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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: S33Z

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00995

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

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WALKER**
(L4) **209 BIRCHWOOD AVENUE WEST PO BOX 700**
(L5) **WALKER, MN** (L6) **56484**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **08/05/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Theresa Gullingsrud, HFE NEII 08/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 09/15/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/16/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5323
August 15, 2014

Mr. Shane Roche, Administrator
Golden LivingCenter - Walker
209 Birchwood Avenue West PO Box 700
Walker, Minnesota 56484

Dear Mr. Roche:

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 July 9, 2014 the above facility is certified for:

40 Skilled Nursing Facility/Nursing Facility Beds

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

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 15, 2014

Mr. Shane Roche, Administrator
Golden LivingCenter - Walker
209 Birchwood Avenue West PO Box 700
Walker, Minnesota 56484

RE: Project Number S5323023

Dear Mr. Roche:

On June 17, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 30, 2014. 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 August 5, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 30, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 9, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 30, 2014, effective July 9, 2014 and therefore remedies outlined in our letter to you dated June 17, 2014, 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245323	A. Building B. Wing	8/5/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **07/09/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/09/2014**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **07/09/2014**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **07/09/2014**
ID Prefix **F0364** Reg. # **483.35(d)(1)-(2)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **07/09/2014**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	08/15/2014	33562	08/05/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245323	A. Building B. Wing	8/5/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **07/09/2014**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **07/09/2014**

Reviewed By State Agency	**Reviewed By** LB/mm	**Date:** 08/15/2014	**Signature of Surveyor:** 33562	**Date:** 08/05/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/30/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00995	A. Building B. Wing	8/5/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20005** Reg. # **MN Rule 4658.0015** LSC	Correction Completed **07/09/2014**	ID Prefix **20255** Reg. # **MN Rule 4658.0070** LSC	Correction Completed **07/09/2014**	ID Prefix **20505** Reg. # **MN Rule 4658.0300 Subp. 1 A-I** LSC	Correction Completed **07/09/2014**
ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 2** LSC	Correction Completed **07/09/2014**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **07/09/2014**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp. 4** LSC	Correction Completed **07/09/2014**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **07/09/2014**	ID Prefix **20905** Reg. # **MN Rule 4658.0525 Subp. 4** LSC	Correction Completed **07/09/2014**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	Correction Completed **07/09/2014**
ID Prefix **20915** Reg. # **MN Rule 4658.0525 Subp. 6 A** LSC	Correction Completed **07/09/2014**	ID Prefix **20920** Reg. # **MN Rule 4658.0525 Subp. 6 B** LSC	Correction Completed **07/09/2014**	ID Prefix **20960** Reg. # **MN Rule 4658.0600 Subp. 1** LSC	Correction Completed **07/09/2014**
ID Prefix **21000** Reg. # **MN Rule 4658.0610 Subp. 4** LSC	Correction Completed **07/09/2014**	ID Prefix **21390** Reg. # **MN Rule 4658.0800 Subp. 4 A-I** LSC	Correction Completed **07/09/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 4** LSC	Correction Completed **08/05/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	LB/mm	08/15/2014	33562	08/05/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00995	A. Building B. Wing	8/5/2014

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **21540** Reg. # **MN Rule 4658.1315 Subp. 2** LSC	Correction Completed **07/09/2014**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp. 4** LSC	Correction Completed **07/09/2014**	ID Prefix **21870** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	Correction Completed **07/09/2014**
ID Prefix **21942** Reg. # **MN St. Statute 144A.10 Subd. 8** LSC	Correction Completed **08/05/2014**				

Reviewed By _____ **State Agency**	**Reviewed By** LB/mm	**Date:** 08/15/2014	**Signature of Surveyor:** 33562	**Date:** 08/05/2014
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/30/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

August 15, 2014

Mr. Shane Roche, Administrator
Golden LivingCenter - Walker
209 Birchwood Avenue West PO Box 700
Walker, Minnesota 56484

Re: Reinspection Results - Project Number S5323023

Dear Mr. Roche:

On August 5, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on, May 30, 2014. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: S33Z

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

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245323**

2.STATE VENDOR OR MEDICAID NO.
(L2) **677088600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - WALKER**
(L4) **209 BIRCHWOOD AVENUE WEST PO BOX 700**
(L5) **WALKER, MN** (L6) **56484**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **04/01/2006**

6. DATE OF SURVEY **05/30/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **40** (L18)

13.Total Certified Beds **40** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NEII 07/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath
Enforcement Specialist 07/16/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00454
(L31)

30. REMARKS
Posted 07/16/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 17, 2014

Mr. Dan Stockdale, Administrator
Golden Livingcenter - Walker
209 Birchwood Avenue West
PO Box 700
Walker, Minnesota 56484

RE: Project Number S5323023

Dear Mr. Stockdale:

On May 30, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

<u>Remedies</u> - 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;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and
<u>Informal Dispute Resolution</u> - 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:

Lyla Burkman, Unit Supervisor
Minnesota Department of Health
705 - 5th Street NW, Suite A
Bemidji, Minnesota 56601-2933
Telephone: (218) 308-2104
Fax: (218) 308-2122
Email: lyla.burkman@state.mn.us

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 June 9, 2014, 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 June 9, 2014 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own

compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition

of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 30, 2014 (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 November 30, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING _____ B. WING _____	05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

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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 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the least restrictive restraint device was used for the least amount of time as necessary for 1 of 1 resident (R31) in the sample who utilized a physical restraint device (lap buddy). Findings include: R31's order summary report dated 4/24/14, identified R31's diagnosis as Parkinson's disease, depression, hallucinations, anxiety, and generalized muscle weakness.	F 221	1. Resident #31 use of a Physical Restraint has been re-assessed, and is using the least restrictive device indicated. Staff are being trained on removing the device and on leaving it on for the shortest time possible. 2. Other residents that have the potential to be affected have been reviewed. 3. Staff have been re-educated on the Physical Restraints. 4. Monitoring to ensure compliance will be completed by the DNS/Designee, through random audits of residents,	7/9/14

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

Electronically Signed | 06/30/2014

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F 221	Continued From page 1 R31's quarterly Minimum Data Set (MDS) dated 4/14/14, indicated R31 had severe cognitive impairment and required extensive assist with transferring, dressing, eating and toileting. R31's PHYSICAL RESTRAINT/DEVICE SCREENING FORM dated 4/9/14, indicated the type of restraint/device recommended was a lap buddy (a thick cushion that fits over a resident's lap and is secured to the armrests of the wheelchair, which can restrict the residents' ability to remove themselves from the wheelchair). R31 was also identified as not being able to independently remove the restraint on command. R31's care plan dated 4/9/14, directed staff to check on R31 every 30 minutes when the lap buddy (restraint) was in place, release the restraint every two hours and at meal time when under direct supervision of staff. On 5/29/14, at 12:46 p.m. R31 was observed wheeled into the dining room with the lap buddy secured to her wheelchair. During the noon meal observation from 12:46 p.m. through 1:30 p.m. R31 was continuously observed and the lap buddy was kept secured to R31's wheelchair. At R31's table licensed practical nurse (LPN)-A, nursing assistant (NA)-A and NA-B were observed to be seated at R31's table as they assisted residents with their meals. On 5/29/14, at 1:30 p.m. LPN-A confirmed R31's lap buddy had remained secured during the noon meal. LPN-A stated if it was up to her she would have removed the lap buddy during meal times, although she had only seen it on R31.	F 221	through care observations and record review. The results of the audits will be reviewed at the monthly Quality Assurance Meeting.	

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F 221	Continued From page 2 On 5/29/14, at 2:00 p.m. the assistant director of nursing (ADON) confirmed R31's lap buddy was considered a restraint. The ADON verified her expectation was for R31's lap buddy to be removed during meal time as the facility should be using the least restrictive restraint. On 5/30/14, at 11:23 a.m. the director of nursing services (DNS) confirmed R31's lap buddy should be off at meal times and the facility should be using the least restrictive type of restraint for the least amount of time. The facility's Restraint Devices, Physical policy [undated] specified the goal should be for removal of the restraint or use of the less restrictive measure.	F 221		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act upon resident grievances for the last 5 of 5 resident council meetings regarding food palatability. Findings include:	F 244	1. Resident 38, food choices and concerns have been reviewed, is receiving food that is palatable. The facility system for identifying and following up on grievances has been reviewed and revised, including food palatability concerns. 2. Resident Council Meetings will be held	7/9/14

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F 244	Continued From page 3 R38 was interviewed on 5/28/14, at 1:30 p.m. and stated the food quality is horrible and they (residents) have complained numerous times. R38 added the quality of the food is not palatable, sometimes it is undercooked, sometimes it is over cooked and just mush. R38 stated there are residents who cannot always speak for themselves, but you see that they are not eating the food. The residents have not heard or seen anything from the dietary department, many times the menu is changed without notice because they don't have the food item, and the comments are they did not get the order in in time to be delivered. R38 added they have made numerous complaints about the food quality and there is no follow up. R38 continued there is tuna casserole with no tuna, the vegetables are overcooked and at times mushy, meat is overcooked and you cannot chew it. R38 stated, "We have requested that a member of the upper staff come and have a meal with us and do this weekly, so they see the quality of food that has not happened." R38 stated he was going to talk to the social service designee to find out why all of the food complaints are not documented in the resident council minutes. The resident council minutes were reviewed and documentation included: 1/22/14, residents brought up concerns that the food is cold and food is not cooked thoroughly. On 2/20/14, five residents brought up concerns that the food is cold. 3/28/14, "Is there any diabetic desserts besides fruit? When is the spring menu coming here? Would like to have a spring picnic with picnic food. Does the Administration here listen to your suggestion?" Answer was: No. Number of residents who agree: All. "Food portions are too	F 244	monthly, and grievances brought forward will be addressed by the IDT team. 3. The Therapeutic Recreation Director has been educated on identification and follow up on grievances brought up at the Resident Council Meeting. Staff have been educated on the Grievance Process. Identified Grievances are documented on the Grievance Form, the follow up is allocated to the appropriate department identified in the Grievance. 4. The ED/Designee signs off on all identified Grievances, the Social Services Designee logs all of the Grievances. The Grievance Logs are reviewed daily at Stand Up, and at the Monthly Quality Assurance Meeting.	

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F 244	Continued From page 4	F 244		

small. Please let kitchen know I don't want any more pasta. Meal items missing and food cold and late."
4/25/14, "Is there any diabetic desserts besides fruit? Would like to have Department heads eat with residents at least one time a week."
5/16/14, "Food items dropped or substitute the day of menu, i.e. salmon, over loaded on carbohydrates, Food over and under cooked-vegetables also meat."

On 5/30/14, at 9:40 a.m. during an interview with the social service designee (SSD) regarding the resident council concerns regarding the unpalatable food that is being served, the SSD stated, " If there is a problem or complaint regarding the food, I just go to dietary and tell them verbally. I have not filled out any forms to give to the kitchen regarding the residents' concerns. I know the residents have had many complaints about the quality of the food." SSD added, "The dietary manager would have a monthly meeting and I would just step in and bring up complaints. I have never filled out the form to notify the kitchen of food concerns of the residents from the council meetings." When asked why all the food complaints are not documented in the minutes the SSD stated,"I would just go tell dietary the concerns." The SSD stated, "We have a form to fill out to go to the departments that the resident council had concerns with. I am the one who would fill out the form for the departments, I have not done that." The SSD verified, "The forms have not been filled out regarding the complaints the resident council has regarding the palatability of the food and the multiple complaints that were brought up in the resident council meetings regarding food quality." The SSD provided documentation titled,

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F 244	Continued From page 5 Resident Council Process which indicated, "It is the Golden Living standard that the SSD and RSD are to be involved in the council. If two or more residents have issues, then the Department Response form (DRF) is to be utilized. If the DRF's need to have a plan to correct the situation completed and signed by the appropriate department head, and then signed. At the next council meeting the resident will decide whether the issue has been resolved or remains ongoing and needs to re-address using the same format. Repetitive problems may need further address." The SSD verified that the policy had not been followed. On 5/30/14, at 9:55 a.m. the consulting dietician (CD) was asked if she had received any resident council complaint forms, the dietician stated, " I have not, but I have talked to some of the more vocal residents and I asked how the food has been because they have complaints about the quality of the food. We are aware of the problems with the quality of the food and we have to work to improve this." On 5/30/14, at 11:40 a.m. the director of nursing services (DNS) verified the resident council policy should be followed, and the residents' concerns regarding the poor quality of food should have been addressed.	F 244		
F 279 SS=D	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	F 279		7/9/14

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F 279	Continued From page 6 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 interview and document review, the facility failed to develop a care plan with measurable goals and interventions to address the care and treatment of Clostridium Difficile (c-diff) infection for 1 of 1 resident (R22) with the diagnosis of c-diff. Findings include: R22's MDS dated 4/18/14, indicated R22 requires extensive assist of one for bed mobility and toileting. The MDS included diagnoses of multiple sclerosis, intestinal infections due to c-diff, atrial fibrillation and hypertension. Physicians orders dated 5/1/14, indicated the following medications: Vancomycin (antibiotic to treat range of bacterial infections) 125 milligrams by mouth every six hours and Loperamide two	F 279	1. Resident 22 Clostridium has been resolved. 2. Other residents that are on Hospice, or Diagnosis of Clostridium Difficile care plans have been reviewed and revised as indicated. 3. Staff have been educated on developing comprehensive care plans 4. Monitoring by the DNS/Designee through random weekly audits that care plans are comprehensive. The results of thses audits will be reviewed at the Monthly Quality Assurance Meeting.	

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F 279	Continued From page 7 milligram tablet by mouth in evening for diarrhea related to intestinal infections due to c-diff. The orders included to monitor stools every day and night shift and follow up as needed if diarrhea continues, and infections disease consult in Bemidji for chronic urinary tract infections and c-diff. Provider progress notes dated 5/21/14, indicated: "infectious disease follow up for c-diff pt [patient] getting better, continue Vancomycin 125 milligrams by every six hours by mouth until 5/26/14, continue to monitor stool. Follow up as need or if diarrhea recurs. Patient should be able to leave room and go outside as long as continent." R22's current undated plan of care with print date of 5/29/14, lacked a problem statement, goal or any approaches related to the treatment and risks of c-diff. On 5/30/14, at 10:40 a.m. the assistant director of nursing (ADON) stated the c-diff infection should definitely be on the resident's care plan with interventions. The ADON verified that the resident's c-diff infection was not on the plan of care and should be. On 5/30/14, at 12:15 p.m. the director of nursing (DON) verified that R22's care plan should reflect the c-diff problem and appropriate interventions as well.	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	F 280		7/9/14

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F 280	Continued From page 8 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 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 update the care plan to include removal of a physical restraint during meal times for 1 of 1 resident (R31) in the sample with a physical restraint (lap buddy). Findings include: R31's order summary report dated 4/24/14, identified R31's diagnosis as Parkinson's disease, depression, hallucinations, anxiety, and generalized muscle weakness. R31's quarterly Minimum Data Set (MDS) dated 4/14/14, indicated R31 had severe cognitive impairment and required extensive assist with transferring, dressing, eating and toileting.	F 280	1. Resident 31, care plan has been reviewed and revised as indicated for the use of ;physical restraints 2. Other residents care plans are being reviewed and revised for accuracy. 3. Staff have been educated on reviewing and revising carfe plan interventions as they are identifiedand implemented. 4. Monitoring for compliance will be completed by the DNS/Designee through random weekly care plan audits that interventions are current. The results of these audits will be reviewed at the Monthly Quality Assurance Meeting.	

