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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: SIKJ

Facility ID: 00799

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245540**

2.STATE VENDOR OR MEDICAID NO.
(L2) **438670100**

3. NAME AND ADDRESS OF FACILITY
(L3) **HENNING REHABILITATION & HEALTHCARE CENTER**
(L4) **907 MARSHALL AVENUE, PO BOX 57**
(L5) **HENNING, MN** (L6) **56551**

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

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

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

6. DATE OF SURVEY **05/18/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:

____1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(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 :
Gail Anderson, Unit Supervisor 05/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 05/22/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1990
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/11/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245540

May 22, 2018

Mr. Patrick Krejci, Administrator
Henning Rehabilitation & Healthcare Center
907 Marshall Avenue, PO Box 57
Henning, MN 56551

Dear Mr. Krejci:

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 May 4, 2018 the above facility is recommended for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

An equal opportunity employer.

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
May 22, 2018

Mr. Patrick Krejci, Administrator
Henning Rehabilitation & Healthcare Center
907 Marshall Avenue, PO Box 57
Henning, MN 56551

RE: Project Number S5540028

Dear Mr. Krejci:

On April 17, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 29, 2018. 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 May 18, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 7, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 29, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 4, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 29, 2018, effective May 4, 2018 and therefore remedies outlined in our letter to you dated April 17, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

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(L5) **HENNING, MN** (L6) **56551**

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3. Termination 4. CHOW
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6. DATE OF SURVEY **03/29/2018** (L34)

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FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

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

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

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NE II 05/09/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/10/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
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22. ORIGINAL DATE OF PARTICIPATION
04/01/1990
(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**
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02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 17, 2018

Mr. Patrick Krejci, Administrator
Henning Rehabilitation & Healthcare Center
907 Marshall Avenue, PO Box 57
Henning, MN 56551

RE: Project Number S5540028

Dear Mr. Krejci:

On March 29, 2018, 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 electronically delivered CMS-2567 whereby corrections are required.

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**

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

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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 May 8, 2018, 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 May 8, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 29, 2018 (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 September 29, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING ______ B. WING ______	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENNING REHABILITATION & HEALTHCARE CENTER	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 3/26/18, to 3/29/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 3/26/18 through 3/29/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.	F 550		5/4/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/25/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING ______ B. WING ______	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 550	Continued From page 1 §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to perform dignified cares for 1 of 1 residents (R1) observed during catheter and incontinence cares.	F 550	Does not include plans to monitor its performance to make sure that solutions are sustained. include visual auditing of cares --perineal and or cares with catheter	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245540	A. BUILDING ______ B. WING ______	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENNING REHABILITATION & HEALTHCARE CENTER	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

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F 550	Continued From page 2 Findings include: R1's quarterly Minimum Data Set (MDS) assessment, dated 12/23/17, identified diagnoses which included cerebral vascular accident (CVA), diabetes mellitus and obstructive uropathy. R1 was cognitively intact and required extensive assistance with bed mobility, dressing and hygiene. R1's MDS further identified R1 utilized an indwelling catheter. R1's care plan, updated 3/24/18, indicated R1 used an indwelling catheter related to a neurogenic bladder. The care plan indicated R1 would be free from catheter-related trauma and directed staff to position catheter bag and tubing below the level of the bladder and away from entrance room door. R1's care plan further identified R1 had tested positive for C-Diff (clostridium difficile; bacterial infection with symptoms of watery diarrhea) and R1 was on contact precautions. The facility nursing assistant care sheet, untitled, undated, indicated R1 was on contact precautions for C-Diff and was incontinent of bowel. The care sheet also identified R1 had a foley catheter. On 3/27/18, at 8:33 a.m. R1 was lying on back on his bed. R1's catheter bag was attached to the bed frame, uncovered. A moderate amount of dark amber urine was present in the bag and was visible from the hall, while R1's room door was opened wide to the hall. On 3/28/18, at 9:34 a.m. R1 was observed lying on his back in bed, with R1's catheter bag was	F 550	patients This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. Some of the many ways that this has been achieved for resident #1 is by ensuring resident has catheter bag covered always, supplies in room for staff to do cares appropriately and in clean and professional manner provide dignified care. In this case, after the surveyor reported finding resident catheter bag on floor and visible to anyone walking by immediately catheter was placed in an appropriate bag and hooked to bed frame. Upon witnessing incontinent care on same resident R1 it was noted incontinent items were passed to another staff over resident face. This immediately was reviewed, and all staff reminded to promote dignity and respect and ensure adequate supplies available next to them to do cares in professional manner. 2. Because all residents that reside in the facility calling it their home, all are	

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	245540	A. BUILDING ______ B. WING ______	03/29/2018

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F 550	Continued From page 3 visible through the door from the hallway. R1's catheter bag was uncovered, the bottom 1/3 of the bag was rested directly on the floor. On 3/28/18, at 10:16 a.m. R1 remained on his back in his bed, covered with linens. His catheter tubing was observed running from under his blanket, down to the catheter bag, which was unhooked from the bed, uncovered and rested directly on the floor with the lower 1/3 of the bag resting on the floor. NA-B and NA-E entered his room, emptied R1's catheter bag, then proceeded to perform perineal cares. R1 was incontinent of a large amount of dark brown loose stool, which had leaked onto his thighs, the cloth incontinence pad under him and his sheet. A tan, plastic garbage can was observed on each side of R1's bed, near the head of the bed. NA-E and NA-B assisted R1 to his left side then removed his brief. The brief had a large amount of brown, loose stool, visible on the inside and outside of the brief. NA-E handed the dirty brief to NA-B who moved it over R1's head and placed it in the garbage can, located directly below R1's face, on the floor next to the left side of his bed. NA-E used several disposable wipes to cleanse R1's perineal area, buttocks and thighs of the dark brown stool. Each time she used a wipe, she handed the soiled wipe to NA-B, who then placed it below R1's face in the garbage can. R1 was observed multiple times looking at the soiled brief and wipes, then looked towards staff. Registered nurse (RN)-C entered the room with a supply of additional wipes and handed the wipes to NA-E and NA-B, as they continued with R1's incontinence care. NA-E continued to wipe R1's perineal area and thighs multiple times, hand the wipes over to NA-B, who placed the dirty wipes directly below R1's face, in the garbage can, until	F 550	potentially affected by the cited deficiency. No other residents currently have a catheter. Care sheets also reinforced this practice. All staff were reminded to make sure bags are in all wastebaskets after use and pre-gather supplies and equipment prior to cares to ensure being done according to standards taught in nursing aide classes. When staff note any resident not having garbage can, garbage liners or catheter bags they are immediately to correct the solution for any resident. Current residents were audited by director of nursing to ensure they had supplies needed, catheters covered and that any cares were completed to promote the resident rights. No other residents were affected. The Policy and Procedure for quality of life was reviewed. 3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all staff attended in-service training regarding resident rights, quality of care, dignity, and proper catheter/incontinence care. The training will emphasize the importance of understanding covering catheter bags for privacy and respect, the example of the care witnessed and review the disrespect it would cause to anyone, and the importance of supplies being available and in place for next person providing care. Residents should be encouraged to express their concerns regarding care and feel like they live in a comfortable homelike environment. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the	

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F 550	Continued From page 4 they assisted him to turn to his right side. On 3/29/18, at 3:34 p.m. R1 indicated he felt it was not good to have the garbage can with soiled products placed close to his face during his incontinence cares. He indicated he would of preferred staff to use the garbage can on the other side of the bed, not the one in front of his face. On 3/28/18, at 2:05 p.m. NA-B indicated she had noticed the placement of the garbage can after she completed R1's incontinence cares. NA-B confirmed she had to reach over R1's head with the soiled brief and soiled wipes during cares and confirmed the soiled brief and soiled wipes were placed in front of R1's face in the garbage can. NA-B indicated she later talked to R1 about the handling of the soiled products and wipes, indicated she had told him she would not of been happy if someone had treated her grandparent in this manner and apologized. NA-B indicated she had been unaware R1's catheter was uncovered and rested on the floor. On 3/28/18, at 2:17 p.m. NA-E indicated when she entered the room she had not noticed the catheter bag was on the floor, but felt it may have slipped out the cloth bag. NA-E stated she was aware there were two garbage cans in R1's room, but indicated she had handed the used items soiled, with brown loose stool, to NA-B because the garbage can on R1's right side did not have a new liner in it. She indicated she did not even think of the position of the garbage can during R1's incontinence cares. NA-E confirmed it was a concern to hand the soiled brief and soiled wipes over R1 and place them into the garbage can directly in front of his face.	F 550	DON to monitor resident care, privacy and dignity,and incontinence/catheter care. The DON or designee will complete 2 audits per week x 4 weeks on catheter bags,having proper supplies in rooms, and to ensure catheter/incontinent cares are done appropriately. then 1 audit weekly for 4 weeks ensure staff comply with best practices. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON will be responsible for this POC.	

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F 550	Continued From page 5 On 3/29/18, at 1:08 p.m. director of nursing (DON) indicated R1's catheter bag should be covered with a cloth bag at all times, and had been aware R1's catheter bag had been uncovered in the past. DON indicated R1 indicated he did not care if it was uncovered, but she informed him it needed to be covered, not only for his dignity, but for residents and visitors in the facility. DON indicated she would expect nursing staff to handle soiled products appropriately, plan cares to ensure the correct supplies/equipment were available. She indicated she felt placing soiled items directly in front of a residents face during incontinence cares was not dignified care. The facility policy titled Quality of Life-Dignity, dated 12/27/17, indicated all residents shall be treated with dignity and respect at all times, meaning resident would be assisted in maintaining and enhancing his or her self-esteem and self-worth. Demeaning practices and standards of care that compromise dignity is prohibited. The policy further instructed staff to help residents keep catheter bags covered.	F 550		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State	F 623		5/4/18

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F 623	Continued From page 6 Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged;	F 623		

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F 623	Continued From page 7 (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure	F 623		

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F 623	Continued From page 8 to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the ombudsman of facility initiated discharges for 3 of 3 residents (R6, R124, R22) who were discharged to the hospital. Findings include: R6's admission Minimum Data Set (MDS) dated 1/15/18, identified diagnoses which included hypertension and weakness. R6's Progress Notes dated 2/1/18, at 9:42 a.m. indicated R6 began having emesis on 1/31/18, symptoms worsened, and R6 had been admitted to the hospital at that time. R124's quarterly MDS dated 3/1/18, identified diagnoses which included diabetes mellitus, hypertension and chronic obstructive pulmonary disease (COPD). R124's Progress Notes dated 3/14/18, R124 presented with weakness and decreased oxygen saturation of 83%, had been sent R124 to hospital emergency room (ER) for evaluation. At 10:25 p.m. facility received a phone call informing them R124 had been transferred to St. Cloud hospital for admission for pneumonia and congestive heart failure (CHF). R22's Admission Record identified diagnoses	F 623	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility report all transfers and discharges to the ombudsmen. R6, R124, and R22 were all sent to the hospital and notification was not made regarding their transfer to the ombudsman office as stipulated should be by regulations. When the surveyor noted these residents to have no documentation supporting notification it was noted that this practice had not yet been implemented within facility. Immediately policy and procedure on transfers/discharges was updated, staff were educated, reminders sent to nursing stations with policy and requirements. 2. Because all residents that reside in the facility do either discharge or have visits to ER, all are potentially affected by the cited deficiency. Immediately all residents being transferred or discharged were reviewed and update was noted to ombudsman. When staff note any	

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F 623	Continued From page 9 which included anoxic brain damage, seizures and chronic obstructive pulmonary disease. R22's Progress Notes on 3/4/18, indicated R22 had been sent to emergency department and admitted for aspiration pneumonia. Review of R6, R124 and R22's medical records lacked documentation the notification of the facility initiated emergency transfer/discharge had been sent to the Long-Term Care (LTC) Ombudsman. On 3/28/18, at 1:10 p.m. licensed social worker (LSW)-A confirmed she had not notified the ombudsman of R6, or R124's hospital transfers. LSW-A confirmed her usual practice did not include notifying the ombudsman of discharges, unless it was a "reportable" kind of discharge. On 3/28/18, at 1:41 p.m. during a group interview with the regional director of clinical services (RDCS), administrator and director of nursing (DON), they indicated they was unaware of the need to notify the ombudsman of transfers and discharges. The administrator indicated they would update their policy to include notification of the ombudsman.	F 623	resident leaving they are aware of notification needed and in turn make appropriate note in resident chart. Current residents were audited by director of nursing to ensure all had appropriate notification in place. No other residents were affected. The Policy and Procedure for transfers/discharges was revised on 3/29/2018; reviewed on 4/17/2018 3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all staff will attended in-service training regarding this policy and the importance of notifying ombudsman. The training will emphasize this is to be done as soon as possible for transfers and up to 30 days prior for discharges and documentation of notification is critical. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the SW in conjunction with DON to monitor any transfers and discharges to ensure appropriate notification given. The SW or designee will complete 2 audits per week x 4 weeks on residents that have transferred or discharged, then 1 audit weekly for 4 weeks ensure staff comply with current policy. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. SW will be responsible for this POC.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)	F 625		5/4/18

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F 625	Continued From page 10 §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident or resident's representative was informed of the bed hold policy at the time of hospitalization for 2 of 3 residents (R22, R6) reviewed for hospitalization. Findings include:	F 625	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and	

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F 625	Continued From page 11 Review of R22's Admission Record indicated diagnoses which included anoxic brain damage, seizures and chronic obstructive pulmonary disease. R22's Progress Notes on 3/4/18, indicated R22 had been sent out to emergency department and admitted for aspiration pneumonia. R22 returned to the facility on 3/8/18. The medical record lacked documentation that bed hold information was sent to the hospital for R22, or given to R22's resident representative at the time of transfer to the hospital, or attempts to contact the resident representative to offer the bed hold policy. On 3/29/18. at 2:43 p.m. the regional director of clinical services (RDCS) confirmed the bed hold policy was not offered to R22 or R22's resident representative at the time of transfers to acute care and that the facility was working on updating the bed hold policy. R6's admission Minimum Data Set (MDS) assessment dated 1/15/18, identified diagnoses which included hypertension and weakness. R6's Progress Notes on 2/1/18, at 9:42 a.m. note indicated R6 had been admitted to the hospital for evaluation of weakness, fever and diarrhea. The medical record lacked documentation that bed hold information was sent to the hospital for R6, or given to R6's resident representative at the	F 625	federal law. 1. It is the policy of this facility to ensure bed hold consent obtained from POA and copy given to hospital receiving resident and that POA also receives copy. R6 and R22 were sent to the hospital and no indication bed hold policy was sent to hospital or POA per regulation. When the surveyor reported lack of documentation that this occurred, it was noted that this practice had not yet been reviewed and implemented appropriately within facility. Immediately policy and procedure on bed holds was updated, staff were educated, reminders sent to nursing stations with policy and requirements. 2. Because all residents that reside in the facility make visits to hospitals on occasion or go on therapeutic leaves, all are potentially affected by the cited deficiency. Immediately all residents being transferred or on leave were reviewed and updated bed hold policy given out. When staff note any resident leaving they are aware to get POA consent for bed hold, send bed hold with resident to hospital or with resident taking leave and get copy to POA with note in resident chart. Current residents were audited by director of nursing to ensure all had appropriate notification in place. No other residents were affected. The Policy and Procedure for bed holds was reviewed on 4/17/2018 3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all staff will attended in-service training regarding this policy and the importance of bed holds. The training will emphasize this	

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F 625	Continued From page 12 time of transfers to the hospital, or attempts to contact the resident representative to offer the bed hold policy. On 3/28/18, at 1:10 p.m. licensed social worker (LSW)-A confirmed she did not notify residents or residents' representatives of the facility bed hold policy and indicated the business office completed bed hold policies. On 3/28/18, at 1:41 p.m. director of nursing (DON) confirmed R6's medical record lacked documentation of bed hold information given to R6 or R6's representative. DON confirmed the facility interdisciplinary team had discussed this and would review their process in the near future and make changes as needed. The facility policy titled Transfer or Discharge, Emergency, revised 3/28/18, identified the facility would notify the representative (sponsor) or other family member; ask if they would like bed held for any temporary transfers. This could be documented in a progress note that they would like bed held.	F 625	must be done with all residents being sent out of facility going out on leave or transferring to hospital. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the SW in conjunction with DON to monitor any transfers to ensure appropriate notification given. The SW or designee will complete 2 audits per week x 4 weeks on residents that have transferred or left, then 1 audit weekly for 4 weeks ensure staff comply with current policy. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. SW will be responsible for this POC.	
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths,	F 636		5/4/18

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F 636	Continued From page 13 goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not	F 636		

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F 636	Continued From page 14 apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure resident Care Area Assessments (CAA) included a comprehensive analysis of a resident's needs, strengths, goals, history and preferences for 4 of 5 residents (R9, R14,R15, R124) reviewed. Findings include: R9 R9's significant change Minimum Data Set (MDS) dated 5/23/17, identified severe cognitive impairment and diagnoses which included neurogenic bladder (bladder dysfunction) dementia, and anxiety. The MDS indicated R9 required supervision with transfer, ambulation and eating, and required extensive assistance with toileting and personal hygiene, The MDS indicated R9 had behaviors not directed at others one to three times during the assessment period and received, antidepressant and diuretic medication daily, antibiotics five days and antianxiety medication two days. R9's Care Area Assessments (CAA) dated 5/23/17, identified nine care areas had triggered from the data entered into the MDS requiring analysis. The following care areas were triggered:	F 636	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to ensure all residents are assessed correctly via assessments and MDS to coordinate appropriate care plans. Some of the many ways that this has been achieved for R9, R14, R15, and R124 is by reviewing each of the triggered care areas and since the areas lacked comprehensive analysis as to why the areas triggered, each care area was reviewed and corrected to ensure adequate assessments were completed to gather data based on direct observation and communication with resident and staff on all shifts. The MDS nurse was instructed per the RAI manual to identify and use tolls that are grounded in current clinical standards…to gather data that is necessary in completing the CAA process.	

