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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: RY1Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00255

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245289**

2. STATE VENDOR OR MEDICAID NO. (L2) **604140000**

3. NAME AND ADDRESS OF FACILITY (Crystal Care Center)
(L3) **CENTENNIAL GARDENS FOR NURSING & REHABILITATIC**
(L4) **3245 VERA CRUZ AVENUE NORTH**
(L5) **CRYSTAL, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **12/20/2013**

6. DATE OF SURVEY **03/25/2016** (L34)

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

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

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

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

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

12.Total Facility Beds **130** (L18)

13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(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):
Documentation supporting the facility's request for a continuing waiver involving K67 has been forwarded. Approval of the waiver request Has been approved. Refer to the CMS form 2567b. This facility was previously known as Crystal Care Center.

17. SURVEYOR SIGNATURE — Date :
Kathy Sass, HPR-Dietary Specialist — 04/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 05/11/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1984** (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. **00325** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245289

April 1, 2016

Ms. Annette Thorson, Administrator
Centennial Gardens For Nursing & Rehabilitation
3245 Vera Cruz Avenue North
Crystal, MN 55422

Dear Ms. Thorson:

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

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

Effective March 16, 2016 the above facility is certified for:

130 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 130 skilled nursing facility beds located in rooms .

We have recommended CMS approve the waivers that you requested for the following Life Safety Code Requirements: K67.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 1, 2016

Ms. Annette Thorson, Administrator
Centennial Gardens For Nursing & Rehabilitation
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: Project Number S5289027

Dear Ms. Thorson:

On February 24, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 5, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 25, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 24, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 16, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 5, 2016, effective March 16, 2016 and therefore remedies outlined in our letter to you dated February 24, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245289 Y1	A. Building B. Wing Y2	3/25/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0156	Correction	ID Prefix	F0246	Correction	ID Prefix	F0272	Correction
Reg. #	483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. #	483.15(e)(1)	Completed	Reg. #	483.20(b)(1)	Completed
LSC		03/16/2016	LSC		03/16/2016	LSC		03/16/2016
ID Prefix	F0279	Correction	ID Prefix	F0280	Correction	ID Prefix	F0281	Correction
Reg. #	483.20(d), 483.20(k)(1)	Completed	Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(k)(3)(i)	Completed
LSC		03/16/2016	LSC		03/16/2016	LSC		03/16/2016
ID Prefix	F0282	Correction	ID Prefix	F0309	Correction	ID Prefix	F0312	Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25	Completed	Reg. #	483.25(a)(3)	Completed
LSC		03/16/2016	LSC		03/16/2016	LSC		03/16/2016
ID Prefix	F0314	Correction	ID Prefix	F0323	Correction	ID Prefix	F0329	Correction
Reg. #	483.25(c)	Completed	Reg. #	483.25(h)	Completed	Reg. #	483.25(l)	Completed
LSC		03/16/2016	LSC		03/16/2016	LSC		03/16/2016
ID Prefix	F0372	Correction	ID Prefix	F0412	Correction	ID Prefix	F0428	Correction
Reg. #	483.35(i)(3)	Completed	Reg. #	483.55(b)	Completed	Reg. #	483.60(c)	Completed
LSC		03/16/2016	LSC		03/16/2016	LSC		03/16/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	4/1/2016	18623	3/25/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245289 Y1	A. Building B. Wing Y2	3/25/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0431	Correction	ID Prefix F0465	Correction		
Reg. # 483.60(b), (d), (e)	Completed	Reg. # 483.70(h)	Completed		
LSC	03/16/2016	LSC	03/16/2016		

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

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/5/2016	☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245289	A. Building 01 - MAIN BUILDING 01 B. Wing	3/24/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CENTENNIAL GARDENS FOR NURSING & REHABILITATION	3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0027	Correction Completed 03/16/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 03/16/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 4/1/2016	SIGNATURE OF SURVEYOR 37009	DATE 3/24/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/2/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: RY1Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00255

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245289**

2. STATE VENDOR OR MEDICAID NO. (L2) **604140000**

3. NAME AND ADDRESS OF FACILITY (Crystal Care Center)
(L3) **CENTENNIAL GARDENS FOR NURSING & REHABILITATIC**
(L4) **3245 VERA CRUZ AVENUE NORTH**
(L5) **CRYSTAL, MN** (L6) **55422**

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) **12/20/2013**

6. DATE OF SURVEY **02/05/2016** (L34)

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

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

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

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

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

12.Total Facility Beds **130** (L18)

13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B 5** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(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):
Documentation supporting the facility's request for a continuing waiver involving K67 will be forwarded. Approval of the waiver request will be recommended. Refer to the CMS 2786R Provision Number K84 Justification Page. **This facility was previously known as Crystal Care Center.**

17. SURVEYOR SIGNATURE Date :
Kathy Sass, HPR-Dietary Specialist 03/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/30/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **11/01/1984** (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. **00325** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered
February 24, 2016

Ms. Annette Thorson, Administrator
Crystal Care Center
3245 Vera Cruz Avenue North
Crystal, MN 55422

RE: Project Number S5289027

Dear Ms. Thorson:

On February 5, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

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 March 16, 2016, 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 March 16, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (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 May 5, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 5, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245289	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CRYSTAL CARE CENTER	**3245 VERA CRUZ AVENUE NORTH CRYSTAL, MN 55422**

(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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		3/16/16

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

Electronically Signed | 03/07/2016

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) or uniform denial letter upon termination of all Medicare (MC) Part A skilled services for 1 of 3 residents (R136) reviewed for liability notice and beneficiary appeal rights. In addition, the facility failed to provide a list of services that would and would not be charged for 1 of 1 (R112) resident. Findings include: Medicare: R136's medical record was reviewed and revealed the Notice of Medicare Non-Coverage Effective letter indicated, "Date of your coverage (PT/OT) [Physical Therapy/Occupational	F 156	The policy and procedure regarding Medicare Part A non-coverage notices dated February 2015 was present in the building during the time of the survey. The policy and procedure has been provided to the staff issuing the notices and they have been re-instructed on the proper documentation regarding the notices, including when something is out of the ordinary. A copy of the revised charges has been mailed to R 122 family member by 2-26-2016. The revised charges form will be reviewed at the next resident council meeting on 3/2/2016. The Admissions Coordinator will deliver a copy of the list of	

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F 156	Continued From page 3 Therapy] Services will end: Th [Thursday] 12/3/15." The reason given for ending coverage was, "Your Medicare coverage will be ending. You have met your goals." R136 signed the letter on 12/2/15. The Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) dated 12/2/15, indicated "Option 2 NO" was checked indicating R136 choose not to receive these items or services and not to appeal facility opinion that Medicare would not pay for these services after 12/3/15. R136 signed the form on 12/2/15. During interview on 2/4/16, at 3:44 p.m. registered nurse (RN)-F said, "The time frame for denial notices is supposed to be at least 48 hours, I like to do them 72 hours to a week before their last covered day. [R136] got sick towards the end of stay with a sore throat. We were going to wait for [R136's] last covered day until [R136] came back from an ENT [ear, nose and throat] appointment. When [R136] got back from the appointment [R136] did not want to sign it that night. [R136] wanted to wait for his wife to be there. I did not document the discussion, it was 7:00 p.m. when [R136] came back." RN-F said; "I had my coat on so I waited to the next day and then prepared the forms." When asked was the denial given timely? RN-F replied, "it was not given timely." IDT (Interdisciplinary Team) note indicated Resident discharged 12/4/15, at 6:26 p.m. Medicare denial letter policy requested but not provided. Admissions: R112 was interviewed on 2/2/16, at 12:15 p.m. and when asked, "Did the staff give you a list of	F 156	services to all transitional care unit residents by March 1, 2016. The list of charges that the resident will and will not be charged for has been revised as of February 23, 2016 and will be reviewed monthly by the billing office for necessary updates. The list of chargeable services is included in all admission packets going forward. To monitor, the Director of Nursing or designee will audit the notices monthly and report on compliance at Quality Assurance committee monthly. As well, the facility administrator will audit monthly to ensure that charges are updated at least monthly and distributed to residents so that they remain advised and will report to the Quality Assurance Committee about this program. The facility alleges compliance 3-16-16	

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F 156	Continued From page 4 services and items that you would and would not be charged for?" The family member (F)-A that was present stated, "Not to my knowledge that I remember." During interview on 2/5/16, at 9:01 a.m. the business office manager (BOM) verified R122 was on Medical Assistance. The BOM said the list of services and items that the resident would and would not be charged for was in the admissions packet. "Admissions does the packet with the resident or family, it is then scanned to those who need it, and then brought down to the business office. There are several packets that did not make it to the business office. Prior to me starting in June 2015, the packets often went to medical records." R122 did not have an admissions record in the business office. During interview on 2/5/16, at 12:41 p.m. the executive director said, "I don't believe that they will find the record of admission. We had a different person who used to do this. She does not work here and the filing was not being done." Nursing Home Admission Agreement copyrighted 2014 indicated, "SERVICES INCLUDED IN BACIS (sic) CARE SERVICES MAY VARY BASED ON SOURCE OF PAYMENT Special services: These services are subject to change from time to time. Special Services available at the Facility include but are not limited to the following:"	F 156		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable	F 246		3/16/16

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F 246	Continued From page 5 accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R95) call lights were in reach in accordance with the care plan to prevent and/or minimize injury from falls. Findings include: During initial tour on 2/1/16, at 2:28 p.m. the observed call light was tucked into roll of toilet paper on top of R95's bedside table. Nursing assistant (NA)-I verified the call light was not within reach and placed it within R95's reach. R95's admission Minimum Data Set (MDS) dated 1/8/16, indicated R95 was moderately cognitively impaired. The MDS also noted R95 had the ability to comprehend others when spoken to, had clear speech and was able to express ideas and wants. R95's Incident Post Fall Scene Investigation Tool for fall on 1/10/16, indicated staff were alerted to a fallen resident by, "resident calling out and call light on." The report noted the resident fell during a self transfer. The Falls Care Area Assessment dated 1/14/16, indicated R95 had a history of a fall prior to admission resulting in a broken nose, a fall since admission and needed assist of one person with	F 246	Resident #95 has a new call light program which ensures that her call light will be available for her should she need it. Residents on each unit were reviewed to determine whether or not their call lights were available readily for their use to call and corrections made where necessary. Staff were trained on the new program for resident call lights and in-serviced about the importance of making sure residents can always reach their call lights to call for assistance. Therapy department was in-serviced on ensuring that resident call lights are placed within their reach following therapy services. A new program has been developed whereby nursing staff checks resident call lights on each round to ensure that they are available and within reach for residents. Staff members will document their reviews on the nurse aide assignment sheet. Additionally, therapy services will include giving the resident their call light switch upon returning them to their room from therapy as a matter of protocol.	

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F 246	Continued From page 6 transfers but does not always remember to ask and wait for assist. The fall care plan initiated 1/21/16, indicated R95 was high risk for falls related to being unaware of safety needs, confusion, psychoactive drug use, and gait balance problems. R95 needed assist with transfers and ambulation. R95 had a history of falls prior to admission and on 1/10/16, while self-transferring. R95's care plan interventions included, "Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance." During interview on 2/1/16, at 2:28 p.m. NA-I stated "[R95] does use call light, [R95] requires an assist to transfer." Facility undated Call Light Management policy instructs staff: "12. Staff is to position the call light button in a place that is convenient for the resident to reach and to advise the resident of its location." "16. On rounds, be sure call lights are not on the floor or out of reach of residents." An All Staff Meeting Minutes dated October 27 and 28, 2015, instructed staff: "Check for call cord placement in rooms-is it within reach of the resident at all times?"	F 246	The Unit Managers will audit 3 times weekly for four weeks and then monthly thereafter to ensure that the new program is running properly and that resident call lights are within their reach and staff members routinely evaluated it. The Director of Nursing will report on this program at the QA Committee. Facility alleges compliance with this program 3-16-16	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.	F 272		3/16/16

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F 272	Continued From page 7 A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 1 of 4 residents (R83) who was smoker at	F 272	Resident #83 has been placed on the smoking program and is due to discharge soon.	

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F 272	Continued From page 8 the time of admission reviewed for accidents. Findings include: On 2/1/16, at 8:00 p.m. R83 was observed smoking in front of the building on the sidewalk. On 2/2/16, at 9:47 a.m. during a tour to the smoking shack located behind the facility noted a brown hard covered plastic garbage can to the right of the shack. On the outside of the can cover were burn marks. Inside the garbage can were three Newport cigarette boxes that were burnt. There were multiple cigarette butts in the garbage can. There was a white paper napkin that had blackened edges in the trash can. The plastic garbage can was lined with a plastic bag. On the ground in the floorless smoking shack were 13 cigarette butts and on the ground around the trash can there were four cigarette butts. -At 10:30 a.m. during another tour to the smoking area with the maintenance staff (MS)-B removed the garbage can cover and verified the cover had burned marks stated "They [residents] are using it to put out the cigarettes." MS-B verified inside the can were multiple butts and there were four cigarette boxes that were burned. When asked if residents had been educated not to dispose cigarettes in the trash can MS stated as he pointed to the ash tray and indicated residents were supposed to dispose them there. MS-B also indicated though the boxes had been burned before being disposed inside the garbage can as the plastic can liner was not burnt. MS stated the area was a resident smoking area only. The admission Minimum Data Set (MDS) dated 11/23/15, indicated R83 did not smoke (The facility had prior knowledge of R83's smoking as	F 272	Residents who smoke at the facility have been reviewed and added to the new smoking program. All other residents have been reviewed to ensure they are not smoking without the new program. Staff members were in-serviced by 2-24-16 on the new resident smoking program and the necessity of advising Social Services so a thorough smoking assessment can be conducted. In the absence of Social Services, nursing staff are trained to conduct the smoking assessment. Based on the new program, if a resident is admitted and decides they wish to smoke after admission, the facility immediately institutes the new smoking program which includes a thorough smoking assessments conducted by Social Services. The Director of Social Services and Executive Director will audit for signs of resident smoking in all areas of residential living in the facility during routine rounds (daily) or their designees on weekends or when they are not at the facility. Any resident smoking occurring will be managed as per the new smoking policy and program. Additionally, the Executive Director will conduct an audit weekly for four weeks and then monthly thereafter of resident charts via PCC to ensure that resident smoking assessments are being	

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F 272	Continued From page 9 the admission MDS completed 5/11/15, noted the resident use tobacco products). During review of the medical records for R83 no smoking assessment was observed in both the paper and electronic records. In addition, R83 did not have a care plan that addressed the smoking yet the facility was aware R83 was a frequent smoker as identified by the previous MDS dated 5/11/15. On 2/2/16, at 11:06 a.m. health unit coordinator (HUC)-A verified after going through the entire medical record a smoking assessment had not been completed since resident had been admitted on 11/16/15. HUC-A stated a different social worker was working at the facility at the time R83 had been admitted and directed surveyor to follow up with the director of social service. On 2/2/16, at 11:18 a.m. when asked if all R83 was supposed to be assessed, the director of social services (DSS) stated "Not necessary he is not supposed to smoke and knows we are not a smoking facility. I can't say yes or no. We are looking for a smoking facility for him." When asked again if R83 was supposed to have been assessed since the facility knew he was a smoker, DSS stated "We are aware he is smoking and an assessment was not done but he has been looked at when he is smoking. He is aware of his cigarettes and able to handle the cigarettes. We don't want to go far when we know he is able to do it independently." DSS verified R83 had not been assessed and no care plan had even been developed even though the facility was knowledgeable of resident going outside to smoke. On 2/2/16, at 11:25 a.m. stated DSS smoking	F 272	completed as per policy and procedure. The Executive Director will report to the Quality Assurance Committee monthly on this program. The facility alleges compliance with this program by 3-16-16.	

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assessment was supposed to be done on admission and then reviewed during care conferences as there was no requirement.

On 2/5/16, at 12:16 p.m. when asked about if an assessment was supposed to have been completed as directed by the facility policy the direct of nursing (DON) stated a resident had the right to refuse to be asked questions. When asked if R83 was supposed to have been evaluated DON stated resident was non-complaint and the facility was in the processes of getting resident to a different setting. When asked if there should have been documentation of resident refusing the smoke assessment, DON was not able to respond to the question and again continued to state R83 was non-complaint. When told what the facility policy directed, DON stated the facility was going to not allow residents that smoked but was having a problem with hospitals not being forth right with the issue.

