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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RUF9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00712

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245412**

2.STATE VENDOR OR MEDICAID NO.
(L2) **961043000**

3. NAME AND ADDRESS OF FACILITY
(L3) **COKATO MANOR**
(L4) **182 SUNSET AVENUE**
(L5) **COKATO, MN** (L6) **55321**

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)

6. DATE OF SURVEY **12/31/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)

0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program
X Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(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 :
Carole Bode, HFE NE II 02/02/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 02/24/2015 (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
01/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
January 15, 2015

Mr. James Broich, Administrator
Cokato Manor
182 Sunset Avenue
Cokato, Minnesota 55321

RE: Project Number S5412025

Dear Mr. Broich:

On December 31, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 9, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 9, 2015 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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 remedies be imposed:

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by March 31, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 1, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
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
	245412	A. BUILDING _____ B. WING _____	12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	182 SUNSET AVENUE COKATO, MN 55321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to effectively respond to individual grievances, related loud noises made by R22 during the overnight hours, for 3 of 4 residents (R33, R19 and R16) reviewed with expressed concerns of loud noise levels within the facility. Findings include: R22's quarterly Minimum Data Set (MDS) dated 12/12/14, identified her cognition was moderately impaired, with some signs/ symptoms of delirium present, including inattention and disorganized	F 166	Corrective action for those affected: Administrator, social worker and psychologist met with resident #33, 19 and 16 and reviewed grievances related to loud noises within the facility. Also provided potential strategies to minimize loud noise in the corridor until resolution of this problem. Identification of others having potential to be affected: Resident council minutes reviewed from last meeting, social worker interviewed other residents that are in	2/5/15

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

Electronically Signed | 01/23/2015

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F 166	Continued From page 1 thinking which fluctuated and changes in severity. There were no behaviors identified. The MDS also identified R22 had clear speech, was sometimes able to make herself understood and was sometimes able to understand others. R33's admission MDS dated 10/23/14, identified her cognition was intact. When interviewed on 12/29/14, at 3:17 p.m. R33 stated, "She [R22] hollers all night long. It drives me crazy and bothers others on the wing. It goes on every day and night. You can even hear it through the closed door. I have talked with staff about it, no one seems to do anything about it and I never hear anything back from the staff." R19's annual MDS dated 12/5/14, identified her cognition was intact. When interviewed on 12/29/14, at 4:12 p.m. R19 stated, "She [R22] hollers all night long. I have told the social worker (SW) and nothing ever happens. She hollers from 7:45 p.m. until 11:00 p.m. every day, I can not believe where she gets her energy." R16's annual MDS dated 10/10/14, identified his cognition was intact. When interviewed on 12/29/14, at 6:47 p.m. R16 stated, "That lady [referring to R22] was yelling all night long. People down the hall have complained. I have told [nursing assistants (NAs)] no one has responded to my complaining." On 12/31/14, several nursing assistants (NA)'s were interviewed regarding these complaints. At 1:15 p.m., NA-A stated, "They tell us about her hollering in report." At the same time, NA-F confirmed residents had asked "about all the yelling." At 1:18 p.m., NA-D stated, "The	F 166	close vicinity of noise on the corridor. Measures to ensure practice will no recur: To ensure timely resolution of resident grievances, the use of Cokato Manor grievance forms will be re-introduced to residents at the next resident council meeting on 1/23/2015, with additional reminders at quarterly care conferences. All other Cokato Manor staff were re-educated on Cokato Manor grievance form from 12/29/14 to 1/30/2015. The Social Worker will retain all completed grievance reports and will keep a log summarizing details and responses. The deficiency will be reviewed at an all-staff meeting on 2/5/2015. Monitoring: The social worker or designee will monitor daily, then weekly until compliance is reached and report back to Quality Assurance. This deficiency was reviewed at the Quality Assurance meeting on 1/11/2015.	

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F 166	Continued From page 2	F 166		

residents have told me about the yelling like [R19] and [R33] who will put their music up loud to drown out the sound."

When interviewed on 12/31/14, at 1:22 p.m. SW-A stated, "I don't have anything written [a grievance] but I have heard about it [the yelling] and we have talked about it in some meetings." SW-A confirmed R33 and R19 had complained to her about the yelling. SW-A agreed this was a grievance, but could not explain why it had not been handled officially, following the facility's grievance process.

When interviewed on 12/31/14, at 1:28 p.m. the director of nursing (DON) defined a grievance as something a resident or family brought up as a problem. The DON stated, "We are aware about the complaint, but what are we suppose to do with her? [R22] is one of our people too." The DON added, they moved her (R22) to that room because there was the same problem in her previous room. We have tried different strategies but are "not successful." The DON reported the facility nursing staff had discussed the concern, but denied having sought guidance from the facility's quality assessment and assurance (QA&A) committee for ideas on how to address the concern. The DON denied having updated residents on the facility's progress toward resolution of their expressed concerns about R22.

The facility's undated Resident Grievance policy directed, "Prompt efforts shall be made by the facility to resolve grievances that resident may have... including those with respect to the behavior of other residents... investigation will be within three working days, and the resident/

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F 166	Continued From page 3 resident representative(s) informed..." The policy was not followed.	F 166		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to honor each resident's choice of bathing frequency and bathing method, for 2 of 3 residents (R47 and R6) reviewed for choices. Findings include: R47's annual Minimum Data Set (MDS) dated 6/6/14, indicated he had short and long term memory problems, required extensive assistance with activities of daily living (ADL)'s and required physical help to complete bathing. The MDS identified that choosing between a tub bath, shower, bed bath or sponge bath was very important to R47. A quarterly MDS dated 11/21/14, indicated R47 continued to require physical help with bathing. R47's care plan dated 11/25/14, indicated he required physical assistance with ADLs due to cognitive impairment and coordination deficits resulting from a stoke. The care plan lacked any	F 242	corrective action for those affected: Social worker and administrator met with resident family member FM-E about her expectations with husband's bathing and changed bath schedule accordingly. Also met with resident #6 and changed bath schedule to accommodate is choice for bathing. Identification of others having potential to be affected: Social worker will interview residents on bathing preferences according to care conference schedule and change schedule accordingly. On measure to ensure practice will no recur: Cokato Manor will implement a new questionnaire upon admission to verify resident choice of bathing method and time of day and will be reflected on the bath schedule. This will be reviewed at quarterly Care Conferences. Staff will	2/5/15

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F 242	Continued From page 4 indication of how often or by what method R47 preferred to be bathed. The facility bathing schedule dated 12/29/14, through 1/4/15, indicated R47 was scheduled for bathing on Wednesday and Saturday mornings. During interview on 12/29/14, at 7:24 p.m. R47's family member (FM)-E stated that R47 showered daily when he lived at home, but now only received a shower twice per week. FM-E reported they had requested R47 be bathed daily while at the facility. FM-E stated, "I would love to see him showered every single day. I have told the staff this over and over," but nothing as changed. R6's admission MDS dated 6/17/14, indicated he required physical help with bathing activities. The MDS identified it was was very important for R6 to make his own choice between a tub bath, shower, bed bath or sponge bath. R6's current care plan, dated 12/4/14, indicated he was at risk for requiring assistance with dressing and grooming related to cognitive deficits. The care plan interventions included encouragement to start bathing his upper torso and assistance from one staff to complete bathing of his body and hair as needed. The care plan did not identify how often or by what method R6 preferred to be bathed. During interview on 12/30/14, at 10:36 a.m. R6 stated, "I only get a shower one time per week. I would like a bath a couple times per week. I don't even think they have a tub here to take a bath." R6 added, "I would like to take a bath, but it	F 242	be educated on quality of life choice policy at an all-staff in-service on 2/5/2015 to review this deficiency. Monitoring: The social worker or designee will monitor weekly, then monthly until compliance is reached and report back to Quality Assurance. This deficiency was reviewed at the Quality Assurance meeting on 1/22/2015.	

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F 242	Continued From page 5	F 242		

would inconvenience the staff."

When interviewed on 12/30/14, at 3:23 p.m. nursing assistant (NA)-C stated NA's do not determine if a resident gets a bed bath or shower, rather the nurses determined this. NA-C reported, "We just follow the schedule in the book on which residents get their baths or showers for the day."

During interview on 12/30/14, at 3:30 p.m. licensed practical nurse (LPN)-C stated when residents were admitted, they were assigned a bath day. If the resident requested a change to their bath schedule, the facility adjusted it. Further, if a resident had a preference for bathing and "were adamant about it," then the facility would honor that preference.

When interviewed on 12/31/14, at 7:47 a.m. ward clerk (WC)-G stated residents were assigned a weekly bath day when they were admitted to the facility. Residents requesting additional bathing were given an extra bath during the week. WC-G added the facility only had one tub and two showers available for resident use.

During interview on 12/31/14, at 9:30 a.m. the director of nursing (DON) stated residents were not assessed upon admission for bathing preferences. The DON stated, "It would be great to give every resident a bath or shower every day; however, that is not realistic."

A facility policy on bathing and choices was requested but not provided.