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Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcer and Psychotropic Drug Use.

-Cognitive Loss/Dementia CAA revealed the care area was an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included: Neurological factors, observable characteristics, mood and behavior, medical problems, pain, functional status and other considerations, requiring additional assessment/analysis of R9's cognition. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R9's cognitive functioning. The CAA further lacked any other considerations that could affect R9's cognitive functioning from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-Communication CAA revealed the care area was an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas, which included: diseases and conditions, medications and characteristics of the communication impairment which required additional assessment/analysis of R9's communication. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R9's communication. The CAA further lacked any other considerations that could affect R9's communication from resident observation, communication with licensed and non-licensed

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In this case, after the surveyor reported all residents listed above had care area assessments that were inaccurate or incomplete based on documentation and MDS; all care plans have been reviewed and updated, MDS nurse has completed further CAA training and is aware of how to properly document on CAA's.

2. Because all residents are assessed to determine their appropriate plan of care based on their assessments all are potentially affected by the cited deficiency, on 4/17/2018, the MDS nurse reviewed accuracy of CAA's and MDS that surveyors noted to be inaccurate. All other resident CAA's will be reviewed for timeliness and accuracy. Furthermore, all CAA's being created as of 4/17/2018 will be double checked by regional reimbursement coordinator prior to submission to ensure compliance. Policy on MDS/CAA was reviewed. No other residents were affected.

3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all staff received in-service training regarding state and federal requirements for documentation, assessments and proper follow up on all missing information to ensure clear and correct care plans. The training will also emphasize the importance of the MDS nurse to follow up on items that are not being addressed during assessment period and ensuring care areas are complete.

4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the

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F 636	Continued From page 16 staff members and resident and/or family input for care planning considerations. -ADL Functional/Rehabilitation Potential CAA revealed the care area was an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas, which included possible underlying problems affecting R9's function, medications and problems R9 was at risk for because of functional decline. The CAA lacked ADL problem evaluation, possible ADL goals and a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R9's ADL functioning. The CAA further lacked any other considerations that could affect R9's ADL functioning from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations. -Urinary Incontinence and Indwelling Catheter CAA revealed the care area was an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: modifiable factors contributing to R9's urinary incontinence, diseases and conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's incontinence. The CAA further lacked any other considerations that could affect R9's continence from resident observation, communication with licensed and non-licensed staff and resident and /or family input for care planning considerations. -Behavioral Symptoms CAA revealed the care area was a potential problem for R9, but did not	F 636	MDS nurse to that all residents will be reviewed at time of admission or annual to ensure CAA's are being completed thoroughly and completely. All triggers will be care planned and communicated to staff via care sheets and communication book if new interventions in place. Audits of CAA's will be completed for accuracy and timeliness; they will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. MDS nurse will be responsible for this POC.	

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F 636	Continued From page 17 indicate why. The CAA revealed multiple pre-populated check marked areas which included: cognitive status problems that can cause or exacerbate R9's behavior. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's behavior. The CAA further lacked any other considerations that could affect R9's behavior from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations. -Falls CAA revealed the care area was a potential problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R9's physical performance limitations, medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's fall risk. The CAA further lacked any other considerations that could have affected R9's fall risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations. -Nutritional Status CAA revealed the care area was a an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R9's functional and mental status, behavioral problems, disease conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's nutritional risk. The CAA further lacked any other considerations that could have affected R9's	F 636		

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nutritional risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Pressure Ulcer CAA revealed the care area was a potential problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: internal and external risk factors, medications and conditions that present complications or increase R9's risk for pressure ulcers. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's risk of pressure ulcers. The CAA further lacked any other considerations that could have affected R9's risk of pressure ulcers from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Psychotropic Drug Use CAA revealed the care area was an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: classes of medication R9 was taking, treatable reasons for use of psychotropic drug and adverse consequences of anti-depressant and anti-psychotic medication. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's risk of using psychotropic medications. The CAA further lacked any other considerations that could have affected R9's risk of using psychotropic medications from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

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R14
R14's Annual Minimum Data Set (MDS) dated 8/31/17, identified R14 had sever cognitive impairment, had diagnoses which included Cerebral Palsy and gastric esophageal reflux (GERD). The MDS identified R14 required extensive assistance for bed mobility, locomotion, dressing and hygiene, total assistance with toileting and transfer, supervision with eating and had no natural teeth.

R14's Care Area Assessments (CAA) dated 8/31/17, identified eight care areas had triggered from the data entered into the MDS requiring analysis. The following care areas were triggered: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dental Care, Pressure Ulcer and Psychotropic Drug Use.

-Cognitive Loss/Dementia CAA revealed the care area was an actual problem for R14, due to cognitive loss and mental health diagnoses. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included: observable characteristics, mood and behavior, medical problems, pain, functional status and other considerations, requiring additional assessment/analysis of R14's cognition. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R14's cognitive functioning. The CAA further lacked any other considerations that could affect R14's cognitive functioning from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for

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care planning considerations.

-Visual Function CAA revealed the care area was an actual problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included: disease conditions, and medications, requiring additional assessment/analysis of R14's cognition. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R14's visual function. The CAA further lacked any other considerations that could affect R14's cognitive functioning from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-Communication CAA revealed the care area was an actual problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas, which included: diseases and conditions, medications and characteristics of the communication impairment which required additional assessment/analysis of R9's communication. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R14's communication. The CAA further lacked any other considerations that could affect R14's communication from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-Urinary Incontinence and Indwelling Catheter CAA revealed the care area was an actual problem for R14, due to frequent incontinence of bladder and required total dependence for

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toileting.. The CAA revealed multiple pre-populated check marked areas which included: modifiable factors contributing to R14's urinary incontinence, diseases and conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's incontinence. The CAA further lacked any other considerations that could affect R14's continence from resident observation, communication with licensed and non-licensed staff and resident and /or family input for care planning considerations.

-Falls CAA revealed the care area was a potential problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R14's physical performance limitations, medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's fall risk. The CAA further lacked any other considerations that could have affected R14's fall risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Nutritional Status CAA revealed the care area was a an actual problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R14's functional and mental status, behavioral problems, communication, disease conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's nutritional risk. The CAA further lacked any other considerations that could have

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F 636	Continued From page 22 affected R14's nutritional risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations. -Dental Care CAA revealed the care area was a an actual problem for R14, due to R14 has no natural teeth, has upper and lower full dentures that he will wear as he chooses. The CAA revealed multiple pre-populated check marked areas which included: R14's cognitive and functional problems and disease conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's dental risk. The CAA further lacked any other considerations that could have affected R14's dental risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations. -Pressure Ulcer CAA revealed the care area was a potential problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: internal and external risk factors, medications and conditions that present complications or increase R14's risk for pressure ulcers. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's risk of pressure ulcers. The CAA further lacked any other considerations that could have affected R14's risk of pressure ulcers from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.	F 636		

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F 636	Continued From page 23 -Psychotropic Drug Use CAA revealed the care area was an actual problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: classes of medication R14 was taking, treatable reasons for use of psychotropic drug and adverse consequences of anti-depressant and anti-psychotic medication. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's risk of using psychotropic medications. The CAA further lacked any other considerations that could have affected R14's risk of using psychotropic medications from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations. On 3/29/18, at 4:00 p.m. MDS coordinator (MDSC)-A verified she had completed R9 and R14's CAAs. MDSC-A verified the CAAs lacked analysis of the pre-populated data and were not a comprehensive assessment.	F 636		

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R15
R15's admission Minimum Data Set (MDS) dated 6/19/17, identified R15 had moderately impaired cognition, and diagnoses which included Parkinson's disease, dementia and depression. The MDS identified R15 required assistance with activities of daily living (ADL) such as, supervision for transfers, walking and eating, and required extensive assistance from staff for bed mobility, dressing, toileting and personal hygiene. The MDS indicated R15 had hallucinations, other behavioral symptoms not directed at others and wandered on 1-3 days of the 7 day assessment period. The MDS further identified R15 received a daily anti-psychotic medication and a daily anti-depressant medication.

R15's Care Area Assessments (CAA) dated 6/29/17, identified eight care areas had triggered from the data entered into the MDS requiring analysis, the following care areas were triggered: Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Behavioral Symptoms, Falls, Pressure Ulcer and Psychotropic Drug Use.

-Cognitive Loss/Dementia CAA revealed the care area was an actual problem for R15, related to a diagnosis of dementia. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included: neurological factors and ADL function, requiring additional assessment/analysis of R15's

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cognition. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R15's cognitive functioning. The CAA further lacked any other considerations that could affect R15's cognitive functioning from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-Communication CAA revealed the care area was an actual problem for R15, but did not indicate why. The CAA revealed multiple pre-populated check marked areas, which included: diseases and conditions, medications and characteristics of the communication impairment which required additional assessment/analysis of R15's communication. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R15's communication. The CAA further lacked any other considerations that could affect R15's communication from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-ADL Functional/Rehabilitation Potential CAA revealed the care area was an actual problem for R15 related to diagnoses of Parkinson's disease and dementia. The CAA indicated R15 was able to perform ADLs independently at times, while other times R15 required staff assistance. The CAA revealed multiple pre-populated check marked areas, which included possible underlying problems affecting R15's function, medications and problems R15 was at risk for because of functional decline. The CAA lacked ADL problem evaluation, possible ADL goals and a

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F 636	Continued From page 26 comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R15's ADL functioning. The CAA further lacked any other considerations that could affect R15's ADL functioning from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations. -Urinary Incontinence and Indwelling Catheter CAA revealed the care area was an actual problem for R15, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: modifiable factors contributing to R15's urinary incontinence, diseases and conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R15's incontinence. The CAA further lacked any other considerations that could affect R15's continence from resident observation, communication with licensed and non-licensed staff and resident and /or family input for care planning considerations. -Behavioral Symptoms CAA revealed the care area was a potential problem for R15, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: nature of the behavioral disturbance, conditions that can cause behavior problems and factors that can cause or exacerbate R15's behavior. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R15's behavior. The CAA further lacked any other considerations that could affect R15's behavior from resident observation, communication with licensed and non-licensed staff and resident	F 636		

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and/or family input for care planning considerations.

-Falls CAA revealed the care area was a potential problem for R15, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R15's physical performance limitations, medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R15's fall risk. The CAA further lacked any other considerations that could have affected R15's fall risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Pressure Ulcer CAA revealed the care area was a potential problem for R15, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: internal and external risk factors, medications and conditions that present complications or increase R15's risk for pressure ulcers. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R15's risk of pressure ulcers. The CAA further lacked any other considerations that could have affected R15's risk of pressure ulcers from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Psychotropic Drug Use CAA revealed the care area was an actual problem for R15, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which

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included: classes of medication R15 was taking, treatable reasons for use of psychotropic drug and adverse consequences of anti-depressant and anti-psychotic medication. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R15's risk of using psychotropic medications. The CAA further lacked any other considerations that could have affected R15's risk of using psychotropic medications from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

On 3/29/18, at 3:55 p.m. MDS coordinator (MDSC)-A confirmed she completed R15's CAAs dated 6/29/17. MDSC-A stated R15's CAAs lacked analysis of pre-populated data from R15's MDS and had no further considerations which could affect R15's care areas and therefore were not a comprehensive assessment.

R124
R124's annual MDS, dated 6/29/17, identified diagnoses which included; diabetes mellitus, cancer, arthritis and chronic obstructive pulmonary disease (COPD). R124's MDS further identified R124 was cognitively intact and required extensive assistance with bed mobility, transfers, hygiene and toilet use. R124 had frequent urinary incontinence and occasional bowel incontinence. The MDS also identified R124 had no natural teeth, had fallen since last assessment and was at risk for pressure ulcers.

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R124's CAAs dated 7/2/17, identified six care areas triggered from the data entered into the MDS requiring analysis, the following areas were triggered; ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dental Care and Pressure Ulcer.

-ADL Functional/Rehabilitation Potential CAA revealed the care area was an actual problem for R124. The CAA identified R124 required extensive assistance with bed mobility, transfers, locomotion, dressing toilet use and personal hygiene. The CAA revealed multiple pre-populated check marked areas, which included possible underlying problems affecting R124's function and problems. R124 was at risk of functional decline. The CAA lacked ADL problem evaluation, possible ADL goals and a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R124's ADL functioning. The CAA further lacked any other considerations that could affect R124's ADL functioning from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-Urinary Incontinence and Indwelling Catheter CAA revealed the care area was an actual problem for R124, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: modifiable factors contributing to R124's urinary incontinence, diseases and conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R124's incontinence. The

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CAA further lacked any other considerations that could affect R124's continence from resident observation, communication with licensed and non-licensed staff and resident and /or family input for care planning considerations.

-Falls CAA revealed the care area was an actual problem for R124, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R124's physical performance limitations, medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R124's fall risk. The CAA further lacked any other considerations that could have affected R124's fall risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Nutritional Status CAA revealed the care area was an actual problem for R124, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included; R124's functional problems, cognitive problems, other diseases and conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R124's fall risk. The CAA further lacked any other considerations that could have affected R124's fall risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Dental Care CAA revealed the care area was an actual problem for R124, bud did not indicate

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why. The CAA revealed multiple pre-populated check marked areas which included: R124's cognitive problems, functional impairment, medications, diseases and conditions. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R124's fall risk. The CAA further lacked any other considerations that could have affected R124's fall risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Pressure Ulcer CAA revealed the care area was a potential problem for R124, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: internal and external risk factors, medications and conditions that present complications or increase R124's risk for pressure ulcers. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R124's risk of pressure ulcers. The CAA further lacked any other considerations that could have affected R124's risk of pressure ulcers from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

On 3/29/18, at 3:41 p.m. MDSC-A confirmed R124's CAAs were not complete. MDSC-A indicated she had completed R124's CAAS, but indicated she was not sure why R124's CAAS lacked a comprehensive analysis and only contained the pre-populated check marked areas. MDSC-A provided a facility document titled CAA Examples, undated. MDSC-A indicated she used the CAA Examples reference guide to complete

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all resident's CAAs. MDSC-A indicated she had recently been informed this had happened at another facility she was working at, and planned on contacting the facility consultant to help determine why her documentation had not been saved.