On 2/5/16, at 12:34 p.m. when asked if all residents in the facility who were known smokers were supposed to be assessed as directed by the facility policy, which included upon admission, the executive director (ED) stated "Yes. I talked to [DSS] and I guess we were not on the same understanding about the policy."

Smoking policy dated 4/1/15, directed:
2. Smoking areas will be provided with metal containers equipped with self self closing covers to be used solely for the disposal of cigarette butts and ashes.
a. A sign to that effect will be posted on the containers
b. All cigarette and other smoking materials will

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be promptly disposed of in these containers and are not allowed to be discarded elsewhere on the Crystal Care Center grounds...

C. Staff is responsible for ensuring that smoking by "grandfathered in" residents is done in a safe manner.

1. Residents will be allowed to smoke and use smoking materials only as specified in their care plan.

2. Residents who smoke will be evaluated for the ability to smoke safely and independently. This evaluation will be performed upon admission within 24 hours of admission and demonstrates that the resident is able to smoke safely to use the lighter, safely handle lit smoking material, and demonstrates safe smoking behavior. This will be done by a social worker, or if not during social service work hours, by a nurse. The assessment includes cognitive ability to make good judgements, and physical mobility to get to a smoke area.

a. These residents will be reevaluated on at least a quarterly basis, or more frequently as dictated by any significant changes in condition...

7. Residents who do not comply with the smoking policy or who persist in smoking even when unsafe will be given an appropriate transfer notice to another setting and if needed, will be supervised by family members or staff while waiting for their transfers."

The MDS 3.0 manual dated 10/15, defined for staff that "TOBACCO USE Includes tobacco used in any form." In addition, the manual directed staff to assess the resident by "1. Ask the resident if he or she used tobacco in any form during the 7-day look-back period.

2. If the resident states that he or she used

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 12 tobacco in some form during the 7-day look-back period, code 1, yes." And finally the facility was to implement "Planning for Care · This item opens the door to negotiation of a plan of care with the resident that includes support for smoking cessation. · If cessation is declined, a care plan that allows safe and environmental accommodation of resident preferences is needed." R83 was not comprehensively assessed for smoking.	F 272		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 279	Resident #77 and #35 have been	3/16/16

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F 279	Continued From page 13 review, the facility failed to develop a care plan for 2 of 3 residents (R77, R35) observed with bruising reviewed for non-pressure related skin conditions. Findings include: R77's diagnoses included long term (current) use of Aspirin (a mild analgesic), age related osteoporosis and anxiety obtained from Admission Record dated 2/4/15. On 2/1/16, at 7:05 p.m. during interview, resident was observed with a quarter size bruise on left arm above the wrist. When asked how she had sustained the bruise, resident stated the nurse had told her she may have bumped herself on something "but I don't remember." The resident was also observed with fading old bruises on the right posterior forehand by the thumb. R77's quarterly Minimum Data Set (MDS) dated 12/30/15, indicated R77 had intact cognition. Pressure ulcer Care Area Assessment (CAA) dated 7/2/15, indicated resident had a minimal risk for pressure ulcers as she is able to make frequent purposeful position changes. The CAA directed staff to check resident skin weekly with showers. R77's care plan dated 10/6/14, indicated resident had an activities of daily living (ADL) self-care performance deficit and indicated staff was to assist with bathing and applying lotion. Both the CAA and care plan did not indicate the resident received Aspirin and had the potential to bruise. On 2/3/16, at 3:23 p.m. registered nurse (RN)-A nurse manager verified there was no	F 279	evaluated by a physician for their bruising. They have also had their care plans updated. Residents have been reviewed for bruising and interventions placed where bruising has been found. Additionally, resident care plans have been reviewed and updated to match their needs. Nursing has been in-serviced on the necessity of proper interventions for bruising and care planning that matches those interventions as stated below in the new program. Residents will be examined routinely for bruising including daily during cares and weekly during showers. When bruising is found, the Unit Manager will be notified if on duty; if not on duty, the nursing supervisor will be notified and the program for injuries of unknown origin will be instituted immediately. Where sources of bruising are discovered, a care plan intervention will be initiated for that resident within (24) hours. Where the bruise is considered an injury of unknown origin, that program will be followed through with and a specific care plan intervention written for a bruise as an injury of unknown origin. The IDT will review all bruises and care plan interventions to ensure proper management of bruises. The Director of Nursing or her delegate will audit resident skin reviews for bruising and the management of bruises	

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F 279	Continued From page 14 documentation in the medical record regarding any bruises including on the weekly skin checks that had been completed. RN-A stated she was going to talk to the evening nurse to assess her. RN-A stated she expected staff to report any bruising immediately to make sure they were assessed. RN-A further stated reporting bruises was addressed on all meetings with staff. RN-A stated acknowledged the care plan should have addressed R77 was on Aspirin and had the potential to bruise. When asked who developed the resident's care plans, RN-A stated the MDS nurses did. -At 3:25 p.m. surveyor and RN-A went to room observed R77 seated on her wheelchair. RN-A approached R77 and verified the bruises and R77 stated about three days ago she had noticed the bruise which caught her by surprise and at the time a female nurse indicated she probably may have bumped on something but she did not remember. The resident indicated at times she got bruises as she was pointing to the right thumb that had an old purple bruise but was not sure the cause. On 2/4/16, at 9:12 a.m. the director of nursing (DON) stated any skin concerns were supposed to be reported to the wound nurse and her which included unexplained bruising, or any other changes and staff were to look at the resident medical history to find the cause of the bruise. DON acknowledged the nurse who had observed R77's bruise should have documented it and reported it to the nurse manager immediately. R35's diagnoses included end stage renal disease, anemia in chronic kidney disease, vitamin D deficiency, dementia, and heart failure obtained from Admission Record dated 2/4/15.	F 279	discovered weekly for four weeks and then monthly thereafter. The Director of Nursing will report on this program monthly to the Quality Assurance Committee. The facility alleges compliance 3-16-16.	

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F 279	Continued From page 15 On 2/3/16, at 7:26 a.m. during an interview R35 was observed with bruises on top of right and left hands. When asked how it happened R35 said, "I do not know." On 2/4/16, at 10:24 a.m. R35 was observed walking to bible study with bruise top of right and left hand that was dark purple in color. R35 said it must have happened during blood draws at dialysis. The Admission Admit Assessment dated 1/2/16, indicated bruising left hand 7 x 4 centimeter (cm.) and bruising right hand 7 x 6 cm. A review of the Nursing Notes dated 1/5/16, through 2/3/16, revealed there was no documentation on the bruises. In addition, review of weekly Nurse Bath Skin Check assessments revealed on 1/15/16, and 1/22/16, it had been documented resident had refused weekly bath and weekly skin check was not completed. Copy of all Nurse Bath Skin Checks since admission requested but not provided. R35's admission MDS dated 1/12/16, indicated R35 had moderately impaired cognition. R35's care plan dated 1/26/16, indicated resident had history of diabetic ulcer of the feet and indicated staff was to complete weekly skin assessments with weekly bath. The care plan did not indicate resident received Plavix (used to prevent blood clots) and had the potential to bruise easy. During review of R35's February Electronic Medication Record (EMAR) it was revealed resident was received Plavix 75 milligrams (mg) by mouth in the morning for congestive heart failure.	F 279		

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F 279	Continued From page 16 During review of R35's February Electronic Treatment Record (ETAR) it was revealed resident was to receive a head to toe skin and body assessment every week. During interview on 2/4/16, at 10:48 a.m. RN-C when asked about the bruises on top of R35's hand said, "I was not aware of the bruises. I will follow up." - At 11:21 a.m. RN-C reported the results of investigation. Physical Therapy (PT) said it had been there almost a month. I did not know about. PT thought it was just a discoloration. - At 2:30 p.m. RN-E verified should have every shift monitoring for bruises and a care plan. RN-E verified Plavix was not on the care plan and should be. - At 2:56 p.m. RN-C said the nurses should monitor bruises every shift and document every shift on the TAR If a bruise was on admission assessment it should have been put on the temporary care plan, a progress note written, and the nurse should have put a monitoring order in the computer. RN-C verified staff do not have every shift monitoring for her. RN-C verified there was no care plan for the bruises and would expect staff to have done a care plan. Verified there was no care plan for risk of blood thinners or Plavix. - At 3:24 p.m. RN-D said, "If I knew about a bruise on a residents admission I would care plan it until resolved. I think we care plan Coumadin, (blood thinner) I do not think so for Plavix. Plavix has a risk for bruising." - At 3:33 p.m. RN-F said, "I review the chart to see if there is an issue. The nurses on the floor do the immediate plan of care. I would not necessarily care plan bruises if it was noted on	F 279		

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F 279	Continued From page 17 day one depending on where it is and if it is resolving on its own. It is not necessarily care plan Plavix, I tend to notice Coumadin rather than Plavix. In [R35's] case they are looking at her arms quite often because of dialysis. They do skin assessments with weekly baths. Bruises should be noted on skin assessment. The documentation dated 1/11/16, the skin assessment does not mention any bruising. The skin care plan only has history of diabetic foot ulcers. I think of the Coumadin not the Plavix." Crystal Care Center Care Plan Policy and Procedure dated 6/15, instructed staff: "8. The care plan is to be changed and up dated as the care changes for the resident and as the resident changes (any temporary problems will be added to comprehensive care plan if no resolution in 30 days). It is to be current at all times...."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280		3/16/16

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F 280	Continued From page 18 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise a care plan for safe smoking for 1 of 4 residents (R34) reviewed for accidents. Findings include: R34's quarterly Minimum Data Set (MDS) dated 12/23/15, indicated resident had moderately impaired cognition. In addition the MDS indicated resident diagnoses include dementia without behavioral disturbances, peripheral vascular disease, difficulty walking and chronic obstructive pulmonary disease. R34's smoking care plan dated 3/31/14, indicated R34 had chosen to smoke daily, was able to take himself outside, safely handle, light and dispose of cigarettes and materials and R34 had been found smoking out front. The care plan directed "Cigarettes kept at south nurses desk and given one at a time with reminder to smoke in back of facility. Remind him to smoke in the designated area back of facility. He tends to smoke only part of a cigarette and put the rest back in his pack. [R34] is aware of the risks of putting out cigarettes and putting in his pocket. Smoking assessment completed according to policy..." The care plan had not been revised to reflect R34 handled/stored all the tobacco supplies.	F 280	On 2/16/2016 the Director of Social Services met with R34 and his son regarding issues related to smoking. R34 now has a revised safe smoking care plan. Residents who smoke were evaluated to determine if any needed a revised safe smoking care plan and when necessary, this was accomplished. Residents were also advised that smoking is prohibited in front of the facility as of 2-22-16. All staff were in-serviced regarding the smoking policy and procedure on 2/23 and 2/24. Nursing and social service staff will be in-serviced regarding the care planning policy and procedure by March 15, 2016. The executive director or designee will audit weekly for four weeks and then monthly thereafter that care plans are prepared for residents who smoke and that appropriate updates for safe smoking are being accomplished within seven (7) days. The Social Services Director will report on	

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F 280	Continued From page 19 R34's Visual Function Care Area Assessment (CAA) dated 4/1/15, indicated R34 had impaired vision, had left eye blindness from old retinal detachment, wore glasses and was able to read newspaper. On 2/2/16, at 10:27 a.m. R34 was observed sleeping, held a lighter in his right hand and a whole cigarette was lying on the lap to the right as he sat on the wheelchair (w/c) by the main lobby. No burn holes were observed on the clothing. At 4:20 p.m. R34 was observed at the main lobby and inside his shirt pocket was a box of cigarette and a lighter. On 2/2/16, at 11:25 a.m. the director of social services (DSS) stated he thought the smoking assessment was completed annually and indicated resident was a known smoker and should have one in the medical record. DSS added R34 smoking was reviewed during each care conference. DSS reviewed all the assessments in R34's both the paper and electronic medical records verified the last assessment had been completed in 5/11/12. On 2/3/16, at 1:30 p.m. during a random observation resident was observed at the front lobby reading the newspaper and a box of cigarette and lighter were observed stored in the shirt pocket. On 2/4/16, at 3:11 p.m. when asked if he knew where resident smoking supplies were stored licensed practical nurse (LPN)-G stated he did not know and stated would find out and then thought probably the nurse manager or DSS would know. -At 3:19 p.m. when asked where R34's smoking	F 280	this program monthly to the Quality Assurance Committee. The facility alleges compliance by 3-16-16.	

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F 280	Continued From page 20 supplies were stored, DSS verified R34's care plan was not accurate of the storage as R34 kept his own supplies on him as the family was not supportive of the facility policy and would bring R34 cigarettes and hand them to resident during visits. DSS further stated because of lack of support from the family it was difficult to reinforce the facility smoking policy. DSS further stated R34 had been observed smoking no concerns had been identified even though resident had vision problems and had been known to smoke in the front of the building and not in the designated smoking area at the back. On 2/5/16, at 8:34 a.m. when approached and asked where he smoke resident stated he smoke in the front of the building. When asked why, the resident stated he knew he was supposed to smoke in the back shack however he did not like the fact that he had to stand up from his wheelchair to open the doors to the back. When asked where he disposed the cigarette butts after resident then reached to his front pocket retrieve a box of cigarettes and showed surveyor stated he was not really a smoke as such and when he was done because the ones he used did not have a filter he would open the seam and blew the tobacco into the air. When asked if he had any problems with handling his smoking supplies resident stated "I have smoked for years and am good with this" as he smiled. No burn holes observed on the clothing. - At 12:22 p.m. when asked if a smoking assessment was supposed to be done for residents who had been grandfathered the director of nursing stated "yes." The director of nursing acknowledged the resident's care plan should have been revised to reflect the current plan of care.	F 280		

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F 280	Continued From page 21 - At 12:34 p.m. when asked if all residents in the facility who were known smokers were supposed to be assessed as directed by the facility policy the executive director (ED) stated "Yes. I talked to [DSS] and I guess we were not on the same understanding about the policy." Smoking policy dated 4/1/15, directed: "C. Staff is responsible for ensuring that smoking by "grandfathered in" residents is done in a safe manner. 1. Residents will be allowed to smoke and use smoking materials only as specified in their care plan. 2. Residents who smoke will be evaluated for the ability to smoke safely and independently. This evaluation will be performed upon admission within 24 hours of admission and demonstrates that the resident is able to smoke safely to use the lighter, safely handle lit smoking material, and demonstrates safe smoking behavior. This will be done by a social worker, or if not during social service work hours, by a nurse. The assessment includes cognitive ability to make good judgements, and physical mobility to get to a smoke area. a. These residents will be reevaluated on at least a quarterly basis, or more frequently as dictated by any significant changes in condition ..."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by:	F 281		3/16/16

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F 281	Continued From page 22 Based on observation, interview and document review, the facility failed to develop an initial care plan to include smoking safety for 1 of 1 resident (R144) who was newly admitted and was observed smoking since admission to the facility. Findings include: During an observation on 2/5/16, at 12:13 p.m., R144 was observed propelling himself in front of the entrance to the facility. R144 skidded to a stop on the sidewalk and dropped a pack of cigarettes on the ground at which time an unidentified individual walking up the sidewalk was noted to assist R144 to pick up his cigarette and assist him with a lighter. R144 admitted to the facility on 2/3/16. His Admission History and Physical dated 2/2/16, indicated he suffered from weakness as well as poor coordination and control of right arm and leg. The history and physical further indicated R144 had a 20 year pack history of smoking and reported he had been smoking cigarettes. A facility assessment labeled NUR [nurse] Q Shift Post Admit Charting, dated 2/5/16, indicated R144 required extensive assist for transfers, was alert to person only, and was at risk for falls. A review of Crystal Care Center Progress Notes indicated on 2/3/16, R144 was noted by staff "walking and wanting to leave the facility." The note further indicated R144 was found on the floor inside the front entrance of the facility the same evening while attempting to go outside and smoke a cigarette. While Progress Notes indicated staff was aware of R144's desire to smoke, and that R144 had fallen in the facility attempting to go outside and smoke, there was	F 281	Resident #144 has had her plan of care for smoking updated. Residents were evaluated to determine if any other resident was missing a plan of care for smoking. Where any errors were discovered, corrections were made. Residents were also advised that as of 2-22-16, smoking is prohibited in front of the facility. Staff members were in-serviced on the importance of ensuring that initial plans of care for residents are complete and reflect the highest practical level of services being given. The Director of Nursing or her designee will evaluate all new admissions to ensure that an acceptable plan of care has been initiated shortly after admission, including a care plan problem for smoking if appropriate for each resident. As part of the weekly IDT meeting, newly admitted residents will be reviewed by the IDT committee to ensure that proper initial plans of care were initiated. This review will be documented in the IDT administrative file. The Director of Nursing will report to the Quality Assurance Committee on this program monthly. The Facility alleges compliance on 3-16-16.	