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F 280	Continued From page 9 R31's PHYSICAL RESTRAINT/DEVICE SCREENING FORM dated 4/9/14, indicated the type of restraint/device recommended was a lap buddy (a thick cushion that fits over a resident's lap and is secured to the armrests of the wheelchair, which can restrict the residents' ability to remove themselves from the wheelchair). R31 was also identified as not being able to independently remove the restraint on command. R31's care plan dated 4/9/14, directed staff to check on R31 every 30 minutes when the lap buddy (restraint) was in place; release and reposition every two hours and at meal time when under direct supervision. R31's care plan dated 5/29/14, identified a focus area for utilization of a physical restraint (lap buddy). However, the care plan lacked interventions which directed the staff when to monitor R31 when the restraint was in place and when to release the restraint. On 5/29/14, at 12:46 p.m. R31 was wheeled into the dining room with the lap buddy secured to her wheelchair. During the noon meal from 12:46 p.m. through 1:30 p.m. R31 was continuously observed and the lap buddy was kept secured to R31's wheelchair. On 5/29/14, at 1:30 p.m. LPN-A confirmed R31's lap buddy had remained secured during the noon meal. On 5/29/14, at 2:00 p.m. the assistant director of nursing (ADON) confirmed R31's lap buddy was considered a restraint. ADON verified her expectation was for R31's lap buddy to be	F 280		

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F 280	Continued From page 10 removed during meal time as the facility should be using the least restrictive restraint. ADON confirmed the interventions to monitor R31 every 30 minutes when the restraint was in place and to release the restraint every two hours and during meal time had not been carried over from 4/9/14's care plan to the current care plan dated 5/29/14. The facility's Restraint Devices, Physical policy [undated] directed staff to develop or review resident care plan for type of restraint device, reason for use, monitoring of resident and frequency and length of time restraint device is released. No facility policy or procedure for care plan development, revision and review was provided.	F 280		
F 282 SS=E	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, the facility failed to follow the resident's care plan for 2 of 2 residents (R45, R26) for timely repositioning and incontinence care, for 1 of 1 resident (R26) resident requiring assistance with eating, for 1 of 1 resident (R39) reviewed for dialysis with a fluid restriction, and for 1 of 1 resident (R39) who required assistance with	F 282	1. Resident's 45 and 26 are receiving care per care plan for repositioning, and incontinence care. Resident 39, is receiving care per care plan for ambulation assistance and fluid restriction. Resident 26,is receiving care per care plan for eating assistance. 2. Other residents are receiving care per	7/9/14

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	245323	A. BUILDING _____ B. WING _____	05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

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F 282	Continued From page 11 ambulation. Findings include: TOILETING/REPOSITIONING: R45's care plan dated 3/31/14, indicated R45 was to be repositioned hourly and as needed. In addition, R45's brief was to be checked and changed every 2 hours and as needed. On 5/29/14, R45 was observed continuously from 6:50 a.m. until 10:02 a.m. At 9:36 a.m. nursing assistant (NA)-B and NA-C stood R45 with a gait belt and walker. At 9:55 a.m. NA-C stated R45 was placed in the wheelchair at 7:55 a.m. according to her NA group sheet that she had written on. The surveyor told NA-C that R45 was in the wheelchair at 6:50 a.m.. (2 hours & 46 minutes without repositioning). NA-C stated they were "short" and there were only 2 NAs working on the floor as the third NA did baths and restorative/rehab for the residents. NA-C stated normally they track their own group of residents. NA-C stated she must have written the time done incorrectly for R45. At 11:24 a.m. NA-A and NA-B transferred R45 with the gait belt to bed. NA-A stated right before R45 was placed in the wheelchair at 6:50 a.m. his brief was changed as R45 had been incontinent of urine. At 11:25 a.m. NA-A removed R45's brief and R45 had been incontinent of urine (4 hours & 35 minutes since the last brief change). NA-A stated they were "short" a 6:00 a.m. to 10:00 a.m. NA which was their busiest time of the day. NA-B stated when they are "short" then each NA does not have their own group of residents and it becomes confusing.	F 282	care plans. 3. Staff have been educated on providing care per care plan. 4. Monitoring for compliance will be completed by the DNS/designee, through random weekly audits of direct care observations, that cares are being provided per care plan. The results of these audits will be reviewed monthly at the Quality Assurance Meeting.	

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F 282	Continued From page 12 On 5/29/14, at 1:15 p.m. the assistant director of nursing (ADON) stated R45's brief was to be checked every 2 hours. The ADON verified the care plan was not followed for incontinence care. R26's care plan dated 12/4/13, directed staff to reposition R26 every 2 hours and as needed. In addition, R26's incontinence brief was to be checked and changed and R26 was to be offered the toilet every two hours and as needed. On 5/29/14, at 7:07 a.m. R26 was observed to be up and dressed, seated in a wheelchair and propelling herself, via her feet, out of her room and into the hallway. R26 was continuously observed until 10:03 a.m. during which time she was observed to propel herself throughout the facility. On 5/29/14, at 9:55 a.m. NA-C stated R26 had not been toileted or repositioned, to her knowledge, since approximately 7:00 a.m. when she provided morning cares. On 5/29/14, at 10:03 p.m. R26 was returned to her room by nursing assistant NA-A and licensed practical nurse (LPN)-A for toileting and repositioning services. On 5/29/14 at 11:33 a.m. NA-A confirmed R26 was up in her chair from approximately 7:00 a.m. until 10:00 a.m. without repositioning or toileting. NA-A confirmed R26 should have been checked and repositioned every 2 hours. On 5/30/14, at 10:12 a.m. DON stated she would expect R26 would have been toileted and	F 282		

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F 282	Continued From page 13 repositioned every 2 hours as the care plan directed. EATING: R26's care plan dated 12/4/13, directed staff to provide R26 eating assistance of 1. On 5/29/14, R26 was continuously observed from 7:00 a.m. until 10:03 a.m. -At 7:00 a.m. R26 was observed in her own room, seated on the edge of a low bed. -At 7:07 a.m. R26 was observed to be up and dressed and independently propelling herself in her wheelchair via her feet throughout the facility and dining room. -At 7:45 a.m. R26 was observed going in and out of the dining room while other residents were eating breakfast. Staff was present, however, did not offer R26 any food or drink. R26 was noted to have a place set up for her at a dining room table. -At 8:45 a.m. R26 continued to independently propel herself up and down the halls. R26 had not been offered food or beverage. -At 8:50 a.m. LPN-B stated R26 was resistive when staff try to feed her and usually did not eat so, " we just give her supplements. " -At 9:12 a.m. R26 was observed to be in the activity area watching the birds with a visitor -At 9:20 a.m. R26 was observed to propel herself throughout the activity room. R26 had not been offered food or beverage. -At 9:30 a.m. the cook verified all residents had been served breakfast and stated the meal service was complete. At no time was R26 offered any food or beverage. -At 9:46 a.m. social service designee (SSD) brought R26 to her room and visited with her 1:1.	F 282		

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F 282	Continued From page 14 No food or drink was offered to R26. On 5/29/14, at 12:56 p.m. consulting dietician (RD) stated she had offered R26 to eat, however, R26 refused. The RD confirmed she had not "physically" assisted R26. When asked if R26 had been offered finger foods, the RD stated she did not know. The RD stated staff should have offered R26 food and drink for the breakfast meal. On 5/29/14, at 1:01 p.m. LPN-C confirmed R26 did not eat much, however, stated staff should have provided her a breakfast meal. On 5/29/14, at 1:11 p.m. LPN-B verified she had served the breakfast meal in the dining room. She further stated R26 " absolutely would not eat " and would not stay still for long enough to eat. LPN-B verified she had not offered R26 any food or drink for breakfast and stated R26 "did not want any", R26 said no when offered. However, when asked, LPN-B confirmed she had not attempted to offer R26 any food or drink at breakfast time. LPN-B stated food probably should have been offered. FLUID RESTRICTION R39 was admitted on 1/14/14, and diagnoses included end stage renal disease (ESRD) diabetes, hypertension, and renal dialysis status. Current physician orders dated 4/23/14, indicated fluid restriction of 1500 milliliters (ml)/day. Nursing to provide 780 ml over 3/shifts, dietary to provide 720 ml from meals (or 240 ml per meal). Nursing to check meal tray, review intake and output sheet and fluids given to resident. Total volume of fluids ingested each shift must be recorded.	F 282		

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F 282	Continued From page 15 Dietary to send 240 ml/meal. Nursing no more than 260 ml/8 hour shift. Restriction is 1500/day. R39's plan of care dated 2/2/14, indicated a problem of altered nutrition related to end stage renal disease, on a therapeutic diet, with goal to be without signs and symptoms of fluid overload. Intervention listed were: 1500 ml/day fluid restriction. Dietary gives 720 ml, 780cc from nursing. Alteration in kidney function due to end stage renal disease. Encourage patient to follow nutritional and hydration program interventions. On 5/28/14, at 2:16 p.m. NA-E was observed to be passing water to R39 in a water mug. NA-E stated she was not sure how much water the mug holds. At 2:29 p.m. NA-E stated that R39's water mug holds 720 ml. NA-E added, "[R39] is provided two of these for sure, once on the evening shift and then on the overnight shift. I am not sure how much he gets on the day shift. He gets water or something to drink with his meals also." Review of the NA assignment sheet for R39 indicated: dialysis T-Th-SA, 1500 ml fluid restriction/day-no water at bedside-8 ox fluid per meal-dietary gives 720 ml/day-document intake on clipboard,-NA 1 glass per shift. When asked if NA-E was aware of R39's 1500 ml fluid restriction and that 1440 ml of water was being provided just at the bedside, NA-E stated, "I was not aware of that, it might be even more than that because he will go fill his jug himself, he is over his fluid amount. I will go talk to my nurse." On 5/30/14, at 10:14 a.m. the ADON stated R39 should not be receiving that much fluid at bedside, and added, "I was not aware that that was happening." The ADON verified the care plan was not followed for fluid restrictions.	F 282		

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F 282	Continued From page 16 On 5/30/14, at 12:00 p.m. the director of nursing (DON) stated they should not be contributing to R39's excess fluid problem with his fluid restriction. The DON verified R39's plan of care was not being followed for fluid restriction. AMBULATION: R39's plan of care dated 2/2/14, indicated R39 has a physical functioning deficit related mobility impairment related to weakness, with a goal to improve current level of physical functioning. Interventions listed were rehab therapy services as ordered. R39's Therapy Communication to Nursing form dated 2/21/14, indicated current functional status, ambulate 100-150 feet with wheeled walker. Goal: Maintain current level of mobility. Approach: ambulate with gait belt and assist of one and wheel chair to follow. R39's Restorative Records were reviewed from March 5, 2014 to May 30, 2014, and instructed staff to ambulate R39 with gait belt, assist of one, and follow with forward wheeled walker. Ambulate 125-150 feet as resident allows one time a day to maintain current level of mobility. The flow sheets indicated the following: - March 5-31, 2014, out of 27 opportunities to ambulate, 21 opportunities were blank. For 6 of 27 opportunities R39 was ambulated 70, 125, 80, 70, and 70 feet. - April 1-30, 2014, out of 30 opportunities to ambulate, 25 opportunities were blank. For 5 of 30 opportunities R39 was ambulated 140, 100, 70, 50, and 70 feet.	F 282		

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F 282	Continued From page 17 - May 1-30, 2014, out of 30 opportunities to ambulate, 28 opportunities were blank. For 2 of 30 opportunities R39 was ambulated 76 and 60 feet. On 5/30/14, at 10:00 a.m. NA-B who provides restorative nursing services to R39 stated, "Sometimes he refuses but I could not tell you what days those are." NA-B verified that any blanks indicated R39 did not receive ambulation services. NA-B was observed to apply a gait belt to R39 and ambulate from room and down hallway, about 100 feet. R39 stated, "That is enough it is too warm in here today." R39's spouse was present during ambulation and stated, "That is the first time I have seen him ambulate since he came here. But maybe they are doing it at a time when I am not here." On 5/30/14, at 10:14 a.m. the ADON stated, "[R39] should be receiving ambulation services, and if he is refusing staff should be reporting that he is not ambulating." The ADON verified the care plan was not followed for ambulation. On 5/30/14, at 12:00 p.m. the DON stated, "Staff should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. A care plan policy was requested but not provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		7/9/14

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F 309	Continued From page 18 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 monitor fluid intake and follow fluid restrictions as directed by the physician for 1 of 1 resident (R39) receiving dialysis services. Findings include: R39's Diagnoses Report dated 1/16/14, indicated R39 ' s diagnoses included diabetes with end stage renal disease. R39 ' s quarterly Minimum Data Set (MDS) dated 4/18/14, indicated R39 had moderate cognitive impairment, received dialysis treatments, required limited staff assistance for ambulation in his room and supervision with one staff assist for eating. The MDS indicated R39 had not ambulated outside of his room. Current physician orders dated 4/23/14, indicated fluid restriction of 1500 milliliters (ml)/day. Nursing to provide 780 ml over 3/shifts, dietary to provide 720 ml from meals (or 240 ml per meal). Nursing to check meal tray, review intake and output sheet and fluids given to resident. Total volume of fluids ingested each shift must be recorded. Dietary to send 240 ml/meal. Nursing no more than 260 ml/8 hour shift. Restriction is 1500/day.	F 309	1. Resident 39 fluid restrictions are being monitored per physician order. 2. There are currently no other residents on fluid restriction. If other residents receive a physician order for fluid restriction, a monitoring system will be put into place. 3. Staff have been educated on the monitoring of residents on fluid restriQctions. 4. Monitoring to ensure compliance will be completed by the DNS/Designee through random audits of the resident currently on fluid restriction, and of any other residents that may be started on fluid restrictions. The results of these audits will be reviewed Monthly at the Quality Assurance Meeting.	

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F 309	Continued From page 19 R39's plan of care dated 2/2/14, indicated a problem of altered nutrition related to end stage renal disease, on a therapeutic diet, with goal to be without signs and symptoms of fluid overload. Intervention listed were: 1500 ml/day fluid restriction. Dietary gives 720 ml, 780cc from nursing. Alteration in kidney function due to end stage renal disease. Encourage patient to follow nutritional and hydration program interventions. On 5/28/14, at 2:16 p.m. NA-E was observed to be passing water to R39 in a water mug. NA-E stated she was not sure how much water the mug holds. At 2:29 p.m. NA-E stated that R39's water mug holds 720 ml. NA-E added, "[R39] is provided two of these for sure, once on the evening shift and then on the overnight shift. I am not sure how much he gets on the day shift. He gets water or something to drink with his meals also." Review of the NA assignment sheet for R39 indicated: dialysis T-Th-SA, 1500 ml fluid restriction/day-no water at bedside-8 ox fluid per meal-dietary gives 720 ml/day-document intake on clipboard,-NA 1 glass per shift. When asked if NA-E was aware of R39's 1500 ml fluid restriction and that 1440 ml of water was being provided just at the bedside, NA-E stated, "I was not aware of that, it might be even more than that because he will go fill his jug himself, he is over his fluid amount. I will go talk to my nurse." On 5/30/14, at 10:14 a.m. the assistant director of nursing (ADON) stated R39 should not be receiving that much fluid at bedside, and added, "I was not aware that that was happening." She added, "We should not be providing two 720 ml water containers at bedside, that's almost twice what he should be getting from nursing." The ADON verified the care plan was not followed for	F 309		

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F 309	Continued From page 20 fluid restrictions. On 5/30/14, at 12:00 p.m. the director of nursing (DON) stated they should not be contributing to R39's excess fluid problem with his fluid restriction. The DON verified R39's plan of care was not being followed for fluid restriction. A fluid restriction policy was requested but not provided.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the appropriate ambulation services to maintain or improve ambulation ability for 1 of 1 resident (R39) who required assistance with ambulation. Findings include: R39's plan of care dated 2/2/14, indicated R39 has a physical functioning deficit related mobility impairment related to weakness, with a goal to improve current level of physical functioning. Interventions listed were rehab therapy services as ordered. R39's Therapy Communication to Nursing form dated 2/21/14, indicated current functional status, ambulate 100-150 feet with wheeled walker.	F 311	1. Resident 39 is receiving appropriate ambulation assistance per care plan. 2. Other residents that require assistance with ambulation, are receiving assistance per care plan. 3. Staff have been educated on providing ambulation assistance for residents per care plan. 4. Monitoring to ensure compliance will be completed by the DNS/Designee through random direct care observations, that residents are receiving ambulation assistance per care plan. The results of these audits will be reviewed Monthly at the Quality Assurance Meeting.	7/9/14

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F 311	Continued From page 21	F 311		

Goal: Maintain current level of mobility. Approach: ambulate with gait belt and assist of one and wheel chair to follow.

R39's Restorative Records were reviewed from March 5, 2014 to May 30, 2014, and instructed staff to ambulate R39 with gait belt, assist of one, and follow with forward wheeled walker. Ambulate 125-150 feet as resident allows one time a day to maintain current level of mobility. The flow sheets indicated the following:

- March 5-31, 2014, out of 27 opportunities to ambulate, 21 opportunities were blank. For 6 of 27 opportunities R39 was ambulated 70, 125, 80, 70, and 70 feet.

- April 1-30, 2014, out of 30 opportunities to ambulate, 25 opportunities were blank. For 5 of 30 opportunities R39 was ambulated 140, 100, 70, 50, and 70 feet.