On 3/29/18, at 4:00 p.m. DON confirmed R124's CAAs lacked a comprehensive analysis, and only contained re-populated check marked areas. DON indicated her expectation would be for notes and summaries to be included in the CAAs.

The facility policy titled MDS/CAA Policy, dated 3/22/18, indicated the MDS nurse will monitor the completion of the CAA summary sections. The policy instructed staff to complete documentation for each triggered condition including clinical decision-making process. In the documented decision, a focused statement will include key causal factors, problems, complications and risk factors. The CAA summary and the CAA Assessment/Analysis to be completed by the designated date.

RAI manual dated 10/17, identified Care Areas were triggered by the MDS items in responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning. The RAI manual identified the CAA process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directed facility staff to evaluate triggered care areas. Further the RAI manual identified whereas the MDS identified actual or potential problems, the CAA process provides for further assessment of the triggered

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F 636	Continued From page 33 areas by guiding staff to look for causal or confounding factors and was important the CAA documentation included the causal or unique risk factors for decline or lack of improvement. In addition the RAI manual indicated facilities were instructed to identify and use tools that were current and grounded in current clinical standards of practice and when applied to practice, the use of sound clinical problem solving and decision making skills were imperative in completing the CAA process.	F 636		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where	F 661		5/4/18

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F 661	Continued From page 34 the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an accurate discharge summary for 1 of 1 resident (R24) who was discharged to home from the facility. Findings include: Review of the Admission Record dated 1/4/18, indicated R24 was admitted to the facility on 12/13/17, with diagnoses which included depression, diabetes and hypoxemia. Review of R24's Physician Discharge Summary (PDS) listed R24's name, attending physician, R24's medical record number, the date of admission 12/13/17, and the date of discharge 1/12/18 at 12:45 p.m. The remainder of the discharge summary was not completed, left blank: admission diagnosis, summary of course in nursing facility, condition upon discharge, other information, signature of person completing above information, date, prognosis (include rehabilitation potential), physician orders for immediate care, discharge diagnosis and signature of attending physician. In addition, the summary form lacked documentation of reconciliation of R24's medications sent home, Review of R24's Progress Notes from 1/4/18 to 1/12/18 revealed the following: -1/4/18, social services (SS) met with R24 and significant other about discharging, plan to	F 661	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of this facility to ensure all residents who discharge from facility have all the information and tools they need to discharge successfully. This would include but not limited to: medication list, medical and nonmedical appointments and treatments and recapitulation of resident stay. R24 was discharged home without appropriate discharge plan. When the surveyor reported lack of documentation, it was noted that the practice of discharge planning needed to start sooner and be complete for all residents upon discharging, this practice had not been followed per policy and best practice. Immediately policy and procedure on discharge planning was reviewed and SW would initiate discharge planning prior to resident discharge. 2. Because many residents that come to facility do so for short stays many are potentially affected by the cited deficiency. Immediately all residents being	

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F 661	Continued From page 35 discharge on 1/18/18 due to significant other having the day off. Discussed steps to enter home and lack of handrail at entrance. SS faxed medical doctor and he signed a referral for home health services (HHS). -1/12/18 writer provided education to husband staff felt R24 was not quite ready to go home. Husband indicated R24 wanted to go home and he was going to take her home. R24 indicated she was feeling better now, had agreed to go see her primary medical doctor on 2/8/18, and information given to husband. Medications sent with R24, pharmacy notified, medical director aware. Skin upon discharge, psoriasis patches, red skin folds with powders applied. Discharged from facility with all medications and personal belongings with spouse. R24's PDS had not been completed to ensure R24 received continuous and coordinated, person-centered care following discharge. The summary did not indicate if R24 was going to receive these services after discharge or if they were contacted to ensure HHS would be able to assist R24 in her home. The summary did not include any information from physical and occupational therapy, did not include information on home medications or what those medications were or if R24 knew what medications she was supposed to be taking. On 3/29/18 at 3:14 p.m. assistant director of nursing (ADON) stated she felt the director of nursing (DON) did not know she was supposed to be completing discharge summaries and were not being done. The ADON indicated she felt R24 was to receive home health services for therapy services after discharge and SS worked with	F 661	discharged were reviewed and discharge plan in place and sent with resident to ensure successful discharge. When staff are alerted a resident is discharging the planning should start immediately with therapy and then nursing to get current treatments, medications, adaptive equipment in check, along with current level of ADL functioning. Discharging residents were audited by SW to ensure all had appropriate discharge plan in place. No other residents were affected. The Policy and Procedure for discharge planning was reviewed on 4/17/2018 3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all staff attended in-service training regarding this policy and the importance of discharge planning. The training will emphasize this must be done with all residents discharging to ensure the resident has all information, tools and resources to discharge successfully. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the SW in conjunction with DON to monitor any discharges to ensure appropriate planning was completed. The SW or designee will complete 2 audits per week x 4 weeks on residents that have transferred or left, then 1 audit weekly for 4 weeks ensure staff comply with current policy. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for	

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F 661	Continued From page 36 setting the services up for the resident. She indicated SS usually called the residents once they were discharged to check how they were doing at home. ADON indicated the discharge summaries were to be completed after any resident was discharged from the facility. On 3/29/18 at 3:18 p.m. DON confirmed a discharge summary including a recapitulation was not completed when R24 discharged from the facility. The DON indicated the summary should include discharge orders, home health if needed, medications, pharmacy resident wanted and equipment needed at home. The DON indicated she just got a pile of discharges on her desk last week that went back several months. The DON indicated the facility had a new medical records person recently and she was not bringing her the charts to complete the discharge summaries. Review of facility policy titled, Discharging the Resident dated 12/23/17, indicated the goal was to ensure the resident was ready for their discharge to the next place. They will need doctors order, list of medications and treatments and any special instructions as to therapy or physician services they will need after discharge. Ensure residents have all supplies and services in place to offer a continuation of care.	F 661	further review or corrective action. 5. SW will be responsible for this POC.	
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances	F 676		5/4/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 676	Continued From page 37 of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide necessary services to maintain activities of daily living for 1 of 1 resident (R14) who required assistance with oral cares. Findings include:	F 676	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	

F 676 Continued From page 38

R14's quarterly Minimum Data Set (MDS) dated 2/19/18, identified R14 had severe cognitive impairment and had diagnoses which included Cerebral Palsy, Diabetes Mellitus and gastric esophageal reflux (GERD). The MDS identified R14 had no natural teeth, and required extensive assistance for bed mobility, locomotion, personal hygiene and dressing, total assistance for transfer and toilet use.

R14's Care Area Assessment (CAA) dated 8/31/17, identified R14 cognitive loss, mental health diagnosis, had no natural teeth, had full upper and lower dentures that he wears as he chooses, no issues with dentures, no mouth concerns, staff to assist as needed. The CAA listed R14 had unstable diabetes related to oral infection and the overall objective was to maintain current level of functioning, avoid complications and minimize risks.

R14's care plan revised 9/5/17, identified R14 required assistance with activities of daily living and listed various interventions which included set up of oral care supplies, encourage and assist with oral cares twice a day and as needed. Further, the care plan listed to encourage R14 to wear dentures, use fixodent for fit, and would often refuse to wear dentures.

On 3/28/18, at 7:00 a.m. nursing assistant (NA)-A and NA-D assisted R14 with morning cares. NA-D obtained a basin of water in the adjoining bathroom while NA-A applied R14's stockings and placed gray sweat pants on R14's lower legs. NA-A and NA-D worked together to wash and dress R14. R14 had no natural teeth, his mouth had a slightly sunken appearance with his mouth

F 676

requirements established by state and federal law.

1. It is the policy of this facility to provide care and services for activities of daily living. Some of the many ways that this has been achieved for R14 is to assist resident with his dentures and provide oral cares in morning and evening. In this case, after the surveyor determined R14 was not offered any oral cares nor aided with placing dentures, immediately staff were reminded the importance of assisting residents with all aspects of the ADL's including oral care. Care sheets were updated to include residents that need assistance with oral care and those that have dentures.
2. Because all residents are to have good oral care all are potentially affected by the cited deficiency, on 4/17/2018, the DON and ADON reviewed all residents to ensure all are receiving proper oral care. Other residents determined to wear dentures were identified and monitored for denture placement. Policy and procedure on ADL's has been reviewed. No other residents were affected.
3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all staff received in-service training regarding assistance with ADL's. The training will emphasize the importance of monitoring ADL's listed on care sheets and providing that care to dependent residents.
4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the DON and ADON to monitor resident's

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	245540	A. BUILDING ______ B. WING ______	03/29/2018

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F 676	Continued From page 39 closed. At 7:14 a.m. R14 was lifted from the bed on a sling with a full body lift and seated in his wheel chair. NA-D continued to assist R14 to wash and dry his face, neck, glasses and combed his hair, while NA-A made R14's bed. After NA-D and NA-A completed R14's cares, NA-D placed the soiled linens and garbage into separate opaque plastic bags, and NA-A and NA-D exited the room. At 7:21 a.m. NA-D and NA-A stated they had finished providing R14's morning cares and he would be assisted to breakfast later. On 3/29/18, at 1:13 p.m. NA-D confirmed she had not assisted R14 with oral cares on 3/28/18, and confirmed she had not rinsed or swabbed R14's mouth nor had she offered him to wear his dentures. NA-D indicated the usual facility practice was to provide assistance with oral cares for dependent residents. She indicated she did not usually offer R14 his dentures because he did not wear them at times. On 3/29/18, at 1:31 p.m. NA-A confirmed she had not assisted R14's with oral cares nor has she offered his dentures on 3/28/18. She stated the usual facility practice was to assist residents with oral cares. NA-A stated she was not aware if R14 had dentures and did not offer to assist him with dentures. On 3/29/18, at 2:32 p.m. the director of nursing (DON) verified R14's current working care plan, the nursing assistant care guide and R14's oral assessment. The DON verified she expected staff to assist with oral cares morning and evening, including residents with no natural teeth to be offered to swish and spit or use a toothette (a dental sponge). The DON also verified she	F 676	dependent on staff for ADL's. The DON or designated quality-assurance representative will perform the following systematic audits of residents receiving assistance with ADL's to ensure staff are completing cares per assessment and care plan by conducting 4 audits per week x 4 weeks then 2 audits per week x 2 months to ensure compliance in this area. All residents will be reviewed at time of quarterly or annual to ensure care plan and care sheets are updated to meet resident needs. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON will be responsible for this POC.	

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F 676	Continued From page 40 expected staff to offer R14 his dentures as the care plan directed. The facility policy titled Mouth Care dated 12/27/18, identified the purpose to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth.	F 676		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690		5/4/18

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F 690	Continued From page 41 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with toileting for 1 of 1 resident (R9) observed for toileting needs during the survey. In addition the facility failed to provide appropriate catheter care for 1 of 1 (R1) residents reviewed with an indwelling catheter. Findings include: R9's significant change Minimum Data Set (MDS) dated 5/23/17, identified severe cognitive impairment and diagnoses which included neurogenic bladder (bladder dysfunction) dementia, and anxiety. The MDS indicated R9 required supervision with transfer and ambulation and required extensive assistance with toileting and personal hygiene. R9's care plan revised 9/16/17, revealed a physical functioning deficit related to self care impairment, toileting assistance of 1 PRN (as needed). Staff to help change and wash. R9 is resistive to care around toileting r/t (related to) dementia, becomes confused and refuses to allow nursing staff to assist him when he is incontinent. If resident resists with activities of daily living reassure resident, leave and return 5-10 minutes later and try again. Provide resident with opportunities for choice during care	F 690	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to provide incontinence care to all residents who need it based on bowel and bladder assessment and offer option of toileting program or continence program if resident is able; as well as ensure proper care of indwelling catheters. One of the many ways that this has been achieved for resident #9 is to create a better toileting program to keep resident dry by reviewing bowel and bladder patterns, cognitive ability to cue or toilet and overall functional ability. R1 has been monitored by nursing to confirm staff were aware of safe and proper catheter cares. After survey noted the R9 was confused and consistently wet it was determined a new process needed to be developed to prevent increased moisture to resident with potential impaired skin integrity and to meet basic need to be clean and dry. R9 noted	

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F 690	Continued From page 42 provision. R9 had bladder incontinence r/t activity intolerance, dementia, HX (history) of urinary tract infection, physical limitations, poor toileting habits, use/side effects of medication antidepressants. Use of pull up disposable briefs. Offer to assist to the bathroom every two hours and PRN. Clean perineal area with each incontinence episode. On 3/26/18, at 3:38 p.m. family member (FM)-A identified a concern that the facility staff were not providing R9 with timely toileting needs. FM-A described an incident when R9 was taken on an outing which resulted in a return to the facility in an hour with R9's brief "soaking wet." During continuous observations on 3/28/18, the following was observed: -At 6:51 a.m. R9 was seated in a stationary brown leather chair in the common area near the entry of the facility. -At 7:26 a.m. R9 remained seated in the chair. -At 7:59 a.m. R9 Remained seated in the chair. -At 8:06 a.m. R 9 stood and walked to the dining room independently with his front wheeled walker. R9 sat in a stationary chair at a dining table. -At 8:28 a.m. R9 Remained seated in stationary chair in the dining room independently eating. -At 8:45 a.m. R9 stood from the dining table independently and returned to the brown leather stationary chair in the common area of the facility. -At 9:02 a.m. R9 remained seated. -At 9:11 a.m. R9 remained seated. -At 9:21 a.m. R9 remained seated. -At 9:23 a.m. R9 remained seated. -At 9:37 a.m. R9 remained seated. -At 9:56 a.m. R9 remained seated. -At 10:07 a.m. R9 remained seated. -At 10:12 a.m. R9 remained seated. -At 10:13 a.m. registered nurse (RN)-B	F 690	needing A1 with toileting and on a set time schedule. The toileting program in place was not effective so has been reevaluated. R1 was noted to have catheter on floor and during cares catheter tubing was taught being pulled to far which could've dislodged the catheter. Also noted was staff holding catheter above bladder to drain contents. All of these are great concerns and staff immediately were educated on potential infection and lack of dignity these mistakes cause to the resident. On 4/17/2018 bowel and bladder assessment completed, and resident and staff interview completed to determine toileting plan more effective since new data gathered to toilet and change upon rising, before meals and before bed with rounds added at 12 and 4 am for R9 and staff have been ensuring safe catheter handling on R1. Care sheets and care plans updated. 2. Because all residents are required to have toileting assessments and re-evaluated regularly, and many have changes in overall condition all are potentially affected by the cited deficiency. DON reviewed with staff appropriate programs for residents they consistently find saturated in bed or wheelchair. All current residents assessed for continence via bowel and bladder assessments and appropriate interventions for toileting or check and changing have been put in place. Care sheets updated and care plan. No other residents were affected. The policy on toileting – bowel and bladder assessments has been reviewed.	