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no evidence the facility developed and implemented interventions to decrease the risk of falls for R144 related to smoking.

R144's care plan dated 2/4/16, identified R144 at risk for falls but did not identify smoking as a causative factor even though R144 had fallen while attempting to exit the facility to smoke a cigarette nor did they implement interventions to reduce the risk of falls.

During an interview on 2/5/16, at 12:30 p.m., the executive director (ED) stated R144 should have a Wanderguard to alert staff if he was attempting to leave the facility to smoke. ED further stated R144 was "not in any way shape or form able to be outside by himself."

During an interview on 2/5/16, at 1:10 p.m., the director of social services (DSS) stated the facility was a non-smoking facility and if a resident was identified to be smoking, staff was to take the resident's cigarettes away and call family. He further stated if a resident wishes to smoke, they had to move to another facility. The DSS stated there were no residents currently in the facility that were deemed unsafe to smoke so safety interventions had not been addressed in regard to accident prevention related to smoking.

A facility policy titled Crystal Care Center Care Plan Policy And Procedure, dated 6/15, indicated, "It is the policy of Crystal Care and Rehabilitation Center to provide a temporary care plan within 24 hours of admission." The care plan would ensure the appropriate care required to maintain or attain the resident the highest level of practicable function possible.

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F 282	Continued From page 24	F 282		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, facility failed to follow the plan of care for 1 of 3 residents (R112) reviewed for activities of daily living (ADLs), 1 of 4 residents (R75) reviewed for pressure ulcers and 1 of 4 residents (R93) reviewed for smoking safety. Findings include: Oral cares: R112's care plan with revision date 11/9/15, identified R112 to have self-care performance deficit due to dementia and confusion, does follow some direction, is friendly and non-resistant and directed staff to anticipate needs as she cannot state them. Interventions included "extensive assist 1 staff brushes teeth" and "will see dentist per family wishes." During continuous observation on 2/3/16, from 11:11 a.m. to 11:49 a.m. nursing assistant (NA)-A and NA-B were observed to assist R112 with morning cares. NA-A cleaned R112's face and provided peri cares. After transferring R112 to her wheelchair, NA-A combed her hair and put on her shoes. NA-A put dirty clothing and bedding into the plastic bags emptied the wash basin, put new plastic bag into waste container and stated "I am	F 282	Residents #75, 93, and 112 have had their care plans reviewed by the IDT and updated. Care for these residents has also been reviewed across (3) shifts to ensure that staff members caring for them are meeting all the requirements of their updated care plans. Residents were reviewed to ensure that those with care plan interventions for smoking, pressure ulcers, and ADLs were receiving care specifically in accordance with those care plan interventions. Staff were in-serviced on the new programs care plan approaches and programs in this tag by 3-16-16. In accordance with the IDT, the Unit Managers have developed a care checklist (Care Plan Monitoring Form - CPMF) that includes all those residents who are care planned for pressure ulcer interventions, ADL interventions, and safe smoking interventions. Based on this program, the unit manager, or her designee, verifies with nursing staff across each (24) hour period that these	3/16/16

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F 282	Continued From page 25 done." NA-A did not offer or assist R112 with oral cares. During interview on 2/2/16, at 12:00 p.m. family member (F)-A stated that she did not think staff were taking the time with her mother's oral care, further stating "I don't believe they are doing it, her gum line has plaque." During an interview on 2/3/16, at 11:50 a.m. NA-A verified that no oral cares were offered or completed. NA-A stated "I forgot." During interview on 2/3/16, at 11:55 a.m. registered nurse (RN)-C verified oral care should have been done and stated "the care plan outlines what they should do." Review of the Crystal Care Center Care Plan Policy and Procedure dated 6/15, indicated the care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible, however, did not direct staff to follow the care plan. ADLs: On 2/3/16, during continuous observation from 9:24 a.m. until 12:38 p.m. -9:30 a.m. Staff observed wheeling R75 toward the dining room. -9:32 a.m. R75 sitting in dining room in wheelchair. ROHO cushion not visible in wheel chair. -10:16 a.m. R75 wheeled self out of dining room. -10:23 a.m. Staff wheeled R75. R75's ROHO (a specialty cushion used to reduce pressure) cushion was lying in his sitting chair by the window another surveyor present and verified.	F 282	care plan interventions have been met. The checklist is marked by the Unit Manager or designee to verify that specific care in these (3) areas was done as designated by the care plan. The Director of Nursing or her designee will audit weekly for four weeks and monthly thereafter (5%) of residents on this program to ensure that they are being checked-off on the Care Plan Monitoring Form (CPMF) and that the care designated as per care plan is being performed. The Director of Nursing will report monthly to the Quality Assurance Committee about this program. The Facility alleges compliance on 3-16-16.	

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F 282	Continued From page 26 R75 was sitting in wheelchair next to bed. -11:04 a.m. NA-G made R75's bed. ROHO cushion remains in chair (not wheel chair). -11:17 a.m. NA-G wheeled R75 to the dining room. The ROHO cushion remained in resident room No ROHO cushion or any other type of cushion visible in chair. -11:57 p.m. R75 wheeled self out of the dining room. -12:07 p.m. NA-G met R75 in hall and wheeled him to his room. -12:13 p.m. LPN-D notified by surveyor that R75 had not been repositioned since 9:24 a.m. -12:30 p.m. LPN-D, NA-G, and NA-H entered R75's room. LPN-D asked R75 if he had a cushion under him in his chair. R75 said, "No." NA-G and NA-H stood R75 up using a standing lift. LPN-D verified there was no ROHO cushion under him. LPN-D and NA-H pulled down R 75's pants and removed incontinent product. LPN-D verified outer buttocks non blanchable. R75 had a medium soft brown bowel movement present on in continent pad. NA-H wiped bottom removed gloves and put on new gloves. NA-H applied incontinence brief and pulled up R75's pants. NA-G put ROHO cushion in wheelchair. NA-G said (R75) was supposed to be up one hour after lunch and lowered R75 back into wheelchair. The NAs finished cares at 12:38 p.m. NA-G stated would return at 1:00 p.m. to placed (R75) in bed. Urinary Incontinence Care Area Assessment (CAA) dated 12/21/15, indicated R75 had a diagnosis of dementia with mild to moderate cognitive loss, recent fall with right hip fracture, a history of a stroke, diabetes and end stage renal disease with dialysis. R75 needed assist of one to two staff to transfer on and off the toilet and assist of one staff to use a urinal. R75 was frequently	F 282		

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incontinent of bowel and bladder and had decreased awareness of toileting needs. Staff were to check and change every two hours and offer toileting and/or urinal.

Care plan revised on 1/3/16, indicated R75 had a stage three pressure ulcer on coccyx. Development related to increased dependence with all mobility and severe peripheral neuropathy. Diagnosis of hidradenitis supportive (boil like skin infections) on buttocks. Care plan interventions included, administer treatments as ordered and monitor for effectiveness. "Assess/record/monitor wound healing weekly: Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD [medical doctor],The resident needs (SPECIFY: monitoring/reminding/assistance) to turn/reposition at least every 2 hours, more often as needed or requested. The resident needed encouragement, assistance, with use of bed rails, for resident to assist with turning. The resident Requires Pressure relieving/reducing device on bed: LAL mattress on bed and ROHO cushion in w/c [wheel chair]. Send ROHO with to dialysis."

Nursing assistant assignment sheet dated 2/2/16, indicated R75 was to be turned and repositioned every two hours and receive assist of one with the urinal.

During interview on 2/3/16, at 11:04 a.m. in R75's room NA-G said, "I am just going to make his bed. He is not going to lie down now, not until after lunch." NA-G did not offer to reposition resident, check incontinence product or to assist R75 to use the urinal.

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F 282	Continued From page 28 - At 12:07 p.m. NA-G said, "He is an assist of two so I have to wait for [NA-G]. He has a sore on his bottom so he is an every two hour reposition. I don't know what time he got up. I did not get here until 9:30 a.m." - At 2:26 p.m. LPN-D said (R75) usually likes to go to bed right after a meal but we need to have him sit up for about an hour. Being up longer than two hours could cause further breakdown of wound and other areas of bottom. - At 2:38 p.m. registered nurse (RN)-G said, "My expectation is that they are to reposition him every two hours like their care sheet." Policy and Procedure For the Prevention and Treatment of Skin Breakdown dated 2010, indicated "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care." R75 did not receive the care and services as directed by the care plan for toileting, repositioning, and placement of the ROHO cushion. Smoking: R93 was observed sitting outside in the smoking shack behind the facility on 2/1/16, at 12:30 p.m. R93 was smoking a cigarette with a long gray ash attached to it. A few gray ashes were on the front of R93's purple fleece jacket. No holes were observed in R93's clothing. There were three chairs in the smoking shack and two metal ash trays. Ten cigarette butts were on ground in shack. On 2/2/16, at 9:47 a.m. during a tour to the	F 282		

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smoking shack located behind the facility with another surveyor a brown hard covered plastic garbage can was observed to the right of the shack. On the outside of the can top were burn marks. Inside the garbage can were three Newport cigarette boxes that were burnt. There were multiple cigarette butts in the garbage can. There was a white paper napkin that had blackened edges in the trash can. On the ground in the smoking shack there were 13 cigarette butts and on the ground around the trash can there were four cigarette butts.

During a random observation on 2/3/16, at 10:14 a.m. R93 was observed sitting in the lobby on 1st floor wearing a green poncho that covered R93 and the back of R93's wheelchair. There were three small circular holes on the front of the poncho.

On 2/5/16, at 8:30 a.m. observed R93 smoking in smoking shack. R93 had ash on gray fleece coat R93 brushed the ash off. R93 said I do that when they (ashes) fall. They are not hot, just dead ashes. Her gray pants had a two centimeter hole on right leg. R93 said that happened a long time ago in my van.

R93 smoking care plan dated 8/14/13, indicated R93 had chosen to smoke daily, could take self-outside, safely handle, light and dispose of of cigarettes and materials. R93 was responsible for smoking materials and will not lend or give them to others. The care plan directed, "Explain smoking policy as needed observe and document any unsafe incidents and/or burns, marks on clothing or skin. May keep smoking materials in room. Update MD [medical doctor]/NP [nurse practitioner] and family of any changes in

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F 282	Continued From page 30 smoking or if inappropriate smoking occurs. Smoking assessment completed per policy." During interview on 2/3/16, at 9:00 a.m. director of social services (DSS) said, "We do not do a smoking assessment, just review policy at care conference." During interview on 2/3/16, at 2:53 p.m. DSS said facility is smoke free except for people grandfathered in. Facility went smoke free before I started in November of 2014. Residents grandfathered in are not subject to the policy. New admissions are offered a nicotine patch, I let them know they cannot smoke on property, review policy and offer to find them a place where they can smoke. New residents can smoke if not on property. We do not recommend it. How I look at it is we review it prior to care conference. R93 is grandfathered in. There is no documentation that I witnessed her smoking but I do it. Criteria to determine if a resident is smoking safely includes handling cigarettes safely, when smoking not falling asleep, dispose of cigarettes in appropriate container, no long ash, no burns on fingers or clothing. Smoking in appropriate place (R93) is not always found smoking in the shack. Staff will tell me about it because it will be after we leave. Staff does not document or fill out an incident report. I have never personally caught her smoking out front. I have never seen ash on her clothing, never noticed holes in front of cape or other clothing. I have never seen her fall asleep while smoking. I don't know who is leaving all the butts on the ground by the smoke shack. Staff should tell me. Residents would lose their privileges if we are looking at something significantly unsafe like burning themselves or starting a fire.	F 282		

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F 282	Continued From page 31 During interview on 2/4/16, at 8:55 a.m. R93 said, "Yes sometimes I get ash on my clothing. I have gotten burns on my clothing but it has been a couple of months. It happens when I smoke in my van. There is a entrance ramp that is bad and can cause the cigarette to fall or a live spark to fall. We recently got a new van so that should not be a problem." I have never dropped a cigarette on myself when I have been smoking here. I sometimes smoke out front at night. The door by the smoking shack is locked at 9 p.m. so it is safer to go out front if I want to smoke in the winter." During interview on 2/04/16, at 8:59 a.m. RN-A if (R93) says something there are facts from her own perspective and experience. She is a woman of clear thinking when it comes to her own thoughts. I see little black tiny pin marks but not a burn hole. She smokes outside and in her van when she goes with her son. I would think every assessment should be documented somewhere. On 2/5/16, at 12:22 p.m. when asked if a smoking assessment was supposed to be done for residents who had been grandfather the director of nursing (DON) stated, "yes." DON acknowledged resident care plan should have been revised to reflect the current plan of care. R93 did not receive the services according to the care plan as the facility did not monitor unsafe smoking. Smoking policy dated 4/1/15, directed: 2. Smoking areas will be provided with metal containers equipped with self-closing covers to be used solely for the disposal of cigarette butts and ashes.	F 282		

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F 282	Continued From page 32 a. A sign to that effect will be posted on the containers b. All cigarette and other smoking materials will be promptly disposed of in these containers and are not allowed to be discarded elsewhere on the Crystal Care Center grounds... C. Staff is responsible for ensuring that smoking by "grandfathered in" residents is done in a safe manner. 1. Residents will be allowed to smoke and use smoking materials only as specified in their care plan. 2. Residents who smoke will be evaluated for the ability to smoke safely and independently. This evaluation will be performed upon admission within 24 hours of admission and demonstrates that the resident is able to smoke safely to use the lighter, safely handle lit smoking material, and demonstrates safe smoking behavior. This will be done by a social worker, or if not during social service work hours, by a nurse. The assessment includes cognitive ability to make good judgements, and physical mobility to get to a smoke area. a. These residents will be reevaluated on at least a quarterly basis, or more frequently as dictated by any significant changes in condition... 7. Residents who do not comply with the smoking policy or who persist in smoking even when unsafe will be given an appropriate transfer notice to another setting and if needed, will be supervised by family members or staff while waiting for their transfers."	F 282		
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		3/16/16

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F 309	Continued From page 33 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify non-pressure related skin conditions for 3 of 3 residents (R77, R96, R35) with observed bruising reviewed for non-pressure related pressure conditions. In addition, the facility failed to ensure coordination of hospice care for 1 of 1 residents (R57) who was receiving hospice care. Findings include: R77's diagnoses included long term (current) use of Aspirin, age related osteoporosis and anxiety obtained from Admission Record dated 2/4/15. On 2/1/16, at 7:05 p.m. during interview, resident was observed with a quarter size bruise on left arm above the wrist. When asked how she had sustained the bruise, resident stated the nurse had told her she may have bumped herself on something "but I don't remember." Resident was also observed with fading old bruises on the right posterior forehand by the thumb. R77's quarterly Minimum Data Set (MDS) dated 12/30/15, indicated R77 had intact cognition. Pressure ulcer Care Area Assessment (CAA) dated 7/2/15, indicated resident had a minimal	F 309	Residents #35, 77, and 96 have been evaluated by a physician for their bruising and changes made to their blood thinning medications as necessary. Their care plans have also been updated. Resident #57 was also seen by a physician and her hospice program was re-evaluated and re-instituted. Residents facility-wide have been evaluated for bruises and interventions instituted where found. Additionally, nursing management has obtained a list of anticoagulant (blood thinner) agents in order to identify those residents who are at risk for bruising. Interventions have been incorporated into their care plans and nursing staff is working with those residents accordingly. Residents were re-evaluated to determine if any would need or require the services of hospice. Where hospice services exist for residents, the nature and quality of that care was re-assessed and corrected where necessary. Nursing staff has been in-serviced on the	

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F 309	Continued From page 34 risk for pressure ulcers as she is able to make frequent purposeful position changes. The CAA directed staff to check resident skin weekly with showers. R77's care plan dated 10/6/14, indicated resident had an activities of daily living (ADL) self-care performance deficit and indicated staff was to assist with bathing and applying lotion. Both the CAA and care plan did not indicated resident received Aspirin and had the potential to bruise easy. On 2/3/16, at 3:23 p.m. registered nurse (RN)-A nurse manager verified there was no documentation in the medical record regarding any bruises including on the weekly skin checks that had been completed. RN-A stated she was going to talk to the evening nurse to assess her. RN-A stated she expected staff to report any bruising immediately to make sure they were assessed. RN-A further stated reporting bruises was addressed on all meetings with staff. -At 3:25 p.m. surveyor and RN-A went to room observed R77 seated on her wheelchair. RN-A approached R77 and verified the bruises and R77 stated about three days ago she had noticed the bruise which caught her by surprise and at the time a female nurse indicated she probably may have bumped on something but she did not remember. Resident indicated at times she got bruises as she was pointing to the right thumb that had an old purple bruise but was not sure the cause. R96's bruises of unknown cause were not assessed. On 2/1/16, at 7:16 p.m. R96 was observed seated on the wheelchair by the nursing station wearing	F 309	importance of identifying and evaluating based on root cause analysis resident bruises and about reporting them in a timely manner based on the new policy. They have also been in-serviced on the new Resident Bruise Management Program explained below. Nursing staff was also in-serviced on the requirements for ensuring that residents who require hospice services receive them in a timely manner and that they are conducted according to the proper standard of practice. Crystal Care Center has initiated a new Resident Bruise Management Program that involves the following steps: 1. Evaluating residents for pharmaceutical or treatment causes for bruising such as anti-coagulant therapy or blood draws per phlebotomy. These residents will receive treatment according to the nature of the bruise and required manner of treatment. Care planning and follow-up documentation will be completed. 2. Residents will have their skin evaluated routinely during daily care and weekly showers to assess for skin concerns including bruising. The policy for resident bruising will be initiated when bruises are found, care planning started, and documentation completed. 3. Resident bruises will also be managed via Incident/Accident Reports with notification to the appropriate authority based on policy.	

