	21810		

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21810	Continued From page 126 bed or confined to a chair make sure call light is within easy reach of the resident. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have a call light within reach. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21810		
21885	MN St. Statute 144.651 Subd. 21 Patients & Residents Of HC Fac.Bill of Rights Subd. 21. Communication privacy. Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. (Only portions indicated of this subdivision are subject to assessment.) This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident mail was delivered on Saturdays and reasonable	21885	corrected	5/8/18

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access to the Internet was provided. This had the potential to affect all 23 residents residing in the facility.

Findings include:

During the resident council meeting held on 3/20/18, at 2:29 p.m. R17 and R13 both stated resident personal mail was not being delivered on Saturdays.

On 3/25/18, at 9:20 a.m. nursing assistant (NA)-B confirmed the residents' mail was not delivered on Saturdays and had not been for about the past year.

On 3/26/18, at 10:38 a.m. both the administrator and director of nursing (DON) stated they were unaware the residents' personal mail was not being delivered on Saturdays. The administrator stated she would assign a staff member to begin delivering the mail on Saturdays, as required.

On 3/27/18, at approximately 9:00 a.m. both NA-B and NA-F stated they thought there was a computer for the residents to use in the resident lounge room, "or at least there used to be."

-At 10:33 a.m. the administrator and DON stated there used to be a computer in the lounge room for the residents to use and upon observation of the room, confirmed it was not there. Both stated if the residents wanted a computer to use, they could put a computer in the activity room.

Superior Healthcare Management Resident Mail policy and procedure dated 12/23/17, indicated the residents would have the opportunity to stay in contact with family/friends/community through mail services. The Living Center would provide

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21885	Continued From page 128 mail delivery services and mail sending services within 24 hours of receipt of mail or residents request to send mail. This includes Saturdays delivery. Reasonable access to electronic mail would also be provided as available. SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure mail was delivered every day mail is delivered by the United States Postal Service and electronic means of communication was available for resident use, if desired. The administrator could educate all appropriate staff. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21885		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:	21980		5/8/18

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21980	Continued From page 129 (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure all allegations of abuse,	21980	corrected	

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neglect of care and injuries of unknown source were reported timely to the administrator and/or State agency for 1 of 1 resident (R13) who was intentionally hit by another resident, and for 1 of 1 resident (R226) who had eloped from the facility, twice. In addition, the facility failed to report injuries of unknown source to the State agency for 1 of 1 resident (R5) who was found to have a left forearm bruise of unknown source.

Findings include:

R13 stated during interview on 3/19/18, at 9:24 a.m. that R21 used to be his roommate and currently lived a couple doors from him, however, he could not get along with R21. R13 stated R21 would threaten to "beat him up" most recently being just two days ago. R13 stated about two months ago, when he was by the nursing station with staff present, R21 had "rolled up and punched him in the left shoulder." R13 denied being injured. R13 stated the staff who had witnessed the incident told R21 he had to "settle down." R13 denied being afraid of R21 and stated "all he is, is one big mouth" and that he tried to stay away from R21 as much as he could.

On 3/20/18, at 1:10 p.m. nursing assistant (NA)-B stated R21 and R13 used to be roommates who did not get along and would swear at each other so they got separate rooms. NA-B stated currently, when R13 would wheel past R21's room, R21 would call R13 names. NA-B stated approximately four months ago, she and another staff member who she could not recall which staff member it was, had witnessed R21 intentionally go up to R13 and punch him in the arm. NA-B stated as staff were moving R13 away from R21, R13 had called R21 the "F-word." NA-B stated this physical altercation was the only incident she

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was aware of between the two residents. NA-B also stated she had reported the altercation to a nurse but was not 100% sure which nurse she had reported to. The facility lacked evidence the aforementioned resident to resident altercation was reported to the administrator or the State agency, within two hours as required.

R226 eloped from the facility according to the facility's computerized Risk Management Incident list. The note indicated R226 could not be located within the facility so a building and grounds search was conducted which was unsuccessful in locating R226 and 911 was called. When 911 was called, they informed the facility their missing resident was at the local police department. The police returned the resident to the facility, unharmed. The facility provided a copy of their facility Minnesota Incident Report from the Risk Management List which was dated 12/3/17, at 7:30 a.m. and revised on 12/5/17, which indicated R226 had eloped from the facility and a temporary wanderguard was placed, and every 15 minute checks were initiated. However, it lacked evidence the Stage agency was notified.