During interview on 12/31/14, at 1:09 p.m. the DON stated a facility policy pertaining to bathing

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	245412	A. BUILDING _____ B. WING _____	12/31/2014

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COKATO MANOR	182 SUNSET AVENUE COKATO, MN 55321

(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 242	Continued From page 6 and choices did not exist. She added, "We always let them have their choice if it is realistic."	F 242		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess, adequately monitor the condition of, and implement new interventions to heal a reoccurring pressure ulcer for 1 of 3 residents (R44) reviewed for pressure ulcers. Findings include: R44's Physician Order Report from 11/1/14 to 12/1/14 identified diagnoses of candidiasis (skin/nails), diabetic (a metabolic disease causing high blood glucose and can cause poor healing), Congestive heart failure, chronic obstructive pulmonary disease, malaise, fatigue, and leukocytosis. R44's admission Minimum Data Set (MDS), dated 8/5/14, indicated R44 was cognitively intact, required extensive assistance with activities of	F 314	Corrective action for those affected: Resident #44 was seen by his primary doctor on 1/5/2015 to ensure current treatment plan promotes healing and prevents new sores from developing and comprehensively re-assessed for new interventions. This included starting him on a nutritional supplement. His Braden scale and tissue tolerance were re-assessed on 1/5/2015. Identification of others having the potential to be affected: Nursing department audited all residents with a Braden scale below 15 to identify residents who are at risk for pressure ulcer formation and developed interventions based on the audit. Measures to ensure practice will not	2/8/15

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F 314	Continued From page 7 daily living (ADL), was at risk for pressure ulcer development, and was admitted with two stage II pressure ulcers (partial thickness loss of skin presenting as a shallow, open ulcer with a pink or red wound bed). Further, the MDS identified the "most severe tissue type in the ulcers" was granulation tissue (new vascular tissue, indicative of healing). A 14-day MDS, dated 8/11/14, 6 days after his admission MDS, indicated he remained at risk for pressure ulcer development, however, now had only one stage II pressure ulcer with granulation tissue present in the wound bed. A PPS (prospective payment system) MDS, dated 8/25/14, indicated he no longer had any pressure ulcers. The MDS identified under the heading of "risk of pressure ulcers" was left blank. R44's quarterly MDS, dated 10/31/14, indicated he had severe cognitive impairment, required extensive assistance with ADLs, was at risk for pressure ulcer development, and had two stage II pressure ulcers with granulation tissue in the wound bed that had developed on 10/24/14. R44's associated Care Area Assessment (CAA) worksheet, dated 8/11/14, indicated he did not have a pressure ulcer and was confined to a bed or chair most of the time, and required a special mattress or seat cushion to reduce or relieve pressure on his skin. R44's Cokato Manor Admission Head to Toe Body Review, dated 7/29/14, indicated, "sores on bottom > [applied] orange cream." Further, the review had a picture of a body identified a "lg [large] sore" on his left buttock, and a "sore" on his right buttock, near his coccyx. The form	F 314	recur: Education was provided to licensed nursing staff on the correct staging of pressure ulcers on 1/28/2015 by Pathway Education Center. Cokato Manor reviewed our pressure ulcer protocol and implemented the skin integrity condition portion available on our Matrix Care. This includes measurement of the skin condition, interventions and referrals. This deficiency was reviewed at the Quality Assurance meeting on 1/11/2015. Monitoring: The DON or designee will monitor residents with a Braden scale below 15 to ensure current treatment plan prevents pressure sores.	

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lacked any measurements of the identified "sores," there was no description of the wound bed, and what interventions, if any, were implemented.

R44's care plan, dated 11/4/14, indicated he was at risk for pressure ulcer development related to mobility deficits, and had a history of pressure ulcers on his buttocks, with a goal of care including that skin will remain intact on a daily basis. Further, it identified interventions of using an alternating pressure mattress on his bed, assisting with repositioning every 2 hours, observing skin with cares, and treating skin concerns per the physician orders and facility protocol.

During observation of morning cares on 12/31/14 at 7:17 a.m., R44 was lying in bed, and was assisted to roll to his right side by nursing assistant (NA)-D. R44 had red, excoriated and denuded skin on his bilateral medial (both sides, in the middle) buttocks, with a scabbed area present at the center of the excoriated area on his left buttock. He had no urinary or bowel incontinence noted during the observation, however stated his bottom hurts, "A little bit".

When interviewed on 12/31/14, at 7:46 a.m. NA-D stated R44 was at risk for pressure ulcers as he was unable to reposition himself and required extensive assistance from staff for his care. NA-D stated R44 was being laid down after meals, and had been repositioned side to side in bed since his mobility had declined prior to Thanksgiving. Further, the denuded, excoriated areas on his buttocks often gets better and then get worse again but was not sure why.

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A review of R44's nursing progress notes indicated the following:
7/29/14 - R44 admitted to the facility and, "has 2 open sores on rectum applied house cream and left open to air."
7/31/14 - "Small amount of bleeding noted from left buttock wound. House barrier cream applied after bleeding stopped."
8/7/14 - "Resident has open area on left buttocks that measures 2 cm (centimeters) X (by) 0.5 cm, sensa cream applied. No other open areas noted."
8/13/14 - Resident's area on left buttocks measures 0.8 cm X 0.1 cm. is almost healed. No other open areas, right buttocks noted to be pink. Will continue with the sensa care cream."
8/20/14 - "No open areas noted on buttocks, noted to be slightly pink."

A review of R44's nursing progress notes identified the following:
10/20/14 - "Resident has open excoriated areas to both buttocks. Resident has been more incontinent of bowels and they have been more frequent. Barrier cream applied to areas. Encourage repositioning every two hours and frequent brief changes." Although R44 pressure ulcers healed on 8/20/14 he had an open area on 10/20/14, 60 days after healing the previous pressure ulcers.
10/22/14 - "Bottom continues to be open and sore on both buttcheeks. Had large incontinent stool. A&D/zinc to bottom. Fas [sic] sent to MD."
10/28/14 - "Resident continues with reddened areas on buttock. Areas are blanching." There was no indication if the area was open, closed or what size the pressure ulcers were or if there were any pressure ulcers.
10/29/14 - "Res. [resident] sore on R [right]

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F 314	Continued From page 10 buttocks has been closing up. Has purplish color around sore and on L buttocks also. Has a cushion on recliner from OT [occupational therapy] that he can know [sic] sit on." 10/30/14 - "Left buttocks 8 X 4 cm. Right buttocks 6 X 4 cm. Areas look sheared. Areas have improved since initially. Has been laying in bed on sides. Using cavalon spray to areas as barrier. Color is purple/red." There was no indication of pressure ulcer staging, exudate, pain, or what the wound bed characteristics were including the type of tissue, and a description of wound edges and surrounding tissue. 10/30/14 - "No open areas noted on bottom, sheared area intact Cavalon spray applied, and zinc cream with tena around area. Will continue to monitor." 11/5/14 - "Areas on buttocks have shown improvement. Left measures 9 cm X 3 cm, the one on the right measures 7 cm X 2 cm, inside this area noted to have abrasion looking area that measures 3 cm X 0.8 cm. Cavalon spray to the reddened areas and zinc to the surrounding skin. Will continue with current treatment." There was no indication if the measurements identified that the area was open or description of wound bed, edges or if the area was discolored, denuted, excoriated or was a pressure ulcers. Also, the note identified the "area had improved," even though the previous note on 10/30/14 identified there were "no open areas" with the "shear area intact." 11/7/14 - "Cavalon spray and zinc cream applied to bottom, placed on left side in bed tonight." 11/12/14 - "Superficial openings on bottom are improving. Surrounding skin is intact. Using Cavalon Spray to openings and house cream to surrounding skin." 11/20/14 - "Continue to use the Cavalon spray to	F 314		

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areas on bottom that are superficial. House cream to surrounding skin. Areas look, they become irritated after a loose stool. Is laid down after each meal and put on his side."
11/26/14 - "Bottom remains intact, continue with the Cavalon spray. Resident laid down after each meal and placed on his side. Has a new mattress which is also helping to maintain the skin."
12/3/14 - "Sores on butt are open again. Zinc/A&D mix was applied with every brief change. Side to side position during the night."
12/7/14 - "Right butt cheek has 2 superficial open areas. Did apply the cavalon spray, cream does not adhere to wound. Was laid down and put on his side."
12/10/14 - "SKIN: Noted to have 2 small open areas on right butt cheek, one is pinpoint and the other is 0.6 cm X 0.3 cm. There is some discoloration noted, otherwise bottom is intact. Using only Cavalon spray at this time. Is to lay in bed on his side, not in his recliner until bottom is completely healed."
12/18/14 - "Buttocks noted to have a open area, continue with the cavalon spray and lay on his side while in bed. No recliner at this time."

There were no additional progress notes which identified R44 pressure ulcer after 12/18/14. R44 continued to have open areas, even though the area continued to fluctuate from open, to closed to the right buttock measuring 3 cm X 0.8 cm on 11/15/14. The last note that identified the size of the pressure ulcer was on 12/10/14, 18 days ago.

R44's Braden Scale for Prediction of Pressure Sore Risk, dated 8/2/14, indicated he was considered at risk for pressure ulcers, and indicated "no referrals were necessary." A

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subsequent Braden Scale, dated 10/28/14, indicated he remained at risk for pressure ulcers, and still needed "no referrals" despite his pressure ulcers re-developing. R44's Tissue Tolerance Assessment, (ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects) dated 8/1/14, indicated he had no redness noted on bony prominence's after sitting for a 2 hour period. The assessment did not indicate how long R44 could tolerate laying in bed before redness developed, but the assessment did identify he required a 2 hour repositioning schedule.