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F 309	Continued From page 35 a short sleeved t-shirt and was observed with multiple bruises on both forehands and arms. On 2/3/16, at 7:15 a.m. observed resident wheeling around the unit noted to have the bruising in the forehand. When approached and asked how he had slept resident stated good. Resident was wearing a long sleeve sweat shirt. -At 8:44 a.m. resident observed waiting for his medications by the nursing station. At 8:45 a.m. RN-B was observed standing next to resident as resident took medications. R96 at 8:48 was overheard indicate to RN-B he was not going to take one of the pills in the cup. Resident then wheeled away from the nursing station RN-B never asked resident about the bruises that were visible. -At 9:57 am. R97 was observed wheeling around the unit then at 10:00 a.m. went into his room and the forearm bruises were visible. -At 10:02 a.m. resident come out of room and requested the health unit coordinator (HUC)-B to assist him to remove his sweat shirt and the HUC-B was observed assist R96 then resident requested the HUC-B to hang it in the room. Resident was then observed wheel around the nursing station waited as HUC-B brought him a cup of water, HUC-B never asked about the bruises which were visible in both arms and forehands. Resident then wheeled to the dayroom. At 10:09 a.m. resident was observed wheel back to his room. Bruises were visible at this time. On 2/4/16, at 10:00 a.m. to 11:00 a.m. resident was observed on the unit was wearing a short sleeved t-shirt and both arms were observed with multiple bruises which were all visible. Resident observed wheeling around the unit, by the nursing	F 309	The Director of Nursing has previously contacted the hospices that we contract with that the nurses should check in and out with our nursing staff for updates each visit. The DON will follow up with a written request to each hospice and personal contact request to regularly scheduled visiting hospice nurses by March 11 requesting this again. The Director of Nursing or her designee will audit the bruising program weekly for weeks and then monthly thereafter; an audit form has been created which evaluates the effectiveness of each step of the new program. The Director of Nursing or designee will audit documentation within the facility such as hospice reports, hospice calendars, or nursing progress notes to evaluate whether proper communication is occurring. The Director of Nursing will report on these programs monthly to the Quality Assurance Program. The facility alleges compliance by 3-16-2016.	

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F 309	Continued From page 36	F 309		

station with multiple staff going by resident none acknowledged the bruises.

On 2/4/16, at approximately 2:13 p.m. resident was observed approach licensed practical nurse (LPN)-A asked for a bandage LPN-A asked what he needed it for resident then got upset and started to curse at LPN-A and wheeled himself down the hallway came by the nursing station and asked surveyor to wheel him to his room. Surveyor asked a nursing assistant (NA) who never asked resident about the bruises and never reported to the nurse.

R96's diagnoses included heart failure, diabetes mellitus type two, presence of cardiac pacemaker, mild cognitive impairment, intermittent explosive disorder, unspecified dementia with behavioral disturbance, personality disorder and long term (current) use of anticoagulants obtained from Admission Record dated 2/5/16.

During review of R96's February Electronic Medication Record (EMAR) it was revealed resident was received the following medications:
- Coumadin (Blood thinner) 2 milligram (mg) by mouth one time a day every Sunday, Monday, Wednesday and Friday for atrial fibrillation.
- Coumadin 3 mg by mouth one time a day every Tuesday, Thursday and Saturday
- Plavix 75 mg (blood thinner) by mouth in the morning for coronary artery disease (CAD)

Review of nursing notes dated 1/1/16, through 2/3/16, revealed there was no documentation on the bruises. In addition review of assessments revealed on 1/15/16, and 1/22/16, it had been documented resident had refused weekly bath

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F 309	Continued From page 37 and skin to be checked no follow up documentation after. R96's annual MDS dated 12/23/15, indicated resident had moderate impaired cognition. Pressure ulcer CAA dated 12/28/15, indicated resident received Coumadin and coronary artery disease medications, was fairly independent with cares, had history of refusing body checks and directed staff to continue to encourage weekly showers and skin audits. R96's care plan dated 7/6/15, indicated resident had CAD, had a pacemaker, had atrial fibrillation, had a mitral valve disorders and hypertension. Care plan indicated resident was on daily Coumadin and Plavix. The care plan directed staff to administer cardiac medications and to document response to medication and any side effects. On 2/4/16, at 8:55 a.m. RN-A stated as long as she had worked with residents he had always had bumps in his arms. RN-A stated resident was aggressive but had gotten better over time, continued to refuse cares which included medications, skin checks and others. RN-A verified after going through all the progress notes in the medical record there was no documentation of the bruises which were visible in both arms even though resident refused weekly skin checks and baths. RN-A acknowledged even though resident refused skin checks staff was supposed to have documented the bruises that were visible. RN-A further stated although the care plan directed staff to document side effects, the care plan did not indicate resident was prone to easy bruising and bleeding due to Coumadin use "from my own experience the care plan should address resident is easy to bruise due to the Coumadin use."	F 309		

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F 309	Continued From page 38 On 2/5/16, at 9:47 a.m. resident was observed wheel by the nursing station observed large dark purple bruise on the right forehand with a dry skin tear. When approached and asked about the bruises, resident pulled his sweat shirt sleeves and stated he did not know how they happened but thought was from bumping himself. Resident also stated he was taking Coumadin which made him to bruise easy. On 2/5/16, at 11:37 a.m. LPN-A stated resident had the current bruises for "quite some time. If we see a new bruise we are supposed to notify the doctor, family and the director of nursing and an incident report is supposed to be filled and would monitor the bruises." On 2/4/16, at 9:12 a.m. the director of nursing (DON) stated any skin concerns were supposed to be reported to the wound nurse and her which included unexplained bruising, or any other changes and staff were to look at the resident medical history to find the cause of the bruise. DON acknowledged the nurse who had observed R77's bruise should have documented it and reported it to the nurse manager immediately. R35 bruises of unknown cause were not assessed. R35's diagnoses included end stage renal disease, anemia in chronic kidney disease, vitamin D deficiency, dementia, and heart failure obtained from Admission Record dated 2/4/15. On 2/3/16, at 7:26 a.m. during interview R35 was observed with bruises on top of right and left hands. When asked how it happened R35 said, "I do not know. "	F 309		

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F 309	Continued From page 39 On 2/4/16, at 10:24 a.m. R35 was observed walking to bible study with bruise top of right and left hand that was dark purple in color. R35 said it must have happened during blood draws at dialysis. R35's admission MDS dated 1/12/16, indicated R35 had moderately impaired cognition. R35's care plan dated 1/26/16, indicated resident had history of diabetic ulcer of the feet and indicated staff was to complete weekly skin assessments with weekly bath. The care plan did not indicate resident received Plavix and had the potential to bruise easy. During review of R35's February Electronic Medication Record (EMAR) it was revealed resident was received the following medications: - Plavix 75 mg (blood thinner) by mouth in the morning for congestive heart failure During review of R35's February Electronic Treatment Record (ETAR) it was revealed resident was to receive a head to toe skin and body assessment every week. Nursing Admission Admit Assessment dated 1/2/16, indicated bruising left hand 7 x 4 centimeter (cm.) and bruising right hand 7 x 6 cm. Review of nursing notes dated 1/5/16, through 2/3/16, revealed there was no documentation on the bruises. In addition review of Weekly Bath and Skin assessments revealed on 1/15/16, and 1/22/16, it had been documented resident had refused weekly bath and skin to be checked no follow up documentation after. During interview on 2/04/16, at 10:48 a.m. RN-C when asked about the bruises on top of R35's hand said, "I was not aware of the bruises. I will	F 309		

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F 309	Continued From page 40 follow up." During interview on 2/4/16, at 11:21 a.m. RN-C reported the results of investigation. PT (Physical Therapy) said it had been there almost a month. I did not know about. PT though it was just a discoloration. During interview on 2/4/16, at 2:30 p.m. RN-E verified should have every shift monitoring for bruises and a care plan. RN-E verified Plavix was not on the care plan and should be. During interview on 2/4/16, at 2:56 p.m. RN-C said the nurses should monitor bruises every shift and document every shift on the TAR If a bruise was on admission assessment it should have been put on the temporary care plan, a progress note written, and the nurse should have put a monitoring order in the computer. RN-C verified staff do not have every shift monitoring for her. RN-C verified there was no care plan for the bruises and would expect staff to have done a care plan. Verified there was no care plan for risk of blood thinners or Plavix. During interview on 2/04/16, at 3:24 p.m. RN-D said, "If I knew about a bruise on a resident's admission I would care plan it until resolved. I think we care plan Coumadin. I do not think so for Plavix. Plavix has a risk for bruising." Review of the undated Crystal Care Center Skin Policy directed staff to complete the Other Skin Conditions Form upon discovery of a skin condition and then at least weekly thereafter. In addition the policy directed once the area was healed staff was to file the form into the resident medical record.	F 309		

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R57 did not have coordination of hospice care.

R57's quarterly MDS dated 11/12/15, indicated he was severely cognitively impaired and required extensive assistance with all activities of daily living. R57's cared plan dated 11/23/15, indicated he was admitted to the facility for hospice/comfort care and directed staff to communicate with hospice as needed. R57's Home Health/Hospice Aide Care Plan dated 12/26/14, indicated a hospice aide visit would occur one time weekly and directed the aide to perform personal cares that included bathing and shaving.

Fairview Home Care and Hospice Facility Documentation Records were reviewed for the dates of 12/24/15 through 2/3/15. The notes indicated a hospice aide visit occurred only two times during the six week period, even though the care plan directed weekly visits.

During an observation on 2/2/16, at 9:52 a.m., R57 was lying in bed on his left side wearing a hospital gown and incontinent brief. R57's room had a strong urine odor present. R57's hair was unclean and uncombed, his facial hair had not been removed.

During an interview on 2/1/16, at 2:18 p.m., family member (F)-B indicated R57 was receiving one bath per week. He stated the bath was usually performed by the hospice aide. He further stated the facility had given R57 his bath the previous week due to the hospice aide ' s inability to come to the facility.

During an interview on 2/3/16, at 10:01 a.m. NA-L stated hospice gave R57 a bath weekly. She

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stated she did not know when the facility bathed him. She further stated, she usually shaved R57 and indicated she had shaved him the previous day.

During an interview on 2/3/16, at 10:03 a.m. RN-B stated the facility gave R57 a bath on Saturdays and hospice gave R57 a bed bath when they visited him, but stated, "Sometimes they don't tell us when they are coming."

During an interview on 2/4/16, at 11:01 a.m., RN-A stated, the amount of tie hospice comes to visit R57, depends on their case load. She further stated "hospice does not communicate." RN-A stated hospice was supposed to put a schedule in the chart but she had not looked to see if it was being done. She stated, "I don't think my staff knows when they are coming."

During a subsequent interview on 2/4/16, at 3:10 p.m., RN-A stated she did not remember when she last saw a hospice aide.

During an interview on 2/5/16, at 8:57 a.m., the hospice RN stated the hospice aide should be marking their visits on the calendar in R57's chart. She further stated R57's hospice aide had not been out for a few weeks and was not scheduled for the current week. She stated, "We have had some problems staffing him." The hospice RN stated they had been communicating with R57's son, but should have communicated with the facility as well.

During an interview on 2/5/16, at 10:31 a.m., DON stated the RN case manager was responsible for overseeing the coordination of care with hospice. She stated hospice should be

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F 309	Continued From page 43 communicating with the facility. The DON stated she was not aware the hospice aide had not been to the facility to see R57. A facility policy regarding coordination of care for patients receiving hospice services was requested, but none received.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral care and/or urinary incontinence care for 1 of 3 residents (R112) evaluated for activities of daily living. Findings include: R112 was dependent upon staff assistance for personal hygiene and received inadequate oral care as evidenced by observation on 2/3/16, at 11:11 a.m. R112's annual Minimum Data Set (MDS) dated 9/22/15, identified "obvious or likely cavity or broken natural teeth" and indicated R112 had severely impaired cognitive skills for daily decision making. A Care Area Assessment (CAA) dated 9/22/15, indicated R112 had some missing	F 312	Resident #312 has received oral care according to her needs. Residents have been evaluated for their dental needs and arrangements have been made with dentistry to meet these needs within a reasonable period of time and based on the need. Staff have been in-serviced on the need to provide good oral care to residents and on the need to arrange dental care as necessary. They have also been in-serviced on the new Resident Dental tickler file system. Nursing has created a Resident Dental tickler file designed to monitor dental care for facility residents. Based on this new	3/15/16

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F 312	Continued From page 44 natural teeth and needs and receives assist of one for all oral cares. Review of R112's care plan with revision date 11/9/15, identified R112 to have self-care performance deficit due to dementia and confusion, staff was to anticipate needs as she cannot state them, R112 did follow some direction, was friendly and non-resistant. Interventions include "extensive assist 1 staff brushes teeth" and "will see dentist per family wishes." Continuous observations were made of R112 on 2/3/16, from 11:11 a.m. to 11:49 a.m. At 11:11 a.m., nursing assistants (NA)-A and NA-B provided morning cares to R112 in her room. NA-A cleaned R112's face and provided peri cares. After transferring R112 to her wheelchair, NA-A combed her hair and put on her shoes. NA-A put dirty clothing and bedding into the plastic bags emptied the wash basin, put new plastic bag into waste container and stated "I am done." During interview on 2/2/16, at 12:00 p.m. family member (F)-A stated that she did not think staff were taking the time with her mother's oral care, further stating "I don't believe they are doing it, her gum line has plaque." During an interview on 2/3/16, at 11:50 a.m. NA-A verified that no oral cares were offered or completed. NA-A stated "I forgot." During interview on 2/3/16, at 11:55 a.m. registered nurse (RN)-C verified oral care should have been done and stated "the care plan outlines what they should do."	F 312	program, residents have all had their dental needs evaluated and arrangements made for dentistry to meet those needs. In the tickler file, tracking is started for each facility resident: those who have received recent dental care begin at that point and follow-up is scheduled and those without any dental needs have another review set. This Resident Dental tickler file represents the complete dental care needs of this body of residents. Newly admitted residents will be added to the Resident Dental tickler file system. The Director of Nursing or her designee will be responsible for this program. The Facility Administrator will audit the new Resident Dental tickler file system weekly x 4 and then monthly thereafter to ensure that it is being managed properly and that residents are getting their dental care managed professionally. The Facility Administrator will report to the Quality Assurance Committee on this program. The Facility alleges compliance on 3-15-16.	