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F 690	Continued From page 43 approached R, talked with him briefly and walked with R9 to his room. R9 was observed with a large sagging area in his pants, between his legs. At 10:18 a.m. RN-B offered R9 to use the bathroom, and he accepted. At that time, RN-B cued R9 to sit on the bed until he had finished eating a piece of chocolate candy. -At 10:21 a.m. after R9 had finished eating the candy, R9 stood from the bed, he pointed to the hall, and asked "where do I go out there?" The large, sagging bulging area in R9 's pants remained present. RN-B assisted R9 out of his room and into the hall. RN-B had not assisted or cued R9 to use the bathroom. -At 10:24 a.m. R 9 walked to the brown leather chair in the common area and sat down. -At 10:52 a.m. the surveyor prompted staff to assist R9 to toilet. NA-A walked with R9 to his room, and cued R9 to go into the bathroom. NA-A pulled down R9's pants and saturated incontinent product. R9 sat on the toilet and urinated as NA-A removed the completely saturated brief. On 3/28/18, at 10:53 a.m. NA-A verified R9's incontinent product was soaked and hung down between his legs due to the weight of the saturation. NA-A indicated staff were to offer R9 assistance to toilet every two hours because he had short term memory loss. On 3/28/18, at 11:06 a.m. NA-D stated although R9 was able to walk independently he required reminders for meals and physical assistance for dressing and toileting. NA-D stated staff offered R9 assistance for toileting every three to four hours. On 3/28/18, at 1:29 p.m. NA-B identified R9 required staff assistance with toileting and were	F 690	3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all staff received in-service training for appropriate toileting, incontinent care, check and change and importance of clean dry skin to prevent alterations in skin integrity as well as safe dignified catheter care and importance of tube placement during emptying and turning. The training will also emphasize the importance of following the plan but also encouraging residents to be as independent as they can with their care but ensure staff intervene when resident unable to complete basic ADL on their own. Staff educated on appropriately assessing toileting needs and appropriate interventions. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents who trigger for incontinent care or have catheters to ensure appropriate plan in place and cares are done appropriately. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will audit 5 residents on bowel and bladder program in conjunction with assessment and interventions 2x per week for 3 weeks than 3 residents 2x per week for 3 weeks to ensure toileting plan or check and change program appropriate for the residents. Also audit staff with catheter cares 3x per week for 4 weeks then 1 resident weekly for 2 months to ensure	

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F 690	Continued From page 44 to check with R9 every two hours to assist with use of the toilet or to have his brief changed. NA-B indicated staff worked together as a team to care for all residents, however; stated she had not assisted R9 with toileting needs today. On 3/28/18, at 1:39 p.m. RN-B indicated she was not aware R9 had not been toileted in a timely manor. RN-B indicated staff were expected to follow the care directed by the care plan for R9 who required staff assistance with toileting. RN-B identified timely toileting was important in order to keep R9 clean and dry and to prevent skin issues. On 3/28/18, at 1:59 p.m. The director of nursing (DON) indicated toileting plans were developed for each resident by identifying the individual needs with a three day study of the residents bowel and bladder pattern. The DON verified staff were expected to assist residents with cares in the time frame directed by the care plan. The DON agreed three and a half hours was too long for R9 to not have been assisted with toileting needs.	F 690	compliance. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. DON will be responsible for this POC.	

F 690 Continued From page 45 F 690

Center for Disease Control (CDC) guidelines for prevention of associated urinary catheter infections 2009, updated 2/15/17, identified proper techniques for Urinary Catheter Maintenance included; to keep the collection bag below the level of the bladder at all times and to not rest the bag on the floor.

R1's quarterly Minimum Data Set (MDS) assessment, dated 12/23/17, identified diagnoses which included dysuria, poor urinary stream, frequency and urgency of urination. R1 was cognitively intact and required extensive assistance with bed mobility, dressing and hygiene. R1's MDS further identified the use of an indwelling catheter.

R1's care plan, updated 3/24/18, indicated use of an indwelling catheter related to a neurogenic bladder. The care plan indicated R1 would be free from catheter-related trauma and listed various interventions which included to position catheter bag and tubing below the level of the bladder and away from entrance room door and monitor intake and output per facility policy.

The facility nursing assistant care sheets, untitled, undated, identified R1 had a foley catheter. The care sheet lacked further instructions for care of the indwelling catheter.

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F 690	Continued From page 46	F 690		

On 3/27/18, at 8:33 a.m. R1 was lying on his bed back on the bed. R1's catheter bag was attached to the bed frame, uncovered. Dark amber urine was present in the bag and was visible from the hall, while R1's room door was opened wide.

On 3/28/18, at 9:34 a.m. R1 was lying in bed, with a catheter bag attached to the bed frame. Dark amber urine was visible in the bag, and the catheter bag was visible through the door from the hallway. R1's catheter bag was uncovered, the bottom 1/3 of the bag was rested on the floor.

On 3/28/18, at 10:16 a.m. R1 was lying on his back in his bed, eyes open, covered with a bedding. nursing assistant (NA)-B and NA-E entered R1's room. His catheter tubing was observed running from under his blanket, down to the catheter bag, which was unhooked from the bed, uncovered and rested on the floor with the lower 1/3 of the bag resting on the floor. NA-E lifted up R1's catheter bag, then placed it in a black cloth bag attached to the bed frame. NA-B indicated they should empty R1's catheter bag and she removed it from the black cloth bag, then hooked the catheter bag to the bed frame. NA-B retrieved a plastic graduate measuring device from the bathroom and handed it to NA-E. NA-E stood next to R1's bed, and held the graduate at the level of her hips. R1 remained lying in his bed, a foot lower than the measuring graduate. NA-B proceeded to pick up the catheter bag, raise to the level of her chest, approximately 2 feet higher than R1 lying in bed, used an alcohol wipe and cleansed the drainage tube, unclamped it and allowed the urine to drain into the graduate held by NA-E at waist level. After the catheter bag was empty, NA-B hooked the catheter bag to

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F 690	Continued From page 47 the bed frame on R1's right side. NA-B and NA-E assisted R1 to turn towards NA-B onto his left side, while the catheter tubing was still attached to the right side of his bed. The catheter tubing was stretched taut when R1 was assisted to roll to left side. After NA-E and NA-B noticed R1's catheter tubing was stretched taut, they assisted R1 back to his back. NA-E unhooked the bag and laid it by R1's feet. They again turned R1 back to his left side towards NA-B and performed perineal cares. At that time NA-B hooked the bag onto the bed frame on R1's left side of the bed. NA-B and NA-E completed perineal cares, then assisted R1 to turn to his right side to cleanse his other side. Again R1's catheter tubing was pulled tight, and NA-E said R1's catheter was "pulling." Again they assisted R1 to his back, unhooked the bag from the left side of the bed-frame, then rolled him to his right side and attached his catheter bag to his right side. On 3/28/18, at 2:05 p.m. NA-B indicated her usual practice to empty R1's catheter bag involved two staff: one person held the graduate, while the other person drained the catheter bag. NA-B indicated she had never been informed the height a catheter bag should be held and confirmed R1's catheter tubing was pulled tight during the cares. NA-B indicated R1's catheter should be placed in the cloth cover bag and indicated she did not notice R1's catheter bag was resting on the floor. On 3/28/18, at 2:17 p.m. NA-E indicated she did not usually perform resident catheter cares. NA-E confirmed R1's catheter bag was held above his bladder while she held the plastic graduate at her hip level while NA-B emptied the catheter bag.	F 690		

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F 690	Continued From page 48 On 3/29/18, at 1:08 p.m. director of nursing (DON) identified important things that must be done when providing catheter cares included; no tugging or pulling of the catheter tubing, to make sure it was secure, keep the bag lower than the resident's bladder and to assure the catheter bag was not resting on the floor. DON indicated she would expect those procedures should be followed during catheter cares. The facility policy titled Urinary Catheter Care, dated 12/27/17, indicated the catheter bag must be held or positioned lower than the bladder to prevent urine in the tubing and drainage bag from flowing back into the urinary bladder. The policy instructed staff to assure catheter bags were kept off the floor.	F 690		
F 755 SS=F	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-	F 755		5/4/18

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F 755	Continued From page 49 §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system for accurate accounting of medications in 1 of 1 emergency kits (E-Kit) to prevent potential loss or diversion. Findings include: On 3/27/18 at 2:52 p.m. a medication storage room tour was conducted with registered nurse (RN)-A. Located in a cupboard above the sink area was a gray metal box which was identified by RN-A as the facility emergency stock medication box A (E-Kit). The gray metal box was secured with a white plastic strip/lock attached to the clasp of the box. The white plastic strip had the number 0037535 on the tab of the strip. Review of the facility log titled, Emergency Box for Security Tag Number and Out-Dated Medication Monitoring revealed the most recent entry was dated 7/15/16. Review of an untitled 3 ring notebook the facility used to track medication	F 755	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to ensure drug records are in order. The facility e-kit was noted to not have the tag documented upon arrival from the pharmacy to confirm it was the original tie supplied on arrival thus making it difficult to note what had been taken out or switched when a medication removed. The surveyor precluded this potentially could lead to possible drug diversion – the record log did accurately list medications that had been removed based on documentation and did note the documented number of the new ties put in place. Upon determining there could be a	

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Continued From page 50

taken out of the E-Kit indicated on 3/11/18, Doxycycline 100 milligrams (mg) times five tablets was taken and a plastic strip had been replaced with the number 3086618, which did not match the current strip/lock currently attached to the E-Kit. No further documentation was found regarding the replacement or securing of the E-Kit was found in the notebook.

At 3:10 p.m. RN-A confirmed the above findings and called the pharmacy to see when the E-Kit had been switched out. The pharmacy indicated E-Kit A had been replaced on 3/23/18. RN-A indicated the facility did not log the strips/lock when pharmacy switched the E-Kits out, that she was aware of. RN-A indicated they used to log the E-Kits numbers in the past but had not done this for along time.

On 3/27/18 at 3:18 p.m. consulting pharmacist (CP) indicated he thought E-Kit A was switched out with E-Kit B on 3/15/18. PTD indicated when the E-Kits were brought over to the facility, they open the cupboard, put the new E-Kit in the cupboard and take the old one with them back to the pharmacy. The CP indicated the facility did not track anything when switching out the E-Kits and did not track any of strips/locks at all.

On 3/27/18 at 3:41 p.m. director of nursing (DON) confirmed the above findings and indicated the facility had not tracked the strips/locks since 2016, almost 2 years ago. The DON verified the strips were not tracked when the E-Kits were switched out and indicated the facility had stopped doing it. The DON indicated the strips/locks needed to be tracked due to potential drug diversion and indicated it was the facilities responsibility to make sure the locks were being

F 755

diversion it was determined every new e-kit would be logged upon arrival.
2. Because all staff have access to the e-kit the undocumented receiving of the e-kit has the potential to affect all residents if medications they need are not available due to missing mediations. All staff dispensing meds and accessing the e-kit will be reminded to log all e-kits as they are delivered to the facility. The policy on medication reconciliation was reviewed and updated to include logging tie number upon receipt. No other residents were affected.
3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all nursing staff was in-serviced on logging e-kits upon entry to facility.
4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor e-kit ties upon entry and each time it is changed when opened to remove a medication. The DON or designee will complete 2 audits per week x 4 weeks, then 1 audit weekly x2 months to ensure compliance of new policy to monitor ties and documentation in log book. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5. Pharmacy and DON will be responsible for this POC.

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F 755	Continued From page 51 tracked. Review of the facility policy titled, Medications Reconciliation dated "12/27/18", identified the facilty will document the identificaiton number in a booklet to confirm the E-Kit was locked. In addition when the box is relocked the pharmacy will confirm the identification number matches the facility log. Further the policy listed the facility would review the e-kit contents annually in QAPI as well as any reconcillation errors.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these	F 758		5/4/18

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F 758	Continued From page 52 drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure target behaviors were identified, monitored, and evaluated for the use of Seroquel (anti-psychotic medication) for 1 of 5 residents (R15) reviewed for unnecessary medications. Findings include: R15's admission Minimum Data Set (MDS) dated 6/19/17, indicated R15 had moderately impaired cognition, and diagnoses which included Parkinson's disease, dementia and depression. The MDS identified R15 required assistance with activities of daily living (ADL) such as, supervision	F 758	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is the policy of the facility to follow guidelines regarding use of psychotropic medications. R15 has Lewy body dementia with behavioral disturbances. Seroquel was ordered however no target behaviors were listed nor documentation	

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F 758	Continued From page 53 for transfers, walking and eating, and required extensive assistance from staff for bed mobility, dressing, toileting and personal hygiene. The MDS indicated R15 had hallucinations, behavioral symptoms not directed at others and wandered on 1-3 days of the 7 day assessment period. The MDS further identified the use of a daily anti-psychotic medication and a daily anti-depressant medication. R15's Care Area Assessment (CAA) dated 6/22/17, identified diagnoses of dementia and Parkinson's disease and a potential for behavioral problems, but did not indicate the nature of the potential problem. The CAA identified (through pre-populated data entered into the MDS) R15 received anti-psychotic medication and had hallucinations, however the CAA did not identify or complete an analysis of the anti-psychotic medication, or hallucinations. R15's care plan revised on 3/25/18, indicated R15 received anti-psychotic medication related to behavior management and disease process. R15's care plan listed various interventions which included: administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness, consult with pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly, review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy, educate about risks and benefits and monitor/document/report any adverse reactions of psychotropic medications. R15's care plan lacked identification of targeted behaviors and non-pharmacological interventions to use for the behaviors.	F 758	to validate behavioral disturbances. When surveyor noted the missing target behaviors the need for Seroquel was reviewed and determined may be necessary for dose reduction. Target behaviors were added and staff aware to watch for adverse reactions and monitor target behaviors as stated in updated care plan. 2. Because many residents have orders for psychotropics, many are potentially affected by the cited deficiency, staff were reminded to ensure all residents with psychotropic drug use have appropriate diagnosis with a list of target behaviors to monitor and if behaviors not noted resident is a candidate for dose reduction and MD should be notified. All residents on psychotropics have been reviewed for appropriate use. No other residents were affected. The policy on psychotropic medications has been updated. 3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all nursing staff received in-serviced on utilizing psychotropic medications that are ordered, reviewing target behaviors and need to document behaviors. Psychotropic medications will be reviewed at quarterly and annual review to determine need, effectiveness or dose reduction and ensure target behaviors listed for nursing to document on per care plan. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents	

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F 758	Continued From page 54 R15's signed Physician Orders dated 1/30/18, included Seroquel 12.5 milligram (mg) in the evening for Lewy Body dementia related to dementia with behavioral disturbance, ordered on 9/6/17 and Seroquel 25 mg at bedtime Lewy Body dementia related to dementia with behavioral disturbance, ordered on 9/6/17. Review of R15's monthly electronic medication administration record (EMAR) and electronic treatment administration record (ETAR) from January 2018, to March 2018, revealed R15 received Seroquel twice daily, at 4:00 p.m. and 8:00 p.m. and anti-psychotic medication side effect monitoring each shift. However, R15's EMAR and ETAR's lacked target behavior identification for Seroquel use. A request for behavior monitoring for R15 was placed, however the facility was unable to provide any monitoring for R15's behaviors. On 3/27/18, at 3:30 p.m. R15 was seated in an arm chair in the day room. R15's head was bent down with chin tucked on to chest. R15's nose had clear drainage hanging down. Staff approached R15 and offered a tissue. R15 thanked staff member and wiped his nose. At 3:53 p.m. R15 remained seated in the chair with his head down and chin tucked to chest. On 3/28/18, at 7:01 a.m. R15 had returned to his room after completing a bath. Nursing assistant (NA)-B assisted R15 to dress while seated on the bath chair. R15 was given choices for what to wear and was able to follow simple directions from NA-B. On 3/28/18, at 7:49 a.m. NA-B stated R15 was	F 758	with orders for psychotropic meds. The director of nurses or designated quality-assurance representative will perform the following systematic audits on residents with orders for psychotropics and target behaviors to be assessed for care planning, pharmacy review, and target behavior monitoring; 5 residents per week x 4 weeks, then 3 residents weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. The Pharmacy, SW and DON will be responsible for this POC.	