R44's Comprehensive Skin Review and Assessment, dated 8/11/14, indicated R44 had a present pressure ulcer, diabetes mellitus, was incontinent of bowel and bladder, had cardiovascular disease, and was bedfast or chair bound. R44 had a Braden score (a scale used to determine pressure ulcer risk) of 18, (which identifies at risk for pressure ulcer development) and was, "Admitted c [with] pressure ulcer on Lt [left] & [and] Rt [right] buttocks." Further, the assessment identified a treatment for his pressure ulcers of Tena cream with Zinc, and staff to reposition every 2 hours. A RN Quarterly Review and Re-eval assessment, dated 11/6/14, indicated R44 had a Braden score of 15, (meaning at risk for pressure ulcer development) and continued to receive Tena cream with Zinc to a pressure ulcer on his right buttock with Cavalon spray being applied to the surrounding skin. No other comprehensive skin assessments were located in R44's medical record.

During interview on 12/31/14 at 8:27 a.m., licensed practical nurse (LPN)-D stated there were no documented weekly skin checks of

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resident skin. The NA (nursing assistants)'s are expected to report concerns and the nurses will record them in the progress notes. R44 has chronic skin issues with his buttocks, and it, "comes and goes with the healing." Further, the skin on his buttocks has healed and reopens. She would be observing R44's pressure ulcers later today.

During observation of pressure ulcer care with LPN-D on 12/31/14, at 9:45 a.m. LPN-D stated R44 had a scabbed area in the center of the excoriated skin on his left buttock, measured it to be 0.2 cm X 0.2 cm in size, and is considered to be unstageable due to no longer being able to visualize the wound bed. R44 was observed to have denuded skin on his right buttock, which was approximately 5 cm by 3 cm. LPN-D stated the area was "superficial" and not measurable and that (R44) spends a majority of his day in bed.

When interviewed on 12/31/14, at 11:29 a.m., NA-G stated R44's loose stools had not been occurring for awhile, and had stopped, "A couple months ago." He used to sit in his recliner chair, but he no longer does since his skin condition worsened, however she was not exactly sure how his skin was.

Review of R44's Vitals Report, dated 10/30/14 to 12/30/14, indicated R44 had only 10 episodes of incontinent, loose stools in the past 60 days.

During interview on 12/31/14 at 11:58 a.m., LPN-D stated pressure ulcer evaluations are to be documented in the progress notes. The areas of excoriated skin on R44's buttocks were

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reoccurring and as a result of shearing. R44 admitted with pressure ulcers, and they had improved in August 2014. The progress notes, identified on August 20th, 2014 the area was closed and reopened again in October 2014. LPN-D stated, "We do good for awhile," and there was nothing else being completed for (R44)beside the application of cream and positioning schedule because this seemed to work. "We just keep reinforcing the same thing because eventually it does work." LPN-D stated occupational therapy (OT) had been involved for short periods in the past, however, he stopped using his recliner chair and was being laid down in bed after meals since 12/10/14. R44 had always had a pressure relieving cushion in his chair, and LPN-D was unaware when the air mattress had been implemented. The pressure ulcers should have been looked at daily, and measured by a nurse at least weekly to ensure they are healing, and to be able to assess the effectiveness of the interventions, "Improvement is needed." LPN-D stated they had not reassessed R44's skin risk and pressure ulcers each time they healed or re-develop which would help to assist in developing new approaches and interventions to reduce further skin breakdown. "Something else should have been put into place."

OT Therapist Progress note, dated 11/24/14, indicated R44 received a new cushion to trial in his recliner to reduce the pressure in his chair. The note further identified, "Client remains @ (at) risk for skin breakdown but currently does not have any open areas."

A Rehabilitation Screen form, dated 12/10/14, indicated R44 had a change in skin integrity, and

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F 314	Continued From page 15 R44's bottom was, "Red and opening again...All pressure relieving measures are in place. Will monitor." OT identified an evaluation was not needed for R44's reoccurring pressure ulcers. When interviewed on 12/31/14 at 12:37 p.m., the director of nursing (DON) stated she had not seen R44's skin breakdown for approximately two weeks as she rely's on the nursing staff to care for it. Nursing should be completing weekly monitoring of the pressure ulcers, and assessment of his skin risk and interventions should have been completed each time the pressure ulcers healed and re-developed, "He's been open and closed so many different times." Although R44's area on his buttock/coccyx were opened and closed there was no indication the facility was consistently monitoring the wound for staging, size, identifying if there was exudate, pain, characteristics of wound bed and surrounding tissue. The facility had not reassessed R44 skin when it reopened each time to determine appropriate interventions to help reduce the risk for continued pressure ulcer development. A facility Skin Integrity Protocol, dated 11/11, indicated, "This facility identifies residents who are at risk for pressure ulcer formation and develops interventions." Residents are assessed for skin breakdown at admission, weekly for four weeks after admission, quarterly, and as necessitated by resident condition changes. Further, a skin team will address problems, goals, and interventions directed towards prevention and/or resolution of the pressure ulcers.	F 314		
F 329	483.25(l) DRUG REGIMEN IS FREE FROM	F 329		1/21/15

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F 329 SS=D	Continued From page 16 UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete routine laboratory monitoring to ensure effective medication management, for 2 of 5 residents (R39 and R44) reviewed for unnecessary medication use. Findings include: R39's quarterly Minimum Data Set (MDS) dated	F 329	Corrective action for those affected: Resident #39 Hemoglobin A1C was drawn on 1/5/2015. Resident #44 Digoxin level was drawn on 1/5/2015. Identification of others having the potential to be affected: DON and RN coordinator audited all current resident charts that are diabetic or on Digoxin to identify past lab	

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F 329	Continued From page 17 10/24/14, indicated she required insulin, a medication used to lower blood sugar. R39's signed Physician Order Report dated 12/29/14, directed the following: humolog mix 50-50 (insulin lispro protam and lispro), 20 units before breakfast each morning and humolog mix 50-50, 10 units before dinner each evening. The order identified R39's insulin medications were initiated on 2/3/14. There were no physician orders for laboratory monitoring of R39's hemoglobin A1c (a test used to monitor the glucose control of diabetics over a period of several months). A review of R39's medical record identified no laboratory monitoring of her hemoglobin A1c. Review of R39's Administration History forms from 11/1/14, through 12/31/14, indicated blood sugar results ranged from 64 to 452 mg/dL (milligrams per deciliter). During an interview on 12/30/14, at 2:01 p.m. the director of nursing (DON) reported there were no laboratory monitoring of R39's hemoglobin A1c could be located. The DON added, "We relied upon the physician to make determinations of when to order laboratory monitoring." During a telephone interview on 12/31/14, at 9:19 a.m. the facility's consulting pharmacist (CP) stated it would have been a good idea to have completed a hemoglobin A1c for R39. CP added, "I like to have one every three to six months." During a telephone interview on 12/31/14, at 11:45 a.m. the attending physician stated, "I would greatly appreciate and would expect the	F 329	values pertaining to this deficiency. Measures to ensure practice will not recur: Medical director and nursing department reviewed and updated current Cokato Manor standing orders. Digoxin level will be drawn every six months. Hemoglobin A1C will be drawn every three months. This deficiency was reviewed at the Quality Assurance meting on 1/11/2015. Monitoring: The DON or designee will monitor residents who are diabetic for A1C levels and residents on digoxin to ensure correct frequency of lab values according to Cokato Manor Standing Orders.	

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nurses to notify me, or give input of resident needs. A protocol would solve this issue at the facility."

R44's quarterly MDS dated 10/31/14, identified he required anticoagulant (used to inhibit the coagulation of blood) and a diuretic (used to remove excess fluid from the body) medications on a daily basis.

R44's signed Physician Order Report dated 12/2/14, indicated he had diagnoses of atrial fibrillation (a type of abnormal heart beat) and congestive heart failure (a condition in which the heart struggles to pump enough blood to the body). The orders directed the following medications: demadex (a diuretic) 20 mg (milligrams) daily; zaroxolyn (a diuretic) 2.5 mg three times weekly; and digoxin (a potentially toxic steroid used in small doses as a cardiac stimulant) 125 mcg (micrograms) daily, initiated on 11/6/14. The physician orders lacked direction for laboratory monitoring of R44's digoxin levels.

A review of R44's medical record identified no laboratory monitoring to ensure therapeutic dosing of his digoxin.

During interview on 12/31/14, at 9:03 a.m. licensed practical nurse (LPN)-A reported R44 started taking digoxin on 11/6/14, for atrial fibrillation. Further, LPN-A confirmed R44 lacked any digoxin laboratory monitoring. LPN-A added, "I know you're supposed to do one."