- May 1-30, 2014, out of 30 opportunities to ambulate, 28 opportunities were blank. For 2 of 30 opportunities R39 was ambulated 76 and 60 feet.

On 5/30/14, at 10:00 a.m. nursing assistant (NA)-B who provides restorative nursing services to R39 stated, "Sometimes he refuses but I could not tell you what days those are." NA-B verified that any blanks indicated R39 did not receive ambulation services. NA-B was observed to apply a gait belt to R39 and ambulate from room and down hallway, about 100 feet. R39 stated, "That is enough it is too warm in here today." R39's spouse was present during ambulation and stated, "That is the first time I have seen him ambulate since he came here. But maybe they

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F 311	Continued From page 22 are doing it at a time when I am not here." On 5/30/14, at 10:14 a.m. the ADON stated, "[R39] should be receiving ambulation services, and if he is refusing staff should be reporting that he is not ambulating." The ADON verified the care plan was not followed for ambulation. On 5/30/14, at 12:00 p.m. the DON stated, "Staff should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. A care plan policy was requested but not provided.	F 311		
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 assistance with eating for 1 of 1 resident (R26) who required assistance with eating for 1 of 2 dining observations. Findings include: R26's quarterly Minimum Data Set (MDS) dated	F 312	1. Resident 26 is receiving assistance with eating per care plan. 2. Other residents identified as needing assistance with eating, are receiving eating assistance per care plan. 3. Staff have been educated on providing eating assistance per care plan. 4. Monitoring to ensure compliance will be completed by the DNS/Designee through	7/9/14

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F 312	Continued From page 23 2/24/14, indicated R26 had severe cognitive impairment and required extensive assistance of one with eating. R26's Diagnosis Report dated 2/20/14, indicated R26 had diagnoses that included dementia with behavioral disturbance, heart failure and a history of closed femur fracture. R26's care plan dated 12/4/13, directed staff R26 required eating assistance of 1. The Change of Condition Nutrition Assessment dated 5/20/14, identified nutritional interventions to include: staff to assist and encourage resident at meals. On 5/29/14, R26 was continuously observed from 7:00 a.m. until 10:03 a.m. -At 7:00 a.m. R26 was observed in her own room, seated on the edge of a low bed. -At 7:07 a.m. R26 was observed to be up and dressed and independently propelling herself in her wheelchair via her feet throughout the facility and dining room. -At 7:45 a.m. R26 was observed going in and out of the dining room while other residents were eating breakfast. Staff was present, however, did not offer R26 any food or drink. R26 was noted to have a place set up for her at a dining room table. -At 8:45 a.m. R26 continued to independently propel herself up and down the halls. R26 had not been offered food or beverage. -At 8:50 a.m. licensed practical nurse (LPN)-B stated R26 was resistive when staff try to feed her and usually did not eat so, "we just give her supplements." -At 9:12 a.m. R26 was observed to be in the	F 312	weekly random audits during meal times, that residents are receiving assistance per care plan. The results of these audits will reviewed Monthly at the Quality Assurance Meeting.	

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F 312	Continued From page 24 activity area watching the birds with a visitor -At 9:20 a.m. R26 was observed to propel herself throughout the activity room. R26 had not been offered food or beverage. -At 9:30 a.m. the cook verified all residents had been served breakfast and stated the meal service was complete. At no time was R26 offered any food or beverage. -At 9:46 a.m. social service designee (SSD) brought R26 to her room and visited with her 1:1. No food or drink was offered to R26. On 5/29/14, at 12:56 p.m. consulting dietician (RD) stated she had offered R26 to eat, however, R26 refused. The RD confirmed she had not "physically" assisted R26. When asked if R26 had been offered finger foods, the RD stated she did not know. The RD stated staff should have offered R26 food and drink for the breakfast meal. On 5/29/14, at 1:01 p.m. LPN-C confirmed R26 did not eat much, however, stated staff should have provided her a breakfast meal. On 5/29/14, at 1:11 p.m. LPN-B verified she had served the breakfast meal in the dining room. She further stated R26 "absolutely would not eat" and would not stay still for long enough to eat. LPN-B verified she had not offered R26 any food or drink for breakfast and stated R26 "did not want any," R26 said no when offered. However, when asked, LPN-B confirmed she had not attempted to offer R26 any food or drink at breakfast time. LPN-B stated food probably should have been offered. On 5/29/14 at 1:16 p.m. the RD stated she could	F 312		

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F 312	Continued From page 25 not find any documentation related to the attempts of providing R26 finger foods to consume while roaming throughout the facility. During an interview on 5/30/14 at 11:50 a.m. hospice director (HD) stated that the philosophy of hospice is to "go with the flow" regarding patient and family goals for clients of hospice. They encourage them to do what they are able to do without force feeding or pushing. HD stated it would be her expectation that if R26 was able she would be brought to meals to participate and be offered the same courtesy and services as the other residents in the facility. HD also stated her expectation would be that R26 would be provided assistance to eat or adaptive equipment and or props if necessary. If there were nutrition concerns with R26, she would expect those to be communicated to the hospice nurse caring for R26. A policy regarding provision of assistance at meals was requested but none was provided.	F 312		
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	F 314		7/9/14

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F 314	Continued From page 26 by: Based on observation, interview, and document review, the facility failed to ensure residents who were identified at risk for skin breakdown received timely repositioning according to their assessed needs for 2 of 2 residents (R45, R26) reviewed for positioning. Findings include: R45's progress notes dated 3/12/14, indicated R45 was admitted with an unstageable pressure ulcer (PU) (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough and/or eschar in the wound bed) to the right and left heel. R45 also had three stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), and an "almost" stage III (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss), PUs on the coccyx/sacral area. On 5/20/14, the progress notes indicated R45's coccyx area remained healed. R45's significant change Minimum Data Set (MDS) dated 4/25/14, indicated R45 had severe cognitive impairment. The MDS also indicated R45 was diagnosed with Alzheimer's disease and diabetes. The Activity of Daily Living Care Area Assessment (CAA) dated 5/5/14, indicated R45 required extensive assistance with bed mobility and transfers. Staff were to observe R45's skin during cares for signs of breakdown. The Tissue Tolerance (ability of skin to withstand pressure) Observation form dated 3/11/14,	F 314	1. Residents 45,26 care plans have been reviewed and revised for positioning assistance, and are receiving repositioning assistance per care plan. 2. Other residents identified at risk for skin breakdown care plans have been reviewed and revised, and are receiving repositioning assistance per care plan. 3. Staff have been educated on providing repositioning for residents per care plan. 4. Monitoring to ensure compliance will be completed by the DNS/Designee through random weekly audits of direct care observations that repositioning is being provided per care plan. The results of these audits will be reviewed Monthly at the Quality Assurance Meeting.	

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F 314	Continued From page 27 indicated R45 was at high risk for skin breakdown and required every two hour repositioning. R45's care plan dated 3/31/14, indicated R45 was to be repositioned hourly and as needed. The nursing assistant (NA) group care sheets indicated R45 was to be repositioned every 2 hours and as needed. On 5/29/14, R45 was observed continuously from 6:50 a.m. until 10:02 a.m. At 6:50 a.m. R45 was observed up in his wheelchair in the hallway. At 6:58 a.m. R45 was observed in the dining room. At 7:40 a.m. R45 wheeled himself from the dining room down the hallway towards his room. At 8:03 a.m. the director of nursing services (DNS) brought R45 into his room. From 8:08 a.m. until 9:12 a.m. R45 remained in his wheelchair in his room. At 9:12 a.m. R45's clip wheelchair alarm sounded and NA-A entered the room and opened the drapes. NA-A did not provide any cares for R45. At 9:20 a.m. R45 remained up in the wheelchair. At 9:25 a.m. R45 stated his bottom was sore from sitting up. At 9:36 a.m. NA-B and NA-C stood R45 with a gait belt and walker for few minutes to relieve pressure from bottom. The wheelchair was observed to have a cushion on the seat. At 9:39 a.m. NA-C stated R45 was to be repositioned every 2 hours. At 9:55 a.m. NA-C stated R45 was placed in the wheelchair at 7:55 a.m. according to her NA group sheet that she had written on. The surveyor told NA-C that R45 was in the wheelchair at 6:50 a.m. (2 hours & 46 minutes since repositioning). NA-C stated they were "short" and there were only 2 NAs working on the floor as the third NA did baths and restorative/rehab for the residents.	F 314		

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F 314	Continued From page 28 NA-C stated normally they track their own group of residents. NA-C stated she must have written the time done incorrectly for R45. At 11:24 a.m. NA-A and NA-B transferred R45 with the gait belt to bed. At 11:25 a.m. NA-A removed R45's brief and a slight redness was noted behind R45's right thigh. NA-B stated the redness would be from being seated in the wheelchair. R45's skin on the buttocks/coccyx area was noted to be intact with no PU. NA-A stated they were "short" a 6:00 a.m. to 10:00 a.m. NA which was their busiest time of the day. NA-B stated when they are "short" then each NA does not have their own group of residents and it becomes confusing. At 1:15 p.m. the assistant director of nursing (ADON) stated she was not aware the NAs were working "short" today. The ADON stated there would normally be three NAs working the floor, and in addition, there would be a restorative/rehab NA. The ADON stated the last she knew R45 was to be repositioned every hour and as needed. The ADON stated the previous interim DNS wanted R45 to be on an every hour repositioning schedule, even though there was not a Tissue Tolerance Assessment which reflected hourly. On 5/30/14, at 11:13 a.m. the ADON stated R45 was at risk for PU development since he had been admitted with multiple PUs. The ADON verified the care plan was not followed for repositioning. The ADON added R45 had been on an hourly repositioning schedule since he was admitted, and she did not know why the NA group sheet read every 2 hours. In addition, the ADON	F 314		

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stated R45 should have been reassessed for PU development when his significant change MDS was completed on 4/25/14.

The policy Clinical Guideline for Preventative Skin Care dated 4/24/06, indicated residents should be assessed for risk of skin breakdown when there was a change in their condition.

R26's quarterly MDS dated 2/24/14, indicated R26 had severe cognitive impairment and required extensive assistance of one for bed mobility and transfer.

R26's Diagnosis Report dated 2/20/14 indicated R26 had diagnoses that included dementia with behavioral disturbance, heart failure and a history of closed femur fracture.

R26's care plan dated 12/4/13, directed staff to monitor R26 for positional changes with staff assist of 1-2 with turning and repositioning every 2 hours and as needed for the prevention of pressure ulcers.

The undated East Group 3 sheet directed staff R26 required assistance of one for turning and repositioning every 2 hours and as needed.

On 5/29/14, at 7:07 a.m. R26 was observed to be up and dressed, seated in a wheelchair and propelling herself, via her feet, out of her room and into the hallway. R26 was continuously observed until 10:03 a.m. during which time she was observed to propel herself throughout the facility. At 9:55 a.m. NA-C stated R26 had not been repositioned, to her knowledge, since

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F 314	Continued From page 30 approximately 7:00 a.m. when she provided morning cares. At 10:03 p.m. R26 was returned to her room by NA-A and licensed practical nurse (LPN)-A for repositioning. R26's brief was removed and skin was observed to be intact. On 5/29/14, at 11:33 a.m. NA-A confirmed R26 was up in her chair from approximately 7:00 a.m. until 10:00 a.m. without repositioning. NA-A confirmed R26 should have been checked and repositioned every 2 hours. On 5/30/14, at 10:12 a.m. director of nursing service (DNS) stated she would expect R26 would have been toileted and repositioned every 2 hours as the care plan directed. A policy for turning and repositioning for the prevention of pressure ulcers was requested but none was provided.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 315	1. Residents 26, 45 care plans have been	7/9/14

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F 315	Continued From page 31 review, the facility failed to ensure that timely incontinence care was completed for 2 of 2 residents (R45, R26) reviewed for incontinence care. Findings include: R45's significant change Minimum Data Set (MDS) dated 4/25/14, indicated R45 had severe cognitive impairment. The MDS also indicated R45 was diagnosed with Alzheimer's disease and diabetes. The Urinary Incontinence Care Area Assessment (CAA) dated 5/5/14, indicated R45 was always incontinent of bladder, and staff would check and change the brief every 2 hours and as needed. The care plan dated 3/31/14, indicated R45 was to be checked and changed every 2 hours and as needed. The nursing assistant (NA) group care sheets indicated R45 was to be assisted with toileting every 2 hours and as needed. On 5/29/14, R45 was observed continuously from 6:50 a.m. until 10:02 a.m.. At 6:50 a.m. R45 was observed up in his wheelchair in the hallway. At 6:58 a.m. R45 was observed in the dining room. At 7:40 a.m. R45 wheeled himself from the dining room down the hallway towards his room. At 8:03 a.m. the director of nursing services (DNS) brought R45 into his room. From 8:08 a.m. until 9:12 a.m. R45 remained in his wheelchair in his room. At 9:12 a.m. R45's clip wheelchair alarm sounded and NA-A entered the room and opened the drapes. NA-A did not	F 315	reviewed and revised for incontinence care, are receiving incontinence care per care plan. 2. Other residents identified as needing assistance with incontinence care, are receiving cares per care plan. 3. Staff have been educated on providing incontinence cares per care plan. 4. Monitoring to ensure compliance will be completed by the DNS/Designee through random weekly audits of direct care observations that incontinence care is being provided per care plan. The results of these audits will be reviewed Monthly at the Quality Assurance Meeting.	

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provide any cares. At 9:20 a.m. R45 remained up in the wheelchair. At 9:36 a.m. NA-B and NA-C stood R45 with a gait belt and walker to relieve pressure to R45's bottom. R45's brief was not checked. At 9:39 a.m. NA-C stated R45 was placed in the wheelchair at 7:45 a.m. The surveyor told NA-C that R45 was in the wheelchair at 6:50 a.m. (2 hours & 46 minutes since toileting or repositioning). At 9:55 a.m. NA-C stated R45 knew when he needed the bathroom so his brief was not checked when he was stood.

At 11:03 a.m. NA-A stated when R45's clip alarm sounded, she went in the room, and asked R45 if he needed the toilet. NA-A stated R45 said no. NA-A stated her group sheet directed staff to assist with toileting every 2 hours and as needed. NA-A stated R45 knew when he needed to have a bowel movement. NA-A stated they do accept R45's answer when he stated he did not need the bathroom. RN-A stated R45's brief had not been checked since he was placed in the wheelchair that morning.

At 11:24 a.m. NA-A and NA-B transferred R45 with the gait belt to bed. NA-A stated right before R45 was placed in the wheelchair at 6:50 a.m. his brief was changed as R45 had been incontinent of urine. At 11:25 a.m. NA-A removed R45's brief and R45 had been incontinent of urine (4 hours & 35 minutes since the last brief change). NA-A stated they were "short" a 6:00 a.m. to 10:00 a.m. NA which was their busiest time of the day. NA-B stated when they are "short" then each NA does not have their own group of residents and it becomes confusing.

On 5/29/14, at 1:15 p.m. the assistant director of

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nursing (ADON) stated R45's brief was to be checked every 2 hours. The ADON verified the care plan was not followed for incontinence care.

An Incontinence Care policy was requested and a procedure directing staff how to do incontinence care was provided.

R26's quarterly MDS dated 2/24/14, indicated R26 had severe cognitive impairment and required extensive assistance of one for bed mobility, transfer, and toilet use.

R26's Diagnosis Report dated 2/20/14 indicated R26 had diagnoses that included dementia with behavioral disturbance, heart failure and a history of closed femur fracture.

R26's care plan dated 12/4/13, directed staff to check and change R26 every two hours and as needed, as well as offer to toilet R26 every two hours and as needed for urge incontinence.

The undated East Group 3 sheet directed staff R26 required toileting every 2 hours and as needed for incontinence.

On 5/29/14, at 7:07 a.m. R26 was observed to be up and dressed, seated in a wheelchair and propelling herself out of her room and into the hallway.

On 5/29/14, at 9:55 a.m. NA-C stated R26 had not been toileted, to her knowledge, since approximately 7:00 a.m. when she provided morning cares.

R26 was continuously observed until 10:03 a.m.