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able to follow simple directions and assist with activities of daily living. NA-B stated R15 had no behaviors, was pretty quite and was "sweet."

At 9:05 a.m. R15 was eating independently after staff assisted to set up the meal. After R15 completed breakfast, staff assisted him to the bathroom and then back to the day room. R15 walked to an arm chair with staff and sat down. At 10:12 a.m. R15 remained seated in the arm chair with head bent down and chin tucked to chest.

On 3/29/18, at 3:32 p.m. R15 was seated in an arm chair in the day room. R15's head was bent down and chin was tucked to chest. R15 was seated quietly with a visitor seated to the left.

On 3/29/18, at 3:34 p.m. registered nurse (RN)-A stated R15 received Seroquel for dementia with behaviors and indicated the target behavior was wandering. RN-A stated R15 had more mannerisms than behaviors.

On 3/29/18, at 3:44 p.m. NA-C stated R15 walked with his head down and would walk into things. NA-C stated R15 displayed a behavior of wandering a little, but was redirectable.

On 3/29/18, at 3:55 p.m. assistant director of nursing (ADON) stated R15 had no targeted behaviors for Seroquel identified on the physician orders or the care plan. The ADON confirmed R15 had no behavior monitoring.

On 3/29/18, at 4:05 p.m. social services designee (SSD) stated the facility's normal practice for monitoring target behaviors was to place them on the resident's EMAR. SSD stated she would

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review the EMAR and progress notes for behaviors and then update providers as needed. SSD confirmed R15's EMAR lacked target behavior monitoring. SSD stated R15 does not really have behaviors, except wandering and R15 was easily redirected.

On 3/29/18, at 4:12 p.m. director of nursing (DON) stated R15's Seroquel was ordered for psychosis related to Lewy Body dementia. DON stated R15's care plan lacked targeted behaviors for use of an anti-psychotic medication and would expect them to be on R15's care plan, so that staff knew what to monitor. DON reviewed R15's EMAR and confirmed it lacked monitoring for Seroquel use. The DON stated she would expect daily monitoring for the indicated use of an anti-psychotic medication.

On 3/29/18, at 4:33 p.m. advanced practice registered nurse (APRN) stated R15's Seroquel was ordered for psychosis related to Lewy Body dementia. APRN stated R15's target behavior was hallucinations. APRN stated he would expect some type of monitoring being completed on R15 as staff are giving him a report prior to his visit.

On 3/29/18, at 4:41 p.m. consultant pharmacist (CP) stated the usual practice of the CP was to review every resident's medical chart for a medication regimen review on a monthly basis. CP stated if an irregularity was found, a recommendation would be made. CP stated anti-psychotic medications are reviewed for appropriate indication for use, monitoring for benefit, side effect monitoring and potential reductions. CP stated R15's Seroquel was ordered for psychosis related to Lewy Body dementia and therefore felt would not need target

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F 758	Continued From page 57 behavior monitoring. CP stated the facility would be monitoring psychosis. A policy for psychotropic medication use was requested, however none were provided.	F 758		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the water and ice machine to prevent potential contamination for all 22 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R21, R22, R124) who currently resided in the facility. Findings include:	F 812	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	5/4/18

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On 3/26/18, at 12:33 p.m. during an initial tour of the facility, a water and ice machine located in the main dining room of the facility, was observed to have a crusted hard water lime scale build up under the ice and water dispenser. The tray was also noted to have light water lime scale build up and heavy hard water lime scale running around the entire outer edge of the machine. The resident refrigerator located in the north family room was observed to have encrusted hard water lime scale build up under the ice and water dispenser and the tray was also noted to have light water lime scale build up on it.

On 3/27/18, at 1:07 p.m. a tour of the kitchen was conducted with the dietary manager (DM), The following concerns were identified:
-the water and ice machine located in the main dining room of the facility continued to have encrusted hard water lime scale build up under the ice and water dispenser. The tray was also noted to have light water lime scale build up and heavy hard water lime scale running around the entire outer edge of the machine. The DM indicated the water and ice machine had a leak and had just gotten fixed. The DM noted flakes of white lime scale that could be chipped off under the ice and water dispenser. The DM indicated the staff cleaned the ice and water machine everyday but felt the staff did not think to clean under the ice and water dispenser.

- the resident refrigerator located in the north family room continued to have encrusted hard water lime scale build up under the ice and water dispenser and the tray was also noted to have light water lime scale build up on it. The DM confirmed finding and indicated the residents get

F 812

1. It is the policy of this facility to ensure healthy and safe meal service. Some of the many ways that this has been done is ensuring clean environment and safely preparing and serving food and beverages to residents. After the surveyor reported finding lime scale build up on ice machine in dining room and north family room fridge. Although it was noted the lime scale was bad within the ice machine it also included outside the machine. Immediately the ED and maintenance department determined necessary cleaning measures to deep clean the machine.
2. Because all residents receive their meals here in facility all are potentially affected by the cited deficiency, 4/4/2018, the dietary manager along with ED did do deep clean of both ice machines. Since deep clean lime scale has been clear. The ice makers will be cleaned daily but deep cleaned every 6 months unless noted to need sooner. Policy on cleaning ice machines was reviewed.
3. To enhance currently compliant operations and under the direction of the director of dietary, on 4/24/2018, all staff that serve residents ice water or any food item were in-serviced on the importance of updating dietary manager or ED if they note any appliance, machine, or area that touches residents food or drink has any visible scale, rust or debris that could lead to bacteria.
4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the director of dietary to monitor lime scale

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HENNING REHABILITATION & HEALTHCARE CENTER	907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551

(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 812	Continued From page 59 water and ice from both locations within the building. The DM verified staff pass water to the resident three times a day in rooms, at every meal and indicated she did not realize the ice machines were that "bad" with buildup. On 3/27/18 at 1:24 p.m. nursing assistant (NA)- confirmed staff pass water to the residents from both locations three times a day for water in their rooms and confirmed the above findings. Review of facility policy titled, Ice Machine Cleaning Policy, created on 3/27/18, identified to ensure ice machine does not have unsanitary germs from day to day operations and to keep machine operating at optimum level, ice machines outside, tray and dispensers were to be cleaned daily, and every 6 months a deep clean should be done inside and out.	F 812	build up on ice machines. The director of dietary or designated quality-assurance representative will perform audits of ice machines to be done 2x per week for 4 weeks then 1x per week for 2 months to ensure compliance via dietary manager or designee. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly QAPI meeting for further review or corrective action. 5. Dietary manager and maintenance will be responsible for this POC.	
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement an infection control program which included a antibiotic stewardship program. This had the potential to affect all 22 residents who resided in the facility.	F 881	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that	5/4/18

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F 881	Continued From page 60 Findings include; A review of the facility's infection control surveillance program was conducted on 03/29/18, at 8:35 a.m. and identified the facility lacked a functioning antibiotic stewardship program. The infection control program lacked protocols for a facility-wide system to monitor the use of antibiotics including (but not limited to) appropriate prescribing of antibiotics and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns identified. The facility forms titled Essential Data, undated, included the following; date/resident, indication, microbiology test results, type/route/frequency antibiotic order, start date, stop date, DOT (actual number of days antibiotic was used, should equal start date to stop date) infection surveillance line-list/log, Is Loeb minimum criteria met (for initiation of antibiotic use). Review of the facility forms titled Essential Data revealed; -November 2017, three residents were treated with antibiotics, for skin breakdown, cellulitis and C-Difficile (D-Diff). Two indicated no microbiology test results, and one indicated positive lab from hospital discharge. Antibiotics used were listed and symptoms were listed. Two indicated Loeb criteria met, and one indicated non applicable (N/A). The form lacked identification of pathogen, sensitivity reports and analysis of data.	F 881	one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1 It is the policy of the facility to follow guidelines regarding antibiotic stewardship. Upon implementation of this regulation it was noted all facilities must develop and initiate an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. The program has been created and is now in use for all residents that are on antibiotics. 2 Because many resident's use antibiotics, many are potentially affected by the cited deficiency. All residents on antibiotics have been reviewed for appropriate use. All infections are reviewed for microbiology r/t infection. No other residents were affected. The policy on antibiotic use and monitoring has been updated. 3 To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all nursing staff received in-serviced on antibiotic regulations and appropriate documentation and follow up. Antibiotic orders will be reviewed immediately upon order and infection control nurse will ensure all aspects of monitoring are in place. 4 Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the infection control nurse to monitor residents with orders for antibiotics. The infection control nurse or designated	

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F 881	Continued From page 61 -December 2017, six residents listed to use antibiotics, two for pneumonia, one for C-Diff, two for urinary tract infection (UTI) and one for prophylactic use on admission. Two indicated positive lab results and four indicated N/A on admission. Antibiotics used were listed. Four entries indicated N/A for Loeb criteria met, and two indicated they did not. The form lacked identification of pathogen, sensitivity reports and analysis of data. -January 2018, one resident listed as treated for cellulitis. The form listed antibiotic use and symptoms, and indicated the Loeb minimum criteria was not met. The form lacked identification of pathogen, sensitivity reports and analysis of data. -February 2018, two residents were listed as treated for UTI and respiratory. The form indicated Klebsiella pneumoniae and pseudomonas aureoginosa for UTI microbiology test results, and indicated it met the Loeb's minimum criteria. The respiratory was documented as pneumonia on admission and N/A for microbiology test results. The form lacked sensitivity report and analysis of data. -No March 2018 form was provided. On 3/29/18, at 12:57 p.m. director of nursing (DON) confirmed RN-C was responsible for the infection control program which included the antibiotic stewardship program. DON confirmed RN-C was new to her position and had trained herself. DON indicated at the beginning of March, the nursing staff were not to start an antibiotic without reviewing it with RN-C first. DON confirmed the antibiotic stewardship program was	F 881	quality-assurance representative will perform the following systematic audits on residents with antibiotics orders, and that their organism has been tracked; 3 residents per week x 4 weeks, then 1 resident weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5 The Pharmacy and infection control nurse and DON will be responsible for this POC.	

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F 881	Continued From page 62 not fully functioning. During interview on 3/29/18, at 8:35 a.m. registered nurse (RN)-C indicated she was the facility infection prevention nurse. RN-C indicated she had just begun the antibiotic stewardship program, and had trained herself for the role of infection control nurse. RN-C indicated she had spoken to the nurses and medical director regarding criteria before antibiotic use, but indicated this was not always followed. RN-C indicated some of the nursing staff had tried alternative treatment before antibiotic use, but not all were on board yet. RN-C confirmed she had not consistently obtained or reviewed lab results, sensitivity reports or pathogens. RN-C confirmed the program was still being developed. The facility policy titled Anti-microbial Stewardship Program, undated, listed the core elements of the antibiotic stewardship program which included; leadership commitment, accountability, drug expertise, action, tracking, reporting and education. The antibiotic stewardship team included the medical director, consulting pharmacist, director of nursing and infection prevention nurse.	F 881		
F 908 SS=D	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain equipment in a safe operating manner for 1 of 1 resident (R19)	F 908	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission	5/4/18

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F 908	Continued From page 63 who had a broken wheelchair. Findings include: R19's annual Minimum Data Set (MDS) dated 2/27/18, identified intact cognition and diagnoses which included hemiplegia. On 3/26/18, at 12:59 p.m. R19 stated her wheel chair needed to be repaired. R19 indicated the left leg rest was broken and needed to be replaced because she had cut her leg on the broken, sharp metal two times. R19 indicated she knew the facility was aware of the broken leg rest and had indicated for the past two months the plan was to purchase a new wheel chair, however; the facility had not replaced the wheelchair yet. R19's progress note dated 3/13/18, revealed the following: "Note Text: CNA (certified nursing assistant) reported scratch on outer left leg from wheelchair pedal. Was bleeding. Area cleaned and open to air. " On 3/28/18, at 7:47 a.m. nursing assistant (NA)-A and NA-D transferred R19 to her wheelchair with the use of a full body lift. The left leg rest was noted to be in poor repair. NA-A attempted to place R19's left leg on the wheelchair leg rest repeatedly before able to keep the leg rest in place. NA-A held the black padded foot cradle in place on the metal bars of the the leg rest, placed a pillow onto the cradle and then placed R19's leg onto the leg rest. On 3/28/18, at 7:50 a.m. NA-A verified R19's black foot cradle was no longer attached to R19's leg rest. NA-A indicated she was aware of R19's	F 908	of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1 It is the policy of the facility to maintain all patient care equipment in safe operating condition. When surveyor noted that R19 had reported a broken wheelchair and foot pedal, it was determined resident needed new wheelchair ordered for her safety and comfort. 2. Because many residents use wheelchairs or patient care equipment, many are potentially affected by the cited deficiency, staff were reminded to ensure all residents have safe working equipment. All resident□s wheelchairs were audited for safety, cleanliness and good working order. No other residents were affected. The policy on wheelchair maintenance has been updated. 3. To enhance currently compliant operations and under the direction of the director of nurses, on 4/24/2018 all staff received in-serviced on wheelchairs □ for proper working order, safe parts, good fit, and cleanliness. The training will also include understanding that all patient care equipment is in safe operating order. 4. Effective 4/17/2018, a quality-assurance program was implemented under the supervision of the executive director to monitor wheelchairs. The ED or designated quality-assurance representative will perform the following systematic audits on residents with	

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F 908	Continued From page 64 broken leg rest and had reported it to a nursing supervisor in the past. On 3/28/18, at 7:52 a.m. NA-D indicated the broken leg rest had been verbally reported to the director of nursing (DON), administrator and the maintenance director (M)-A, and a repair slip had been filled out in the past few weeks. On 3/29/18, at 2:02 p.m. M-A indicated the usual facility practice was to inspect each resident room quarterly and staff were to verbally notify him or complete a repair slip to alert him to needed repairs. M-A indicated he had replaced R19's wheel chair leg rest approximately four to five months earlier and explained the wheel chair was so old it was difficult to find replacement parts. M-A indicated in the past month the administrator had spoken about purchasing a new wheel chair for R19. On 3/29/18, at 2:18 p.m. the administrator verified a new wheel chair had not been purchased for R19. The administrator indicated therapy would need to evaluate R19's current wheel chair and see what is needed. On 3/29/18, at 2:23 p.m. the DON indicated some repairs had been made to R19's wheel chair a while ago and at that time the therapy department had recommended a new wheel chair for R19. The DON verified a wheel chair had not been ordered, therapy had not completed any further evaluation for R19's wheel chair nor had an order been requested for therapy evaluation or treatment. The DON indicated she was not aware of recent concerns with R19's wheel chair. The facility policy titled Wheelchair Maintenance Policy reviewed 12/27/18, The purpose of the	F 908	wheelchairs to ensure they are safe, clean and in good working order; 3 residents per week x 4 weeks, then 1 resident weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5. The therapy department, maintenance department and ED will be responsible for this POC.	