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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 ensure interventions were implemented to ensure wound healing for a stage 3 pressure ulcer (full thickness skin loss involving damage to or necrosis of subcutaneous tissue that may extend down to, but not through, underlying fascia. The ulcer presents clinically as a deep crater with or without undermining of adjacent tissue) for 1 of 3 residents (R75) reviewed for pressure ulcers. Findings include: R75 was observed on 2/3/16, during continuous observation from 9:24 a.m. until 12:38 p.m. -9:30 a.m. Staff observed wheeling R75 toward the dining room. -9:32 a.m. R75 sitting in dining room in wheelchair. ROHO (a speciality cushion used to reduce pressure) cushion not visible in wheel chair. -10:16 a.m. R75 wheeled self out of dining room. -10:23 a.m. Staff wheeled R75. R75's ROHO cushion was lying in his sitting chair by the	F 314	Resident #75 was seen by a wound care physician and is undergoing care. Resident is also receiving her cushion for comfort as ordered by the physician. Residents with wounds and who have orders for comfort or preventive devices have been evaluated to ensure that they are receiving wound care as ordered and that their preventive devices are being applied as ordered by the physician. Nursing staff were in-serviced on 3-15-16 on the necessity of adhering to the treatment plan for resident wound care and implementing devices for prevention and comfort as ordered by the physician. Resident treatment sheets will now carry the name of any device for resident prevention and comfort of wounds and the administration times; nurses and NAs follow these schedules routinely. A master wound treatment list is now developed by	3/16/16

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F 314	Continued From page 46 window another surveyor present and verified. R75 was sitting in wheelchair next to bed. -11:04 a.m. nursing assistant (NA)-G made R75's bed. ROHO cushion remained in chair (not in the wheelchair under the resident). -11:17 a.m. NA-G wheeled R75 to the dining room. ROHO cushion remained in resident room No ROHO cushion or any other type of cushion visible in chair. -11:57 p.m. R75 wheeled self out of the dining room. -12:07 p.m. NA-G met R75 in hall and wheeled him to his room. -12:13 p.m. licensed practical nurse (LPN)-D notified by surveyor R75 had not been repositioned since 9:24 a.m. -12:30 p.m. LPN-D, NA-G, NA-H entered R75's room. R75 had not been repositioned for three hours and six minutes. LPN-D asked R75 if he had a cushion under him in his chair. R75 said, "No." NA-G and NA-H stood R75 up using a standing lift. LPN-D verified there was no ROHO cushion under him. LPN-D and NA-H pulled down R75's pants and removed incontinence product. LPN-d verified the both outer buttocks were non blanchable. R75 feces was noted on the incontinent pad. NA-H wiped bottom removed gloves and put on new gloves. NA-H applied incontinence brief and pulled up R75's pants. NA-G put the ROHO cushion in wheelchair. NA-G said R75 was supposed to be up one hour after lunch and lowered R75 back into wheelchair. Both NAs finished cares at 12:38 p.m. NA-G stated, "I would have returned at 1:00 p.m. to place [R75] in bed." R75's admission Minimum Data Set (MDS) dated 12/16/15, indicated R75 had moderate cognitive impairment and Required assistance with bed	F 314	the Unit Managers who ensure that nursing manages resident treatments as ordered this master list is compared to the treatment sheets in the possession of the floor nurse for accuracy and to ensure that treatments for wounds are always managed properly. The Director of Nursing or her designee will monitor 10% of the residents on the wound care program and who have preventive or comfort devices to ensure that treatments for wounds and application of devices are being managed in a timely manner, as ordered. The Director of Nursing will report on this program to the Executive Director and the Quality Assurance committee monthly. The facility alleges compliance by 3-16-16	

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mobility, transfers, dressing, toileting, and personal hygiene. R75 was frequently incontinent of bowel and bladder. Diagnoses listed on MDS include end stage renal disease, diabetes, hip fracture, stroke and a stage three pressure ulcer in the sacral region.

The Pressure Ulcer care area assessment dated 12/21/15, indicated R75 had been admitted to facility with a stage three pressure ulcer on coccyx. Frequently incontinent of bowel and bladder. Needed assist of one to two staff to turn and reposition every two hours. Low air loss mattress (LAL) on bed, ROHO wheelchair cushion. Daily skin observations with cares and weekly skin/wound assessments were to be completed.

The care plan revised on 1/3/16, indicated R75 had a stage three pressure ulcer on coccyx. Development related to increased dependence with all mobility and severe peripheral neuropathy. Diagnosis of hidradenitis supprativa (boil like skin infections) on buttocks. The care plan interventions included, administer treatments as ordered and monitor for effectiveness. "Assess/record/monitor wound healing weekly: Measure length, width and depth where possible. Assess and document status of wound perimeter, wound bed and healing progress. Report improvements and declines to the MD [medical doctor]. The resident needs (SPECIFY: monitoring/reminding/assistance) to turn/reposition at least every 2 hours, more often as needed or requested. The resident needs: encouragement, assistance, with use of bed rails, for resident to assist with turning. The resident Requires Pressure relieving/reducing device on bed: LAL [low air loss] mattress on bed and

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F 314	Continued From page 48 ROHO cushion in w/c [wheel chair]. Send ROHO with to dialysis." R75 did not receive the turning and repositioning as indicated on the plan of care. Nursing assistant assignment sheet dated 2/2/16, indicated R75 was to be turned and repositioned every two hours and receive assist of one with the urinal. R75 did not receive the turning and repositioning as indicated on the NA assignment sheet. Weekly Wound Documentation form. Date first observed 12/9/15. 12/9/15, 10.5 cm. (centimeter) x 8.5 cm. 30 percent (%) granulation, 70 % slough stage III scant serous drainage, intact dry wound edges. 12/16/15, 9 cm. x 8 cm. 30 % granulation 70% slough scant drainage. 12/23/15, 9 cm. x 7 cm. 35% granulation 65% slough. 12/30/15, 8 cm. x 7 cm. 35% granulation 65% slough. Scant serous drainage intact pink dry wound edges. VOHRA (name of company for wound specialist) Wound Care Specialist Evaluation dated 1/29/16, indicated R75 had a stage three pressure wound that had been present for greater than 50 days. Healing wound size 5.0 cm. x 6.0 cm x not measurable. Surface area 30 cm square cluster wound with light serosanguineous exudate. 15% skin 85% Hypergranulation tissue present within the wound margins. Wound progress: improving, decreased surface area. Interventions included support surface group 2 ROHO in chair, and gripper socks on feet. Chemical cauterization for hypergranulation tissue performed on sacrum wound with topical anesthesia to facilitate healing.	F 314		

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Progress note in Point Click Care dated 2/3/15, at 12:38 p.m. indicated, "Resident did not have ROHO cushion on w/c (wheel chair) from time that got up from after lunch. Resident denies having pain or discomfort at wound site. Resident repositioned and ROHO placed on w/c. Inner buttocks non-blanchable, and outer buttocks blanchable."

On 2/3/16, at 9:18 a.m. during interview R75 stated ROHO cushion does not go to dialysis with him all the time. R75 stated occasionally has pain with coccyx wound, but it is getting better.

During an interview on 2/3/16, at 11:04 a.m. in R75's room NA-G said, "I am just going to make his bed. He is not going to lie down now, not until after lunch." NA-G did not offer to reposition resident, check incontinence product or to assist R75 to use the urinal.
- At 12:07 p.m. NA-G said, "He is an assist of two so I have to wait for [NA-G]. He has a sore on his bottom so he is an every two hour reposition. I don't know what time he got up. I did not get here until 9:30 a.m."
- At 12:13 p.m. LPN-D said R75 was to be repositioned every two hours.
- At 2:12 p.m. NA-G stated, "When I got here he was up. We will reposition him between breakfast and lunch. [R75] is to stay up until one hour after lunch. If he were to stay up longer than he was supposed to, his sore would get worse."
- At 2:19 p.m. NA-H said the aide who got him went up to the second floor. He told me every one was in the dining room. (R75) is to be re-positioned every two hours,
- At 2:26 p.m. LPN-D said R75 usually liked to go to bed right after a meal but we need to have him sit up for about an hour. "Being up longer than

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F 314	Continued From page 50 two hours could cause further breakdown of wound and other areas of bottom." - At 2:38 p.m. registered nurse (RN)-G, Nurse Manager said, "My expectation is that they are to reposition him every two hours like their care sheet. I was pretty upset that the nurse assistant did not put the ROHO in the wheel chair. Will check the assignment sheet and try to provide them with education to put it in the chair if it is in the other chair." The Policy and Procedure For the Prevention and Treatment of Skin Breakdown dated 2010, indicated "It is the policy to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity and pressure ulcers; to implement preventative measures; and to provide appropriate treatment modalities for wounds according to industry standards of care."	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 4 residents (R83, R34, R144, R93) were assessed for their ability to smoke safely; and failed to ensure	F 323	Resident #83 was assessed for smoking on 2-2-16 and deemed to be a safe smoker. Resident #144 was assessed for safe smoking on 2-8-16 and is supervised	3/16/16

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F 323	Continued From page 51 supervision and assistived devices were provided to ensure the safety of 2 of 4 residents (R34, R144) while they smoked. In addition, the facility failed to maintain safe water temperatures for 2 of 6 cognitively impaired residents (R60, R76) reviewed. Findings include: R83 was not assessed for smoking On 2/2/16, at 9:47 a.m. during a tour to the smoking shack located behind the facility with another surveyor a hard plastic covered garbage can was observed to the right of the shade. In the outside of the can were burn marks and in the inside were observed three Newport cigarette boxes that were burnt and multiple cigarette butts were disposed in the garbage bag. In addition a white paper napkin was observed also to be burned. -At 10:30 a.m. during another tour to the smoking area with the maintenance staff (MS)-B removed the garbage can cover and verified the cover had burned marks stated "they are using it to put out the cigarettes." MS-B verified inside the can were multiple butts and there were four boxes that were burned. -When asked if residents had been educated not to dispose cigarettes in the trash can MS-B stated as he pointed to the ash tray and indicated residents were supposed to dispose them there. MS-B also indicated it appeared as though the boxes had been burned before being disposed inside the garbage can as the plastic can liner was not burnt. MS-B stated the area was a resident smoking area only. On 2/2/16, at 11:06 a.m. health unit coordinator	F 323	now with smoking. Resident #93 refused the smoking assessment and transferred to another facility. Resident #34□s smoking materials are now kept safely at the nurse□s station. Residents #60 and #76 have been evaluated by a physician and water temperatures observed routinely to ensure they remain at appropriate temperatures. The hot water boilers were repaired on 2-3-16 and temperatures have remains within safe limits at 114 degrees or below. Residents who smoke at the facility were re-assessed to ensure they are safe smokers. All other residents were assessed to be sure they are not smoking. Anyone smoking was entered into the smoking program and assessed. All temperatures for water were checked throughout the facility to ensure safety for each resident. Staff were trained on the new smoking program and the need to assess in a timely manner to ensure for resident safety. Staff were also trained on the importance of observing hot water and appropriate temperatures and to notify maintenance if water seems too hot. Signs have been posted in the smoking shed informing residents that cigarette butts are to be disposed of in ashtrays and not trash baskets. Smoking residents have been advised regarding these signs. Water temperatures are audited routinely □ weekly x 4 weeks and then monthly	

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F 323	Continued From page 52 (HUC)-A verified after going through the entire medical record a smoking assessment had not been completed since resident had been admitted on 11/16/15. HUC-A stated a different social worker was working at the facility at the time R83 had been admitted and directed surveyor to follow up with the director of social service. On 2/2/16, at 11:18 a.m. when asked if all R83 was supposed to be assessed, the director of social services (DSS) stated "Not necessary he is not supposed to smoke and knows we are not a smoking facility. I can't say yes or no. We are looking for a smoking facility for him." When asked again if R83 was supposed to have been assessed since the facility knew he was a smoker, DSS stated "We are aware he is smoking and an assessment was not done but he has been looked at when he is smoking. He is aware of his cigarettes and able to handle the cigarettes. We don't want to go far when we know he is able to do it independently." DSS verified R83 had not been assessed and no care plan had even been developed even though the facility was knowledgeable of resident going outside to smoke. On 2/2/16, at 11:25 a.m. DSS stated smoking assessment was supposed to be done on admission and then reviewed during care conferences as there was no requirement. R83's diagnoses included altered mental status, nicotine dependence cigarettes, hemiplegia and hemiparesis obtained from Admission Record dated 2/4/16. Cognitive loss/dementia Care Area Assessment (CAA) dated 11/23/15, identified resident had confusion, had behaviors, mood	F 323	thereafter in random rooms of 10% of residents, one-third of the 10% on each of the (3) floors of the facility. The findings from these water temperature audits, done by the maintenance supervisor or his designee, are documented in a temperature log. Based on these audits, temperatures for water are adjusted to be within the acceptable range in the industry. The Social Services Director or designee will audit the signage for safe smoking and the Facility Executive Director will audit smoking assessments for completion. Each will report monthly to the Quality Assurance Committee. The facility alleged compliance by 3-16-16.	

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concerns, had both hearing and vision impairments which may have an impact on ability to process information.

During review of the medical records for R83 no smoking assessment was observed in both the paper and electronic records. In addition R83's care plan did not address/identify resident smoked yet the facility was aware R83 was a frequent smoker.

On 2/5/16, at 12:16 p.m. when asked about if an assessment was supposed to have been completed as directed by the facility policy the director of nursing (DON) stated a resident had the right to refuse to be asked questions. When asked if R83 was supposed to have been evaluated DON stated resident was non-complaint and the facility was in the processes of getting resident to a different setting. When asked if there should have been documentation of resident refusing the smoke assessment, DON was not able to respond to the question and again continued to state R83 was non-complaint. When told what the facility policy directed, DON stated the facility was going to not allow residents that smoked but was having a problem with hospitals not being forth right with the issue.

R34 was not assessed for smoking and facility failed to ensure supervision of smoking materials.

R34 was observed on 2/2/16, at 10:27 a.m. asleep, holding a lighter in his right hand and a whole cigarette was lying on the lap to the right as he sat on the wheelchair (w/c) by the main lobby. No burn holes were observed on the clothing.

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On 2/2/16, at 4:20 p.m. R34 was observed at the main lobby and inside his shirt pocket was a box of cigarette and a lighter.

On 2/3/16, at 1:30 p.m. during a random observation resident was observed at the front lobby reading the newspaper and a box of cigarette and lighter were observed stored in the shirt pocket.

R34's quarterly Minimum Data Set (MDS) dated 12/23/15, indicated resident had moderately impaired cognition. In addition the MDS indicated resident diagnoses include dementia without behavioral disturbances, peripheral vascular disease, difficulty walking and chronic obstructive pulmonary disease.

R34's smoking care plan dated 3/31/14, indicated R34 had chosen to smoke daily, was able to take himself outside, safely handled, light and dispose of cigarettes and materials and R34 had been found smoking out front. The care plan directed "Cigarettes kept at south nurses desk and given one at at time with reminder to smoke in back of facility. Remind him to smoke in the designated area back of facility. He tends to smoke only part of a cigarette and put the rest back in his pack. [R34] is aware of the risks of putting out cigarettes and putting in his pocket. Smoking assessment completed according to policy..."

R34's visual function CAA dated 4/1/15, indicated R34 had impaired vision, had left eye blindness from old retinal detachment, wore glasses and was able to read newspaper.

During review of Care Conference Summary notes dated 9/30/15, and 12/29/15, it was

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revealed R34 had not attended either of the care conferences meetings. On the 9/30/15, meeting it was indicated R34 understood the smoking policy however no assessment had been completed.