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F 315	Continued From page 34 during which time she was observed to propel herself throughout the facility. At 10:03 a.m. R26 was returned to her room by NA-A and licensed practical nurse (LPN)-A for toileting and repositioning services. NA-A reported R26's incontinence brief was wet and stated R26 was to be toileted every two hours and as needed. NA-A indicated R26 was last toileted at approximately 7:10 a.m. according to her care sheet. On 5/29/14 at 11:33 a.m. NA-A confirmed R26 was up in her wheelchair from approximately 7:00 a.m. until 10:00 a.m. without repositioning or toileting. On 5/30/14, at 10:12 a.m. director of nursing service (DNS) stated she would expect R26 would have been toileted and repositioned every 2 hours as the care plan directed. An Incontinence Care policy was requested and a procedure directing staff how to do incontinence care was provided.	F 315		
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	F 329		7/9/14

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F 329	Continued From page 35 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure that non-pharmacological interventions were attempted prior to administering an anti-anxiety medication (Lorazepam) for 1 of 5 residents (R45) whose drug regimen was reviewed. Findings include: R45's significant change Minimum Data Set (MDS) dated 4/25/14, indicated R45 had severe cognitive impairment. The MDS also indicated R45 was diagnosed with Alzheimer's Disease and diabetes. R45 was admitted to hospice services on 4/18/14, diagnosed with failure to thrive per the physician's order. The care plan dated 3/31/14, indicated R45 had a history of anxiety and had a medication to use. The Behavior Monthly Flow Sheets dated April and May 2014, indicated R45 was diagnosed with	F 329	1. Resident 45 medication regimen has been reviewed, to include non pharmacological interventions. 2. Other resident's drug regimen reviews are being followed to include non pharmacological interventions. 3. Staff have been educated on attempting non pharmacological interventions prior to the initiatino of a psychoactive medication. 4. Monitoring to ensure compliance will be completed by the DNS/Designee through weekly audits of current and new medication orders. The results of these audits will be reviewed at the Monthly Quality Assurance Meeting.	

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F 329	Continued From page 36 a generalized anxiety disorder. The current Physician's Orders dated 5/28/14, read, Lorazepam 0.5 milligrams (mg) every 8 hours as needed for anxiety or agitation. Prior to administration try non-pharmacological interventions first: (1) Remove resident from stimulation (2) Hand massage (3) Unmet need, address pain, toileting, hunger/thirst, is resident hot/cold (4) then try the Lorazepam. According to the medication administration records for April and May 2014, MAR, R45 received the Lorazepam on 4/14/14, 4/27/14, 5/8/14, 5/14/14, 5/17/14, 5/20/14, and 5/26/14. On 5/29/14, at 1:53 p.m. the assistant director of nursing (ADON) stated 90% of the time the nurses do not document in the progress notes that they tried the non-pharmacological interventions prior to giving the Lorazepam. The ADON stated the nurses should be documenting on the Behavior Monthly Flow Sheets the non-pharmacological interventions tried prior to the Lorazepam administration. On 5/30/14, at 11:15 a.m. the ADON stated there was no documentation that prior to R45 receiving the Lorazepam on seven occasions that non-pharmacological interventions were tried prior. At 11:53 a.m. nursing assistant (NA)-A stated R45 would ask for his mother, and would be looking to change clothes to go to a wedding or a funeral. NA-A stated she would be able to re-direct R45 by showing him his wedding picture.	F 329		

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F 329	Continued From page 37 The undated Behavior Management policy directed staff to use non-pharmacological interventions, prior to considering initiation of any psychoactive medications.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		7/9/14

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F 356	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to post the required information on the nurse staff posting. This had the potential to affect all 28 residents residing in the facility, family members and any visitors who chose to view this information. Findings include: On 5/27/14, at 1:30 p.m. the nurse posting on the wall across from the nurses station was dated 5/27/14. However, the facility's census was not documented. The shifts were not delineated for actual hours worked. The posting read, Day shift, Evening shift, and Night shift. The Day shift indicated there was one licensed practical nurse (LPN) on duty for 12 hours. There were no hours indicated for the LPN on the Evening shift. There were no registered nurse (RN) hours indicated for the Day or Evening shift. On 5/28/14, at 9:43 a.m. the nurse posting indicated the Day shift was 6:00 a.m. to 2:00 p.m., the Evening shift was 2:00 p.m. to 10:00 p.m. and the Night shift was 10:00 p.m. to 6:00 a.m. The Day shift indicated one RN for 6 hours, 2 LPNs for 22 hours, and 2 nursing assistants (NAs) for 16 hours. The Evening shift read 2 LPNs for 8 hours. On 5/29/14, at 7:19 a.m. the nurse posting was not dated and there was no facility census identified. There was one RN indicated with no actual hours identified. On 5/30/14, at 9:39 a.m. the nurse posting	F 356	1. The system for posting of nursing hours has been reviewed and revised. 2. The required information for nursing hours is posted daily. 3. Staff have been educated on the current requirements for posting of nursing hours. 4. Monitoring to ensure compliance will be completed by the DNS/Designee through daily audits of the posted hours. The results of these audits will be reviewed Monthly at the Quality Assurance Meeting.	

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F 356	Continued From page 39 indicated one RN for 6 hours. On 5/30/14, at 9:39 a.m. the director of nursing services (DNS) stated she did not include herself on the nurse posting. The four days of nurse postings were reviewed with the DNS. -5/30/14, the DNS stated the posting was not accurate as there were 2 RNs on duty for 16 hours, and the posting indicated 1 RN for 6 hours. The DNS stated the night nurse would be responsible for posting the hours according to the nursing schedule. The DNS stated she did not put herself on the nursing schedule. In addition, the assistant director of nursing (ADON) who was an RN was designated as "other" on the nursing schedule. The DNS stated the night nurse would not know the ADON was the RN on duty. The DNS stated the Evening shift for 5/30/14, was not accurate as it indicated 1 RN for 2 hours, and the DNS was on duty for part of the Evening shift. -The DNS stated the RNs did not work 6:00 a.m. to 2:00 p.m. as the posting indicated, as their shifts would be 8:00 a.m. to 4:00 p.m. or 9:00 a.m. to 5:00 p.m. - The DNS verified there were no RN hours indicated for the Day shift on 5/27/14. The DNS stated she was on duty along with the assessment RN, which would be 2 RNs for 15 hours. The DNS stated the night nurse would not have known that information. There were no LPN or RN hours indicated for the Evening shift. The DNS stated the ADON would be 2 hours on duty and the DNS worked 8 hours. -The DNS stated she would be adjusting the nurse posting, as the NAs work 10:00 p.m. to 6:00 a.m. on the Night shift, and the nurse works 6:00 a.m. to 6:00 p.m. .	F 356		

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F 356	Continued From page 40 The Nursing Staff Hour policy revised 3/1/13, indicated the following information would be posted on a daily basis at the beginning of each shift. -Center/location name -Current date -Total number and actual hours worked by licensed and unlicensed staff responsible for resident care, including RNs, LPNs and CNAs. -Resident census	F 356		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food that was palatable and at the right temperature for 2 of 2 (R38, R18) residents in the dining room who were interviewable, and for 14 of 14 residents (R9, R6, R16, R11, R14, R33, R45, R10, R8, R15, R61, R29, R26, R22) who were identified as not interviewable, and who received their meals in the main dining room. In addition, the facility failed to serve eggs prepared to a resident's request for 1 of 1 resident (R9) who ate breakfast in their room. Findings include:	F 364	1. Residents 9, 6, 16, 11, 14,18, 33, 45, 10, 8, 15, 61, 29, 26, 22, 38 are all receiving food that is palatable and at the right temperature. Resident 9 is receiving eggs prepared per request. 2. Other residents are receiving food that is palatable and at the right temperature. The facility system of monitoring dining services has been reviewed and revised. 3. Staff have been educated on providing meals that is palatable and at the right temperature. The Registered Dietitian is going to conduct a Food Council for residents to participate in. Dining Service	7/9/14

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F 364	Continued From page 41 On 5/27/14, at at 5:24 p.m. the evening meal was observed in the dining room. There were five residents that were seated on one half of the dining room, and 11 residents that were seated on the other half of the dining room. On 5/27/14, at 5:29 p.m. the meal was served. The menu was tuna casserole, a slice of garlic bread, and green beans. At 5:37 p.m. R18 stated, "And that was supposed to be garlic toast?" R38 stated, "I had better food in the high school cafeteria." R38 stated the tuna casserole was not made from "scratch." Both R18 and R38 stated they did not know what the alternative meal was to request. At 5:40 p.m. the surveyor requested a sample tray to eat the meal. There was no tuna in the casserole, the garlic toast was tough, and the green beans and casserole were tasteless. At 5:46 p.m. the cook (C)-A stated she had forgot to put the alternate meal on the board, however, it was ham/potatoes. C-A stated the recipe called for tuna and she had forgot to put the tuna in the casserole. At 5:55 p.m. C-A offered the residents meat sandwiches since she had forgot to put the tuna in the casserole. On 5/29/14, at 8:37 a.m. R9 was up in his wheelchair eating breakfast in his room. R9 was served two fried eggs. R9 stated, they fried the "h--ll" out of the eggs. R9 stated he would like his eggs over easy and not over done. The eggs were observed to be fried hard. On 5/30/14, at 10:41 a.m. R38 stated the tuna casserole that was served on 5/27/14, was very bland with no flavor at all. In addition, the garlic	F 364	comment cards are available at the dining room tables. 4. Monitoring to ensure compliance will be completed by the ED/Designee through random weekly audits of the dining room, review of Food Council and Resident Council Minutes, and comment cards. The results of these audits and reviews will be reviewed at the Monthly Quality Assurance Meeting.	

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F 364	Continued From page 42 toast was very tough and there was no taste of garlic on it. R38 stated the green beans were tasteless. R38 stated they have brought up the food concerns in resident council for months. R38 stated everybody's biggest complaint was the food, and instead of it getting better it was getting worse. The Dining Experience policy dated 2011, indicated food would be flavorful and attractive. The Food Service Distribution policy dated 2011, indicated food would be served in an attractive and appetizing manner. In addition, milk would be tested for correct temperature of 41 degrees Fahrenheit (F) or below. On 5/30/14, at 11:16 p.m. the director of nursing services (DNS) confirmed her expectations regarding dining experience was for the meals to be served hot, on time, and appealing to look at as we "eat first with our eyes".	F 364		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 371	1. Residents are receiving food in a	7/9/14

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F 371	Continued From page 43 review, the facility failed to serve food in a sanitary manner. This had the potential to affect all 28 residents residing in and receiving meals from the facility. Findings include: On 5/29/14, at 11:54 a.m. during the noon meal service observation, Cook (C)-A was observed to wash her hands and donned gloves. A red bucket containing a green cloth submerged in a liquid solution was observed on the sink counter. With the same gloved hands, C-A was observed to lift the green cloth from the bucket and wipe the food thermometer probe with the cloth, put the cloth back into the bucket, walk back to stove area and insert the probe into the Taco casserole. Once the casserole temperature was obtained, C-A returned to the bucket and repeated the process of wiping the probe with the same cloth, putting the cloth back into the bucket when done. C-A repeated this process after checking the temperature of the corn and gravy. C-A stated the liquid was a sanitizing solution used to sanitize the probe in between each food item and that was how she was trained to do it. - At 12:07 p.m. the registered dietician (RD) entered the kitchen. When asked if the bucket of sanitizing liquid with the cloth submerged was appropriate for use she stated she did not know and would have to "check on that." C-A was observed to continue the same process of wiping with probe with the submerged cloth, with the same gloved hands. -At 12:12 p.m. the RD returned to the kitchen and was observed to hand C-A a box of alcohol wipes and directed C-A to use the prepackaged,	F 371	sanitary manner. 2. Staff have been educated on providing food in a sanitary manner. 3. Monitoring to ensure compliance will be completed by the ED/Designee through random weekly audits of food preparation and service. The results of the audits will be reviewed at the Monthly Quality Assurance Meeting.	

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individual wipes to clean the probe with in between each food item. With the same gloved hands, C-A was observed to remove a wipe from the box, tear a corner off, and insert the probe into and through the package, withdrew it and obtained the temperature of the picante sauce. C-A was observed to repeat this process prior to obtaining the macaroni salad temperature.

-At 12:15 the RD was observed sorting through individual resident menu sheets that were laying on the service counter in the kitchen, the RD was not observed to wash her hands upon entering the kitchen or prior to handling the resident menu sheets. The RD was observed writing notes on the resident menu sheets. With the same gloved hands, C-A was observed to sort through the same individual resident menu sheets. The RD exited the kitchen.

-At 12:26 p.m. The RD returned to the kitchen with a policy titled, Food Thermometer Guidelines. The policy directed staff to wash, rinse, sanitize and air-dry the thermometer before each use. The policy also indicated a sanitizing mixture or a alcohol fabric wipe could be used for food-contact surfaces. However, the policy also indicated if a sanitizing solution was used, the thermometer must soak in the solution for one minute and allowed to air dry in between each use.

-At 12:28 p.m. C-A was observed to remove the gloves, wash her hands and donned a clean pair of gloves. C-A was observed to pick up the same individual resident menu sheets and sorted them into piles. With the same gloved hands, C-A was observed to dish up the taco casserole from the pan using a spatula. Once the casserole was on

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the spatula, C-A was observed to cover and hold the top of the casserole with her gloved hand while transferring it to a resident meal plate. C-A proceeded to place a cover over the plate, picked up a menu sheet and placed it on top of the cover. C-A continued to sort through the menu papers, select one at a time, dish up another serving of casserole using the same technique. C-A continued this process for another nine resident meal plates and set them on the meal service cart. C-A was observed to enter the dirty dish area and obtained a three tier rolling cart and wheeled it to the food service counter / food tray line. C-A was observed to pick up and sort through additional resident menu sheets and continued to dish up 16 resident casserole dishes using the same technique to transfer the casserole onto the plates and placed them onto the three tiered cart. At no time was C-A observed to remove her gloves or wash her hands.

-At 12:58 p.m. C-A verified she touched food items after contaminating her gloves. C-A stated she should have washed her hands and changed her gloves as she was not supposed to touch the food. C-A also confirmed she had not followed facility policy related to properly cleaning the food thermometer probe in between each use.

-At 1:05 p.m. The RD stated she should have washed her hands upon entering the kitchen and prior to handling the resident menu sheets. The RD verified C-A had not dished up resident food in a sanitary manner and also did not properly sanitize the thermometer probe as directed. In addition, the RD stated C-A should have removed the alcohol wipe from the packaging and wiped the probe with the pad. The RD confirmed the

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F 371	Continued From page 46 facility policies were not followed. The facility's undated Dining Services Hand Washing policy directed staff to wash their hands upon entering the dining service department, before food handling, preparation or service and after handling any soiled or contaminated equipment or cleaning cloths. -At 2:05 p.m. The director of nursing (DON) confirmed the facility's policy was not followed and stated food items should not be handled using unclean gloved hands.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		7/9/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245323	A. BUILDING _____ B. WING _____	05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 47 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to analyze patterns and trends of resident and employee infections. This had the potential to affect all 28 residents who resided in the facility. Findings include: Review of the facility's infection control program revealed a system which lacked a surveillance program with ongoing analysis and interpretation of infections and infection risks. The Line Listing of Resident Infections for 02/14, 03/14, 04/14, and 05/14, revealed only infections with prescribed antibiotics were tracked. The facility's tracking system lacked trending of infections without antibiotics. In addition, a tracking system for employee infections and comparison surveillance between resident and employee illnesses had not been established. On 5/30/14, at 10:20 a.m. the facility infection	F 441	1. The facility has reviewed and revised the system for tracking, trending and analyzing infections for residents and employees. 2. Residents and employees have the potential of being affected. 3. Staff ahve been educated on the system for tracking, trending and analyzing infections of residents and employees. 4. Monitoring to ensure compliance will be completed by the DNS/Designee though audits of resident and staff infections daily at clinical start up. The results of the audits will be reviewed Monthly at the Quality Assurance Meeting.	