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F 908	Continued From page 65 policy is to keep the wheelchair clean and in good repair to prevent any accidents.	F 908		

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

F5540027

PRINTED: 05/01/2018
FORM APPROVED
OMB NO. 0938-0391

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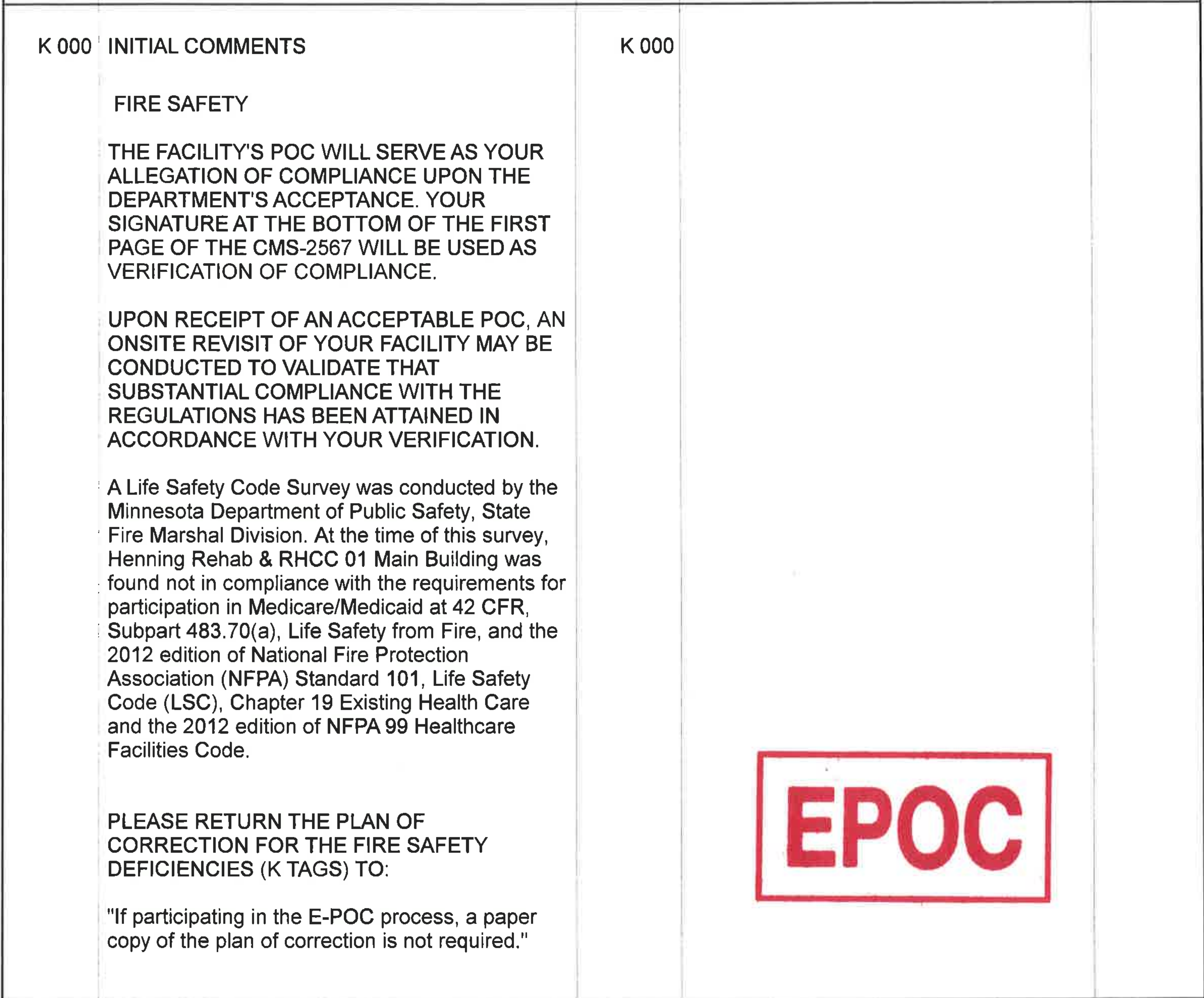
HENNING REHABILITATION & HEALTHCARE CENTER	**907 MARSHALL AVENUE, PO BOX 57** **HENNING, MN 56551**



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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Henning Rehab & RHCC 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99 Healthcare Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: "If participating in the E-POC process, a paper copy of the plan of correction is not required."	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed | TITLE | (X6) DATE: 04/27/2018

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

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

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K 000	Continued From page 1 Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Henning Rehab & RHCC is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II (111) construction. In 1963 an addition was constructed to the north of the original building, is 1-story, without a basement and Type II (111). In 1988, an addition was constructed to the south that was determined to be of Type II (000) construction which is not separated from the original building. The building is protected throughout by an automatic fire sprinkler system installed in	K 000		

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K 000	Continued From page 2 accordance with NFPA 13 The Standard for the Installation of Automatic Sprinkler Systems. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification installed in accordance with NFPA 72 "The National Fire Alarm Code" . The facility has a capacity of 42 beds and had a census of 22 at time of the survey. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET	K 000		
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked ______ b) Who provided system test ______ c) Water system supply source ______ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler	K 353		5/4/18

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K 353	Continued From page 3 system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect 24 of the 42 resident and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:15 am to 11:15 am on 03/27/2018 observations revealed sprinkler heads were blocked as listed. 1. In the basement storage room, the contents was stacked within 18 inches of the sprinkler deflector. 2. In resident rooms 20, 27, and 32 solid cubicle curtains were in use that could block the sprinkler flow. This deficient condition was confirmed by the Environmental Service Director.	K 353	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1. It is facility policy per NFPA regulation to have all rooms with curtains have netted and all sprinklers clear within 18 inches of a sprinkler deflector. All non-netted curtains have been thrown out and rooms 20, 27, and 32 have been checked to ensure compliance by the Maintenance Director and Executive Director. The sprinkler deflectors in the basement storage room have been cleared to allow 18 inches of regulated space. The maintenance director has created in his Preventative maintenance app, a monthly inspection task that prompts him to ensure sprinkler system compliance. 2.Because all residents that reside in the facility calling it their home, all are potentially affected by the cited deficiency. Maintenance director reviewed all sprinkler heads and cubicle curtains as soon as the deficiency was cited. 3.To enhance currently compliant	

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K 353	Continued From page 4	K 353	operations the Maintenance Director and Executive Director reviewed all rooms to ensure all curtains were in compliance. They also reviewed all sprinkler heads for compliance. 4. Effective 4/17/2018 the Maintenance Director ensured compliance with Sprinkler space and cubicle curtains. Audits will be performed by the maintenance director or his designee to ensure all rooms are in compliance with netted cubicle curtains and compliant sprinkler space 3 times a week for 4 weeks then 1 time a week for 2 months.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 17, 2018

Mr. Patrick Krejci, Administrator
Henning Rehabilitation & Healthcare Center
907 Marshall Avenue, PO Box 57
Henning, MN 56551

Re: State Nursing Home Licensing Orders - Project Number S5540028

Dear Mr. Krejci:

The above facility was surveyed on March 26, 2018 through March 29, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson, Unit Supervisor, at (218) 332-5140 or gail.anderson@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00799	A. BUILDING: ______ B. WING ______	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HENNING REHABILITATION & HEALTHCARE C	**907 MARSHALL AVENUE, PO BOX 57 HENNING, MN 56551**

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2 000	Initial Comments	2 000		

*****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

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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 March 26, 2018, through March 29,2018, 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.

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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		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure resident Care Area Assessments (CAA) included a comprehensive analysis of a resident's needs, strengths, goals, history and preferences for 4 of 5 residents (R9, R14,R15, R124) reviewed. Findings include: R9 R9's significant change Minimum Data Set (MDS) dated 5/23/17, identified severe cognitive impairment and diagnoses which included neurogenic bladder (bladder dysfunction) dementia, and anxiety. The MDS indicated R9 required supervision with transfer, ambulation and eating, and required extensive assistance with toileting and personal hygiene, The MDS indicated R9 had behaviors not directed at others one to three times during the assessment period and received, antidepressant and diuretic medication daily, antibiotics five days and	2 545	See State tag for Plan of Correction.	5/4/18

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2 545	Continued From page 3	2 545		

antianxiety medication two days.

R9's Care Area Assessments (CAA) dated 5/23/17, identified nine care areas had triggered from the data entered into the MDS requiring analysis. The following care areas were triggered: Cognitive Loss/Dementia, Communication, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Behavioral Symptoms, Falls, Nutritional Status, Pressure Ulcer and Psychotropic Drug Use.

-Cognitive Loss/Dementia CAA revealed the care area was an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included: Neurological factors, observable characteristics, mood and behavior, medical problems, pain, functional status and other considerations, requiring additional assessment/analysis of R9's cognition. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R9's cognitive functioning. The CAA further lacked any other considerations that could affect R9's cognitive functioning from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-Communication CAA revealed the care area was an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas, which included: diseases and conditions, medications and characteristics of the communication impairment which required additional assessment/analysis of R9's communication. The CAA lacked a comprehensive analysis of the aforementioned

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pre-populated checkmarks which impacted R9's communication. The CAA further lacked any other considerations that could affect R9's communication from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-ADL Functional/Rehabilitation Potential CAA revealed the care area was an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas, which included possible underlying problems affecting R9's function, medications and problems R9 was at risk for because of functional decline. The CAA lacked ADL problem evaluation, possible ADL goals and a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R9's ADL functioning. The CAA further lacked any other considerations that could affect R9's ADL functioning from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-Urinary Incontinence and Indwelling Catheter CAA revealed the care area was an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: modifiable factors contributing to R9's urinary incontinence, diseases and conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's incontinence. The CAA further lacked any other considerations that could affect R9's continence from resident observation, communication with licensed and non-licensed staff and resident and /or family

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input for care planning considerations.

-Behavioral Symptoms CAA revealed the care area was a potential problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: cognitive status problems that can cause or exacerbate R9's behavior. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's behavior. The CAA further lacked any other considerations that could affect R9's behavior from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Falls CAA revealed the care area was a potential problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R9's physical performance limitations, medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's fall risk. The CAA further lacked any other considerations that could have affected R9's fall risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Nutritional Status CAA revealed the care area was a an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R9's functional and mental status, behavioral problems, disease conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated

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2 545	Continued From page 6 check marked areas which impacted R9's nutritional risk. The CAA further lacked any other considerations that could have affected R9's nutritional risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations. -Pressure Ulcer CAA revealed the care area was a potential problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: internal and external risk factors, medications and conditions that present complications or increase R9's risk for pressure ulcers. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's risk of pressure ulcers. The CAA further lacked any other considerations that could have affected R9's risk of pressure ulcers from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations. -Psychotropic Drug Use CAA revealed the care area was an actual problem for R9, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: classes of medication R9 was taking, treatable reasons for use of psychotropic drug and adverse consequences of anti-depressant and anti-psychotic medication. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R9's risk of using psychotropic medications. The CAA further lacked any other considerations that could have affected R9's risk of using psychotropic medications from resident observation, communication with licensed and	2 545		

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non-licensed staff and resident and/or family input for care planning considerations.

R14
R14's Annual Minimum Data Set (MDS) dated 8/31/17, identified R14 had sever cognitive impairment, had diagnoses which included Cerebral Palsy and gastric esophageal reflux (GERD). The MDS identified R14 required extensive assistance for bed mobility, locomotion, dressing and hygiene, total assistance with toileting and transfer, supervision with eating and had no natural teeth.

R14's Care Area Assessments (CAA) dated 8/31/17, identified eight care areas had triggered from the data entered into the MDS requiring analysis. The following care areas were triggered: Cognitive Loss/Dementia, Visual Function, Communication, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dental Care, Pressure Ulcer and Psychotropic Drug Use.

-Cognitive Loss/Dementia CAA revealed the care area was an actual problem for R14, due to cognitive loss and mental health diagnoses. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included: observable characteristics, mood and behavior, medical problems, pain, functional status and other considerations, requiring additional assessment/analysis of R14's cognition. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R14's cognitive functioning. The CAA further lacked any other considerations that could affect R14's cognitive functioning from resident observation, communication with licensed and non-licensed

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staff members and resident and/or family input for care planning considerations.

-Visual Function CAA revealed the care area was an actual problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included: disease conditions, and medications, requiring additional assessment/analysis of R14's cognition. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R14's visual function. The CAA further lacked any other considerations that could affect R14's cognitive functioning from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-Communication CAA revealed the care area was an actual problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas, which included: diseases and conditions, medications and characteristics of the communication impairment which required additional assessment/analysis of R9's communication. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R14's communication. The CAA further lacked any other considerations that could affect R14's communication from resident observation, communication with licensed and non-licensed staff members and resident and/or family input for care planning considerations.

-Urinary Incontinence and Indwelling Catheter CAA revealed the care area was an actual problem for R14, due to frequent incontinence of bladder and required total dependence for

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2 545	Continued From page 9 toileting.. The CAA revealed multiple pre-populated check marked areas which included: modifiable factors contributing to R14's urinary incontinence, diseases and conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's incontinence. The CAA further lacked any other considerations that could affect R14's continence from resident observation, communication with licensed and non-licensed staff and resident and /or family input for care planning considerations. -Falls CAA revealed the care area was a potential problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R14's physical performance limitations, medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's fall risk. The CAA further lacked any other considerations that could have affected R14's fall risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations. -Nutritional Status CAA revealed the care area was a an actual problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: R14's functional and mental status, behavioral problems, communication, disease conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's nutritional risk. The CAA further lacked any other considerations that could have affected R14's nutritional risk from resident	2 545		

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2 545	Continued From page 10	2 545		

observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Dental Care CAA revealed the care area was a an actual problem for R14, due to R14 has no natural teeth, has upper and lower full dentures that he will wear as he chooses. The CAA revealed multiple pre-populated check marked areas which included: R14's cognitive and functional problems and disease conditions and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's dental risk. The CAA further lacked any other considerations that could have affected R14's dental risk from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Pressure Ulcer CAA revealed the care area was a potential problem for R14, but did not indicate why. The CAA revealed multiple pre-populated check marked areas which included: internal and external risk factors, medications and conditions that present complications or increase R14's risk for pressure ulcers. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's risk of pressure ulcers. The CAA further lacked any other considerations that could have affected R14's risk of pressure ulcers from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations.

-Psychotropic Drug Use CAA revealed the care area was an actual problem for R14, but did not

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2 545	Continued From page 11 indicate why. The CAA revealed multiple pre-populated check marked areas which included: classes of medication R14 was taking, treatable reasons for use of psychotropic drug and adverse consequences of anti-depressant and anti-psychotic medication. The CAA lacked a comprehensive analysis of the aforementioned pre-populated check marked areas which impacted R14's risk of using psychotropic medications. The CAA further lacked any other considerations that could have affected R14's risk of using psychotropic medications from resident observation, communication with licensed and non-licensed staff and resident and/or family input for care planning considerations. On 3/29/18, at 4:00 p.m. MDS coordinator (MDSC)-A verified she had completed R9 and R14's CAAs. MDSC-A verified the CAAs lacked analysis of the pre-populated data and were not a comprehensive assessment. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) and/or designee could review the Resident Assessment Instrument (RAI) Manual with responsible facility staff, in regards to how to complete the Care Area Assessments (CAA). The DON could develop a monitoring system to ensure ongoing compliance and share those results with the QA/QI committee for further recommendations. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 545		
2 685	MN Rule 4658.0465 Subp. 2 Transfer, Discharge, and Death	2 685		5/4/18

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2 685	Continued From page 12	2 685		

Subp. 2. Other discharge. When a resident is transferred or discharged for any reason other than death, the nursing home must compile a discharge summary that includes the date and time of transfer or discharge, reason for transfer or discharge, transfer or discharge diagnoses, and condition.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to ensure an accurate discharge summary for 1 of 1 resident (R24) who was discharged to home from the facility.

See State tag for Plan of Correction.

Findings include:

Review of the Admission Record dated 1/4/18, indicated R24 was admitted to the facility on 12/13/17, with diagnoses which included depression, diabetes and hypoxemia.

Review of R24's Physician Discharge Summary (PDS) listed R24's name, attending physician, R24's medical record number, the date of admission 12/13/17, and the date of discharge 1/12/18 at 12:45 p.m. The remainder of the discharge summary was not completed, left blank: admission diagnosis, summary of course in nursing facility, condition upon discharge, other information, signature of person completing above information, date, prognosis (include rehabilitation potential), physician orders for immediate care, discharge diagnosis and signature of attending physician. In addition, the summary form lacked documentation of reconciliation of R24's medications sent home,

Review of R24's Progress Notes from 1/4/18 to 1/12/18 revealed the following:

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2 685	Continued From page 13	2 685		

-1/4/18, social services (SS) met with R24 and significant other about discharging, plan to discharge on 1/18/18 due to significant other having the day off. Discussed steps to enter home and lack of handrail at entrance. SS faxed medical doctor and he signed a referral for home health services (HHS).