When interviewed on 12/31/14, at 9:21 a.m. the CP confirmed a digoxin level should have been completed within 30 days of starting the medication for residents who also received

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	245412	A. BUILDING _____ B. WING _____	12/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	182 SUNSET AVENUE COKATO, MN 55321

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 19 diuretic medication. The CP added, "Their should be some kind of baseline." When interviewed on 12/31/14, at 9:30 a.m. the director of nursing (DON) stated no laboratory monitoring of digoxin could be located for R44. Further, the facility relied upon the physician to make determinations of when to order laboratory monitoring. The DON added, "I would rely more on them." A policy on laboratory monitoring was requested, but none was provided.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure irregularities in routine laboratory monitoring were identified by the consulting pharmacist for 2 of 5 residents (R39, R44) reviewed for unnecessary medication use. Findings include:	F 428	Corrective action for those affected: Resident #39 Hemoglobin A1C drawn on 1/5/2015. Resident #44 Digoxin level drawn on 1/5/2015. Identification of others having the potential to be affected: DON and RN coordinator audited all resident charts that are diabetic	1/21/15

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F 428	Continued From page 20 R39's quarterly Minimum Data Set (MDS), dated 10/24/14, indicated long and short term memory impairment, dependent on staff for all activities of daily living (ADL's) and took insulin (medication to lower blood sugar). R39's signed Physician Order Report, dated 12/29/14, indicated she took the following medications: humolog mix 50-50 (insulin lispro protam and lispro) 20 units before breakfast daily and humolog mix 50-50 (insulin lispro protam and lispro) 10 units before dinner once an evening daily. R39 started taking the insulin on 2/3/14. The report lacked any orders for laboratory monitoring of Hemoglobin A1c (A1c), The A1c test is used to monitor the glucose control of diabetics over the last 2-3 months. A review of R39's medical record identified no laboratory monitoring of A1c. Review of blood sugar results entitled administration history date range from 11/1/14-12/31/14 indicate blood sugar results range from 64 to 452 milligram (MG)/deciliter(dL) . Normal blood sugar level is less than 100 MG/dL before meals. R39's Monthly Medication Regimen Review, dated 10/16/12 to 12/2/14, was completed by the consulting pharmacist (CP). The report lacked any concerns from the CP regarding the lack of physician orders for A1c. laboratory monitoring. During an interview on 2/30/2014 at 2:01 p.m. the director of nursing (DON) stated no laboratory monitoring of A1c could be located for R39.	F 428	or on Digoxin to identify past lab values pertaining to this deficiency. Measures to ensure practice will not recur: Medical Director, consulting pharmacist and nursing department reviewed and updated current Cokato Manor standing orders to include the frequency of Digoxin levels and Hemoglobin A1C. This deficiency was reviewed at the Quality Assurance meeting on 1/11/2015. Monitoring: The DON or designee will monitor residents who are diabetic for A1C levels and residents on digoxin to ensure correct frequency of lab values according to Cokato Manor Standing Orders.	

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F 428	Continued From page 21 Further, "we relied upon the physician to make determinations of when to order laboratory monitoring" During a telephone interview on 12/31/2014 at 9:19 with CP stated, it would been a good idea to have an A1c done, I like to have one every 3-6 months. During a telephone interview on 12/31/14, at 11:45 a.m. the attending physician stated, "I would greatly appreciate and would expect the nurses to notify me, or give input of resident needs. A protocol would solve this issue at the facility." R44's quarterly Minimum Data Set (MDS), dated 10/31/14, indicated he had severe cognitive impairment, and took an anticoagulant (medication used to inhibit the coagulation of blood) and diuretic (medication used to remove excess fluid from the body) daily. R44's signed Physician Order Report, dated 12/2/14, indicated he had diagnoses of atrial fibrillation (a type of abnormal heart beat) and congestive heart failure (a condition in which the heart struggles to pump enough blood to the body), and took the following medications: demadex (a diuretic) 10 mg (milligrams) 2 tablets (for a total dose of 20 mg) orally once daily, zaroxolyn (a diuretic) 2.5 mg orally every Monday, Wednesday and Friday and, digoxin (a potentially toxic steroid used in small doses as a cardiac stimulant) 125 mcg (micrograms) orally once daily. R44 started taking the digoxin on 11/6/14. The report lacked any	F 428		

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F 428	Continued From page 22 orders for laboratory monitoring for digoxin. A review of R44's medical record identified no laboratory monitoring to ensure therapeutic dosing of his digoxin. During interview on 12/31/14, at 9:03 a.m. licensed practical nurse (LPN)-A stated R44 started taking digoxin on 11/6/14 for atrial fibrillation. Further, R44 lacked any digoxin laboratory monitoring, "I know you're supposed to do one." R44's Monthly Medication Regimen Review, dated 8/8/14 to 12/2/14, was completed by the consulting pharmacist (CP). The report only identified an irregularity with R44's medication regimen on 11/5/14, and there was nothing identified about the digoxin levels. R44's Medication Regimen Review Irregularity Report, dated 11/5/14, indicated he was taking digoxin. The report lacked any concerns from the CP regarding the lack of physician orders for digoxin laboratory monitoring. When interviewed on 12/31/14, at 9:21 a.m., the CP stated a digoxin level should be completed within 30 days of starting the medication for residents also taking diuretics, "Their should be some kind of baseline." When interviewed on 12/31/14, at 9:30 a.m., the director of nursing (DON) stated no laboratory monitoring of digoxin could be located for R44. The facility relied upon the physician to make determinations of when to order laboratory monitoring, "I would rely more on them." Further, the pharmacist helps to ensure quality care for	F 428		

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F 428	Continued From page 23 the resident, however did not provide any recommendations to the facility for R44's laboratory monitoring. A policy on laboratory monitoring was requested, but none was provided.	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		1/21/15

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F 441	Continued From page 24 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure community glucometers were sanitized in accordance with the manufacturer's guidelines to prevent blood borne transmission for 2 of 3 residents (R16, R39) who had glucometer checks observed. Findings include: R16's physician orders, dated 12/31/14 indicated a diagnosis of diabetes type II. The physician's orders also indicated R16 was to receive glucometer checks three times a week. During observation on 12/31/14, at 6:54 a.m., licensed practical nurse (LPN)-A approached R16 and moved R16 to an alcove off of the main living area to perform his glucometer check. LPN-A applied gloves and obtained a blood sample via fingerstick from R16's finger, touching the end of the glucometer strip to the blood sample. After obtaining the numeric result, LPN-A returned to her cart and removed her gloves and sanitized her hands with alcohol. LPN-A was observed to wipe the face of the glucometer with a PDI super-sani cloth for 1-2 seconds and returned the meter to the medication cart. She stated it was ready for the next use. The glucometer was observed to be dry at the time it was returned to	F 441	Corrective action for those affected: LPN-A and RN-A were immediately re-educated on the policy of glucometer disinfection including the two minute contact time to disinfect when brought to attention during the survey process. Identification of others having potential to be affected: All nursing staff involved with the glucometer machines were re-educated on 1/5/2015 on the policy including the two minute contact time to ensure disinfection. This deficiency was reviewed at the Quality Assurance meeting on 1/11/2015. Measures to ensure practice will not recur: The glucometer disinfection policy included on nurses new hire orientation. This education will also be provided annually to licensed staff. Monitoring: DON or designee will audit performance based on observation weekly, then monthly until compliance is reached and report back to the Quality Assurance Committee.	

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F 441	Continued From page 25	F 441		

the medication cart.

R39's physician orders sheets, dated 12/31/14 identified a diagnosis of diabetes type II and indicated R39 was to receive blood sugar checks twice a day.

During observation on 12/31/14, at 7:13 a.m. LPN-A stated she was ready to check R39's blood sugar. LPN-A applied gloves, obtained a new lancet and glucometer testing strip and stated she was going to check R39's blood sugar. When interviewed about the proper cleansing of the glucometer meter in between residents, LPN-A stated she thought she only had to wipe the glucometer down with the PDI super-sani cloth. LPN-A visualized the instructions on the PDI super-sani cloth on the canister at this time and stated the machine should have remained wet for two full minutes to ensure proper contact time fore sanitation, and had not used the appropriate technique for cleansing after checking R16's blood sugar and proceeding to R39. LPN-A thought there was a glucometer cleansing procedure in a binder at the nursing station.

During interview on 12/31/14, at 7:22 a.m., registered nurse (RN)-A stated she normally cleansed glucometers between residents with an alcohol swab and had been working at the facility since 5/14. She indicated she had already completed her glucometer checks for the morning and the glucometer meters were shared by the diabetics on each wing.

During interview on 12/31/14, at 7:43 a.m. LPN-B stated the glucometers should be cleansed with a PDI super-sani cloth and should remain moist for

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F 441	Continued From page 26 a full two minutes to sanitize. During interview on 12/31/14, at 8:46 a.m. the director of nursing (DON) stated staff were supposed to ensure a full two minute contact time with the PDI super-sani cloth cleansing agent to ensure proper sanitation of the glucometers. The facility policy, entitled Cokato Manor Glucometer Disinfection Policy and Procedures, dated 4/10 directed after using the glucometer staff were to thoroughly cleanse with a super-sani cloth and allow to remain wet for two minutes and air dry. The PDI super-sani cloth product information sheet, undated, indicated a two minute contact time to disinfect hard, non-porous surfaces.	F 441		
F 520 SS=C	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		1/21/15

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F 520	Continued From page 27 except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to consistently have the required number of members present during their Quality Assurance (QA) meetings, in addition failed to hold the minimum number of required QA meetings per year. This had potential to affect all 48 residents whom resided in the facility, staff, and visitors. Findings include: An interview on 12/31/2014 at 2:35 p.m. director of nursing (DON) stated there are no minutes of the QA meetings this past year, to identify who attended the meetings. The DON stated the facility did not have the minimum required members in attendance at the QA meetings, attending each of the three meeting were DON, medical director (MD), social services (SS) and a licensed practical nurse (LPN) (minimum required attendance at least DON, medical director (MD), and three other facility staff). The DON stated the meetings were on 3/17/14, 6/23/14 and 9/14/14, and there were no meetings held during the 4th quarter of 2014.	F 520	Corrective action for those affected: Quality Assurance meeting held on January 11, 2015 consisting of the Director of Nursing, Medical Director, Administrator and at least 3 other members of the facility's staff. Identification of others having potential to be affected: Cokato Manor Quality Assurance members reviewed past action plans to determine nothing was omitted from this quality process. Measures to ensure practice will not recur: The Quality Assurance Team reviewed current policy and regulation to assure all aware of expectations and importance of meeting schedule. Monitoring: The administrator or designee will monitor to ensure compliance of meeting quarterly and those who attend.	