On 3/20/18, at 6:30 p.m. cook (C)-A stated R226 was not happy about being at the facility and had eloped from the facility a couple of times. C-A stated the incident with the police department was not the only time R226 had gotten away or attempted to leave the facility. C-A recalled another incident which occurred "way" before the police department incident, where he was going to go pick up R226 after he had left the facility and was downtown at a gas station which was across from the police department. C-A stated "somebody" had called the facility and informed the staff that one of their residents was there, however, that "somebody" had given R226 a ride

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back to the facility before he could go get him. C-A stated R226 used a wheelchair and would have had to get downtown by wheeling himself down the middle of the street as that was the only area of the road that had been plowed open following the snow fall. C-A remembered R226 being appropriately dressed for the cold winter temperature. R226's medical record lacked evidence of this prior elopement as well as documentation indicating the incident had been reported to the administrator or State agency.

R5's Progress Note dated 3/13/18, at 11:20 p.m. indicated R5 had a 6.0 centimeter (cm) by 3.0 cm bruise which was yellow/green in color with some pinkness surrounding the bruise. The documentation did not identify where the bruise was located on R5. The quarterly Minimum Data Set (MDS) dated 1/10/18, indicated severe cognitive impairment, total assistance with activities of daily living and no resistance to cares.

A Resident Bruise/Skin Tear/ Injury Report dated 3/13/18, indicated R5 had a 6.0 cm by 3.0 cm bruise on the right forearm which may have been caused by an arm brace. R5's physician, family and director of nurses were notified of the bruise. However, the State Agency was not notified within 24 hours as required of the bruise of unknown source.

On 3/20/18 at 1:41 p.m. when requested to review the facility abuse prevention policy and procedures, the administrator and director of nursing (DON) stated they were unable to locate it within the facility.

-At 1:49 p.m. the administrator and the DON confirmed R13's and R21's dislike for each other. The administrator, the DON and the regional

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	00995	A. BUILDING: _____ B. WING _____	03/27/2018

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

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21980	Continued From page 133	21980		

director of clinical services (RDCS) were informed of the altercation and all stated they were unaware the altercation had occurred and confirmed it should have been reported to the administrator as well as the State agency, as required.

On 3/20/18, at 4:25 p.m. the administrator, RDCS, and the DON confirmed R226 had eloped from the facility and the incident was not reported. When asked about the facility's abuse prevention program related to reporting, the RDCS stated the whole system needed to be "revamped." The administrator stated when her and the DON started at the facility, they became aware of the failure in the system and had begun educating the staff on the abuse prevention program policies and procedures.

On 3/21/18, at 8:40 a.m. the RDCS stated she had only been with the facility's management company for three weeks and this was her first time at the facility. At this time, the RDCS called the Superior Healthcare Management (SHM) executive who overseen this facility. The executive stated the company took over operation of the facility on 2/1/17, whereas there was a former employee who continued to work at the facility through the ownership transition phase which ended June 2017, at which time a RDCS started working at the facility and was responsible for overseeing the clinical nursing operation until November 2017. Following this employee's departure, there was no specific regional director assigned to this "property" therefore a clinical supervisor was not present on site, rather was available for consultation via the phone. The RDCS verified and acknowledged the lack of facility systems and stated she would create a binder to place the facility abuse prevention

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21980	Continued From page 134 program policy and procedures in and provide staff education. On 3/26/18, at 3:26 p.m. licensed practical nurse (LPN)-A stated she was shown the newly created facility abuse prevention program binder last "Tuesday" (six days prior) and verified the binder was kept at the nurses station and contained the facility's policy and procedures related to abuse prohibition in which staff were to refer to when needed. However, LPN-A stated she did not know if any changes had been made to the facility's abuse protocol because she had not reviewed the information yet. On 3/22/18, the RDCS provided a Superior Healthcare Management Abuse Reporting and Investigation policy revised 1/30/17, indicated the facility would notify the State agency and other licensing agencies depending on the circumstances of the allegation or actual event in compliance with Federal and State regulations and Elder Justice Act. The Reporting Abuse to Facility Management policy and procedure indicated it was the responsibility of their employees to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. The administrator or DON must be immediately notified of suspected abuse or actual incidents of abuse. The undated Resident to Resident Altercations policy and implementation form indicated all altercations including those that represent resident to resident abuse would be reported to the nursing supervisor, DON and to the administrator. The undated Elopements policy interpretation and implementation form indicated staff would report all cases of missing residents	21980		

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21980	Continued From page 135 SUGGESTED METHODS OF CORRECTION: The administrator or designee could develop, review, and /or revise policies and procedures to ensure all allegations of abuse and neglect were reported to the State Agency and/or adminstrator directed. The administrator or designee could educate all appropriate staff. The administrator or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21980		