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F 441	Continued From page 48 control program was reviewed with the director of nursing services (DNS). The DNS stated she ran a daily report of residents who were prescribed antibiotics and entered the information onto the Line Listing of Resident Infections form. Information included on the Line Listing of Resident Infections included: resident name, room number, date of birth, admission date, type of infection, symptoms/date, cultures, treatment, other actions if needed and whether the infection was healthcare associated or community acquired. She also stated that, at times, floor nursing staff would notify her of residents prescribed antibiotics to be added to the list. The DNS indicated she then followed those residents on the list and coordinated with physicians and staff to ensure progress was made toward resolution of the infection. The DNS verified she had not been monitoring infections without a prescribed antibiotic and confirmed there was no analysis for trends in resident infections. The DNS indicated she did not gather data for tracking and trending of employee infections and confirmed there was no analysis or comparison of resident and employee infections completed. The Surveillance for Healthcare-Associated Infections policy dated 2001, indicated the infection control coordinator or designated infection control personnel was responsible for gathering and interpreting surveillance data and analyzing the data to identify trends. A policy regarding the tracking of employee infections was requested but none was provided.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		7/9/14

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F 465	Continued From page 49 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 and interview, the facility failed to maintain the kitchen dishwashing area wall, flooring and plumbing in a clean and well maintained manner. This had the potential to affect all 28 residents services by the kitchen. Findings include: During the kitchen tour on 5/29/14, at 10:49 a.m. with dietary aide (DA)-A the wall below the dishwashing counter was observed have crumbling material with duct tape securing tiles to the wall. Rust was also observed on the wall and floor within the same area. A pipe coming from the wall connecting to the garbage disposal and attached to the dishwashing counter was observed rusty and corroded with water observed leaking from the pipe. A rust stain approximately two feet by 3 feet was observed on floor. DA-A stated the area smelled like a barn yard and the odor was "so strong" it "made her sick." DA-A also stated the area was somewhat improved after maintenance had previously worked on it. DA-A verified the wall and floor areas were uncleanable. At 2:20 p.m. the administrator verified the findings and stated the above identified area was "a problem." At 2:33 p.m. during an interview maintenance staff (M)-A confirmed the findings and stated the	F 465	1. The facility has reviewed and revised the kitchen cleaning systems. Bids are being obtained to repair or replace the wall behind the dishwasher. Staff are being inserviced on proper disposal of food left on plates and the proper use of the garbage disposal. 2. The kitchen is functioning in a clean environment. 3. Staff have been educated on the kitchen cleaning systems/processes. 4. Monitoring to ensure compliance will be completed by the ED/Designee through weekly random audits of the kitchen for cleanliness. The results of these audits will be reviewed at the Monthly Quality Assurance Meeting.	

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	245323	A. BUILDING _____ B. WING _____	05/30/2014

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F 465	Continued From page 50 odor was from staff not rinsing the garbage disposal properly after use. In addition, M-A confirmed the wall and floor areas were problems that required fixing.	F 465		
F 492 SS=F	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was properly registered with the Minnesota commissioner as required. This had the potential to affect all 28 residents who resided in the facility. Findings include: During the entrance conference on 5/27/14, at 1:50 p.m. the administrator and director of nursing services (DNS) confirmed the facility utilized the 360 Healthcare Staffing agency to provide nursing coverage. On 5/28/14, at 10:05 a.m. the administrator verified by the current Minnesota Department of Health's Directory of Registered Supplemental Nursing Services Agencies (SNSA's) that the 360 Healthcare Staffing LLC was not one of the	F 492	1. The nurse in question is an employee of the facility. 2. The facility ensured that the supplemental nursing agency is properly registered with the Minnesota Commissioner. 3. Staff educated on the requirement of ensuring that Supplemental Nursing Agencys used in the facility must be registered with the Commissioner. 4. Monitoring to ensure compliance will be completed by the (FSCD) (Field Services Clinical Director) by checking the DHS website to ensure that any Supplemental Nursing Agencies are registered with the Commissioner.	7/9/14

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F 492	Continued From page 51 approved agencies listed. The administrator confirmed registered nurse (RN)-C was currently working full time at the facility. On 5/28/14, at 2:55 p.m. the administrator verified RN-C's hire date at the facility was 5/8/14.	F 492		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 520	1. The facility has Quality Assurance	7/9/14

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F 520	Continued From page 52 facility failed to ensure the quality assessment and assurance (QAA) committee met as required and developed and implemented a quality improvement program for the facility. This had the potential to affect all 28 residents who resided in the facility. Findings include: On 5/29/14, at 10:50 a.m. the director of nursing services (DNS) provided a list of dates and the attendance list for the facility's quality assurance committee meetings. The only meeting date listed over the past year was 4/3/14. On 5/30/14, at 11:06 a.m. the DNS verified the facility's quality assurance committee had only met once over this past year on 4/3/14. The DNS confirmed she was unaware of the facility's quality assurance programs past processes for identifying areas for improvement and developing action plans as she was new to this role. On 5/30/14, at 11:42 a.m. nursing assistant (NA)-A confirmed she was unaware of any quality improvement or quality assurance initiatives the facility was working on. On 5/30/14, at 11:49 a.m. cook (C)-A confirmed she was unaware of any quality improvement or quality initiatives the facility was working on. On 5/30/14, at 11:58 a.m. NA-D confirmed she was unaware of any quality improvement or quality assurance initiatives the facility was working on. On 5/30/14, at 12:02 p.m. licensed practical nurse (LPN)-A confirmed she was unaware of any	F 520	Committee meets Monthly to develop and implement Quality Improvement Programs. 2. Staff have been educated on the requirement of conducting Quality Assurance Meetings Monthly, who is to be in attendance, and of Quality Assurance Programs that have been indentified. 3. Monitoring to ensure compliance will be completed by the FSCD (Field Services Clinical Director) by reviewing Quality Assurance Meetings are being held, and that Quality Assurance Programs are being implemented.	

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F 520	Continued From page 53 quality improvement or quality assurance initiatives the facility was working on. A policy related to the facility's quality improvement program outlining the frequency of meeting times and a charter for the program was requested and not provided.	F 520		

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	245323	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/28/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WALKER	**209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Golden Living Center of Walker was found 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. This facility was surveyed as a single building. Golden Living Center of Walker is a 1-story building with a partial basement. The building was constructed at two different times. The original building was constructed in 1967 and was determined to be of Type II(222) construction. In 1994, an addition was constructed to the east side of the building that was determined to be of Type II(111) construction and separated with a 2 hour fire barrier. The main level is divided into 3 smoke zones. The building is protected by a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response heads. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system and in common areas that is installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition), which is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a	K 000		

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

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

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K 000	Continued From page 1 census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: June 17, 2014

Mr. Dan Stockdale, Administrator
Golden LivingCenter - Walker
209 Birchwood Avenue West
PO Box 700
Walker, Minnesota 56484

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5323023

Dear Mr. Stockdale:

The above facility was surveyed on May 27, 2014 through May 30, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00995	A. BUILDING: _____ B. WING _____	05/30/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 27th, 28th, 29th, 30th, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 005	MN Rule 4658.0015 COMPLIANCE WITH REGULATIONS AND STANDARDS A nursing home must operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in a nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was properly registered with the Minnesota commissioner as required. This had the potential to affect all 28 residents who resided in the facility. Findings include: During the entrance conference on 5/27/14, at 1:50 p.m. the administrator and director of nursing services (DNS) confirmed the facility utilized the 360 Healthcare Staffing agency to provide nursing coverage. On 5/28/14, at 10:05 a.m. the administrator verified by the current Minnesota Department of Health's Directory of Registered Supplemental	2 005	Corrected.	7/9/14

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2 005	Continued From page 3 Nursing Services Agencies (SNSA's) that the 360 Healthcare Staffing LLC was not one of the approved agencies listed. The administrator confirmed registered nurse (RN)-C was currently working full time at the facility. On 5/28/14, at 2:55 p.m. the administrator verified RN-C's hire date at the facility was 5/8/14. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could develop a system to assure appropriate state regulations are in compliance with supplemental nursing service agency. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 005		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must	2 255		7/9/14

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2 255	Continued From page 4 address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee met as required and developed and implemented a quality improvement program for the facility. This had the potential to affect all 28 residents who resided in the facility. Findings include: On 5/29/14, at 10:50 a.m. the director of nursing services (DNS) provided a list of dates and the attendance list for the facility's quality assurance committee meetings. The only meeting date listed over the past year was 4/3/14. On 5/30/14, at 11:06 a.m. the DNS verified the facility's quality assurance committee had only met once over this past year on 4/3/14. The DNS confirmed she was unaware of the facility's quality assurance programs past processes for identifying areas for improvement and developing action plans as she was new to this role. On 5/30/14, at 11:42 a.m. nursing assistant (NA)-A confirmed she was unaware of any quality improvement or quality assurance initiatives the facility was working on. On 5/30/14, at 11:49 a.m. cook (C)-A confirmed she was unaware of any quality improvement or quality initiatives the facility was working on. On 5/30/14, at 11:58 a.m. NA-D confirmed she	2 255	Correction in progress.	

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2 255	Continued From page 5 was unaware of any quality improvement or quality assurance initiatives the facility was working on. On 5/30/14, at 12:02 p.m. licensed practical nurse (LPN)-A confirmed she was unaware of any quality improvement or quality assurance initiatives the facility was working on. A policy related to the facility's quality improvement program outlining the frequency of meeting times and a charter for the program was requested and not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could develop and implement a facility wide quality improvement program, including quality improvement education to staff. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of	2 505		7/9/14

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2 505	Continued From page 6 movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 505	Corrected.	

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2 505	Continued From page 7	2 505		

review, the facility failed to ensure the least restrictive restraint device was used for the least amount of time as necessary for 1 of 1 resident (R31) in the sample who utilized a physical restraint device (lap buddy).

Findings include:

R31's order summary report dated 4/24/14, identified R31's diagnosis as Parkinson's disease, depression, hallucinations, anxiety, and generalized muscle weakness.

R31's quarterly Minimum Data Set (MDS) dated 4/14/14, indicated R31 had severe cognitive impairment and required extensive assist with transferring, dressing, eating and toileting.

R31's PHYSICAL RESTRAINT/DEVICE SCREENING FORM dated 4/9/14, indicated the type of restraint/device recommended was a lap buddy (a thick cushion that fits over a resident's lap and is secured to the armrests of the wheelchair, which can restrict the residents' ability to remove themselves from the wheelchair). R31 was also identified as not being able to independently remove the restraint on command.

R31's care plan dated 4/9/14, directed staff to check on R31 every 30 minutes when the lap buddy (restraint) was in place, release the restraint every two hours and at meal time when under direct supervision of staff.

On 5/29/14, at 12:46 p.m. R31 was observed wheeled into the dining room with the lap buddy secured to her wheelchair. During the noon meal observation from 12:46 p.m. through 1:30 p.m. R31 was continuously observed and the lap buddy was kept secured to R31's wheelchair. At

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2 505	Continued From page 8 R31's table licensed practical nurse (LPN)-A, nursing assistant (NA)-A and NA-B were observed to be seated at R31's table as they assisted residents with their meals. On 5/29/14, at 1:30 p.m. LPN-A confirmed R31's lap buddy had remained secured during the noon meal. LPN-A stated if it was up to her she would have removed the lap buddy during meal times, although she had only seen it on R31. On 5/29/14, at 2:00 p.m. the assistant director of nursing (ADON) confirmed R31's lap buddy was considered a restraint. The ADON verified her expectation was for R31's lap buddy to be removed during meal time as the facility should be using the least restrictive restraint. On 5/30/14, at 11:23 a.m. the director of nursing services (DNS) confirmed R31's lap buddy should be off at meal times and the facility should be using the least restrictive type of restraint for the least amount of time. The facility's Restraint Devices, Physical policy [undated] specified the goal should be for removal of the restraint or use of the less restrictive measure. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding physical restraint use. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION:	2 505		

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2 505	Continued From page 9 Twenty-one (21) days.	2 505		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a care plan with measurable goals and interventions to address the care and treatment of Clostridium Difficile (c-diff) infection for 1 of 1 resident (R22) with the diagnosis of c-diff. Findings include: R22's MDS dated 4/18/14, indicated R22 requires extensive assist of one for bed mobility and toileting. The MDS included diagnoses of multiple sclerosis, intestinal infections due to c-diff, atrial fibrillation and hypertension. Physicians orders dated 5/1/14, indicated the following medications: Vancomycin (antibiotic to treat range of bacterial infections) 125 milligrams by mouth every six hours and Loperamide two	2 560	Initiated/in progress/ongoing.	7/9/14

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2 560	Continued From page 10 milligram tablet by mouth in evening for diarrhea related to intestinal infections due to c-diff. The orders included to monitor stools every day and night shift and follow up as needed if diarrhea continues, and infections disease consult in Bemidji for chronic urinary tract infections and c-diff. Provider progress notes dated 5/21/14, indicated: "infectious disease follow up for c-diff pt [patient] getting better, continue Vancomycin 125 milligrams by every six hours by mouth until 5/26/14, continue to monitor stool. Follow up as need or if diarrhea recurs. Patient should be able to leave room and go outside as long as continent." R22's current undated plan of care with print date of 5/29/14, lacked a problem statement, goal or any approaches related to the treatment and risks of c-diff. On 5/30/14, at 10:40 a.m. the assistant director of nursing (ADON) stated the c-diff infection should definitely be on the resident's care plan with interventions. The ADON verified that the resident's c-diff infection was not on the plan of care and should be. On 5/30/14, at 12:15 p.m. the director of nursing (DON) verified that R22's care plan should reflect the c-diff problem and appropriate interventions as well. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding comprehensive care plan development. The Quality Assessment and	2 560		

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2 560	Continued From page 11 Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the resident's care plan for 2 of 2 residents (R45, R26) for timely repositioning and incontinence care, for 1 of 1 resident (R26) resident requiring assistance with eating, for 1 of 1 resident (R39) reviewed for dialysis with a fluid restriction, and for 1 of 1 resident (R39) who required assistance with ambulation. Findings include: TOILETING/REPOSITIONING: R45's care plan dated 3/31/14, indicated R45 was to be repositioned hourly and as needed. In addition, R45's brief was to be checked and changed every 2 hours and as needed. On 5/29/14, R45 was observed continuously from	2 565	Correction in progress and ongoing.	7/9/14

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2 565	Continued From page 12 6:50 a.m. until 10:02 a.m. At 9:36 a.m. nursing assistant (NA)-B and NA-C stood R45 with a gait belt and walker. At 9:55 a.m. NA-C stated R45 was placed in the wheelchair at 7:55 a.m. according to her NA group sheet that she had written on. The surveyor told NA-C that R45 was in the wheelchair at 6:50 a.m.. (2 hours & 46 minutes without repositioning). NA-C stated they were "short" and there were only 2 NAs working on the floor as the third NA did baths and restorative/rehab for the residents. NA-C stated normally they track their own group of residents. NA-C stated she must have written the time done incorrectly for R45. At 11:24 a.m. NA-A and NA-B transferred R45 with the gait belt to bed. NA-A stated right before R45 was placed in the wheelchair at 6:50 a.m. his brief was changed as R45 had been incontinent of urine. At 11:25 a.m. NA-A removed R45's brief and R45 had been incontinent of urine (4 hours & 35 minutes since the last brief change). NA-A stated they were "short" a 6:00 a.m. to 10:00 a.m. NA which was their busiest time of the day. NA-B stated when they are "short" then each NA does not have their own group of residents and it becomes confusing. On 5/29/14, at 1:15 p.m. the assistant director of nursing (ADON) stated R45's brief was to be checked every 2 hours. The ADON verified the care plan was not followed for incontinence care. R26's care plan dated 12/4/13, directed staff to reposition R26 every 2 hours and as needed. In addition, R26's incontinence brief was to be checked and changed and R26 was to be offered the toilet every two hours and as needed.	2 565		

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2 565	Continued From page 13 On 5/29/14, at 7:07 a.m. R26 was observed to be up and dressed, seated in a wheelchair and propelling herself, via her feet, out of her room and into the hallway. R26 was continuously observed until 10:03 a.m. during which time she was observed to propel herself throughout the facility. On 5/29/14, at 9:55 a.m. NA-C stated R26 had not been toileted or repositioned, to her knowledge, since approximately 7:00 a.m. when she provided morning cares. On 5/29/14, at 10:03 p.m. R26 was returned to her room by nursing assistant NA-A and licensed practical nurse (LPN)-A for toileting and repositioning services. On 5/29/14 at 11:33 a.m. NA-A confirmed R26 was up in her chair from approximately 7:00 a.m. until 10:00 a.m. without repositioning or toileting. NA-A confirmed R26 should have been checked and repositioned every 2 hours. On 5/30/14, at 10:12 a.m. DON stated she would expect R26 would have been toileted and repositioned every 2 hours as the care plan directed. EATING: R26's care plan dated 12/4/13, directed staff to provide R26 eating assistance of 1. On 5/29/14, R26 was continuously observed from 7:00 a.m. until 10:03 a.m. -At 7:00 a.m. R26 was observed in her own room, seated on the edge of a low bed. -At 7:07 a.m. R26 was observed to be up and	2 565		