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F 520	Continued From page 28 The DON agreed Cokato manor did not meet the minimum standards of attendance and frequency for the QA committee. A review of the Cokato Manor Quality Assessment/Assurance form, (undated) identified the, "...quality assessment and assurance committee consisting of the Director of Nursing and at least 3 other members of the facility staff." The form did not identify that a physician designated by the facility and DON were required to attend the meetings in addition to at least 3 other members of the facility staff. The form identified the team was to meet at least quarterly and the Last Meeting Dates were listed as: 3/17/14, 6/23/14 and 9/29/14, there were no December meetings identified. Also, there was no indication of who attended these meetings to ensure all the required members were present at these meetings.	F 520		

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	245412	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/30/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State fire Marshal Division. At the time of this survey, Cokato Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/23/2015

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cokato Manor is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1964 and was determined to be of Type II(111) construction. In 1995, an addition was constructed to the east wing and was determined to be of Type II(111) construction. Another addition was added in 1999 to the south wing and was determined to be Type II (111). Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 56 beds and had a census of 51 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect all patients Findings include: On facility tour between 9:00 AM and 11:00 am on 12/30/2014, observation revealed, that the smoke barrier walls has open penetrations above the drop in ceiling. All smoke barriers throughout the facility needs to be checked.	K 025	All smoke barriers will be inspected and any penetrations will be sealed with the appropriate fire stopping/smoke penetrating material. The inspection will be conducted by the Environmental Services Director who is responsible for correcting and monitoring to prevent a re-occurrence of this deficiency.	2/1/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245412	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/30/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COKATO MANOR	**182 SUNSET AVENUE** **COKATO, MN 55321**

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K 025	Continued From page 3 This deficient practice was confirmed by the Maintenance Director (SS) at the time of discovery.	K 025		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
January 15, 2015

Mr. James Broich, Administrator Administrator
Cokato Manor
182 Sunset Avenue
Cokato, Minnesota 55321

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5412025

Dear Mr. Broich:

The above facility was surveyed on December 29, 2014 through December 31, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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,

Kate Johnston, Program Specialist
Licensing and Certification Program
Health Regulations Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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	00712	A. BUILDING: _____ B. WING _____	12/31/2014

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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 December 29-31th, 2014 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301. 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.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff,	2 255		1/21/15

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2 255	Continued From page 2 representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to consistently have the required number of members present during their Quality Assurance (QA) meetings, in addition failed to hold the minimum number of required QA meetings per year. This had potential to affect all 48 residents whom resided in the facility, staff, and visitors. Findings include: An interview on 12/31/2014 at 2:35 p.m. director of nursing (DON) stated there are no minutes of the QA meetings this past year, to identify who attended the meetings. The DON stated the facility did not have the minimum required members in attendance at the QA meetings, attending each of the three meeting were DON, medical director (MD), social services (SS) and a licensed practical nurse (LPN) (minimum required attendance at least DON, medical director (MD), and three other facility staff). The DON stated the meetings were on 3/17/14, 6/23/14 and 9/14/14, and there were no	2 255	Corrected	

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2 255	Continued From page 3 meetings held during the 4th quarter of 2014. The DON agreed Cokato manor did not meet the minimum standards of attendance and frequency for the QA committee. A review of the Cokato Manor Quality Assessment/Assurance form, (undated) identified the, "...quality assessment and assurance committee consisting of the Director of Nursing and at least 3 other members of the facility staff." The form did not identify that a physician designated by the facility and DON were required to attend the meetings in addition to at least 3 other members of the facility staff. The form identified the team was to meet at least quarterly and the Last Meeting Dates were listed as: 3/17/14, 6/23/14 and 9/29/14, there were no December meetings identified. Also, there was no indication of who attended these meetings to ensure all the required member were present at these meetings. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the Quality Assurance committee attendance and frequency of meetings. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 255		
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:	2 900		1/28/15

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2 900	Continued From page 4 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 comprehensively reassess, adequately monitor the condition of, and implement new interventions to heal a reoccurring pressure ulcer for 1 of 3 residents (R44) reviewed for pressure ulcers. Findings include: R44's Physician Order Report from 11/1/14 to 12/1/14 identified diagnoses of candidiasis (skin/nails), diabetic (a metabolic disease causing high blood glucose and can cause poor healing), Congestive heart failure, chronic obstructive pulmonary disease, malaise, fatigue, and leukocytosis. R44's admission Minimum Data Set (MDS), dated 8/5/14, indicated R44 was cognitively intact, required extensive assistance with activities of daily living (ADL), was at risk for pressure ulcer development, and was admitted with two stage II pressure ulcers (partial thickness loss of skin presenting as a shallow, open ulcer with a pink or red wound bed). Further, the MDS identified the	2 900	Corrected	

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2 900	Continued From page 5 "most severe tissue type in the ulcers" was granulation tissue (new vascular tissue, indicative of healing). A 14-day MDS, dated 8/11/14, 6 days after his admission MDS, indicated he remained at risk for pressure ulcer development, however, now had only one stage II pressure ulcer with granulation tissue present in the wound bed. A PPS (prospective payment system) MDS, dated 8/25/14, indicated he no longer had any pressure ulcers. The MDS identified under the heading of "risk of pressure ulcers" was left blank. R44's quarterly MDS, dated 10/31/14, indicated he had severe cognitive impairment, required extensive assistance with ADLs, was at risk for pressure ulcer development, and had two stage II pressure ulcers with granulation tissue in the wound bed that had developed on 10/24/14. R44's associated Care Area Assessment (CAA) worksheet, dated 8/11/14, indicated he did not have a pressure ulcer and was confined to a bed or chair most of the time, and required a special mattress or seat cushion to reduce or relieve pressure on his skin. R44's Cokato Manor Admission Head to Toe Body Review, dated 7/29/14, indicated, "sores on bottom > [applied] orange cream." Further, the review had a picture of a body identified a "lg [large] sore" on his left buttock, and a "sore" on his right buttock, near his coccyx. The form lacked any measurements of the identified "sores," there was no description of the wound bed, and what interventions, if any, were implemented. R44's care plan, dated 11/4/14, indicated he was	2 900		

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2 900	Continued From page 6 at risk for pressure ulcer development related to mobility deficits, and had a history of pressure ulcers on his buttocks, with a goal of care including that skin will remain intact on a daily basis. Further, it identified interventions of using an alternating pressure mattress on his bed, assisting with repositioning every 2 hours, observing skin with cares, and treating skin concerns per the physician orders and facility protocol. During observation of morning cares on 12/31/14 at 7:17 a.m., R44 was lying in bed, and was assisted to roll to his right side by nursing assistant (NA)-D. R44 had red, excoriated and denuded skin on his bilateral medial (both sides, in the middle) buttocks, with a scabbed area present at the center of the excoriated area on his left buttock. He had no urinary or bowel incontinence noted during the observation, however stated his bottom hurts, "A little bit". When interviewed on 12/31/14, at 7:46 a.m. NA-D stated R44 was at risk for pressure ulcers as he was unable to reposition himself and required extensive assistance from staff for his care. NA-D stated R44 was being laid down after meals, and had been repositioned side to side in bed since his mobility had declined prior to Thanksgiving. Further, the denuded, excoriated areas on his buttocks often gets better and then get worse again but was not sure why. A review of R44's nursing progress notes indicated the following: 7/29/14 - R44 admitted to the facility and, "has 2 open sores on rectum applied house cream and left open to air." 7/31/14 - "Small amount of bleeding noted from left buttock wound. House barrier cream applied	2 900		

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2 900	Continued From page 7	2 900		

after bleeding stopped."
8/7/14 - "Resident has open area on left buttocks that measures 2 cm (centimeters) X (by) 0.5 cm, sensa cream applied. No other open areas noted."
8/13/14 - Resident's area on left buttocks measures 0.8 cm X 0.1 cm. is almost healed. No other open areas, right buttocks noted to be pink. Will continue with the sensa care cream."
8/20/14 - "No open areas noted on buttocks, noted to be slightly pink."

A review of R44's nursing progress notes identified the following:
10/20/14 - "Resident has open excoriated areas to both buttocks. Resident has been more incontinent of bowels and they have been more frequent. Barrier cream applied to areas. Encourage repositioning every two hours and frequent brief changes." Although R44 pressure ulcers healed on 8/20/14 he had an open area on 10/20/14, 60 days after healing the previous pressure ulcers.
10/22/14 - "Bottom continues to be open and sore on both buttcheeks. Had large incontinent stool. A&D/zinc to bottom. Fas [sic] sent to MD."
10/28/14 - "Resident continues with reddened areas on buttock. Areas are blanching." There was no indication if the area was open, closed or what size the pressure ulcers were or if there were any pressure ulcers.
10/29/14 - "Res. [resident] sore on R [right] buttocks has been closing up. Has purplish color around sore and on L buttocks also. Has a cushion on recliner from OT [occupational therapy] that he can know [sic] sit on."
10/30/14 - "Left buttocks 8 X 4 cm. Right buttocks 6 X 4 cm. Areas look sheared. Areas have improved since initially. Has been laying in bed on sides. Using cavalon spray to areas as