-1/12/18 writer provided education to husband staff felt R24 was not quite ready to go home. Husband indicated R24 wanted to go home and he was going to take her home. R24 indicated she was feeling better now, had agreed to go see her primary medical doctor on 2/8/18, and information given to husband. Medications sent with R24, pharmacy notified, medical director aware. Skin upon discharge, psoriasis patches, red skin folds with powders applied. Discharged from facility with all medications and personal belongings with spouse.

R24's PDS had not been completed to ensure R24 received continuous and coordinated, person-centered care following discharge. The summary did not indicate if R24 was going to receive these services after discharge or if they were contacted to ensure HHS would be able to assist R24 in her home. The summary did not include any information from physical and occupational therapy, did not include information on home medications or what those medications were or if R24 knew what medications she was supposed to be taking.

On 3/29/18 at 3:14 p.m. assistant director of nursing (ADON) stated she felt the director of nursing (DON) did not know she was supposed to be completing discharge summaries and were not being done. The ADON indicated she felt R24

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2 685	Continued From page 14	2 685		

was to receive home health services for therapy services after discharge and SS worked with setting the services up for the resident. She indicated SS usually called the residents once they were discharged to check how they were doing at home. ADON indicated the discharge summaries were to be completed after any resident was discharged from the facility.

On 3/29/18 at 3:18 p.m. DON confirmed a discharge summary including a recapitulation was not completed when R24 discharged from the facility. The DON indicated the summary should include discharge orders, home health if needed, medications, pharmacy resident wanted and equipment needed at home. The DON indicated she just got a pile of discharges on her desk last week that went back several months. The DON indicated the facility had a new medical records person recently and she was not bringing her the charts to complete the discharge summaries.

Review of facility policy titled, Discharging the Resident dated 12/23/17, indicated the goal was to ensure the resident was ready for their discharge to the next place. They will need doctors order, list of medications and treatments and any special instructions as to therapy or physician services they will need after discharge. Ensure residents have all supplies and services in place to offer a continuation of care.

SUGGESTED METHODS OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure recapitulations were completed for all discharged residents. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and

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2 685	Continued From page 15 report results to the quality assurance committee for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 685		
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. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide assistance with toileting for 1 of 1 resident (R9) observed for toileting needs during the survey. In addition the facility failed to provide appropriate catheter care for 1 of 1 (R1) residents reviewed with an indwelling catheter. Findings include:	2 910	See State tag for Plan of Correction.	5/4/18

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R9's significant change Minimum Data Set (MDS) dated 5/23/17, identified severe cognitive impairment and diagnoses which included neurogenic bladder (bladder dysfunction) dementia, and anxiety. The MDS indicated R9 required supervision with transfer and ambulation and required extensive assistance with toileting and personal hygiene.

R9's care plan revised 9/16/17, revealed a physical functioning deficit related to self care impairment, toileting assistance of 1 PRN (as needed). Staff to help change and wash. R9 is resistive to care around toileting r/t (related to) dementia, becomes confused and refuses to allow nursing staff to assist him when he is incontinent. If resident resists with activities of daily living reassure resident, leave and return 5-10 minutes later and try again. Provide resident with opportunities for choice during care provision. R9 had bladder incontinence r/t activity intolerance, dementia, HX (history) of urinary tract infection, physical limitations, poor toileting habits, use/side effects of medication antidepressants. Use of pull up disposable briefs. Offer to assist to the bathroom every two hours and PRN. Clean perineal area with each incontinence episode.

On 3/26/18, at 3:38 p.m. family member (FM)-A identified a concern that the facility staff were not providing R9 with timely toileting needs. FM-A described an incident when R9 was taken on an outing which resulted in a return to the facility in an hour with R9's brief "soaking wet."

During continuous observations on 3/28/18, the following was observed:
-At 6:51 a.m. R9 was seated in a stationary brown leather chair in the common area near the entry of the facility.

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2 910	Continued From page 17 -At 7:26 a.m. R9 remained seated in the chair. -At 7:59 a.m. R9 Remained seated in the chair. -At 8:06 a.m. R 9 stood and walked to the dining room independently with his front wheeled walker. R9 sat in a stationary chair at a dining table. -At 8:28 a.m. R9 Remained seated in stationary chair in the dining room independently eating. -At 8:45 a.m. R9 stood from the dining table independently and returned to the brown leather stationary chair in the common area of the facility. -At 9:02 a.m. R9 remained seated. -At 9:11 a.m. R9 remained seated. -At 9:21 a.m. R9 remained seated. -At 9:23 a.m. R9 remained seated. -At 9:37 a.m. R9 remained seated. -At 9:56 a.m. R9 remained seated. -At 10:07 a.m. R9 remained seated. -At 10:12 a.m. R9 remained seated. -At 10:13 a.m. registered nurse (RN)-B approached R, talked with him briefly and walked with R9 to his room. R9 was observed with a large sagging area in his pants, between his legs. At 10:18 a.m. RN-B offered R9 to use the bathroom, and he accepted. At that time, RN-B cued R9 to sit on the bed until he had finished eating a piece of chocolate candy. -At 10:21 a.m. after R9 had finished eating the candy, R9 stood from the bed, he pointed to the hall, and asked "where do I go out there?" The large, sagging bulging area in R9 's pants remained present. RN-B assisted R9 out of his room and into the hall. RN-B had not assisted or cued R9 to use the bathroom. -At 10:24 a.m. R 9 walked to the brown leather chair in the common area and sat down. -At 10:52 a.m. the surveyor prompted staff to assist R9 to toilet. NA-A walked with R9 to his room, and cued R9 to go into the bathroom. NA-A pulled down R9's pants and saturated incontinent product. R9 sat on the toilet and urinated as NA-A	2 910		

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2 910	Continued From page 18	2 910		

removed the completely saturated brief.

On 3/28/18, at 10:53 a.m. NA-A verified R9's incontinent product was soaked and hung down between his legs due to the weight of the saturation. NA-A indicated staff were to offer R9 assistance to toilet every two hours because he had short term memory loss.

On 3/28/18, at 11:06 a.m. NA-D stated although R9 was able to walk independently he required reminders for meals and physical assistance for dressing and toileting. NA-D stated staff offered R9 assistance for toileting every three to four hours.

On 3/28/18, at 1:29 p.m. NA-B identified R9 required staff assistance with toileting and were to check with R9 every two hours to assist with use of the toilet or to have his brief changed. NA-B indicated staff worked together as a team to care for all residents, however; stated she had not assisted R9 with toileting needs today.

On 3/28/18, at 1:39 p.m. RN-B indicated she was not aware R9 had not been toileted in a timely manor. RN-B indicated staff were expected to follow the care directed by the care plan for R9 who required staff assistance with toileting. RN-B identified timely toileting was important in order to keep R9 clean and dry and to prevent skin issues.

On 3/28/18, at 1:59 p.m. The director of nursing (DON) indicated toileting plans were developed for each resident by identifying the individual needs with a three day study of the residents bowel and bladder pattern. The DON verified staff were expected to assist residents with cares in the time frame directed by the care plan. The

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2 910	Continued From page 19 DON agreed three and a half hours was too long for R9 to not have been assisted with toileting needs. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure resident received appropriate assisted toileting care and services. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
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	2 915		5/4/18

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2 915	Continued From page 20	2 915		

by:
Based on observation, interview, and document review, the facility failed to necessary services to maintain activities of daily living for 1 of 1 resident (R14) who required assistance with oral cares.

See State tag for Plan of Correction.

Findings include:

R14's quarterly Minimum Data Set (MDS) dated 2/19/18, identified R14 had severe cognitive impairment and had diagnoses which included Cerebral Palsy, Diabetes Mellitus and gastric esophageal reflux (GERD). The MDS identified R14 had no natural teeth, and required extensive assistance for bed mobility, locomotion, personal hygiene and dressing, total assistance for transfer and toilet use.

R14's Care Area Assessment (CAA) dated 8/31/17, identified R14 cognitive loss, mental health diagnosis, had no natural teeth, had full upper and lower dentures that he wears as he chooses, no issues with dentures, no mouth concerns, staff to assist as needed. The CAA listed R14 had unstable diabetes related to oral infection and the overall objective was to maintain current level of functioning, avoid complications and minimize risks.

R14's care plan revised 9/5/17, identified R14 required assistance with activities of daily living and listed various interventions which included set up of oral care supplies, encourage and assist with oral cares twice a day and as needed. Further, the care plan listed to encourage R14 to wear dentures, use fixodent for fit, and would often refuse to wear dentures.

On 3/28/18, at 7:00 a.m. nursing assistant (NA)-A

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2 915	Continued From page 21	2 915		

and NA-D assisted R14 with morning cares. NA-D obtained a basin of water in the adjoining bathroom while NA-A applied R14's stockings and placed gray sweat pants on R14's lower legs. NA-A and NA-D worked together to wash and dress R14. R14 had no natural teeth, his mouth had a slightly sunken appearance with his mouth closed. At 7:14 a.m. R14 was lifted from the bed on a sling with a full body lift and seated in his wheel chair. NA-D continued to assist R14 to wash and dry his face, neck, glasses and combed his hair, while NA-A made R14's bed. After NA-D and NA-A completed R14's cares, NA-D placed the soiled linens and garbage into separate opaque plastic bags, and NA-A and NA-D exited the room. At 7:21 a.m. NA-D and NA-A stated they had finished providing R14's morning cares and he would be assisted to breakfast later.

On 3/29/18, at 1:13 p.m. NA-D confirmed she had not assisted R14 with oral cares on 3/28/18, and confirmed she had not offered him to wear his dentures. NA-D indicated the usual facility practice was to provide assistance with oral cares for dependent residents. She indicated she did not usually offer R14 his dentures because he did not wear them at times.

On 3/29/18, at 1:31 p.m. NA-A confirmed she had not assisted R14 with oral cares on 3/28/18. She stated the usual facility practice was to assist residents with oral cares. NA-A stated she was not aware if R14 had dentures and did not offer to assist him with dentures.

On 3/29/18, at 2:32 p.m. the director of nursing (DON) verified R14's current working care plan, the nursing assistant care guide and R14's oral assessment. The DON verified she expected

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2 915	Continued From page 22 staff to assist with oral cares morning and evening, including residents with no natural teeth to be offered to swish and spit or use a toothette (a dental sponge). The DON also verified she expected staff to offer R14 his dentures as the care plan directed. The facility policy titled Mouth Care dated 12/27/18, identified the purpose to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise the current ADL policies and procedures to ensure all residents receive ADL assistance as needed, and educate the appropriate staff on the policies/procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
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;	21390		5/4/18

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21390	Continued From page 23 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 implement an infection control program which included a antibiotic stewardship program. This had the potential to affect all 22 residents who resided in the facility. Findings include; A review of the facility's infection control surveillance program was conducted on 03/29/18, at 8:35 a.m. and identified the facility lacked a functioning antibiotic stewardship program. The infection control program lacked protocols for a facility-wide system to monitor the use of antibiotics including (but not limited to) appropriate prescribing of antibiotics and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns	21390	See State tag for Plan of Correction.	

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identified.

The facility forms titled Essential Data, undated, included the following; date/resident, indication, microbiology test results, type/route/frequency antibiotic order, start date, stop date, DOT (actual number of days antibiotic was used, should equal start date to stop date) infection surveillance line-list/log, Is Loeb minimum criteria met (for initiation of antibiotic use).

Review of the facility forms titled Essential Data revealed;

-November 2017, three residents were treated with antibiotics, for skin breakdown, cellulitis and C-Difficile (D-Diff). Two indicated no microbiology test results, and one indicated positive lab from hospital discharge. Antibiotics used were listed and symptoms were listed. Two indicated Loeb criteria met, and one indicated non applicable (N/A). The form lacked identification of pathogen, sensitivity reports and analysis of data.

-December 2017, six residents listed to use antibiotics, two for pneumonia, one for C-Diff, two for urinary tract infection (UTI) and one for prophylactic use on admission. Two indicated positive lab results and four indicated N/A on admission. Antibiotics used were listed. Four entries indicated N/A for Loeb criteria met, and two indicated they did not. The form lacked identification of pathogen, sensitivity reports and analysis of data.

-January 2018, one resident listed as treated for cellulitis. The form listed antibiotic use and symptoms, and indicated the Loeb minimum criteria was not met. The form lacked identification of pathogen, sensitivity reports and

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analysis of data.

-February 2018, two residents were listed as treated for UTI and respiratory. The form indicated Klebsiella pneumoniae and pseudomonas aureoginosa for UTI microbiology test results, and indicated it met the Loeb's minimum criteria. The respiratory was documented as pneumonia on admission and N/A for microbiology test results. The form lacked sensitivity report and analysis of data.

-No March 2018 form was provided.

On 3/29/18, at 12:57 p.m. director of nursing (DON) confirmed RN-C was responsible for the infection control program which included the antibiotic stewardship program. DON confirmed RN-C was new to her position and had trained herself. DON indicated at the beginning of March, the nursing staff were not to start an antibiotic without reviewing it with RN-C first. DON confirmed the antibiotic stewardship program was not fully functioning.

During interview on 3/29/18, at 8:35 a.m. registered nurse (RN)-C indicated she was the facility infection prevention nurse. RN-C indicated she had just begun the antibiotic stewardship program, and had trained herself for the role of infection control nurse. RN-C indicated she had spoken to the nurses and medical director regarding criteria before antibiotic use, but indicated this was not always followed. RN-C indicated some of the nursing staff had tried alternative treatment before antibiotic use, but not all were on board yet. RN-C confirmed she had not consistently obtained or reviewed lab results, sensitivity reports or pathogens. RN-C confirmed the program was still being developed.

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21390	Continued From page 26 The facility policy titled Anti-microbial Stewardship Program, undated, listed the core elements of the antibiotic stewardship program which included; leadership commitment, accountability, drug expertise, action, tracking, reporting and education. The antibiotic stewardship team included the medical director, consulting pharmacist, director of nursing and infection prevention nurse. SUGGESTED METHOD OF CORRECTION: The DON or infection preventionist could develop policies and procedures for the infection control surveillance program to include antibiotic stewardship. The DON or infection preventionist could develop monitoring systems to ensure ongoing compliance. TIME OF CORRECTION: Twenty One days (21)	21390		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained.	21525		5/4/18

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This MN Requirement is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure a system for accurate accounting of medications in 1 of 1 emergency kits (E-Kit) to prevent potential loss or diversion.

See State tag for Plan of Correction.

Findings include:

On 3/27/18 at 2:52 p.m. a medication storage room tour was conducted with registered nurse (RN)-A. Located in a cupboard above the sink area was a gray metal box which was identified by RN-A as the facility emergency stock medication box A (E-Kit). The gray metal box was secured with a white plastic strip/lock attached to the clasp of the box. The white plastic strip had the number 0037535 on the tab of the strip.

Review of the facility log titled, Emergency Box for Security Tag Number and Out-Dated Medication Monitoring revealed the most recent entry was dated 7/15/16. Review of an untitled 3 ring notebook the facility used to track medication taken out of the E-Kit indicated on 3/11/18, Doxycycline 100 milligrams (mg) times five tablets was taken and a plastic strip had been replaced with the number 3086618, which did not match the current strip/lock currently attached to the E-Kit. No further documentation was found regarding the replacement or securing of the E-Kit was found in the notebook.

At 3:10 p.m. RN-A confirmed the above findings and called the pharmacy to see when the E-Kit had been switched out. The pharmacy indicated E-Kit A had been replaced on 3/23/18. RN-A

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indicated the facility did not log the strips/lock when pharmacy switched the E-Kits out, that she was aware of. RN-A indicated they used to log the E-Kits numbers in the past but had not done this for along time.