On 2/2/16, at 11:25 a.m. the DSS stated he thought the smoking assessment was completed annually and indicated resident was a known smoker and should have one in the medical record. DSS added R34 smoking was reviewed during each care conference. DSS reviewed all the assessments in R34's both the paper and electronic medical records verified the last assessment had been completed in 5/11/12.

On 2/4/16, at 3:11 p.m. when asked if he knew where resident smoking supplies were stored licensed practical nurse (LPN)-G stated he did not know and stated would find out and then thought probably the nurse manager or DSS would know.
-At 3:19 p.m. when asked where R34's smoking supplies were stored, DSS verified R34's care plan was not accurate of the storage as R34 kept his own supplies on him as the family was not supportive of the facility policy and would bring R34 cigarettes and hand them to resident during visits. DSS further stated because of lack of support from the family it was difficult to reinforce the facility smoking policy. DSS further stated R34 had been observed smoking; no concerns had been identified even though resident had vision problems and had been known to smoke in the front of the building and not in the designated smoking area at the back.

On 2/5/16, at 8:34 a.m. when approached and asked where he smokes, R34 stated he smokes in the front of the building. When asked why,

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resident stated he knew he was supposed to smoke in the back shack however, he did not like the fact that he had to stand up from his wheelchair to open the doors to the back. When asked where he disposed the cigarette butts after, R34 then reached to his front pocket to retrieve a box of cigarettes and showed surveyor stated he was not really a smoke as such and when he was done because the ones he used did not have a filter he would open the seam and blew the tobacco into the air. When asked if he had any problems with handling his smoking supplies resident stated "I have smoked for years and am good with this" as he smiled. No burn holes observed on the clothing.

On 2/5/16, at 12:22 p.m. when asked if a smoking assessment was supposed to be done for residents who had been grandfathered, the director of nursing stated "yes." DON acknowledged resident care plan should have been revised to reflect the current plan of care.

On 2/5/16, at 12:34 p.m. when asked if all residents in the facility who were known smokers were supposed to be assessed as directed by the facility policy the executive director (ED) stated "Yes. I talked to [DSS] and I guess we were not on the same understanding about the policy." R144 was not assessed for smoking and the facility failed to ensure supervision of smoking materials.

R144 admitted to the facility on 2/3/16. His admission History and Physical dated 2/2/16, indicated he suffered from weakness as well as poor coordination and control of right arm and leg. The history and physical further indicated R144 had a 20 year pack history of smoking and

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reported he has been smoking cigarettes. A facility assessment labeled NUR [nurse] Q Shift Post Admit Charting, dated 2/5/16, indicated R144 required extensive assist for transfers, was alert to person only, and was at risk for falls. R144's care plan dated 2/4/15, identified R144 as a risk for elopement and directed a Wanderguard (a Wanderguard is a perimeter based system that alerts staff of a resident attempting to leave the facility by an armed door.) bracelet be placed on R144.

During an observation on 2/5/16, at 12:13 p.m. R144 was observed propelling himself in front of the entrance to the facility. R144 skidded to a stop on the sidewalk and dropped a pack of cigarettes on the ground. R144 was unable to pick up the pack of cigarettes and required assistance. R144 was unable to grip the pack with his right hand. R144 was again observed to drop his cigarette on the ground, at which time an unidentified individual walking up the sidewalk was noted to assist R144 to pick up his cigarette and assist him with a lighter. At the time of observation, R144 was not wearing a Wanderguard.

A review of Crystal Care Center Progress Notes indicated on 2/3/16, R144 was noted by staff "walking and wanting to leave the facility." The notes further indicated R144 was found on the floor inside the front entrance of the facility the same evening while attempting to go outside and smoke a cigarette. A subsequent Progress Note dated 2/4/16, indicated social worker (SW)-B reviewed the smoking policy with R144 and R144 refused to sign the policy.

While progress notes indicated staff was aware of

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R144's desire to smoke, and even though R144 had fallen in the facility attempting to go outside and smoke, there was no evidence the facility assessed R144's ability to smoke safely. Further, there is no evidence staff initiated any interventions to keep R144 from exiting the facility independently even though he was identified at risk for elopement.

During an interview on 2/5/16, at 12:30 p.m. the ED stated R144 should have a Wanderguard to alert staff if he is attempting to leave the facility to smoke. The administrator further stated R144 was "not in any way shape or form able to be outside by himself."

During an interview on 2/5/16, at 1:10 p.m. the DSS stated he was responsible for performing the resident's smoking assessments which were to be completed upon admission. DSS indicated the facility was a non-smoking facility and if a resident was identified to be smoking, staff was to take the resident's cigarettes away and call family. He further stated if a residents wishes to smoke, they had to move to another facility. The DSS stated there were no residents currently in the facility that were deemed unsafe to smoke. R93 was observed sitting outside in the smoking shack behind the facility on 2/1/16, at 12:30 p.m. R93 was smoking a cigarette with a long gray ash attached to it. A few gray ashes were on the front of R93's purple fleece jacket. No holes were observed in R93's clothing. There were three chairs in the smoking shack and two metal ash trays. Ten cigarette butts were on ground in shack.

On 2/2/16, at 9:47 a.m. during a tour to the smoking shack located behind the facility with

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another surveyor a brown hard covered plastic garbage can was observed to the right of the shack. On the outside of the can top were burn marks. Inside the garbage can were three Newport cigarette boxes that were burnt. There were multiple cigarette butts in the garbage can. There was a white paper napkin that had blackened edges in the trash can. On the ground in the smoking shack there were 13 cigarette butts and on the ground around the trash can there were four cigarette butts.

During a random observation on 2/3/16, at 10:14 a.m. R93 was observed sitting in the lobby on 1st floor wearing a green poncho that covered R93 and the back of R93's wheelchair. There were three small circular holes on the front of the poncho.

On 2/5/16, at 8:30 a.m. observed R93 smoking in smoking shack. R93 had ash on gray fleece coat R93 brushed the ash off. R93 said I do that when they (ashes) fall. They are not hot, just dead ashes. Her gray pants had a two centimeter hole on right leg. R93 said that happened a long time ago in my van.

Retired Smoking Assessment dated 9/10/12, copied from point click care "Res BIMS 11/15 indicating moderate cognitive deficits. Res has been observed smoking and displays safe smoking behavior. Res has been encouraged to use e-cigarette, but refuses. Staff will continue to observe and document any unsafe smoking behaviors, ie: burns on clothing or skin. Based on this information, res is okay to smoke independently." Registered nurse (RN)-B verified that there were no paper assessments in the chart and verified that the most current computer

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F 323	Continued From page 60 assessment for smoking was 9/2012. R93 smoking care plan dated 8/14/13, indicated R93 had chosen to smoke daily, could take self-outside, safely handle, light and dispose of cigarettes and materials. R93 was responsible for smoking materials and will not lend or give them to others. The care plan directed, "Explain smoking policy as needed observe and document any unsafe incidents and/or burns, marks on clothing or skin. May keep smoking materials in room. Update MD [medical doctor]/NP [nurse practitioner] and family of any changes in smoking or if inappropriate smoking occurs. Smoking assessment completed per policy." The IDT (interdisciplinary Team) Note dated 4/6/15, indicated, "Resident informed of new smoking policy. Writer explained residents exemption to the new smoking policy as resident is allowed to smoke in smoking shed in back of building area. Resident informed of loss of privileges if found smoking in area other then designated for smoking. Resident acknowledged understand." R93 Care Conference Summary dated 10/29/15, indicated "Resident is allowed to smoke in shack in back resident knows smoking privileges apply specifically to her. aware of policy." List of persons in attendance did not include R93 or family member." List of persons in attendance did not include R93 or family member. Summary did indicate rescheduled with family and staff on February 4th. R93 Care Conference Summary dated 1/28/16, indicated "Resident is allowed to smoke in shack in rear of building is (I) [independent] with this	F 323		

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(grandfathered in) Propels self (I) with electric wheel chair is seen smoking off ground, Resident knows rules and policy." List of persons in attendance did not include R93 or family member. Summary did indicate rescheduled with family and staff on February 4th.

Summary for 2/4/16, requested but not provided.

During interview on 2/3/16, at 9:00 a.m. director of social services (DSS) said, "We do not do a smoking assessment, just review policy at care conference."

During interview on 2/3/16, at 2:53 p.m. DSS said facility is smoke free except for people grandfathered in. Facility went smoke free before I started in November of 2014. Residents grandfathered in are not subject to the policy. New admissions are offered a nicotine patch, I let them know they cannot smoke on property, review policy and offer to find them a place where they can smoke. New residents can smoke if not on property. We do not recommend it. How I look at it is we review it prior to care conference. R93 is grandfathered in. There is no documentation that I witnessed her smoking but I do it. Criteria to determine if a resident is smoking safely includes handling cigarettes safely, when smoking not falling asleep, dispose of cigarettes in appropriate container, no long ash, no burns on fingers or clothing. Smoking in appropriate place (R93) is not always found smoking in the shack. Staff will tell me about it because it will be after we leave. Staff does not document or fill out an incident report. I have never personally caught her smoking out front. I have never seen ash on her clothing, never noticed holes in front of cape or other clothing. I have never seen her fall asleep

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while smoking. I don't know who is leaving all the butts on the ground by the smoke shack. Staff should tell me. Residents would lose their privileges if we are looking at something significantly unsafe like burning themselves or starting a fire.

During interview on 2/4/16, at 8:55 a.m. R93 said, "Yes sometimes I get ash on my clothing. I have gotten burns on my clothing but it has been a couple of months. It happens when I smoke in my van. There is a entrance ramp that is bad and can cause the cigarette to fall or a live spark to fall. We recently got a new van so that should not be a problem." I have never dropped a cigarette on myself when I have been smoking here. I sometimes smoke out front at night. The door by the smoking shack is locked at 9 p.m. so it is safer to go out front if I want to smoke in the winter."

During interview on 2/4/16, at 8:59 a.m. RN-A if (R93) says something there are facts from her own perspective and experience. She is a woman of clear thinking when it comes to her own thoughts. I see little black tiny pin marks but not a burn hole. She smokes outside and in her van when she goes with her son. I would think every assessment should be documented somewhere.

On 2/5/16, at 12:22 p.m. when asked if a smoking assessment was supposed to be done for residents who had been grandfather the director of nursing (DON) stated, "yes." DON acknowledged resident care plan should have been revised to reflect the current plan of care. R93 did not receive the services according to the care plan as the facility did not monitor unsafe smoking.

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F 323	Continued From page 63 Smoking policy dated 4/1/15, directed: 2. Smoking areas will be provided with metal containers equipped with self-closing covers to be used solely for the disposal of cigarette butts and ashes. a. A sign to that effect will be posted on the containers b. All cigarette and other smoking materials will be promptly disposed of in these containers and are not allowed to be discarded elsewhere on the Crystal Care Center grounds... C. Staff is responsible for ensuring that smoking by "grandfathered in" residents is done in a safe manner. 1. Residents will be allowed to smoke and use smoking materials only as specified in their care plan. 2. Residents who smoke will be evaluated for the ability to smoke safely and independently. This evaluation will be performed upon admission within 24 hours of admission and demonstrates that the resident is able to smoke safely to use the lighter, safely handle lit smoking material, and demonstrates safe smoking behavior. This will be done by a social worker, or if not during social service work hours, by a nurse. The assessment includes cognitive ability to make good judgements, and physical mobility to get to a smoke area. a. These residents will be reevaluated on at least a quarterly basis, or more frequently as dictated by any significant changes in condition... 7. Residents who do not comply with the smoking policy or who persist in smoking even when unsafe will be given an appropriate transfer notice to another setting and if needed, will be	F 323		

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F 323	Continued From page 64 supervised by family members or staff while waiting for their transfers."	F 323		

Unsafe hot water temperatures

On 2/2/16, at 2:18 p.m. the director of maintenance (DM) stated that on 1/29/16, there was blockage in the hot water pipes which at the time produced no hot water. "We unclogged the system late that night." The DM verified no monitoring of temperatures had taken place over the weekend and he was not aware that the temperatures in rooms were high. He stated the heating contractor would come out to check on it, but because of the weather the would not be coming out today.

The water temperature in Room 210, a room shared by R60 and R23, was observed on 2/2/16 at 2:23 p.m., to be measured by DM at 122.6 degrees F (Fahrenheit).

Although R23's annual MDS dated 1/12/16, indicated R23 was non-ambulatory and had severe cognitive impairment, R60's quarterly MDS dated 11/11/15, indicated R60 was independent with ambulation and had severe cognitive impairment.

Room 309, shared by R76 and R131, was observed on 2/2/16, at 2:32 p.m.. The water in the bathroom sink was measured at that time by DM and was noted to be at 123.8 degrees F.

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Although R131's quarterly MDS dated 12/9/15, indicated R131 was extensive assist for ambulation and had severe cognitive impairment, R76's quarterly MDS dated 1/8/16, indicated R76 was independent with ambulation and that R76 had severe cognitive impairment.

On 2/2/16, at 2:45 p.m. DM stated the contracting company would be coming to the facility within the next half hour.

During interview on 2/2/16, at 3:19 p.m. DM stated the hot water temperatures were a safety concern, "I realize that the water is too hot but I cannot fix it myself, the issue started on Friday (1/29/16) and that he did not check the temperatures on the weekend, "I don't work the weekends." DM further stated there is no facility policy but the temperatures are checked once a week in four different areas on each floor, "it's been nothing but nightmares lately."

During interview on 2/3/16, at 8:00 a.m. the ED stated she was unaware that the water temperatures were that high, but did know they were fixing the water last Friday for not being hot enough and DM checked the temperatures "but didn't keep a record of it." ED further stated she was not made aware of the hot water temperatures on 2/1/16, "MS-B is new, he didn't know it was an issue and noone complained so we didn't know." ED stated the contractor was here until late last night, "it is fixed now."