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2 900	Continued From page 8 barrier. Color is purple/red." There was no indication of pressure ulcer staging, exudate, pain, or what the wound bed characteristics were including the type of tissue, and a description of wound edges and surrounding tissue. 10/30/14 - "No open areas noted on bottom, sheared area intact Cavalon spray applied, and zinc cream with tena around area. Will continue to monitor." 11/5/14 - "Areas on buttocks have shown improvement. Left measures 9 cm X 3 cm, the one on the right measures 7 cm X 2 cm, inside this area noted to have abrasion looking area that measures 3 cm X 0.8 cm. Cavalon spray to the reddened areas and zinc to the surrounding skin. Will continue with current treatment." There was no indication if the measurements identified that the area was open or description of wound bed, edges or if the area was discolored, denuted, excoriated or was a pressure ulcers. Also, the note identified the "area had improved," even though the previous note on 10/30/14 identified there were "no open areas" with the "shear area intact." 11/7/14 - "Cavalon spray and zinc cream applied to bottom, placed on left side in bed tonight." 11/12/14 - "Superficial openings on bottom are improving. Surrounding skin is intact. Using Cavalon Spray to openings and house cream to surrounding skin." 11/20/14 - "Continue to use the Cavalon spray to areas on bottom that are superficial. House cream to surrounding skin. Areas look, they become irritated after a loose stool. Is laid down after each meal and put on his side." 11/26/14 - "Bottom remains intact, continue with the Cavalon spray. Resident laid down after each meal and placed on his side. Has a new mattress which is also helping to maintain the skin."	2 900		

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2 900	Continued From page 9 12/3/14 - "Sores on butt are open again. Zinc/A&D mix was applied with every brief change. Side to side position during the night." 12/7/14 - "Right butt cheek has 2 superficial open areas. Did apply the cavalon spray, cream does not adhere to wound. Was laid down and put on his side." 12/10/14 - "SKIN: Noted to have 2 small open areas on right butt cheek, one is pinpoint and the other is 0.6 cm X 0.3 cm. There is some discoloration noted, otherwise bottom is intact. Using only Cavalon spray at this time. Is to lay in bed on his side, not in his recliner until bottom is completely healed." 12/18/14 - "Buttocks noted to have a open area, continue with the cavalon spray and lay on his side while in bed. No recliner at this time." There were no additional progress notes which identified R44 pressure ulcer after 12/18/14. R44 continued to have open areas, even though the area continued to fluctuate from open, to closed to the right buttock measuring 3 cm X 0.8 cm on 11/15/14. The last note that identified the size of the pressure ulcer was on 12/10/14, 18 days ago. R44's Braden Scale for Prediction of Pressure Sore Risk, dated 8/2/14, indicated he was considered at risk for pressure ulcers, and indicated "no referrals were necessary." A subsequent Braden Scale, dated 10/28/14, indicated he remained at risk for pressure ulcers, and still needed "no referrals" despite his pressure ulcers re-developing. R44's Tissue Tolerance Assessment, (ability of the skin and it's supporting structures to endure the effects of pressure without adverse effects) dated 8/1/14, indicated he had no redness noted on bony prominence's after sitting for a 2 hour period. The assessment did not indicate how long R44	2 900		

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2 900	Continued From page 10 could tolerate laying in bed before redness developed, but the assessment did identify he required a 2 hour repositioning schedule. R44's Comprehensive Skin Review and Assessment, dated 8/11/14, indicated R44 had a present pressure ulcer, diabetes mellitus, was incontinent of bowel and bladder, had cardiovascular disease, and was bedfast or chair bound. R44 had a Braden score (a scale used to determine pressure ulcer risk) of 18, (which identifies at risk for pressure ulcer development) and was, "Admitted c [with] pressure ulcer on Lt [left] & [and] Rt [right] buttocks." Further, the assessment identified a treatment for his pressure ulcers of Tena cream with Zinc, and staff to reposition every 2 hours. A RN Quarterly Review and Re-eval assessment, dated 11/6/14, indicated R44 had a Braden score of 15, (meaning at risk for pressure ulcer development) and continued to receive Tena cream with Zinc to a pressure ulcer on his right buttock with Cavalon spray being applied to the surrounding skin. No other comprehensive skin assessments were located in R44's medical record. During interview on 12/31/14 at 8:27 a.m., licensed practical nurse (LPN)-D stated there were no documented weekly skin checks of resident skin. The NA (nursing assistants)'s are expected to report concerns and the nurses will record them in the progress notes. R44 has chronic skin issues with his buttocks, and it, "comes and goes with the healing." Further, the skin on his buttocks has healed and reopens. She would be observing R44's pressure ulcers later today. During observation of pressure ulcer care with LPN-D on 12/31/14, at 9:45 a.m. LPN-D stated	2 900		

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2 900	Continued From page 11 R44 had a scabbed area in the center of the excoriated skin on his left buttock, measured it to be 0.2 cm X 0.2 cm in size, and is considered to be unstageable due to no longer being able to visualize the wound bed. R44 was observed to have denuded skin on his right buttock, which was approximately 5 cm by 3 cm. LPN-D stated the area was "superficial" and not measurable and that (R44) spends a majority of his day in bed. When interviewed on 12/31/14, at 11:29 a.m., NA-G stated R44's loose stools had not been occurring for awhile, and had stopped, "A couple months ago." He used to sit in his recliner chair, but he no longer does since his skin condition worsened, however she was not exactly sure how his skin was. Review of R44's Vitals Report, dated 10/30/14 to 12/30/14, indicated R44 had only 10 episodes of incontinent, loose stools in the past 60 days. During interview on 12/31/14 at 11:58 a.m., LPN-D stated pressure ulcer evaluations are to be documented in the progress notes. The areas of excoriated skin on R44's buttocks were reoccurring and as a result of shearing. R44 admitted with pressure ulcers, and they had improved in August 2014. The progress notes, identified on August 20th, 2014 the area was closed and reopened again in October 2014. LPN-D stated, "We do good for awhile," and there was nothing else being completed for (R44)beside the application of cream and positioning schedule because this seemed to work. "We just keep reinforcing the same thing because eventually it does work." LPN-D stated occupational therapy (OT) had been involved for	2 900		

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2 900	Continued From page 12	2 900		

short periods in the past, however, he stopped using his recliner chair and was being laid down in bed after meals since 12/10/14. R44 had always had a pressure relieving cushion in his chair, and LPN-D was unaware when the air mattress had been implemented. The pressure ulcers should have been looked at daily, and measured by a nurse at least weekly to ensure they are healing, and to be able to assess the effectiveness of the interventions, "Improvement is needed." LPN-D stated they had not reassessed R44's skin risk and pressure ulcers each time they healed or re-develop which would help to assist in developing new approaches and interventions to reduce further skin breakdown. "Something else should have been put into place."

OT Therapist Progress note, dated 11/24/14, indicated R44 received a new cushion to trial in his recliner to reduce the pressure in his chair. The note further identified, "Client remains @ (at) risk for skin breakdown but currently does not have any open areas."

A Rehabilitation Screen form, dated 12/10/14, indicated R44 had a change in skin integrity, and R44's bottom was, "Red and opening again...All pressure relieving measures are in place. Will monitor." OT identified an evaluation was not needed for R44's reoccurring pressure ulcers.

When interviewed on 12/31/14 at 12:37 p.m., the director of nursing (DON) stated she had not seen R44's skin breakdown for approximately two weeks as she rely's on the nursing staff to care for it. Nursing should be completing weekly monitoring of the pressure ulcers, and assessment of his skin risk and interventions should have been completed each time the

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2 900	Continued From page 13 pressure ulcers healed and re-developed, "He's been open and closed so many different times." Although R44's area on his buttock/coccyx were opened and closed there was no indication the facility was consistently monitoring the wound for staging, size, identifying if there was exudate, pain, characteristics of wound bed and surrounding tissue. The facility had not reassessed R44 skin when it reopened each time to determine appropriate interventions to help reduce the risk for continued pressure ulcer development. A facility Skin Integrity Protocol, dated 11/11, indicated, "This facility identifies residents who are at risk for pressure ulcer formation and develops interventions." Residents are assessed for skin breakdown at admission, weekly for four weeks after admission, quarterly, and as necessitated by resident condition changes. Further, a skin team will address problems, goals, and interventions directed towards prevention and/or resolution of the pressure ulcers. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident turning, repositioning and wound care process to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 900		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data	21390		1/21/15

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21390	Continued From page 14 collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure community glucometers were sanitized in accordance with the manufacturer's guidelines to prevent blood borne transmission for 2 of 3 residents (R16, R39) who had glucometer checks observed. Findings include: R16's physician orders, dated 12/31/14 indicated a diagnosis of diabetes type II. The physician's orders also indicated R16 was to receive	21390	Corrected	

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21390	Continued From page 15 glucometer checks three times a week. During observation on 12/31/14, at 6:54 a.m., licensed practical nurse (LPN)-A approached R16 and moved R16 to an alcove off of the main living area to perform his glucometer check. LPN-A applied gloves and obtained a blood sample via fingerstick from R16's finger, touching the end of the glucometer strip to the blood sample. After obtaining the numeric result, LPN-A returned to her cart and removed her gloves and sanitized her hands with alcohol. LPN-A was observed to wipe the face of the glucometer with a PDI super-sani cloth for 1-2 seconds and returned the meter to the medication cart. She stated it was ready for the next use. The glucometer was observed to be dry at the time it was returned to the medication cart. R39's physician orders sheets, dated 12/31/14 identified a diagnosis of diabetes type II and indicated R39 was to receive blood sugar checks twice a day. During observation on 12/31/14, at 7:13 a.m. LPN-A stated she was ready to check R39's blood sugar. LPN-A applied gloves, obtained a new lancet and glucometer testing strip and stated she was going to check R39's blood sugar. When interviewed about the proper cleansing of the glucometer meter in between residents, LPN-A stated she thought she only had to wipe the glucometer down with the PDI super-sani cloth. LPN-A visualized the instructions on the PDI super-sani cloth on the canister at this time and stated the machine should have remained wet for two full minutes to ensure proper contact time fore sanitation, and had not used the appropriate technique for cleansing after checking R16's blood sugar and proceeding to	21390		