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2 565	Continued From page 14 dressed and independently propelling herself in her wheelchair via her feet throughout the facility and dining room. -At 7:45 a.m. R26 was observed going in and out of the dining room while other residents were eating breakfast. Staff was present, however, did not offer R26 any food or drink. R26 was noted to have a place set up for her at a dining room table. -At 8:45 a.m. R26 continued to independently propel herself up and down the halls. R26 had not been offered food or beverage. -At 8:50 a.m. LPN-B stated R26 was resistive when staff try to feed her and usually did not eat so, " we just give her supplements. " -At 9:12 a.m. R26 was observed to be in the activity area watching the birds with a visitor -At 9:20 a.m. R26 was observed to propel herself throughout the activity room. R26 had not been offered food or beverage. -At 9:30 a.m. the cook verified all residents had been served breakfast and stated the meal service was complete. At no time was R26 offered any food or beverage. -At 9:46 a.m. social service designee (SSD) brought R26 to her room and visited with her 1:1. No food or drink was offered to R26. On 5/29/14, at 12:56 p.m. consulting dietician (RD) stated she had offered R26 to eat, however, R26 refused. The RD confirmed she had not "physically" assisted R26. When asked if R26 had been offered finger foods, the RD stated she did not know. The RD stated staff should have offered R26 food and drink for the breakfast meal. On 5/29/14, at 1:01 p.m. LPN-C confirmed R26 did not eat much, however, stated staff should have provided her a breakfast meal.	2 565		

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2 565	Continued From page 15 On 5/29/14, at 1:11 p.m. LPN-B verified she had served the breakfast meal in the dining room. She further stated R26 " absolutely would not eat " and would not stay still for long enough to eat. LPN-B verified she had not offered R26 any food or drink for breakfast and stated R26 "did not want any", R26 said no when offered. However, when asked, LPN-B confirmed she had not attempted to offer R26 any food or drink at breakfast time. LPN-B stated food probably should have been offered. FLUID RESTRICTION R39 was admitted on 1/14/14, and diagnoses included end stage renal disease (ESRD) diabetes, hypertension, and renal dialysis status. Current physician orders dated 4/23/14, indicated fluid restriction of 1500 milliliters (ml)/day. Nursing to provide 780 ml over 3/shifts, dietary to provide 720 ml from meals (or 240 ml per meal). Nursing to check meal tray, review intake and output sheet and fluids given to resident. Total volume of fluids ingested each shift must be recorded. Dietary to send 240 ml/meal. Nursing no more than 260 ml/8 hour shift. Restriction is 1500/day. R39's plan of care dated 2/2/14, indicated a problem of altered nutrition related to end stage renal disease, on a therapeutic diet, with goal to be without signs and symptoms of fluid overload. Intervention listed were: 1500 ml/day fluid restriction. Dietary gives 720 ml, 780cc from nursing. Alteration in kidney function due to end stage renal disease. Encourage patient to follow nutritional and hydration program interventions. On 5/28/14, at 2:16 p.m. NA-E was observed to be passing water to R39 in a water mug. NA-E	2 565		

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2 565	Continued From page 16 stated she was not sure how much water the mug holds. At 2:29 p.m. NA-E stated that R39's water mug holds 720 ml. NA-E added, "[R39] is provided two of these for sure, once on the evening shift and then on the overnight shift. I am not sure how much he gets on the day shift. He gets water or something to drink with his meals also." Review of the NA assignment sheet for R39 indicated: dialysis T-Th-SA, 1500 ml fluid restriction/day-no water at bedside-8 ox fluid per meal-dietary gives 720 ml/day-document intake on clipboard,-NA 1 glass per shift. When asked if NA-E was aware of R39's 1500 ml fluid restriction and that 1440 ml of water was being provided just at the bedside, NA-E stated, "I was not aware of that, it might be even more than that because he will go fill his jug himself, he is over his fluid amount. I will go talk to my nurse." On 5/30/14, at 10:14 a.m. the ADON stated R39 should not be receiving that much fluid at bedside, and added, "I was not aware that that was happening." The ADON verified the care plan was not followed for fluid restrictions. On 5/30/14, at 12:00 p.m. the director of nursing (DON) stated they should not be contributing to R39's excess fluid problem with his fluid restriction. The DON verified R39's plan of care was not being followed for fluid restriction. AMBULATION: R39's plan of care dated 2/2/14, indicated R39 has a physical functioning deficit related mobility impairment related to weakness, with a goal to improve current level of physical functioning. Interventions listed were rehab therapy services as ordered. R39's Therapy Communication to Nursing form	2 565		

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2 565	Continued From page 17 dated 2/21/14, indicated current functional status, ambulate 100-150 feet with wheeled walker. Goal: Maintain current level of mobility. Approach: ambulate with gait belt and assist of one and wheel chair to follow. R39's Restorative Records were reviewed from March 5, 2014 to May 30, 2014, and instructed staff to ambulate R39 with gait belt, assist of one, and follow with forward wheeled walker. Ambulate 125-150 feet as resident allows one time a day to maintain current level of mobility. The flow sheets indicated the following: - March 5-31, 2014, out of 27 opportunities to ambulate, 21 opportunities were blank. For 6 of 27 opportunities R39 was ambulated 70, 125, 80, 70, and 70 feet. - April 1-30, 2014, out of 30 opportunities to ambulate, 25 opportunities were blank. For 5 of 30 opportunities R39 was ambulated 140, 100, 70, 50, and 70 feet. - May 1-30, 2014, out of 30 opportunities to ambulate, 28 opportunities were blank. For 2 of 30 opportunities R39 was ambulated 76 and 60 feet. On 5/30/14, at 10:00 a.m. NA-B who provides restorative nursing services to R39 stated, "Sometimes he refuses but I could not tell you what days those are." NA-B verified that any blanks indicated R39 did not receive ambulation services. NA-B was observed to apply a gait belt to R39 and ambulate from room and down hallway, about 100 feet. R39 stated, "That is enough it is too warm in here today." R39's spouse was present during ambulation and stated, "That is the first time I have seen him	2 565		

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2 565	Continued From page 18 ambulate since he came here. But maybe they are doing it at a time when I am not here." On 5/30/14, at 10:14 a.m. the ADON stated, "[R39] should be receiving ambulation services, and if he is refusing staff should be reporting that he is not ambulating." The ADON verified the care plan was not followed for ambulation. On 5/30/14, at 12:00 p.m. the DON stated, "Staff should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. A care plan policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding care plan implementation. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility	2 570		7/9/14

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2 570	Continued From page 19 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to update the care plan to include removal of a physical restraint during meal times for 1 of 1 resident (R31) in the sample with a physical restraint (lap buddy). Findings include: R31's order summary report dated 4/24/14, identified R31's diagnosis as Parkinson's disease, depression, hallucinations, anxiety, and generalized muscle weakness. R31's quarterly Minimum Data Set (MDS) dated 4/14/14, indicated R31 had severe cognitive impairment and required extensive assist with transferring, dressing, eating and toileting. R31's PHYSICAL RESTRAINT/DEVICE SCREENING FORM dated 4/9/14, indicated the type of restraint/device recommended was a lap buddy (a thick cushion that fits over a resident's lap and is secured to the armrests of the wheelchair, which can restrict the residents' ability to remove themselves from the wheelchair). R31 was also identified as not being able to independently remove the restraint on command.	2 570	Corrected.	

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2 570	Continued From page 20 R31's care plan dated 4/9/14, directed staff to check on R31 every 30 minutes when the lap buddy (restraint) was in place; release and reposition every two hours and at meal time when under direct supervision. R31's care plan dated 5/29/14, identified a focus area for utilization of a physical restraint (lap buddy). However, the care plan lacked interventions which directed the staff when to monitor R31 when the restraint was in place and when to release the restraint. On 5/29/14, at 12:46 p.m. R31 was wheeled into the dining room with the lap buddy secured to her wheelchair. During the noon meal from 12:46 p.m. through 1:30 p.m. R31 was continuously observed and the lap buddy was kept secured to R31's wheelchair. On 5/29/14, at 1:30 p.m. LPN-A confirmed R31's lap buddy had remained secured during the noon meal. On 5/29/14, at 2:00 p.m. the assistant director of nursing (ADON) confirmed R31's lap buddy was considered a restraint. ADON verified her expectation was for R31's lap buddy to be removed during meal time as the facility should be using the least restrictive restraint. ADON confirmed the interventions to monitor R31 every 30 minutes when the restraint was in place and to release the restraint every two hours and during meal time had not been carried over from 4/9/14's care plan to the current care plan dated 5/29/14. The facility's Restraint Devices, Physical policy [undated] directed staff to develop or review	2 570		

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2 570	Continued From page 21 resident care plan for type of restraint device, reason for use, monitoring of resident and frequency and length of time restraint device is released. No facility policy or procedure for care plan development, revision and review was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding appropriate revision of care plans. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.	2 830		7/9/14

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2 830	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor fluid intake and follow fluid restrictions as directed by the physician for 1 of 1 resident (R39) receiving dialysis services. Findings include: R39's Diagnoses Report dated 1/16/14, indicated R39 ' s diagnoses included diabetes with end stage renal disease. R39 ' s quarterly Minimum Data Set (MDS) dated 4/18/14, indicated R39 had moderate cognitive impairment, received dialysis treatments, required limited staff assistance for ambulation in his room and supervision with one staff assist for eating. The MDS indicated R39 had not ambulated outside of his room. Current physician orders dated 4/23/14, indicated fluid restriction of 1500 milliliters (ml)/day. Nursing to provide 780 ml over 3/shifts, dietary to provide 720 ml from meals (or 240 ml per meal). Nursing to check meal tray, review intake and output sheet and fluids given to resident. Total volume of fluids ingested each shift must be recorded. Dietary to send 240 ml/meal. Nursing no more than 260 ml/8 hour shift. Restriction is 1500/day. R39's plan of care dated 2/2/14, indicated a problem of altered nutrition related to end stage renal disease, on a therapeutic diet, with goal to be without signs and symptoms of fluid overload. Intervention listed were: 1500 ml/day fluid restriction. Dietary gives 720 ml, 780cc from nursing. Alteration in kidney function due to end stage renal disease. Encourage patient to follow nutritional and hydration program interventions.	2 830	Correction iniated/POA in progress.	

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2 830	Continued From page 23 On 5/28/14, at 2:16 p.m. NA-E was observed to be passing water to R39 in a water mug. NA-E stated she was not sure how much water the mug holds. At 2:29 p.m. NA-E stated that R39's water mug holds 720 ml. NA-E added, "[R39] is provided two of these for sure, once on the evening shift and then on the overnight shift. I am not sure how much he gets on the day shift. He gets water or something to drink with his meals also." Review of the NA assignment sheet for R39 indicated: dialysis T-Th-SA, 1500 ml fluid restriction/day-no water at bedside-8 ox fluid per meal-dietary gives 720 ml/day-document intake on clipboard,-NA 1 glass per shift. When asked if NA-E was aware of R39's 1500 ml fluid restriction and that 1440 ml of water was being provided just at the bedside, NA-E stated, "I was not aware of that, it might be even more than that because he will go fill his jug himself, he is over his fluid amount. I will go talk to my nurse." On 5/30/14, at 10:14 a.m. the assistant director of nursing (ADON) stated R39 should not be receiving that much fluid at bedside, and added, "I was not aware that that was happening." She added, "We should not be providing two 720 ml water containers at bedside, that's almost twice what he should be getting from nursing." The ADON verified the care plan was not followed for fluid restrictions. On 5/30/14, at 12:00 p.m. the director of nursing (DON) stated they should not be contributing to R39's excess fluid problem with his fluid restriction. The DON verified R39's plan of care was not being followed for fluid restriction. A fluid restriction policy was requested but not provided.	2 830		

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2 830	Continued From page 24 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding care of the dialysis resident. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who were identified at risk for skin breakdown received timely repositioning according to their assessed needs for 2 of 2 residents (R45, R26) reviewed for positioning. Findings include: R45's progress notes dated 3/12/14, indicated	2 905	Correction initiated/ongoing monitoring.	7/9/14

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2 905	Continued From page 25 R45 was admitted with an unstageable pressure ulcer (PU) (full thickness tissue loss in which actual depth of the ulcer is completely obscured by slough and/or eschar in the wound bed) to the right and left heel. R45 also had three stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough), and an "almost" stage III (full thickness tissue loss. Subcutaneous fat may be visible but bone, tendon or muscle are not exposed. Slough may be present but does not obscure the depth of tissue loss), PUs on the coccyx/sacral area. On 5/20/14, the progress notes indicated R45's coccyx area remained healed. R45's significant change Minimum Data Set (MDS) dated 4/25/14, indicated R45 had severe cognitive impairment. The MDS also indicated R45 was diagnosed with Alzheimer's disease and diabetes. The Activity of Daily Living Care Area Assessment (CAA) dated 5/5/14, indicated R45 required extensive assistance with bed mobility and transfers. Staff were to observe R45's skin during cares for signs of breakdown. The Tissue Tolerance (ability of skin to withstand pressure) Observation form dated 3/11/14, indicated R45 was at high risk for skin breakdown and required every two hour repositioning. R45's care plan dated 3/31/14, indicated R45 was to be repositioned hourly and as needed. The nursing assistant (NA) group care sheets indicated R45 was to be repositioned every 2 hours and as needed. On 5/29/14, R45 was observed continuously from 6:50 a.m. until 10:02 a.m. At 6:50 a.m. R45 was	2 905		

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2 905	Continued From page 26 observed up in his wheelchair in the hallway. At 6:58 a.m. R45 was observed in the dining room. At 7:40 a.m. R45 wheeled himself from the dining room down the hallway towards his room. At 8:03 a.m. the director of nursing services (DNS) brought R45 into his room. From 8:08 a.m. until 9:12 a.m. R45 remained in his wheelchair in his room. At 9:12 a.m. R45's clip wheelchair alarm sounded and NA-A entered the room and opened the drapes. NA-A did not provide any cares for R45. At 9:20 a.m. R45 remained up in the wheelchair. At 9:25 a.m. R45 stated his bottom was sore from sitting up. At 9:36 a.m. NA-B and NA-C stood R45 with a gait belt and walker for few minutes to relieve pressure from bottom. The wheelchair was observed to have a cushion on the seat. At 9:39 a.m. NA-C stated R45 was to be repositioned every 2 hours. At 9:55 a.m. NA-C stated R45 was placed in the wheelchair at 7:55 a.m. according to her NA group sheet that she had written on. The surveyor told NA-C that R45 was in the wheelchair at 6:50 a.m. (2 hours & 46 minutes since repositioning). NA-C stated they were "short" and there were only 2 NAs working on the floor as the third NA did baths and restorative/rehab for the residents. NA-C stated normally they track their own group of residents. NA-C stated she must have written the time done incorrectly for R45. At 11:24 a.m. NA-A and NA-B transferred R45 with the gait belt to bed. At 11:25 a.m. NA-A removed R45's brief and a slight redness was noted behind R45's right thigh. NA-B stated the redness would be from being seated in the wheelchair. R45's skin on the buttocks/coccyx area was noted to be intact with no PU. NA-A stated they were "short" a 6:00 a.m. to 10:00 a.m.	2 905		

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2 905	Continued From page 27 NA which was their busiest time of the day. NA-B stated when they are "short" then each NA does not have their own group of residents and it becomes confusing. At 1:15 p.m. the assistant director of nursing (ADON) stated she was not aware the NAs were working "short" today. The ADON stated there would normally be three NAs working the floor, and in addition, there would be a restorative/rehab NA. The ADON stated the last she knew R45 was to be repositioned every hour and as needed. The ADON stated the previous interim DNS wanted R45 to be on an every hour repositioning schedule, even though there was not a Tissue Tolerance Assessment which reflected hourly. On 5/30/14, at 11:13 a.m. the ADON stated R45 was at risk for PU development since he had been admitted with multiple PUs. The ADON verified the care plan was not followed for repositioning. The ADON added R45 had been on an hourly repositioning schedule since he was admitted, and she did not know why the NA group sheet read every 2 hours. In addition, the ADON stated R45 should have been reassessed for PU development when his significant change MDS was completed on 4/25/14. The policy Clinical Guideline for Preventative Skin Care dated 4/24/06, indicated residents should be assessed for risk of skin breakdown when there was a change in their condition. R26's quarterly MDS dated 2/24/14, indicated R26 had severe cognitive impairment and required extensive assistance of one for bed mobility and transfer.	2 905		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - WALKER	209 BIRCHWOOD AVENUE WEST PO BOX 700 WALKER, MN 56484