During an interview on 2/3/16, at 2:18 p.m. DM stated about three weeks ago, he identified the problem on 12/28/15 when residents were complaining that the water was too hot. Adjustments were made between I and the

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F 323	Continued From page 66 contractor, "I was focusing on getting it to function, there are no logs between 12/28/15 and 1/25/16 when I was trying to find the problem." During an interview on 2/3/16, at 2:40 p.m. DM stated he does not complete weekly temperature checks as previously stated, they are completed monthly. Review of Water Temps Log from 8/17/15 to 1/5/16, indicated random room temperatures were taken monthly ranging between 106.4 to 112.3 degrees F. The incident and accident reports were reviewed going back six months from 7/2/15 to 2/2/16 with no burns reported.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of 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	F 329		3/16/16

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F 329	Continued From page 67 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure side effect monitoring of psychotropic and/or anticoagulant (blood thinner) medications was implemented for 2 of 5 residents (R96, R35) reviewed for unnecessary medications, and failed to ensure a gradual dose reduction was attempted for 1 of the 5 (R14) reviewed who utilized an antidepressant. Findings include: R96 did not have side effect monitoring for psychotropic medications. R96's diagnoses included intermittent explosive disorder, unspecified dementia with behavioral disturbance, personality disorder and adjustment disorder with mixed disturbance of emotions and conduct. On 2/3/16, at 8:44 a.m. R96 was observed waiting for his medications by the nursing station. At 8:45 a.m. registered nurse (RN)-B was observed standing next to R96 while the resident took his medications. At 8:48 R96 was overheard telling RN-B he was not going to take one of the pills in the cup and was overheard to yell in an angry tone, "I don't think they get it, I have told them" as he wheeled away. RN-B was heard to	F 329	Residents #35 and #96 were evaluated by a physician (including #96 for side effects) for unnecessary medications and treated accordingly. As well, Resident #14 was evaluated for unnecessary use of an antidepressant and treated accordingly. These residents are also being managed on the new psych program which begins in March 2016. Where anticoagulant therapy is involved, residents with anticoagulant needs have had them met. Residents have been reviewed facility-wide for unnecessary medications, especially psychoactive medications. Where necessary and possible, those medications have been titrated down or removed as per the gradual dose reduction (GDR) program. Residents on the anticoagulant medication program have also been reviewed for any concerns and where concerns exist, they have been met. They too have been seen by a physician. Social Services and Nursing have been in-serviced on the importance of the required steps and elements of a psychoactive medication program that	

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F 329	Continued From page 68 respond to R96, "I will let the doctor know." On 2/3/16, at approximately 2:13 p.m., R96 was observed to approach licensed practical nurse (LPN)-A and requested a bandage. LPN-A asked R96 what he needed the bandage for and R96 became upset and started to swear at LPN-A. The resident initiated wheeling himself down the hallway by the nursing station. When interviewed on 2/4/16 at 8:55 a.m., RN-A verified R96 had orders for side effect monitoring however, stated the monitoring was not being documented in either the Medication Administration Record (MAR) or Treatment Administration Record (TAR). RN-A also stated she did not pass medications and directed surveyor to the floor nurses. On 2/5/16, at 9:47 a.m. R96 was interviewed regarding the medications he received. R96 stated he took a lot of medications. When asked, R96 also stated he was happy and had no problems. On 2/5/16, at 11:37 a.m. LPN-A verified there were orders to monitor side effects of medications for R96, but there was nothing being documented in the TAR. On 2/5/16, at 12:09 p.m. the consultant pharmacist (CP) was interviewed by telephone. The CP confirmed the resident had orders for monitoring side effects for anti-psychotic and anti-depressant medications. On 2/5/16, at 12:11 p.m. the director of nursing (DON) stated staff should be monitoring for medication side effects and should be	F 329	meets the State and Federal regulations promulgated by CMS. They have been trained based on the following program. Nursing has also received additional training on the proper elements of an anticoagulant therapy program which includes monitoring residents for bruising. A new psychoactive program has been instituted at Crystal Care Center that includes the following elements: A) Ensuring that there is supporting diagnosis for each psychoactive medication B) Ensuring that target behaviors have been identified by the physician for each resident on psychoactive medications. C) Behavioral Tracking for residents on psychoactive medications D) Side effect monitoring for residents on psychoactive medications These elements are in addition to the other required elements of a solid psychoactive medication program which go along with the elements stated above. The anticoagulant therapy program has been re-developed in accordance with the policy for anticoagulant management promulgated by the Omnicare Pharmacy policy on Anticoagulant Therapy, with an additional review for nursing to evaluate residents for bruising in accordance with the program explained above in F279. The Social Services Director or designee	

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F 329	Continued From page 69 documenting in the record. On 2/5/16, at 2:07 p.m. LPN-F verified the side effects monitoring had not been scheduled to be completed and was not being completed. RN-A who was at the desk at the same time verified and stated "we will have to train our staff including me to make sure it's done appropriately." R96's psychotropic drug use Care Area Assessment (CAA) dated 12/23/15, indicated resident had unspecified dementia adjustment disorder, intermittent explosive disorder and personality disorder. CAA indicated resident was on Haldol and Celexa with recent increase in dose to stabilize mood. R96's care plan dated 10/6/15, indicated resident was at risk for possible side effects related to the use of Haldol and Celexa. Care plan interventions directed staff to complete an Abnormal Abnormal Involuntary Movement Scale (AIMS) every quarter. During review of R96's February Electronic Medication Administration Record (EMAR) it was revealed resident was received the following medications: - Celexa 20 milligram (mg) by mouth in the morning for major depression. - Haloperidol 1 mg by mouth two times a day related to unspecified dementia with behavioral disturbance. During further document review it was revealed, the physician had requested staff to monitor side effects however, the facility was not conducting the monitoring. R35 was not monitored for response to use of an anticoagulant.	F 329	will audit the new psychoactive medication program to ensure that it is functioning properly; he will audit weekly x 4 and then monthly thereafter. The goal of that audit will be to ensure that each element of the program exists and that they are free of flaws or where flaws exist, they are being addressed. The Director of Nursing or designee will audit the new anticoagulant therapy program and the resident bruise management program with audits weekly x 4 and the monthly thereafter. Both the Social Services Director and the Director of Nursing will report monthly to the Quality Assurance Committee. The Facility alleges compliance by 3-16-16.	

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R35's diagnoses were identified on the Admission Record dated 2/4/15, as including: end stage renal disease, anemia in chronic kidney disease, vitamin D deficiency, dementia, and heart failure.

On 2/3/16, at 7:26 a.m. during interview R35 was observed with bruises on top of right and left hands. When asked how the bruising happened R35 said, " I don't know. "

On 2/4/16, at 10:24 a.m. R35 was observed walking to Bible study and was observed to having bruises on top of her right and left hands that were dark purple in color. R35 said it must have happened during blood draws at dialysis.

R35's admission Minimum Data Set (MDS) dated 1/12/16, indicated R35 had moderately impaired cognition. R35's care plan dated 1/26/16, indicated resident had history of diabetic ulcer of the feet and indicated staff was to complete weekly skin assessments with weekly bath. Care plan did not indicated resident received Plavix and had the potential to bruise easily.

During review of R35's February EMAR it was revealed she received the following medications:
- Plavix 75 mg (blood thinner) by mouth in the morning for congestive heart failure
- Citalopram 20 mg (an antidepressant) for depression

The record further indicated R35 was to have a head to toe skin and body assessment conducted every week.

Review of nursing notes dated 1/5/16, through 2/3/16, revealed no documentation about the bruises. In addition, review of assessment documentation revealed on 1/15/16, and 1/22/16,

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F 329	Continued From page 71	F 329		

the resident had refused her weekly bath and skin check. However, there was no follow up assessment documented. A Nursing Admission Admit Assessment dated 1/2/16, indicated the resident had bruising to the left hand measuring 7 cm x 4 centimeter (cm.) and bruising right hand 7 cm x 6 cm. A copy of the assessment and bath day skin audits was requested and not received.

During interview with RN-C on 2/4/16, at 10:48 a.m. RN-C stated she was "not aware of the bruises" to R35's hand.

During interview on 2/4/16, at 2:30 p.m. RN-E verified there should be monitoring conducted for bruising potentially related to anticoagulant use and a care plan should be developed.

During interview on 2/4/16, at 2:56 p.m. RN-C also said the nurses should monitor for bruising and document on the TAR. RN-C said if a bruise was identified during an admission assessment it should have been put on the temporary care plan, a progress note written, and the nurse should have put a monitoring order in the computer. RN-C verified staff do not have every shift monitoring for her. RN-C verified there was no care plan for the bruises and would expect staff to have done a care plan and verified there was no care plan for risk of blood thinners or Plavix.

During interview on 2/04/16, at 3:24 p.m. RN-D said, " If I knew about a bruise on a resident ' s admission I would care plan it until resolved. I think we care plan Coumadin I do not think so for Plavix. "

Medication Guide Plavix revised July 2015 and distributed by Bristol-Myers Squibb/Sanofi

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F 329	Continued From page 72 Pharmaceuticals Partnership instructed patients: "2. Plavix can cause bleeding which can be serious and can sometimes lead to death. Plavix is a blood thinner medicine that lowers the chance of blood clots forming in your body. While you take Plavix: · you may bruise and bleed more easily · you are more likely to have nose bleeds · it will take longer for any bleeding to stop Call your doctor right away if you have any of these signs or symptoms of bleeding: · unexpected bleeding or bleeding that lasts a long time · blood in your urine (pink, red or brown urine) · red or black stools (looks like tar) · bruises that happen without a known cause or get larger · cough up blood or blood clots · vomit blood or your vomit looks like coffee grounds Tell your doctor about all the medicines you take, including prescription, non-prescription medicines, vitamins and herbal supplements. Plavix may affect the way other medicines work, and other medicines may affect how Plavix works. See "What is the most important information I should know about Plavix? " Taking Plavix with certain other medicines may increase your risk of bleeding. Especially tell your doctor if you take: · aspirin, especially if you have had a stroke. Always talk to your doctor about whether you should take aspirin along with Plavix to treat your condition. · Non-steroidal anti-inflammatory drugs (NSAIDs). Ask your doctor or pharmacist for a list of NSAID medicines if you are not sure.	F 329		

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F 329	Continued From page 73 · warfarin (Coumadin, Jantoven) · selective serotonin reuptake inhibitors (SSRIs) and serotonin norepinephrine reuptake inhibitors (SNRIs). Ask your doctor or pharmacist for a list of SSRI or SNRI medicines if you are not sure. " Medication Guide Celexa (Citalopram) revised July 2014 and distributed by Forrest Laboratories instructed patients: "5. Abnormal bleeding: Celexa and other antidepressant medications may increase your risk of bleeding or bruising,..." R14 did not have a gradual dose reduction for psychotropic medications. R14's quarterly MDS dated 11/12/15, indicated she was severely cognitively impaired, had minimum depression, and displayed no behaviors during the assessment period. R14's previous quarterly MDS dated 8/12/15 indicated she was only moderately cognitively impaired and had minimum depression. R14's care plan dated 11/19/15, indicated an alteration in cognition with a diagnosis of dementia, and use of psychotropic medications. The care plan further indicated R14 "will be on the lowest effective dose [psychotropic medications] without side effects." During an observation on 2/3/16, at 1:54 p.m., R14 was sitting in a common area of unit yelling out. R14 continued yelling out until 2:02 p.m., (eight minutes) until staff responded to her needs. During multiple observations on 2/4/16, R14 was sitting in the common area of the unit. At 10:40 a.m., staff was engaging other residents in an activity. R14 sat in her chair and looked around, but did not engage in activity. At 2:22 p.m., R14 was again sitting in the common area. She was in	F 329		

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F 329	Continued From page 74	F 329		

a wheel chair facing the outside wall of windows, but not close enough to see out. The television was turned on but R14 stated she was not watching it. At 2:27 p.m., R14 began calling out. Staff responded by escorting R14 to bingo where she was engaged in activity.

During an observation on 2/5/16, at 9:59 a.m., R14 was again sitting in her wheel chair in the common area of the unit. The television was turned on, however, R14 was not engaged in the program.

A Crystal Care Center Order Summary Report dated 2/5/15, was reviewed. The report indicated R14 received Mirtazapine 15 mg by mouth every other day, and Trazodone HCL 25 mg by mouth at bedtime related to depressive disorder. R14's current Remeron dose was prescribed on 6/24/14, her current Trazodone dose was prescribed on 2/27/14.

A PharMerica Note To Attending Physician/Prescriber dated 2/5/15, indicated a recommendation evaluate R14's current dose and consider a gradual taper to ensure lowest possible effective dose. The attending prescriber indicated she disagreed with the recommendation but failed to provide a clinical rationale for the continued Remeron dose. The facility was unable to provide ay documentation indicating a gradual dose reduction of R14's Trazodone had been addressed or attempted since 2/27/14.

During an interview on 2/5/16, at 2:41 p.m., the DON stated the recommendations by the pharmacy go to the health unit coordinator to give to the appropriate physician. She indicated there was no process for the facility to follow up on the

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F 329	Continued From page 75 recommendations and stated any follow up on the recommendations should be done by the pharmacist on the next visit. A facility policy regarding gradual dose reductions of psychotropic medications was requested, but none received.	F 329		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper containment of garbage in the outside dumpster to prevent attracting potential pests and rodents. This had the potential to affect all 100 residents residing at the facility. Findings include: On 2/1/16 at 5:42 p.m., a tour to the facility garbage dumpster area was conducted with the food service director. The area was observed to have multiple trash bags and other refuse including used soiled gloves, and other garbage littering the area around the uncovered dumpster. During the observation, the snow was observed to be melted and the litter was completely visible. During the tour, the food service director verified the area was heavily littered and that the dumpster was uncovered. The food service director stated, "It [the dumpster] should be closed, this could attract rodents." The food	F 372	The debris was cleaned up from the dumpster area during the survey. Facility grounds were assessed for any other garbage, and where found, cleaned up. The housekeeping/janitorial/maintenance staff were in-serviced on 2/25/2016 of the importance of keeping the dumpster covers closed and the dumpster area clean. A new housekeeping director was hired 3/3/2016 and will be instructed on the importance of training janitors to neatly dispose of garbage and report if additional help needed to clean up. The dietary staff will be in-serviced by 3/4/2016 to also keep the dumpster covers closed and the dumpster area clean.	3/16/16

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F 372	Continued From page 76 service director stated the maintenance staff were responsible for maintaining the grounds around the dumpster. On 2/2/16, at 10:33 a.m. during a subsequent tour to the dumpster area, maintenance staff (MS)-B verified the area remained littered and that the dumpster uncovered. MS-B stated prior to any snow this season, he had cleaned the area. When asked who was responsible for maintaining the dumpster area, MS-B stated he thought the kitchen staff cleaned after themselves. On 2/5/16, at 9:38 a.m. the director of maintenance (DM) stated the dumpster area was cleaned on an as needed basis, and further added the facility did not have a policy for maintaining the area.	F 372	Maintenance will add the dumpster area to a regular routine to check and clean. an audit will be conducted weekly for four weeks and then monthly thereafter by the Executive Director or designee to ensure that the dumpster lids are kept closed and the area clean. The Executive Director will report monthly to the Quality Assurance Committee on this program. The facility alleges compliance by 3-16-16.	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure routine dental	F 412	Resident #112 has had her dental needs met; she will see the dentist on 4-20-16.	3/16/16

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F 412	Continued From page 77 services were provided for 1 of 3 residents (R112) reviewed for dental status. Findings include: On 2/1/16, at 6:30 p.m. R112 was observed sitting in a wheelchair in the dayroom. When R112 smiled, it was observed she had a missing lower tooth and broken upper teeth. R112 was non-verbal and unable to respond to any questions. On 2/2/16, at 12:00 p.m. during interview, family member (FM)-A verified R112 had a broken tooth in the right upper front that needed to be addressed and FM-A said they'd been told staff would check into it, but added "that was quite some time ago, last October or somewhere around there." R112's annual Minimum Data Set (MDS) dated 9/22/15, identified "obvious or likely cavity or broken natural teeth" and indicated R112 had severely impaired cognitive skills for daily decision making. A Care Area Assessment (CAA) dated 9/22/15, indicated R112 had some missing natural teeth, needs and receives assist of one for all oral cares, had no signs or symptoms of oral pain, and indicated it was unknown when R112 had last been seen by the dentist. The CAA further indicated, "will see dentist per family wishes." Review of R112's care plan with revision date 11/9/15, identified R112 to have self-care performance deficit due to dementia and confusion and listed interventions of "extensive assist 1 staff, brushes teeth" and "will see dentist per family wishes."	F 412	Residents have been evaluated for their dental needs and arrangements have been made with dentistry to meet these needs. Dental consents have been provided for residents with dental needs and signatures obtained for care. Staff have been in-serviced on the need to provide good oral care to residents and on the need to arrange dental care as necessary and to obtain consents for care. They have also been in-serviced on the new Resident Dental tickler file system. Nursing has created a Resident Dental tickler file designed to monitor dental care for facility residents. Based on this new program, residents have all had their dental needs evaluated and arrangements made for dentistry to meet those needs. In the tickler file, tracking is started for each facility resident: those who have received recent dental care begin at that point and follow-up is scheduled and those without any dental needs have another review set. This Resident Dental tickler file represents the complete dental care needs of this body of residents. Newly admitted residents will be added to the Resident Dental tickler file system. The Director of Nursing or her designee will be responsible for this program. The Facility Administrator will audit the new Resident Dental tickler file system weekly x 4 and then monthly thereafter to ensure that it is being managed properly	

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F 412	Continued From page 78 Review of the Nursing Quarterly Data Collection notes dated 12/17/15, indicated R112 was missing some natural teeth with no description of appearance of natural teeth or location of problem areas. During an interview on 2/4/16, at 8:18 a.m. registered nurse (RN)-C stated that when a resident was admitted information was made available in the admission package if the family wanted the resident to see the dentist. During an interview on 2/4/16, at 11:23 a.m. RN-C verified R112 had not been seen by a dentist since admit on 10/3/14. During an interview on 2/4/16, at 1:12 p.m. household unit coordinator (HUC)-A verified R112 had not been seen by the in-house dental service, but was now on the list for April 2016. HUC-A further stated she'd previously had no Care and Concern form brought to her to schedule a dental appointment, and said she had not been told that R112 had a broken tooth that needed to be addressed. During an interview on 2/5/16, at 10:29 a.m. RN-D stated she'd evaluated R112, "her teeth have been the same since I got here, I don't know when she stopped seeing the dentist." RN-D further stated she would have expected R112 to be put on the list to be seen by the dentist earlier and added, "I dropped the ball on this."	F 412	and that residents are getting their dental care managed professionally. The Facility Administrator will report to the Quality Assurance Committee on this program. The Facility alleges compliance on 3-16-16.	
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be	F 428		3/16/16

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F 428	Continued From page 79 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 the consultant pharmacist identified lack of documentation of physician justification for the continued use of antidepressant medications for 1 of 5 residents (R14) reviewed for unnecessary medications. Findings include: R14's quarterly Minimum Data Set (MDS) dated 8/12/15, indicated she was only moderately cognitively impaired and had minimum depression. A subsequent quarterly MDS dated 11/12/15, indicated R14 was severely cognitively impaired, had minimum depression, and displayed no behaviors during the assessment period. R14's care plan dated 11/19/15, indicated she had an alteration in cognition with a diagnosis of dementia, and use of psychotropic medications. The care plan included: "[R14] will be on the lowest effective dose [psychotropic medications] without side effects." During an observation on 2/3/16 at 1:54 p.m., R14 was sitting in a common area of the unit yelling out. R14 continued yelling out until 2:02	F 428	Resident #14 has had her psychotropic medications reviewed according to the new Gradual dose reduction (GDR) policy. Any pharmacy recommendations have been addressed. All residents currently receiving psychotropic medications have been reviewed based on the Gradual Dose Reduction (GDR) policy and appropriate GDRs done where possible. All pharmacy recommendations, especially for GDRs, have been addressed for facility residents. Staff (nursing and social services) were in-serviced on the new program for resident gradual dose reductions (GDR) and how to manage it in conjunction with pharmacy and the physician. They have also been re-inserviced on the proper management of pharmacy consultant recommendations. Crystal Care Center has a new program of gradual dose reductions that is part of their newly formed psych program.	