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21390	Continued From page 16 R39. LPN-A thought there was a glucometer cleansing procedure in a binder at the nursing station. During interview on 12/31/14, at 7:22 a.m., registered nurse (RN)-A stated she normally cleansed glucometers between residents with an alcohol swab and had been working at the facility since 5/14. She indicated she had already completed her glucometer checks for the morning and the glucometer meters were shared by the diabetics on each wing. During interview on 12/31/14, at 7:43 a.m. LPN-B stated the glucometers should be cleansed with a PDI super-sani cloth and should remain moist for a full two minutes to sanitize. During interview on 12/31/14, at 8:46 a.m. the director of nursing (DON) stated staff were supposed to ensure a full two minute contact time with the PDI super-sani cloth cleansing agent to ensure proper sanitation of the glucometers. The facility policy, entitled Cokato Manor Glucometer Disinfection Policy and Procedures, dated 4/10 directed after using the glucometer staff were to thoroughly cleanse with a super-sani cloth and allow to remain wet for two minutes and air dry. The PDI super-sani cloth product information sheet, undated, indicated a two minute contact time to disinfect hard, non-porous surfaces. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the staff education and monitor compliance with Infection Control practices of appropriately	21390		

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21390	Continued From page 17 cleaning the glucometer. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21390		
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: Based on interview and document review, the facility failed to ensure tuberculosis (TB) symptom screenings were completed for 4 of 5 newly admitted residents (R56, R49, R69 and R70) and for 5 of 5 employees (NA-A, NA-B, DA-A, DA-B and DA-C) whose medical/ personnel records	21426	Corrected	1/21/15

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21426	Continued From page 18 were reviewed for TB prevention practices. This had the potential to affect all 48 of 48 residents who resided in the facility. Findings include: RESIDENT TB SYMPTOM SCREENING R56's face sheet dated 12/31/14, identified an admission dated of 7/09/14, but lacked evidence of an initial TB symptom screening. R49's face sheet dated 12/31/14, identified an admission date of 7/30/14, but lacked evidence of an initial TB symptom screening. R69's face sheet dated 12/31/14, identified an admission date of 11/04/14, but lacked evidence of an initial TB symptom screening. R70's face sheet dated 12/31/14, identified an admission date of 11/07/14, but lacked evidence of an initial TB symptom screening. STAFF TB SYMPTOM SCREENING Nursing assistant (NA)-A's personnel record identified a hire date of 6/16/14, but lacked evidence of an initial TB symptom screening. NA-B's personnel record identified a hire date of 7/2/14, but lacked evidence of an initial TB symptom screening. Dietary aide (DA)-A's personnel record identified a hire date of 7/18/14, but lacked evidence on an initial TB symptom screening. DA-B's personnel record identified a hire date of 9/20/14, but lacked evidence of an initial TB symptom screening.	21426		

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21426	Continued From page 19 DA-C's personnel record identified a hire date of 10/07/14, but lacked evidence of an initial TB symptom screening. During interview on 12/31/14, at 8:46 a.m. the director of nursing (DON) stated the facility's TB program, "Needs some work right now, we need to get better with that." The DON indicated there had been a recent change in staff and the symptom screenings for residents and staff had not been completed as required. The DON was unable to locate TB screenings for the above noted residents and staff. The facility's undated Employee Exposure Control Plan Tuberculosis policy lacked direction for when employee TB symptom screenings were to be conducted. A copy of the resident TB symptom screening was requested, but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review/ revise tuberculosis prevention policies and procedures to ensure compliance. Pertinent employees could be retrained on these policies. Resident and employee records could be reviewed to ensure tuberculosis screenings were completed and documented. An auditing system could be developed to ensure on-going compliance, with the results of these audits being reviewed by the facility's Quality Assessment & Assurance committee. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21426		

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21530	Continued From page 20	21530		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality	21530		1/21/15

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21530	Continued From page 21 assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure irregularities in routine laboratory monitoring were identified by the consulting pharmacist for 2 of 5 residents (R39, R44) reviewed for unnecessary medication use. Findings include: R39's quarterly Minimum Data Set (MDS), dated 10/24/14, indicated long and short term memory impairment, dependent on staff for all activities of daily living (ADL's) and took insulin (medication to lower blood sugar). R39's signed Physician Order Report, dated 12/29/14, indicated she took the following medications: humolog mix 50-50 (insulin lispro protam and lispro) 20 units before breakfast daily and humolog mix 50-50 (insulin lispro protam and lispro) 10 units before dinner once an evening daily. R39 started taking the insulin on 2/3/14. The report lacked any orders for laboratory monitoring of Hemoglobin A1c (A1c), The A1c test is used to monitor the glucose control of diabetics over the last 2-3 months. A review of R39's medical record identified no laboratory monitoring of A1c. Review of blood sugar results entitled administration history date range from 11/1/14-12/31/14 indicate blood sugar results range from 64 to 452 milligram (MG)/deciliter(dL)	21530	Corrected	

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21530	Continued From page 22 . Normal blood sugar level is less than 100 MG/dL before meals. R39's Monthly Medication Regimen Review, dated 10/16/12 to 12/2/14, was completed by the consulting pharmacist (CP). The report lacked any concerns from the CP regarding the lack of physician orders for A1c. laboratory monitoring. During an interview on 2/30/2014 at 2:01 p.m. the director of nursing (DON) stated no laboratory monitoring of A1c could be located for R39. Further, "we relied upon the physician to make determinations of when to order laboratory monitoring" During a telephone interview on 12/31/2014 at 9:19 with CP stated, it would been a good idea to have an A1c done, I like to have one every 3-6 months. During a telephone interview on 12/31/14, at 11:45 a.m. the attending physician stated, "I would greatly appreciate and would expect the nurses to notify me, or give input of resident needs. A protocol would solve this issue at the facility." R44's quarterly Minimum Data Set (MDS), dated 10/31/14, indicated he had severe cognitive impairment, and took an anticoagulant (medication used to inhibit the coagulation of blood) and diuretic (medication used to remove excess fluid from the body) daily. R44's signed Physician Order Report, dated 12/2/14, indicated he had diagnoses of atrial fibrillation (a type of abnormal heart beat) and	21530		

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congestive heart failure (a condition in which the heart struggles to pump enough blood to the body), and took the following medications: demadex (a diuretic) 10 mg (milligrams) 2 tablets (for a total dose of 20 mg) orally once daily, zaroxolyn (a diuretic) 2.5 mg orally every Monday, Wednesday and Friday and,
digoxin (a potentially toxic steroid used in small doses as a cardiac stimulant) 125 mcg (micrograms) orally once daily. R44 started taking the digoxin on 11/6/14. The report lacked any orders for laboratory monitoring for digoxin.

A review of R44's medical record identified no laboratory monitoring to ensure therapeutic dosing of his digoxin.

During interview on 12/31/14, at 9:03 a.m. licensed practical nurse (LPN)-A stated R44 started taking digoxin on 11/6/14 for atrial fibrillation. Further, R44 lacked any digoxin laboratory monitoring, "I know you're supposed to do one."

R44's Monthly Medication Regimen Review, dated 8/8/14 to 12/2/14, was completed by the consulting pharmacist (CP). The report only identified an irregularity with R44's medication regimen on 11/5/14, and there was nothing identified about the digoxin levels.

R44's Medication Regimen Review Irregularity Report, dated 11/5/14, indicated he was taking digoxin. The report lacked any concerns from the CP regarding the lack of physician orders for digoxin laboratory monitoring.

When interviewed on 12/31/14, at 9:21 a.m., the CP stated a digoxin level should be completed within 30 days of starting the medication for

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21530	Continued From page 24 residents also taking diuretics, "Their should be some kind of baseline." When interviewed on 12/31/14, at 9:30 a.m., the director of nursing (DON) stated no laboratory monitoring of digoxin could be located for R44. The facility relied upon the physician to make determinations of when to order laboratory monitoring, "I would rely more on them." Further, the pharmacist helps to ensure quality care for the resident, however did not provide any recommendations to the facility for R44's laboratory monitoring. A policy on laboratory monitoring was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident' medications and monitor the pharmacists recommendation for each medication to ensure compliance with the requirements. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the 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	21540		1/21/15

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21540	Continued From page 25 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 interview and document review, the facility failed to complete routine laboratory monitoring to ensure effective medication management, for 2 of 5 residents (R39 and R44) reviewed for unnecessary medication use. Findings include: R39's quarterly Minimum Data Set (MDS) dated 10/24/14, indicated she required insulin, a medication used to lower blood sugar. R39's signed Physician Order Report dated 12/29/14, directed the following: humolog mix 50-50 (insulin lispro protam and lispro), 20 units before breakfast each morning and humolog mix 50-50, 10 units before dinner each evening. The order identified R39's insulin medications were initiated on 2/3/14. There were no physician orders for laboratory monitoring of R39's hemoglobin A1c (a test used to monitor the glucose control of diabetics over a period of	21540	Corrected	

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21540	Continued From page 26 several months). A review of R39's medical record identified no laboratory monitoring of her hemoglobin A1c. Review of R39's Administration History forms from 11/1/14, through 12/31/14, indicated blood sugar results ranged from 64 to 452 mg/dL (milligrams per deciliter). During an interview on 12/30/14, at 2:01 p.m. the director of nursing (DON) reported there were no laboratory monitoring of R39's hemoglobin A1c could be located. The DON added, "We relied upon the physician to make determinations of when to order laboratory monitoring." During a telephone interview on 12/31/14, at 9:19 a.m. the facility's consulting pharmacist (CP) stated it would have been a good idea to have completed a hemoglobin A1c for R39. CP added, "I like to have one every three to six months." During a telephone interview on 12/31/14, at 11:45 a.m. the attending physician stated, "I would greatly appreciate and would expect the nurses to notify me, or give input of resident needs. A protocol would solve this issue at the facility." R44's quarterly Minimum Data Set (MDS), dated 10/31/14, indicated he had severe cognitive impairment, and took an anticoagulant (medication used to inhibit the coagulation of blood) and diuretic (medication used to remove excess fluid from the body) daily. R44's signed Physician Order Report, dated 12/2/14, indicated he had diagnoses of atrial fibrillation (a type of abnormal heart beat) and	21540		

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21540	Continued From page 27	21540		

congestive heart failure (a condition in which the heart struggles to pump enough blood to the body), and took the following medications: demadex (a diuretic) 10 mg (milligrams) 2 tablets (for a total dose of 20 mg) orally once daily, zaroxolyn (a diuretic) 2.5 mg orally every Monday, Wednesday and Friday and,
digoxin (a potentially toxic steroid used in small doses as a cardiac stimulant) 125 mcg (micrograms) orally once daily. R44 started taking the digoxin on 11/6/14. The report lacked any orders for laboratory monitoring for digoxin.