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 905	Continued From page 28 R26's Diagnosis Report dated 2/20/14 indicated R26 had diagnoses that included dementia with behavioral disturbance, heart failure and a history of closed femur fracture. R26's care plan dated 12/4/13, directed staff to monitor R26 for positional changes with staff assist of 1-2 with turning and repositioning every 2 hours and as needed for the prevention of pressure ulcers. The undated East Group 3 sheet directed staff R26 required assistance of one for turning and repositioning every 2 hours and as needed. On 5/29/14, at 7:07 a.m. R26 was observed to be up and dressed, seated in a wheelchair and propelling herself, via her feet, out of her room and into the hallway. R26 was continuously observed until 10:03 a.m. during which time she was observed to propel herself throughout the facility. At 9:55 a.m. NA-C stated R26 had not been repositioned, to her knowledge, since approximately 7:00 a.m. when she provided morning cares. At 10:03 p.m. R26 was returned to her room by NA-A and licensed practical nurse (LPN)-A for repositioning. R26's brief was removed and skin was observed to be intact. On 5/29/14, at 11:33 a.m. NA-A confirmed R26 was up in her chair from approximately 7:00 a.m. until 10:00 a.m. without repositioning. NA-A confirmed R26 should have been checked and repositioned every 2 hours. On 5/30/14, at 10:12 a.m. director of nursing service (DNS) stated she would expect R26 would have been toileted and repositioned every 2 hours as the care plan directed.	2 905		

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2 905	Continued From page 29 A policy for turning and repositioning for the prevention of pressure ulcers was requested but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding care of the resident identified for risk for skin breakdown. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		7/9/14

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2 910	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that timely incontinence care was completed for 2 of 2 residents (R45, R26) reviewed for incontinence care. Findings include: R45's significant change Minimum Data Set (MDS) dated 4/25/14, indicated R45 had severe cognitive impairment. The MDS also indicated R45 was diagnosed with Alzheimer's disease and diabetes. The Urinary Incontinence Care Area Assessment (CAA) dated 5/5/14, indicated R45 was always incontinent of bladder, and staff would check and change the brief every 2 hours and as needed. The care plan dated 3/31/14, indicated R45 was to be checked and changed every 2 hours and as needed. The nursing assistant (NA) group care sheets indicated R45 was to be assisted with toileting every 2 hours and as needed. On 5/29/14, R45 was observed continuously from 6:50 a.m. until 10:02 a.m.. At 6:50 a.m. R45 was observed up in his wheelchair in the hallway. At 6:58 a.m. R45 was observed in the dining room. At 7:40 a.m. R45 wheeled himself from the dining room down the hallway towards his room. At 8:03 a.m. the director of nursing services (DNS) brought R45 into his room. From 8:08 a.m. until 9:12 a.m. R45 remained in	2 910	Plan to be initiated and tracking ongoing.	

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2 910	Continued From page 31 his wheelchair in his room. At 9:12 a.m. R45's clip wheelchair alarm sounded and NA-A entered the room and opened the drapes. NA-A did not provide any cares. At 9:20 a.m. R45 remained up in the wheelchair. At 9:36 a.m. NA-B and NA-C stood R45 with a gait belt and walker to relieve pressure to R45's bottom. R45's brief was not checked. At 9:39 a.m. NA-C stated R45 was placed in the wheelchair at 7:45 a.m. The surveyor told NA-C that R45 was in the wheelchair at 6:50 a.m. (2 hours & 46 minutes since toileting or repositioning). At 9:55 a.m. NA-C stated R45 knew when he needed the bathroom so his brief was not checked when he was stood. At 11:03 a.m. NA-A stated when R45's clip alarm sounded, she went in the room, and asked R45 if he needed the toilet. NA-A stated R45 said no. NA-A stated her group sheet directed staff to assist with toileting every 2 hours and as needed. NA-A stated R45 knew when he needed to have a bowel movement. NA-A stated they do accept R45's answer when he stated he did not need the bathroom. RN-A stated R45's brief had not been checked since he was placed in the wheelchair that morning. At 11:24 a.m. NA-A and NA-B transferred R45 with the gait belt to bed. NA-A stated right before R45 was placed in the wheelchair at 6:50 a.m. his brief was changed as R45 had been incontinent of urine. At 11:25 a.m. NA-A removed R45's brief and R45 had been incontinent of urine (4 hours & 35 minutes since the last brief change). NA-A stated they were "short" a 6:00 a.m. to 10:00 a.m. NA which was their busiest time of the day. NA-B stated when they are "short" then each NA does not have their own group of residents and it becomes confusing.	2 910		

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2 910	Continued From page 32 On 5/29/14, at 1:15 p.m. the assistant director of nursing (ADON) stated R45's brief was to be checked every 2 hours. The ADON verified the care plan was not followed for incontinence care. An Incontinence Care policy was requested and a procedure directing staff how to do incontinence care was provided. R26's quarterly MDS dated 2/24/14, indicated R26 had severe cognitive impairment and required extensive assistance of one for bed mobility, transfer, and toilet use. R26's Diagnosis Report dated 2/20/14 indicated R26 had diagnoses that included dementia with behavioral disturbance, heart failure and a history of closed femur fracture. R26's care plan dated 12/4/13, directed staff to check and change R26 every two hours and as needed, as well as offer to toilet R26 every two hours and as needed for urge incontinence. The undated East Group 3 sheet directed staff R26 required toileting every 2 hours and as needed for incontinence. On 5/29/14, at 7:07 a.m. R26 was observed to be up and dressed, seated in a wheelchair and propelling herself out of her room and into the hallway. On 5/29/14, at 9:55 a.m. NA-C stated R26 had not been toileted, to her knowledge, since approximately 7:00 a.m. when she provided morning cares.	2 910		

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2 910	Continued From page 33 R26 was continuously observed until 10:03 a.m. during which time she was observed to propel herself throughout the facility. At 10:03 a.m. R26 was returned to her room by NA-A and licensed practical nurse (LPN)-A for toileting and repositioning services. NA-A reported R26's incontinence brief was wet and stated R26 was to be toileted every two hours and as needed. NA-A indicated R26 was last toileted at approximately 7:10 a.m. according to her care sheet. On 5/29/14 at 11:33 a.m. NA-A confirmed R26 was up in her wheelchair from approximately 7:00 a.m. until 10:00 a.m. without repositioning or toileting. On 5/30/14, at 10:12 a.m. director of nursing service (DNS) stated she would expect R26 would have been toileted and repositioned every 2 hours as the care plan directed. An Incontinence Care policy was requested and a procedure directing staff how to do incontinence care was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding nutritional care of residents. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		

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2 915	Continued From page 34	2 915		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the appropriate ambulation services to maintain or improve ambulation ability for 1 of 1 resident (R39) who required assistance with ambulation. Findings include: R39's plan of care dated 2/2/14, indicated R39 has a physical functioning deficit related mobility impairment related to weakness, with a goal to improve current level of physical functioning. Interventions listed were rehab therapy services as ordered.	2 915	POA initiated. Ongoing review.	7/9/14

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2 915	Continued From page 35 R39's Therapy Communication to Nursing form dated 2/21/14, indicated current functional status, ambulate 100-150 feet with wheeled walker. Goal: Maintain current level of mobility. Approach: ambulate with gait belt and assist of one and wheel chair to follow. R39's Restorative Records were reviewed from March 5, 2014 to May 30, 2014, and instructed staff to ambulate R39 with gait belt, assist of one, and follow with forward wheeled walker. Ambulate 125-150 feet as resident allows one time a day to maintain current level of mobility. The flow sheets indicated the following: - March 5-31, 2014, out of 27 opportunities to ambulate, 21 opportunities were blank. For 6 of 27 opportunities R39 was ambulated 70, 125, 80, 70, and 70 feet. - April 1-30, 2014, out of 30 opportunities to ambulate, 25 opportunities were blank. For 5 of 30 opportunities R39 was ambulated 140, 100, 70, 50, and 70 feet. - May 1-30, 2014, out of 30 opportunities to ambulate, 28 opportunities were blank. For 2 of 30 opportunities R39 was ambulated 76 and 60 feet. On 5/30/14, at 10:00 a.m. nursing assistant (NA)-B who provides restorative nursing services to R39 stated, "Sometimes he refuses but I could not tell you what days those are." NA-B verified that any blanks indicated R39 did not receive ambulation services. NA-B was observed to apply a gait belt to R39 and ambulate from room and down hallway, about 100 feet. R39 stated, "That is enough it is too warm in here today." R39's spouse was present during ambulation and	2 915		

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2 915	Continued From page 36 stated, "That is the first time I have seen him ambulate since he came here. But maybe they are doing it at a time when I am not here." On 5/30/14, at 10:14 a.m. the ADON stated, "[R39] should be receiving ambulation services, and if he is refusing staff should be reporting that he is not ambulating." The ADON verified the care plan was not followed for ambulation. On 5/30/14, at 12:00 p.m. the DON stated, "Staff should be following the resident's plan of care and providing restorative ambulation at ordered. The NA should be reporting to me if a resident is not ambulating. The DON verified R39's plan of care was not being followed for ambulation. A care plan policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding resident ambulation services. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing	2 920		7/9/14

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2 920	Continued From page 37 home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with eating for 1 of 1 resident (R26) who required assistance with eating for 1 of 2 dining observations. Findings include: R26's quarterly Minimum Data Set (MDS) dated 2/24/14, indicated R26 had severe cognitive impairment and required extensive assistance of one with eating. R26's Diagnosis Report dated 2/20/14, indicated R26 had diagnoses that included dementia with behavioral disturbance, heart failure and a history of closed femur fracture. R26's care plan dated 12/4/13, directed staff R26 required eating assistance of 1. The Change of Condition Nutrition Assessment dated 5/20/14, identified nutritional interventions to include: staff to assist and encourage resident at meals. On 5/29/14, R26 was continuously observed from 7:00 a.m. until 10:03 a.m. -At 7:00 a.m. R26 was observed in her own room, seated on the edge of a low bed. -At 7:07 a.m. R26 was observed to be up and	2 920	Corrective action initiated with ongoing review.	

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2 920	Continued From page 38 dressed and independently propelling herself in her wheelchair via her feet throughout the facility and dining room. -At 7:45 a.m. R26 was observed going in and out of the dining room while other residents were eating breakfast. Staff was present, however, did not offer R26 any food or drink. R26 was noted to have a place set up for her at a dining room table. -At 8:45 a.m. R26 continued to independently propel herself up and down the halls. R26 had not been offered food or beverage. -At 8:50 a.m. licensed practical nurse (LPN)-B stated R26 was resistive when staff try to feed her and usually did not eat so, "we just give her supplements." -At 9:12 a.m. R26 was observed to be in the activity area watching the birds with a visitor -At 9:20 a.m. R26 was observed to propel herself throughout the activity room. R26 had not been offered food or beverage. -At 9:30 a.m. the cook verified all residents had been served breakfast and stated the meal service was complete. At no time was R26 offered any food or beverage. -At 9:46 a.m. social service designee (SSD) brought R26 to her room and visited with her 1:1. No food or drink was offered to R26. On 5/29/14, at 12:56 p.m. consulting dietician (RD) stated she had offered R26 to eat, however, R26 refused. The RD confirmed she had not "physically" assisted R26. When asked if R26 had been offered finger foods, the RD stated she did not know. The RD stated staff should have offered R26 food and drink for the breakfast meal. On 5/29/14, at 1:01 p.m. LPN-C confirmed R26	2 920		

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2 920	Continued From page 39 did not eat much, however, stated staff should have provided her a breakfast meal. On 5/29/14, at 1:11 p.m. LPN-B verified she had served the breakfast meal in the dining room. She further stated R26 "absolutely would not eat" and would not stay still for long enough to eat. LPN-B verified she had not offered R26 any food or drink for breakfast and stated R26 "did not want any," R26 said no when offered. However, when asked, LPN-B confirmed she had not attempted to offer R26 any food or drink at breakfast time. LPN-B stated food probably should have been offered. On 5/29/14 at 1:16 p.m. the RD stated she could not find any documentation related to the attempts of providing R26 finger foods to consume while roaming throughout the facility. During an interview on 5/30/14 at 11:50 a.m. hospice director (HD) stated that the philosophy of hospice is to "go with the flow" regarding patient and family goals for clients of hospice. They encourage them to do what they are able to do without force feeding or pushing. HD stated it would be her expectation that if R26 was able she would be brought to meals to participate and be offered the same courtesy and services as the other residents in the facility. HD also stated her expectation would be that R26 would be provided assistance to eat or adaptive equipment and or props if necessary. If there were nutrition concerns with R26, she would expect those to be communicated to the hospice nurse caring for R26. A policy regarding provision of assistance at meals was requested but none was provided.	2 920		

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2 920	Continued From page 40 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding assistance of residents during dining. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food that was palatable and at the right temperature for 2 of 2 (R38, R18) residents in the dining room who were interviewable, and for 14 of 14 residents (R9, R6, R16, R11, R14, R33, R45, R10, R8, R15, R61, R29, R26, R22) who were identified as not interviewable, and who received their meals in the main dining room. In addition, the facility failed to serve eggs prepared to a resident's request for 1 of 1 resident (R9) who ate breakfast in their room. Findings include: On 5/27/14, at at 5:24 p.m. the evening meal was	2 960	POA initiated with ongoing review.	7/9/14

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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) COMPLETE DATE
2 960	Continued From page 41 observed in the dining room. There were five residents that were seated on one half of the dining room, and 11 residents that were seated on the other half of the dining room. On 5/27/14, at 5:29 p.m. the meal was served. The menu was tuna casserole, a slice of garlic bread, and green beans. At 5:37 p.m. R18 stated, "And that was supposed to be garlic toast?" R38 stated, "I had better food in the high school cafeteria." R38 stated the tuna casserole was not made from "scratch." Both R18 and R38 stated they did not know what the alternative meal was to request. At 5:40 p.m. the surveyor requested a sample tray to eat the meal. There was no tuna in the casserole, the garlic toast was tough, and the green beans and casserole were tasteless. At 5:46 p.m. the cook (C)-A stated she had forgot to put the alternate meal on the board, however, it was ham/potatoes. C-A stated the recipe called for tuna and she had forgot to put the tuna in the casserole. At 5:55 p.m. C-A offered the residents meat sandwiches since she had forgot to put the tuna in the casserole. On 5/29/14, at 8:37 a.m. R9 was up in his wheelchair eating breakfast in his room. R9 was served two fried eggs. R9 stated, they fried the "h--ll" out of the eggs. R9 stated he would like his eggs over easy and not over done. The eggs were observed to be fried hard. On 5/30/14, at 10:41 a.m. R38 stated the tuna casserole that was served on 5/27/14, was very bland with no flavor at all. In addition, the garlic toast was very tough and there was no taste of garlic on it. R38 stated the green beans were	2 960		

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2 960	Continued From page 42 tasteless. R38 stated they have brought up the food concerns in resident council for months. R38 stated everybody's biggest complaint was the food, and instead of it getting better it was getting worse. The Dining Experience policy dated 2011, indicated food would be flavorful and attractive. The Food Service Distribution policy dated 2011, indicated food would be served in an attractive and appetizing manner. In addition, milk would be tested for correct temperature of 41 degrees Fahrenheit (F) or below. On 5/30/14, at 11:16 p.m. the director of nursing services (DNS) confirmed her expectations regarding dining experience was for the meals to be served hot, on time, and appealing to look at as we "eat first with our eyes". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could identify and develop a more palatable dining experience and could provide appropriate staff education regarding food preparation. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene.	21000		7/9/14

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21000	Continued From page 43 Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to serve food in a sanitary manner. This had the potential to affect all 28 residents residing in and receiving meals from the facility. Findings include: On 5/29/14, at 11:54 a.m. during the noon meal service observation, Cook (C)-A was observed to wash her hands and donned gloves. A red bucket containing a green cloth submerged in a liquid solution was observed on the sink counter. With the same gloved hands, C-A was observed to lift the green cloth from the bucket and wipe the food thermometer probe with the cloth, put the cloth back into the bucket, walk back to stove area and insert the probe into the Taco casserole. Once the casserole temperature was obtained, C-A returned to the bucket and repeated the process of wiping the probe with the same cloth, putting the cloth back into the bucket when done. C-A repeated this process after checking the temperature of the corn and gravy. C-A stated the liquid was a sanitizing solution used to sanitize the probe in between each food item and that was how she was trained to do it.	21000	POA initiated. Monitoring will be ongoing.	