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F 428	Continued From page 80 p.m., (eight minutes) until staff responded to her needs. During multiple observations on 2/4/16, R14 was sitting in the common area of the unit. At 10:40 a.m., staff was engaging other residents in an activity. R14 sat in her chair and looked around, but did not engage in the activity. At 2:22 p.m., R14 was again sitting in the common area. She was in a wheel chair facing the outside wall of windows, but not close enough to see out. The television was turned on but R14 stated she was not watching it. At 2:27 p.m., R14 began calling out. Staff responded by escorting R14 to BINGO where she was observed to engage in the activity. During an observation on 2/5/16, at 9:59 a.m., R14 was again sitting in her wheel chair in the common area of the unit. The television was turned on however, R14 was not engaged in the program. R14's Order Summary Report dated 2/5/15, was reviewed. The report indicated R14 received Mirtazapine (Remeron) 15 milligrams (mg) by mouth every other day for depression, and Trazodone HCL 25 mg by mouth at bedtime related to depressive disorder. The record indicated R14's current Remeron dose had been prescribed on 6/24/14, and the current Trazodone dose had been prescribed on 2/27/14. The consultatn pharmacist's note, PharMerica Note To Attending Physician/Prescriber, dated 2/5/15, indicated a recommendation to evaluate R14's current Remeron dose and to consider a gradual taper to ensure lowest possible effective dose. The attending prescriber indicated she disagreed with the recommendation but failed to	F 428	Accordingly, the facility has a Minimum Effective Dose Committee (MEDC) that keeps track of residents receiving psychotropic medications and a schedule of GDRs based on the regulations for GDRs promulgated by Centers for Medicaid and Medicare Services (CMS). As a sub-committee of the IDT, the MEDC will provide constant management on this issue. Additionally, a check system has been developed for pharmacy consultant recommendations whereby each recommendation □ usually submitted by the pharmacy consultant monthly □ is copied and then checked-off by the unit manager and delivered to the Director of Nursing once completed. The delivery is through the physicians who either accept or reject the recommendation and then sign. The Director of Nursing evaluate each pharmacy recommendation, or her designee, to ensure that it has been managed and that the physician, if he rejected, provides a response explanation for why. One the check-off is completed, any missed recommendations are found and managed. The completed recommendations checklist (individual recommendation forms) are filed by the DON in a month-based file (e.g. January, February, March&). The Director of Social Services will monitor the MEDC monthly, including all of its records, schedule, and attempts at GDRs and report monthly to the Quality Assurance Committee. The Executive	

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F 428	Continued From page 81 provide a clinical rationale for the continued Remeron dose. The facility was unable to provide any documentation to indicate whether a gradual dose reduction of R14's Trazodone had been addressed or attempted since 2/27/14. A review of a PharMerica medication Regimen Review indicated the consultant pharmacist had noted on 3/5/15, the Remeron decrease was rejected, but there was no evidence the pharmacist followed up on the lack of clinical rationale for the continued use of Remeron. A subsequent entry dated 9/4/15, indicated the consultant pharmacist had identified a need for a risk versus benefit for the continued use of Remeron and Trazodone, however the facility was unable to provide evidence that had been completed, and there was no evidence of follow up by the consulting pharmacist. During an interview on 2/5/16 at 2:41 p.m., the director of nursing stated the recommendations from the pharmacist go to the health unit coordinator to give to the appropriate physician. However, she indicated there was no process for the facility to follow up on the recommendations and stated any follow up on the recommendations should be done by the pharmacist on the next visit. A facility policy regarding gradual dose reductions of psychotropic medications was requested, but not received.	F 428	Director will audit the report which is provided by the Director of Nursing containing a review of each month□s pharmacy recommendations; her audit is to ensure each one has been addressed and that the physician has provided a clear explanation when his or her response is to reject the recommendation. The Director of Nursing will report monthly to the Quality Assurance Committee on this pharmacy consultant recommendation program. The Facility alleged compliance with this program 3-16-16.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		3/16/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 82 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the security of 1 of 3 medication rooms (1st floor medication room). This had the potential to affect any residents, family and visitors traversing the area.	F 431	Nursing administration and facility maintenance has reviewed each of the medication rooms to determine that in fact the doors have adequately locking doors and latches.	

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	245289	A. BUILDING _____ B. WING _____	02/05/2016

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F 431	Continued From page 83 Findings include: During observation on 2/5/16, at 8:44 a.m. the first floor medication room door was observed to be propped open with a small trash can. The medication room was observed to open into the lobby of the first floor, directly across from the elevator. R34 was sitting in front of the medication room. The executive director (ED) and maintenance staff (MS)-B walked passed the medication room and neither attempted to close the door to the medication room. Housekeeper-A was observed at a housekeeping cart across the lobby from the medication room. On 2/5/16 at 8:45 a.m., registered nurse (RN)-D approached the medication room and removed the trash can propping the door open. RN-D verified the medication room was supposed to be locked when no nurse was present in order to prevent residents, staff or visitors from accessing medications. At that time, the medication room was observed with RN-D to have two unlocked refrigerators in it. One refrigerator was observed to contain supplements, and the other contained medications including: IV (intravenous) antibiotics, insulin pens and vials, a plastic container labeled e-kit medications that was sealed with a numbered plastic zip tie not attached to the refrigerator. The plastic container contained two vials of Ativan (anti-anxiety medication) and three vials of insulin (medication used to control blood sugar). In addition, on the counter in the medication room were two stacks of medication punch cards to be returned to the pharmacy, including Haldol (anti-psychotic medication), blood pressure medications, and diuretics.	F 431	All nursing personnel have been in-serviced on the importance of keeping the medication rooms locked, including the protection of medications. The Director of Nursing or her designee will do impromptu med-room audits to ensure the doors are closed and locked weekly for four weeks and then monthly thereafter. The Director of Nursing will report on this program to the Quality Assurance Committee. The Facility alleges compliance 3-16-16.	

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F 431	Continued From page 84 During interview on 2/5/16, at 8:47 a.m. Housekeeper-A stated the medication room door had been propped open for five minutes. Housekeeper-A said, "The nurse asked me to clean it. She opened the door and then walked away." On 2/5/16 at 8:53 a.m. RN-E said, "I unlocked it for the housekeeper to clean the floor. I went to go get something for a resident. I should not have left it unlocked." During interview at 12:38 p.m. on 2/5/16, the ED stated, "The medication room should not have been left unlocked. I looked to see if there was a nursing staff member around but did not see anyone." R34's record was reviewed. A Minimum Data Set (MDS) assessment dated 12/23/15, indicated R34 was moderately cognitively impaired and was independent with wheelchair locomotion. An undated facility policy, Storage of Medications, instructed staff: "It is the policy of Crystal Care Center to ensure that all medications are properly stored at all times...6. Only authorized personnel have access to medication and medication storage supplies. 7. Administration monitors the safe keeping and storage of medications and equipment associated with medications and their seclusion from the general population, residents and the public....10. Medication storage room doors are to be kept shut and locked except under rare circumstances when authorized staff members are working with medications and using access to those areas."	F 431		

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F 465	Continued From page 85	F 465		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident rooms 4 of 35 census residents (R93, R101, R122, R9) had their rooms maintained in a safe, functional and sanitary manner. Findings include: R93's room was observed on 2/1/16, at 2:07 p.m.. During the observation, the vent on the wall next to the window was observed to be soiled and loose from the wall. During interview on 2/1/16, at 4:40 p.m. R93 stated that there are times when the building was not very clean, especially when housekeeping staff did not show up. R93's quarterly Minimum Data Set assessment dated 1/20/16, indicated resident was cognitively intact and was independent with locomotion in electric wheel chair on and off the unit. On 2/1/16, at 4:44 p.m. the floor perimeter in R101's bathroom was observed to be stained with a buildup of grayish matter. The floor outside of the bathroom was also soiled with a buildup of dirt.	F 465	The facility had work done on some of the heating units in resident rooms during the week of Feb. 8. The vents on the walls are now clean. The floors and walls in rooms belonging to R93, R101,R122, and R9 will be thoroughly cleaned by March 16. If the floor stains are unable to be removed, ownership will be requested to replace. The crack in the room belonging to R122 will be filled/repaired by March 16. The housekeeping and janitorial staff were in-serviced on February 25 regarding the reporting of cleaning needs that they cannot meet to the supervisory staff. Resident rooms will be monitored for cleanliness by the Executive Director and needs reported to the supervisor for scheduling on an ongoing basis. The facility alleges compliance by 3-16-2016.	3/16/16

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F 465	Continued From page 86 During a tour of R122's room on 2/1/16 at 4:56 p.m., the bathroom floor by teh door was observed to be cracked along the wall. During a tour of R9's room on 2/2/16, at 8:59 a.m. a large greyish-black stain was observed on the floor extending from under R9's bed, to the empty bed on the opposite side of the room. In addition, the vent next to the window was observed to be loose and dirty. The bathroom floor was also observed to be soiled and the wall behind the toilet was soiled with dried yellowish stains. The director of maintenance (DM) and executive director (ED) participated with a tour of the environment on 2/5/16 from 9:30 a.m. until 10:15 a.m. The DM said the stain on R9's floor was likely from spillage of a drink the nurses give the resident. The DM stated the resident's floor needed to be stripped. When asked how maintenance or housekeeping staff would be notified of soiling on the floor, the DM said either the nurses or housekeepers should document the information in the housekeeping log book and added, "Stripping a floor takes time and arrangements must be made to ensure residents can remain out of the room long enough for the floor to dry." During the tour, the DM also verified the wall and floor in the resident's bathroom were soiled, and the vent next to window was loose and soiled. The DM also verified R101's bathroom floor was soiled and that the transition between the resident's room and bathroom was cracked and the baseboard was dirty. The DM verified the reddish stain on R122's bathroom floor, and the crack on the bathroom floor. Finally, the DM verified the vent in R93's room was missing screws causing it to be loose, and verified the	F 465		

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F 465	Continued From page 87 vent was dirty. Immediately following the tour, the DM reviewed the Maintenance Request Logs and verified the above findings had not been reported. The facility provided copies of their All Staff Meeting minutes from February 5, 6 and 10, 2015, which included: "HOW TO NOTIFY MAINTENANCE: What are some of the ways Maintenance can be notified? For routine matters, a maintenance log hangs at each nurse's station. You do not need a special license or degree to write on the maintenance log. You do need a little common sense to know what is routine and what is important. Safety issues for residents are best communicated by phone call or voice mail. Urgent matters should be overhead paged or ask the receptionist to find Maintenance on the walkie-talkies. During the evening and night shift, report to the supervisor who will decide what and who to report on."	F 465		

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	245289	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/02/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on Frebruary 2, 2016. At the time of this survey, Crystal Care Center 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: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/07/2016

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

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K 000	Continued From page 1 Marian.Whitney@state.mn.us Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was constructed in 1971 and was determined to be of Type II (111) construction. It has a full basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 130 beds and had a census of 100 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive	K 027		3/16/16

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K 027	Continued From page 2 latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect 19 residents. Findings include: On facility tour between 09:00 AM and 01:00 PM on February 2, 2016, observation revealed that on the first floor, east side, the smoke compartment doors did not self-close due to an obstruction with the door coordinator. This deficient practice was verified by the Director of Environmental Services at the time of the inspection.	K 027	The 1st floor east door was repaired by Maintenance on 2/5/16 but parts are needed and have been ordered. The door coordinator will be repaired by March 16, 2016. To monitor, the doors are checked during each monthly fire drill and reported to Maintenance if not working. The administrator will report the results to QA committee monthly.	
K 050 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Base on review of records and staff interview, it was determined that the facility failed to vary the	K 050	The Maintenance Director was informed to vary the times of the fire drills on	3/16/16

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K 050	Continued From page 3 times of conducted fire drills, for one shift in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect the safety of all 100 residents. Findings include: On facility tour between 9:00 AM and 1:00 PM on February 2, 2016, a review of the available fire drill reports in 2015 and 2016, it revealed that the facility conducted three Evening-Shift fire drills between the hours of 7:44 PM, 7:45 PM, and 7:47 PM not varying the times in accordance with Section 19.7.1.2. This deficient practice was confirmed by the Administrator.	K 050	2/3/2016. An evening shift fire drill was conducted on 2/24/16 at 5:30 p.m. to vary the time of the drill. The Executive Director will monitor the times of the drills for each shift during the year to ensure that the times are varied. The results of the audit will be reported to the QA committee.	
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and staff interviews, it could not be verified that the facility's general ventilating and air conditioning system (HVAC) is installed in accordance with the LSC, Section 19.5.2.1 and NFPA 90A, Section 2-3.11. A noncompliant HVAC system could affect all residents. Findings include:	K 067	A waiver for K 0067 is being requested to be continued and the request is attached.	3/16/16

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K 067	Continued From page 4 On facility tour between 9:00 AM and 1:00 PM on February 02, 2016, observation revealed that the ventilation system has supply ducts serving the corridors with inoperable returns. . This deficient practice was verified by the Director of Environmental Services at the time of the inspection.	K 067		

Name of Facility
Crystal Care Center-1

2000 CODE

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84 K 067 The building heating, ventilation & air conditioning equipment (HVAC) does not comply with LCS (00) Section 9.2 and HFPA 90A, 1999 edition because the corridors are being used as a plenum	Requesting to continue the Annual Wavier for K 067 approved last year. A. Compliance with this provision will cause an unreasonable Financial Hardship because: 1.The most recent cost estimate in 2016 for a complying duct HVAC system is $ 186,100.00 2. Existing non-complying systems can be allowed to continue in use with no adverse effect to safety. B. There will be no adverse effect on the building occupant's safety because: 1. The building is protected by a complete fire sprinkler system that complies with NFPA 13. 2. The facility corridors are equipped with a complying smoke detection system. 3.The building fire alarm system is monitored to provide automatic fire department notification. 4. The facility has a HVAC system that shuts down upon the detection of smoke. 5. Annual service and maintenance inspection/agreements exist to service all the fire protection systems. 6. Fire department stand pipes are provided in the stairways for firefighter use in case of fire. 7. Fire training is provided for all employees on an annual basis and during orientation. 8. Fire Drills are conducted quarterly on each shift.

Surveyor *(Signature)*	Title	Office	Date
T Thomas Ruff	FIRE SAFETY SUPV	STATE FIRE MARSHAL	3/28/16
Fire Authority Official *(Signature)*	Title	Office	Date