A review of R44's medical record identified no laboratory monitoring to ensure therapeutic dosing of his digoxin.

During interview on 12/31/14, at 9:03 a.m. licensed practical nurse (LPN)-A stated R44 started taking digoxin on 11/6/14 for atrial fibrillation. Further, R44 lacked any digoxin laboratory monitoring, "I know you're supposed to do one."

R44's Monthly Medication Regimen Review, dated 8/8/14 to 12/2/14, was completed by the consulting pharmacist (CP). The report only identified an irregularity with R44's medication regimen on 11/5/14, and there was nothing identified about the digoxin levels.

R44's Medication Regimen Review Irregularity Report, dated 11/5/14, indicated he was taking digoxin. The report lacked any concerns from the CP regarding the lack of physician orders for digoxin laboratory monitoring.

When interviewed on 12/31/14, at 9:21 a.m., the CP stated a digoxin level should be completed within 30 days of starting the medication for

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21540	Continued From page 28 residents also taking diuretics, "Their should be some kind of baseline." When interviewed on 12/31/14, at 9:30 a.m., the director of nursing (DON) stated no laboratory monitoring of digoxin could be located for R44. The facility relied upon the physician to make determinations of when to order laboratory monitoring, "I would rely more on them." Further, the pharmacist helps to ensure quality care for the resident, however did not provide any recommendations to the facility for R44's laboratory monitoring. A policy on laboratory monitoring was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident's medication to ensure their medication has proper monitoring and laboratory testing for each medication. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21540		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a	21830		2/5/15

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family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

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

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

(4) inquiring of the physician to whom the resident normally goes for care, if known,

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21830	Continued From page 30 whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by:	21830		

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21830	Continued From page 31 Based on interview and document review, the facility failed to honor each resident's choice of bathing frequency and bathing method, for 2 of 3 residents (R47 and R6) reviewed for choices. Findings include: R47's annual Minimum Data Set (MDS) dated 6/6/14, indicated he had short and long term memory problems, required extensive assistance with activities of daily living (ADL)'s and required physical help to complete bathing. The MDS identified that choosing between a tub bath, shower, bed bath or sponge bath was very important to R47. A quarterly MDS dated 11/21/14, indicated R47 continued to require physical help with bathing. R47's care plan dated 11/25/14, indicated he required physical assistance with ADLs due to cognitive impairment and coordination deficits resulting from a stoke. The care plan lacked any indication of how often or by what method R47 preferred to be bathed. The facility bathing schedule dated 12/29/14, through 1/4/15, indicated R47 was scheduled for bathing on Wednesday and Saturday mornings. During interview on 12/29/14, at 7:24 p.m. R47's family member (FM)-E stated that R47 showered daily when he lived at home, but now only received a shower twice per week. FM-E reported they had requested R47 be bathed daily while at the facility. FM-E stated, "I would love to see him showered every single day. I have told the staff this over and over," but nothing as changed.	21830	Corrected	

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21830	Continued From page 32 R6's admission MDS dated 6/17/14, indicated he required physical help with bathing activities. The MDS identified it was was very important for R6 to make his own choice between a tub bath, shower, bed bath or sponge bath. R6's current care plan, dated 12/4/14, indicated he was at risk for requiring assistance with dressing and grooming related to cognitive deficits. The care plan interventions included encouragement to start bathing his upper torso and assistance from one staff to complete bathing of his body and hair as needed. The care plan did not identify how often or by what method R6 preferred to be bathed. During interview on 12/30/14, at 10:36 a.m. R6 stated, "I only get a shower one time per week. I would like a bath a couple times per week. I don't even think they have a tub here to take a bath." R6 added, "I would like to take a bath, but it would inconvenience the staff." When interviewed on 12/30/14, at 3:23 p.m. nursing assistant (NA)-C stated NA's do not determine if a resident gets a bed bath or shower, rather the nurses determined this. NA-C reported, "We just follow the schedule in the book on which residents get their baths or showers for the day." During interview on 12/30/14, at 3:30 p.m. licensed practical nurse (LPN)-C stated when residents were admitted, they were assigned a bath day. If the resident requested a change to their bath schedule, the facility adjusted it. Further, if a resident had a preference for bathing and "were adamant about it," then the facility would honor that preference.	21830		

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21830	Continued From page 33 When interviewed on 12/31/14, at 7:47 a.m. ward clerk (WC)-G stated residents were assigned a weekly bath day when they were admitted to the facility. Residents requesting additional bathing were given an extra bath during the week. WC-G added the facility only had one tub and two showers available for resident use. During interview on 12/31/14, at 9:30 a.m. the director of nursing (DON) stated residents were not assessed upon admission for bathing preferences. The DON stated, "It would be great to give every resident a bath or shower every day; however, that is not realistic." A facility policy on bathing and choices was requested but not provided. During interview on 12/31/14, at 1:09 p.m. the DON stated a facility policy pertaining to bathing and choices did not exist. She added, "We always let them have their choice if it is realistic." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident personal bathing choice process to ensure their being given a choice, and the residents are getting timely resolution. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21830		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout	21880		2/5/15

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21880	Continued From page 34 their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.	21880		

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21880	Continued From page 35 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to effectively respond to individual grievances, related loud noises made by R22 during the overnight hours, for 3 of 4 residents (R33, R19 and R16) reviewed with expressed concerns of loud noise levels within the facility. Findings include: R22's quarterly Minimum Data Set (MDS) dated 12/12/14, identified her cognition was moderately impaired, with some signs/ symptoms of delirium present, including inattention and disorganized thinking which fluctuated and changes in severity. There were no behaviors identified. The MDS also identified R22 had clear speech, was sometimes able to make herself understood and was sometimes able to understand others. R33's admission MDS dated 10/23/14, identified her cognition was intact. When interviewed on 12/29/14, at 3:17 p.m. R33 stated, "She [R22] hollers all night long. It drives me crazy and bothers others on the wing. It goes on every day and night. You can even hear it through the closed door. I have talked with staff about it, no one seems to do anything about it and I never hear anything back from the staff." R19's annual MDS dated 12/5/14, identified her cognition was intact. When interviewed on 12/29/14, at 4:12 p.m. R19 stated, "She [R22] hollers all night long. I have told the social worker (SW) and nothing ever happens. She hollers from 7:45 p.m. until 11:00 p.m. every day, I can not believe where she gets	21880	Corrected	

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21880	Continued From page 36 her energy." R16's annual MDS dated 10/10/14, identified his cognition was intact. When interviewed on 12/29/14, at 6:47 p.m. R16 stated, "That lady [referring to R22] was yelling all night long. People down the hall have complained. I have told [nursing assistants (NAs)] no one has responded to my complaining." On 12/31/14, several nursing assistants (NA)'s were interviewed regarding these complaints. At 1:15 p.m., NA-A stated, "They tell us about her hollering in report." At the same time, NA-F confirmed residents had asked "about all the yelling." At 1:18 p.m., NA-D stated, "The residents have told me about the yelling like [R19] and [R33] who will put their music up loud to drown out the sound." When interviewed on 12/31/14, at 1:22 p.m. SW-A stated, "I don't have anything written [a grievance] but I have heard about it [the yelling] and we have talked about it in some meetings." SW-A confirmed R33 and R19 had complained to her about the yelling. SW-A agreed this was a grievance, but could not explain why it had not been handled officially, following the facility's grievance process. When interviewed on 12/31/14, at 1:28 p.m. the director of nursing (DON) defined a grievance as something a resident or family brought up as a problem. The DON stated, "We are aware about the complaint, but what are we suppose to do with her? [R22] is one of our people too." The DON added, they moved her (R22) to that room because there was the same problem in her previous room. We have tried different strategies but are "not successful." The DON reported the	21880		

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21880	Continued From page 37 facility nursing staff had discussed the concern, but denied having sought guidance from the facility's quality assessment and assurance (QA&A) committee for ideas on how to address the concern. The DON denied having updated residents on the facility's progress toward resolution of their expressed concerns about R22. The facility's undated Resident Grievance policy directed, "Prompt efforts shall be made by the facility to resolve grievances that resident may have... including those with respect to the behavior of other residents... investigation will be within three working days, and the resident/ resident representative(s) informed..." The policy was not followed. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident grievance process to ensure their complaints are being heard, and the residents are getting timely resolution. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21880		