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21000	Continued From page 44 - At 12:07 p.m. the registered dietician (RD) entered the kitchen. When asked if the bucket of sanitizing liquid with the cloth submerged was appropriate for use she stated she did not know and would have to "check on that." C-A was observed to continue the same process of wiping with probe with the submerged cloth, with the same gloved hands. -At 12:12 p.m. the RD returned to the kitchen and was observed to hand C-A a box of alcohol wipes and directed C-A to use the prepackaged, individual wipes to clean the probe with in between each food item. With the same gloved hands, C-A was observed to remove a wipe from the box, tear a corner off, and insert the probe into and through the package, withdrew it and obtained the temperature of the picante sauce. C-A was observed to repeat this process prior to obtaining the macaroni salad temperature. -At 12:15 the RD was observed sorting through individual resident menu sheets that were laying on the service counter in the kitchen, the RD was not observed to wash her hands upon entering the kitchen or prior to handling the resident menu sheets. The RD was observed writing notes on the resident menu sheets. With the same gloved hands, C-A was observed to sort through the same individual resident menu sheets. The RD exited the kitchen. -At 12:26 p.m. The RD returned to the kitchen with a policy titled, Food Thermometer Guidelines. The policy directed staff to wash, rinse, sanitize and air-dry the thermometer before each use. The policy also indicated a sanitizing mixture or a alcohol fabric wipe could be used for food-contact surfaces. However, the policy also	21000		

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21000	Continued From page 45 indicated if a sanitizing solution was used, the thermometer must soak in the solution for one minute and allowed to air dry in between each use. -At 12:28 p.m. C-A was observed to remove the gloves, wash her hands and donned a clean pair of gloves. C-A was observed to pick up the same individual resident menu sheets and sorted them into piles. With the same gloved hands, C-A was observed to dish up the taco casserole from the pan using a spatula. Once the casserole was on the spatula, C-A was observed to cover and hold the top of the casserole with her gloved hand while transferring it to a resident meal plate. C-A proceeded to place a cover over the plate, picked up a menu sheet and placed it on top of the cover. C-A continued to sort through the menu papers, select one at a time, dish up another serving of casserole using the same technique. C-A continued this process for another nine resident meal plates and set them on the meal service cart. C-A was observed to enter the dirty dish area and obtained a three tier rolling cart and wheeled it to the food service counter / food tray line. C-A was observed to pick up and sort through additional resident menu sheets and continued to dish up 16 resident casserole dishes using the same technique to transfer the casserole onto the plates and placed them onto the three tiered cart. At no time was C-A observed to remove her gloves or wash her hands. -At 12:58 p.m. C-A verified she touched food items after contaminating her gloves. C-A stated she should have washed her hands and changed her gloves as she was not supposed to touch the food. C-A also confirmed she had not followed facility policy related to properly cleaning the food	21000		

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21000	Continued From page 46 thermometer probe in between each use. -At 1:05 p.m. The RD stated she should have washed her hands upon entering the kitchen and prior to handling the resident menu sheets. The RD verified C-A had not dished up resident food in a sanitary manner and also did not properly sanitize the thermometer probe as directed. In addition, the RD stated C-A should have removed the alcohol wipe from the packaging and wiped the probe with the pad. The RD confirmed the facility policies were not followed. The facility's undated Dining Services Hand Washing policy directed staff to wash their hands upon entering the dining service department, before food handling, preparation or service and after handling any soiled or contaminated equipment or cleaning cloths. -At 2:05 p.m. The director of nursing (DON) confirmed the facility's policy was not followed and stated food items should not be handled using unclean gloved hands. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could develop, review or revise policies, provide education for staff regarding regarding appropriate food preparation and sanitation in the kitchen. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		

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21390	Continued From page 47	21390		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to analyze patterns and trends of resident and employee infections. This had the potential to affect all 28 residents who resided in the facility.	21390	POA initiated. Review and correction will be ongoing.	7/9/14

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21390	Continued From page 48 Findings include: Review of the facility's infection control program revealed a system which lacked a surveillance program with ongoing analysis and interpretation of infections and infection risks. The Line Listing of Resident Infections for 02/14, 03/14, 04/14, and 05/14, revealed only infections with prescribed antibiotics were tracked. The facility's tracking system lacked trending of infections without antibiotics. In addition, a tracking system for employee infections and comparison surveillance between resident and employee illnesses had not been established. On 5/30/14, at 10:20 a.m. the facility infection control program was reviewed with the director of nursing services (DNS). The DNS stated she ran a daily report of residents who were prescribed antibiotics and entered the information onto the Line Listing of Resident Infections form. Information included on the Line Listing of Resident Infections included: resident name, room number, date of birth, admission date, type of infection, symptoms/date, cultures, treatment, other actions if needed and whether the infection was healthcare associated or community acquired. She also stated that, at times, floor nursing staff would notify her of residents prescribed antibiotics to be added to the list. The DNS indicated she then followed those residents on the list and coordinated with physicians and staff to ensure progress was made toward resolution of the infection. The DNS verified she had not been monitoring infections without a prescribed antibiotic and confirmed there was no analysis for trends in resident infections. The DNS indicated she did not gather data for tracking and trending of employee infections and confirmed there was no analysis or comparison of	21390		

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21390	Continued From page 49 resident and employee infections completed. The Surveillance for Healthcare-Associated Infections policy dated 2001, indicated the infection control coordinator or designated infection control personnel was responsible for gathering and interpreting surveillance data and analyzing the data to identify trends. A policy regarding the tracking of employee infections was requested but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding a facility wide infection control program. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and	21426		7/9/14

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21426	Continued From page 50 unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: MN Rule 4658.0810 Subp 2 Based on interview and document review, the facility failed to complete a tuberculosis (TB) risk assessment according to the current Centers for Disease Control (CDC) guidelines for preventing the transmission of tuberculosis and failed to ensure screening of active TB symptoms and testing was completed upon admission for 1 of 5 residents (R14). Additionally, the facility failed to provide TB screening and testing for 1 of 5 newly hired employees (director of nursing services) as required. Findings include: R14's Minimum Data Set (MDS) indicated R14 was admitted to the facility on 1/16/14. Review of the undated Baseline TB Screening Tool for Residents revealed R14's history and risk factors and symptoms of active TB disease sections were blank. Additionally, the administration section for the TB blood test was also blank. The two-step tuberculin skin test (TST) section read "Pos PPD" [positive tuberculosis skin test]. No other documentation of a previous positive TST	21426	Correction initiated/ongoing monitoring.	

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21426	Continued From page 51 result was found in R14's medical record. On 5/29/14, at 12:51 p.m. the assistant director of nursing (ADON) confirmed R14's risk assessment, TB symptom screening nor testing was performed or completed. The ADON indicated R14 had a previous positive tuberculosis skin test prior to admission to the facility. The ADON further confirmed there was no documentation of the previous positive tuberculosis testing nor documentation of a baseline chest X-ray on file in R14's medical record to indicate R14 did not have evidence of active TB disease. Review of the director of nursing services personnel record was reviewed and revealed the lack of documentation to indicate the required TB screening and the first or second step TST were completed. On 5/30/14, at 1:18 p.m. DNS confirmed she had not completed a TB screening or a TST prior to or since date of hire at the facility. The CDC Guidelines for Preventing the Transmission of Mycobacterium tuberculosis in Health Care Settings, 2005 indicates a baseline or newly positive TST or BAMT (blood assay for M. tuberculosis) result should receive one chest radiograph to exclude a diagnosis of TB disease (or an interpretable copy within a reasonable timeframe, such as six months). After baseline chest radiograph is performed and the result is documented, repeat radiographs are not needed unless symptoms or signs of TB disease develop or a clinician recommends repeat chest radiograph. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee	21426		

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21426	Continued From page 52 could review or revise policies, provide education for staff regarding resident and employee tuberculosis screening and testing. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21540	Correction initiated.	7/9/14

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21540	Continued From page 53 facility failed to ensure that non-pharmacological interventions were attempted prior to administering an anti-anxiety medication (Lorazepam) for 1 of 5 residents (R45) whose drug regimen was reviewed. Findings include: R45's significant change Minimum Data Set (MDS) dated 4/25/14, indicated R45 had severe cognitive impairment. The MDS also indicated R45 was diagnosed with Alzheimer's Disease and diabetes. R45 was admitted to hospice services on 4/18/14, diagnosed with failure to thrive per the physician's order. The care plan dated 3/31/14, indicated R45 had a history of anxiety and had a medication to use. The Behavior Monthly Flow Sheets dated April and May 2014, indicated R45 was diagnosed with a generalized anxiety disorder. The current Physician's Orders dated 5/28/14, read, Lorazepam 0.5 milligrams (mg) every 8 hours as needed for anxiety or agitation. Prior to administration try non-pharmacological interventions first: (1) Remove resident from stimulation (2) Hand massage (3) Unmet need, address pain, toileting, hunger/thirst, is resident hot/cold (4) then try the Lorazepam. According to the medication administration records for April and May 2014, MAR, R45 received the Lorazepam on 4/14/14, 4/27/14, 5/8/14, 5/14/14, 5/17/14, 5/20/14, and 5/26/14. On 5/29/14, at 1:53 p.m. the assistant director of nursing (ADON) stated 90% of the time the	21540		

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21540	Continued From page 54 nurses do not document in the progress notes that they tried the non-pharmacological interventions prior to giving the Lorazepam. The ADON stated the nurses should be documenting on the Behavior Monthly Flow Sheets the non-pharmacological interventions tried prior to the Lorazepam administration. On 5/30/14, at 11:15 a.m. the ADON stated there was no documentation that prior to R45 receiving the Lorazepam on seven occasions that non-pharmacological interventions were tried prior. At 11:53 a.m. nursing assistant (NA)-A stated R45 would ask for his mother, and would be looking to change clothes to go to a wedding or a funeral. NA-A stated she would be able to re-direct R45 by showing him his wedding picture. The undated Behavior Management policy directed staff to use non-pharmacological interventions, prior to considering initiation of any psychoactive medications. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could develope, review or revise policies, provide education for staff regarding use of non-pharmacological interventions. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		

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	00995	A. BUILDING: _____ B. WING _____	05/30/2014

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21695	Continued From page 55	21695		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to maintain the kitchen dishwashing area wall, flooring and plumbing in a clean and well maintained manner. This had the potential to affect all 28 residents services by the kitchen. Findings include: During the kitchen tour on 5/29/14, at 10:49 a.m. with dietary aide (DA)-A the wall below the dishwashing counter was observed have crumbling material with duct tape securing tiles to the wall. Rust was also observed on the wall and floor within the same area. A pipe coming from the wall connecting to the garbage disposal and attached to the dishwashing counter was observed rusty and corroded with water observed leaking from the pipe. A rust stain approximately two feet by 3 feet was observed on floor. DA-A stated the area smelled like a barn yard and the odor was "so strong" it "made her sick." DA-A also stated the area was somewhat improved after maintenance had previously worked on it. DA-A verified the wall and floor areas were uncleanable.	21695	Correction initiated.	7/9/14

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21695	Continued From page 56 At 2:20 p.m. the administrator verified the findings and stated the above identified area was "a problem." At 2:33 p.m. during an interview maintenance staff (M)-A confirmed the findings and stated the odor was from staff not rinsing the garbage disposal properly after use. In addition, M-A confirmed the wall and floor areas were problems that required fixing. SUGGESTED METHOD OF CORRECTION: The dietary manager and/or designee could develop, review or revise policies, provide education for staff regarding proper maintenance of the dietary department. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act upon resident grievances for the last 5 of 5 resident council meetings regarding	21870	Correction initiated and ongoing.	7/9/14

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21870	Continued From page 57 food palatability. This had the potential to affect all 28 residents who received meals in the facility. Findings include: R38 was interviewed on 5/28/14, at 1:30 p.m. and stated the food quality is horrible and they (residents) have complained numerous times. R38 added the quality of the food is not palatable, sometimes it is undercooked, sometimes it is over cooked and just mush. R38 stated there are residents who cannot always speak for themselves, but you see that they are not eating the food. The residents have not heard or seen anything from the dietary department, many times the menu is changed without notice because they don't have the food item, and the comments are they did not get the order in in time to be delivered. R38 added they have made numerous complaints about the food quality and there is no follow up. R38 continued there is tuna casserole with no tuna, the vegetables are overcooked and at times mushy, meat is overcooked and you cannot chew it. R38 stated, "We have requested that a member of the upper staff come and have a meal with us and do this weekly, so they see the quality of food that has not happened." R38 stated he was going to talk to the social service designee to find out why all of the food complaints are not documented in the resident council minutes. The resident council minutes were reviewed and documentation included: 1/22/14, residents brought up concerns that the food is cold and food is not cooked thoroughly. On 2/20/14, five residents brought up concerns that the food is cold. 3/28/14, "Is there any diabetic desserts besides fruit? When is the spring menu coming here?	21870		

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21870	Continued From page 58	21870		

Would like to have a spring picnic with picnic food. Does the Administration here listen to your suggestion?" Answer was: No. Number of residents who agree: All. "Food portions are too small. Please let kitchen know I don't want any more pasta. Meal items missing and food cold and late."

4/25/14, "Is there any diabetic desserts besides fruit? Would like to have Department heads eat with residents at least one time a week."

5/16/14, "Food items dropped or substitute the day of menu, i.e. salmon, over loaded on carbohydrates, Food over and under cooked-vegetables also meat."

On 5/30/14, at 9:40 a.m. during an interview with the social service designee (SSD) regarding the resident council concerns regarding the unpalatable food that is being served, the SSD stated, " If there is a problem or complaint regarding the food, I just go to dietary and tell them verbally. I have not filled out any forms to give to the kitchen regarding the residents' concerns. I know the residents have had many complaints about the quality of the food." SSD added, "The dietary manager would have a monthly meeting and I would just step in and bring up complaints. I have never filled out the form to notify the kitchen of food concerns of the residents from the council meetings." When asked why all the food complaints are not documented in the minutes the SSD stated,"I would just go tell dietary the concerns." The SSD stated, "We have a form to fill out to go to the departments that the resident council had concerns with. I am the one who would fill out the form for the departments, I have not done that." The SSD verified, "The forms have not been filled out regarding the complaints the resident council has regarding the palatability of the food and the multiple complaints that were brought up in the

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21870	Continued From page 59 resident council meetings regarding food quality." The SSD provided documentation titled, Resident Council Process which indicated, "It is the Golden Living standard that the SSD and RSD are to be involved in the council. If two or more residents have issues, then the Department Response form (DRF) is to be utilized. If the DRF's need to have a plan to correct the situation completed and signed by the appropriate department head, and then signed. At the next council meeting the resident will decide whether the issue has been resolved or remains ongoing and needs to re-address using the same format. Repetitive problems may need further address." The SSD verified that the policy had not been followed. On 5/30/14, at 9:55 a.m. the consulting dietician (CD) was asked if she had received any resident council complaint forms, the dietician stated, " I have not, but I have talked to some of the more vocal residents and I asked how the food has been because they have complaints about the quality of the food. We are aware of the problems with the quality of the food and we have to work to improve this." On 5/30/14, at 11:40 a.m. the director of nursing services (DNS) verified the resident council policy should be followed, and the residents' concerns regarding the poor quality of food should have been addressed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding resident grievance process. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance.	21870		

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21870	Continued From page 60 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to attempt to form a family council within the past calendar year as required. This had the potential to affect all 28 residents who resided in the facility. Findings include: On 5/29/14, at 7:38 a.m. the therapeutic recreation director/social service designee (SSD) gave the surveyor a letter dated 5/22/14, which indicated the next Family Council meeting would be held on 6/11/14, and treats would be served.	21942	Completed.	7/9/14

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21942	Continued From page 61 At 9:08 a.m. the SSD stated there had not been an attempt to establish a Family Council meeting in 2013. The SSD stated the previous social worker would have been responsible during that time. The SSD stated she would be taking over the responsibility for establishing the Family Council on an annual basis. The last Family Council meeting was held on 10/11/12. The Family Council policy revised 10/09, indicated the social services director would provide assistance in coordinating the Family Council meetings. The expectation was to have Family Council available on at least a quarterly basis. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review or revise policies, provide education for staff regarding formulation of a Family Council. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21942		