On 3/27/18 at 3:18 p.m. consulting pharmacist (CP) indicated he thought E-Kit A was switched out with E-Kit B on 3/15/18. PTD indicated when the E-Kits were brought over to the facility, they open the cupboard, put the new E-Kit in the cupboard and take the old one with them back to the pharmacy. The CP indicated the facility did not track anything when switching out the E-Kits and did not track any of strips/locks at all.

On 3/27/18 at 3:41 p.m. director of nursing (DON) confirmed the above findings and indicated the facility had not tracked the strips/locks since 2016, almost 2 years ago. The DON verified the strips were not tracked when the E-Kits were switched out and indicated the facility had stopped doing it. The DON indicated the strips/locks needed to be tracked due to potential drug diversion and indicated it was the facilities responsibility to make sure the locks were being tracked.

Review of the facility policy titled, Medications Reconciliation dated "12/27/18", identified the facilty will document the identificaiton number in a booklet to confirm the E-Kit was locked. In addition when the box is relocked the pharmacy will confirm the identification number matches the facility log. Further the policy listed the facility would review the e-kit contents annually in QAPI as well as any reconcillation errors.

SUGGESTED METHOD OF CORRECTION:

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21525	Continued From page 29 The director of nursing (DON) and the Consulting Pharmacist could establish a system for accurate accounting of medications in the emergency kits to prevent potential loss or diversion. The DON could randomly audit the system and report audits to the quality assurance committee. TIME PERIOD OF CORRECTION: Fourteen (14) days.	21525		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must	21530		5/4/18

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21530	Continued From page 30 refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure target behaviors were identified, monitored, and evaluated for the use of Seroquel (anti-psychotic medication) for 1 of 5 residents (R15) reviewed for unnecessary medications. Findings include: R15's admission Minimum Data Set (MDS) dated 6/19/17, indicated R15 had moderately impaired cognition, and diagnoses which included Parkinson's disease, dementia and depression. The MDS identified R15 required assistance with activities of daily living (ADL) such as, supervision for transfers, walking and eating, and required extensive assistance from staff for bed mobility, dressing, toileting and personal hygiene. The MDS indicated R15 had hallucinations, behavioral symptoms not directed at others and wandered on 1-3 days of the 7 day assessment period. The MDS further identified the use of a daily anti-psychotic medication and a daily anti-depressant medication.	21530	See State tag for Plan of Correction.	

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R15's Care Area Assessment (CAA) dated 6/22/17, identified diagnoses of dementia and Parkinson's disease and a potential for behavioral problems, but did not indicate the nature of the potential problem. The CAA identified (through pre-populated data entered into the MDS) R15 received anti-psychotic medication and had hallucinations, however the CAA did not identify or complete an analysis of the anti-psychotic medication, or hallucinations.

R15's care plan revised on 3/25/18, indicated R15 received anti-psychotic medication related to behavior management and disease process. R15's care plan listed various interventions which included: administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness, consult with pharmacy and physician to consider dosage reduction when clinically appropriate at least quarterly, review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy, educate about risks and benefits and monitor/document/report any adverse reactions of psychotropic medications. R15's care plan lacked identification of targeted behaviors and non-pharmacological interventions to use for the behaviors.

R15's signed Physician Orders dated 1/30/18, included Seroquel 12.5 milligram (mg) in the evening for Lewy Body dementia related to dementia with behavioral disturbance, ordered on 9/6/17 and Seroquel 25 mg at bedtime Lewy Body dementia related to dementia with behavioral disturbance, ordered on 9/6/17.

Review of R15's monthly electronic medication administration record (EMAR) and electronic

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treatment administration record (ETAR) from January 2018, to March 2018, revealed R15 received Seroquel twice daily, at 4:00 p.m. and 8:00 p.m. and anti-psychotic medication side effect monitoring each shift. However, R15's EMAR and ETAR's lacked target behavior identification for Seroquel use.

A request for behavior monitoring for R15 was placed, however the facility was unable to provide any monitoring for R15's behaviors.

On 3/27/18, at 3:30 p.m. R15 was seated in an arm chair in the day room. R15's head was bent down with chin tucked on to chest. R15's nose had clear drainage hanging down. Staff approached R15 and offered a tissue. R15 thanked staff member and wiped his nose. At 3:53 p.m. R15 remained seated in the chair with his head down and chin tucked to chest.

On 3/28/18, at 7:01 a.m. R15 had returned to his room after completing a bath. Nursing assistant (NA)-B assisted R15 to dress while seated on the bath chair. R15 was given choices for what to wear and was able to follow simple directions from NA-B.

On 3/28/18, at 7:49 a.m. NA-B stated R15 was able to follow simple directions and assist with activities of daily living. NA-B stated R15 had no behaviors, was pretty quite and was "sweet."

At 9:05 a.m. R15 was eating independently after staff assisted to set up the meal. After R15 completed breakfast, staff assisted him to the bathroom and then back to the day room. R15 walked to an arm chair with staff and sat down. At 10:12 a.m. R15 remained seated in the arm chair with head bent down and chin tucked to

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chest.

On 3/29/18, at 3:32 p.m. R15 was seated in an arm chair in the day room. R15's head was bent down and chin was tucked to chest. R15 was seated quietly with a visitor seated to the left.

On 3/29/18, at 3:34 p.m. registered nurse (RN)-A stated R15 received Seroquel for dementia with behaviors and indicated the target behavior was wandering. RN-A stated R15 had more mannerisms than behaviors.

On 3/29/18, at 3:44 p.m. NA-C stated R15 walked with his head down and would walk into things. NA-C stated R15 displayed a behavior of wandering a little, but was redirectable.

On 3/29/18, at 3:55 p.m. assistant director of nursing (ADON) stated R15 had no targeted behaviors for Seroquel identified on the physician orders or the care plan. The ADON confirmed R15 had no behavior monitoring.

On 3/29/18, at 4:05 p.m. social services designee (SSD) stated the facility's normal practice for monitoring target behaviors was to place them on the resident's EMAR. SSD stated she would review the EMAR and progress notes for behaviors and then update providers as needed. SSD confirmed R15's EMAR lacked target behavior monitoring. SSD stated R15 does not really have behaviors, except wandering and R15 was easily redirected.

On 3/29/18, at 4:12 p.m. director of nursing (DON) stated R15's Seroquel was ordered for psychosis related to Lewy Body dementia. DON stated R15's care plan lacked targeted behaviors for use of an anti-psychotic medication and would

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expect them to be on R15's care plan, so that staff knew what to monitor. DON reviewed R15's EMAR and confirmed it lacked monitoring for Seroquel use. The DON stated she would expect daily monitoring for the indicated use of an anti-psychotic medication.

On 3/29/18, at 4:33 p.m. advanced practice registered nurse (APRN) stated R15's Seroquel was ordered for psychosis related to Lewy Body dementia. APRN stated R15's target behavior was hallucinations. APRN stated he would expect some type of monitoring being completed on R15 as staff are giving him a report prior to his visit.

On 3/29/18, at 4:41 p.m. consultant pharmacist (CP) stated the usual practice of the CP was to review every resident's medical chart for a medication regimen review on a monthly basis. CP stated if an irregularity was found, a recommendation would be made. CP stated anti-psychotic medications are reviewed for appropriate indication for use, monitoring for benefit, side effect monitoring and potential reductions. CP stated R15's Seroquel was ordered for psychosis related to Lewy Body dementia and therefore felt would not need target behavior monitoring. CP stated the facility would be monitoring psychosis.

A policy for psychotropic medication use was requested, however none were provided.

SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for monitoring of target behaviors with the use of antipsychotic medications. Nursing staff could be educated as necessary to the importance of monitoring of

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21530	Continued From page 35 target behaviors. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21530		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain the water and ice machine to prevent potential contamination for all 22 residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R11, R12, R13, R14, R15, R16, R17, R18, R19, R21, R22, R124) who currently resided in the facility. Findings include: On 3/26/18, at 12:33 p.m. during an initial tour of the facility, a water and ice machine located in the main dining room of the facility, was observed to have a crusted hard water lime scale build up under the ice and water dispenser. The tray was also noted to have light water lime scale build up and heavy hard water lime scale running around the entire outer edge of the machine. The	21685	See State tag for Plan of Correction.	5/4/18

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resident refrigerator located in the north family room was observed to have encrusted hard water lime scale build up under the ice and water dispenser and the tray was also noted to have light water lime scale build up on it.

On 3/27/18, at 1:07 p.m. a tour of the kitchen was conducted with the dietary manager (DM), The following concerns were identified:
-the water and ice machine located in the main dining room of the facility continued to have encrusted hard water lime scale build up under the ice and water dispenser. The tray was also noted to have light water lime scale build up and heavy hard water lime scale running around the entire outer edge of the machine. The DM indicated the water and ice machine had a leak and had just gotten fixed. The DM noted flakes of white lime scale that could be chipped off under the ice and water dispenser. The DM indicated the staff cleaned the ice and water machine everyday but felt the staff did not think to clean under the ice and water dispenser.

- the resident refrigerator located in the north family room continued to have encrusted hard water lime scale build up under the ice and water dispenser and the tray was also noted to have light water lime scale build up on it. The DM confirmed finding and indicated the residents get water and ice from both locations within the building. The DM verified staff pass water to the resident three times a day in rooms, at every meal and indicated she did not realize the ice machines were that "bad" with buildup.

On 3/27/18 at 1:24 p.m. nursing assistant (NA)- confirmed staff pass water to the residents from both locations three times a day for water in their rooms and confirmed the above findings.

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21685	Continued From page 37 Review of facility policy titled, Ice Machine Cleaning Policy, created on 3/27/18, identified to ensure ice machine does not have unsanitary germs from day to day operations and to keep machine operating at optimum level, ice machines outside, tray and dispensers were to be cleaned daily, and every 6 months a deep clean should be done inside and out. SUGGESTED METHOD OF CORRECTION: The director of the dietary manager or designee could develop, review, and /or revise policies and procedures to ensure water and ice machines were maintained in accordance to acceptable infection control practices. The dietary manager or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21685		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area	21880		5/4/18

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	nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.			
	Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.			
	This MN Requirement is not met as evidenced by:			
	Based on observation, interview and record review the facility failed to perform dignified cares for 1 of 1 residents (R1) observed during catheter and incontinence cares.		See State tag for Plan of Correction.	
	Findings include:			
	R1's quarterly Minimum Data Set (MDS)			

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assessment, dated 12/23/17, identified diagnoses which included cerebral vascular accident (CVA), diabetes mellitus and obstructive uropathy. R1 was cognitively intact and required extensive assistance with bed mobility, dressing and hygiene. R1's MDS further identified R1 utilized an indwelling catheter.

R1's care plan, updated 3/24/18, indicated R1 used an indwelling catheter related to a neurogenic bladder. The care plan indicated R1 would be free from catheter-related trauma and directed staff to position catheter bag and tubing below the level of the bladder and away from entrance room door. R1's care plan further identified R1 had tested positive for C-Diff (clostridium difficile; bacterial infection with symptoms of watery diarrhea) and R1 was on contact precautions.

The facility nursing assistant care sheet, untitled, undated, indicated R1 was on contact precautions for C-Diff and was incontinent of bowel. The care sheet also identified R1 had a foley catheter.

On 3/27/18, at 8:33 a.m. R1 was lying on back on his bed. R1's catheter bag was attached to the bed frame, uncovered. A moderate amount of dark amber urine was present in the bag and was visible from the hall, while R1's room door was opened wide to the hall.

On 3/28/18, at 9:34 a.m. R1 was observed lying on his back in bed, with R1's catheter bag was visible through the door from the hallway. R1's catheter bag was uncovered, the bottom 1/3 of the bag was rested directly on the floor.

On 3/28/18, at 10:16 a.m. R1 remained on his

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back in his bed, covered with linens. His catheter tubing was observed running from under his blanket, down to the catheter bag, which was unhooked from the bed, uncovered and rested directly on the floor with the lower 1/3 of the bag resting on the floor. NA-B and NA-E entered his room, emptied R1's catheter bag, then proceeded to perform perineal cares. R1 was incontinent of a large amount of dark brown loose stool, which had leaked onto his thighs, the cloth incontinence pad under him and his sheet. A tan, plastic garbage can was observed on each side of R1's bed, near the head of the bed. NA-E and NA-B assisted R1 to his left side then removed his brief. The brief had a large amount of brown, loose stool, visible on the inside and outside of the brief. NA-E handed the dirty brief to NA-B who moved it over R1's head and placed it in the garbage can, located directly below R1's face, on the floor next to the left side of his bed. NA-E used several disposable wipes to cleanse R1's perineal area, buttocks and thighs of the dark brown stool. Each time she used a wipe, she handed the soiled wipe to NA-B, who then placed it below R1's face in the garbage can. R1 was observed multiple times looking at the soiled brief and wipes, then looked towards staff. Registered nurse (RN)-C entered the room with a supply of additional wipes and handed the wipes to NA-E and NA-B, as they continued with R1's incontinence care. NA-E continued to wipe R1's perineal area and thighs multiple times, hand the wipes over to NA-B, who placed the dirty wipes directly below R1's face, in the garbage can, until they assisted him to turn to his right side.

On 3/29/18, at 3:34 p.m. R1 indicated he felt it was not good to have the garbage can with soiled products placed close to his face during his incontinence cares. He indicated he would of

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preferred staff to use the garbage can on the other side of the bed, not the one in front of his face.

On 3/28/18, at 2:05 p.m. NA-B indicated she had noticed the placement of the garbage can after she completed R1's incontinence cares. NA-B confirmed she had to reach over R1's head with the soiled brief and soiled wipes during cares and confirmed the soiled brief and soiled wipes were placed in front of R1's face in the garbage can. NA-B indicated she later talked to R1 about the handling of the soiled products and wipes, indicated she had told him she would not of been happy if someone had treated her grandparent in this manner and apologized. NA-B indicated she had been unaware R1's catheter was uncovered and rested on the floor.

On 3/28/18, at 2:17 p.m. NA-E indicated when she entered the room she had not noticed the catheter bag was on the floor, but felt it may have slipped out the cloth bag. NA-E stated she was aware there were two garbage cans in R1's room, but indicated she had handed the used items soiled, with brown loose stool, to NA-B because the garbage can on R1's right side did not have a new liner in it. She indicated she did not even think of the position of the garbage can during R1's incontinence cares. NA-E confirmed it was a concern to hand the soiled brief and soiled wipes over R1 and place them into the garbage can directly in front of his face.

On 3/29/18, at 1:08 p.m. director of nursing (DON) indicated R1's catheter bag should be covered with a cloth bag at all times, and had been aware R1's catheter bag had been uncovered in the past. DON indicated R1 indicated he did not care if it was uncovered, but

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21880	Continued From page 42 she informed him it needed to be covered, not only for his dignity, but for residents and visitors in the facility. DON indicated she would expect nursing staff to handle soiled products appropriately, plan cares to ensure the correct supplies/equipment were available. She indicated she felt placing soiled items directly in front of a residents face during incontinence cares was not dignified care. The facility policy titled Quality of Life-Dignity, dated 12/27/17, indicated all residents shall be treated with dignity and respect at all times, meaning resident would be assisted in maintaining and enhancing his or her self-esteem and self-worth. Demeaning practices and standards of care that compromise dignity is prohibited. The policy further instructed staff to help residents keep catheter bags covered. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review and revise policies pertaining to resident rights, educate staff on these policies and perform audits to ensure each resident's rights have been honored. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before	21925		5/4/18

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	discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments.			
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the ombudsman of facility initiated discharges for 3 of 3 residents (R6, R124, R22) who were discharged to the hospital.		See State tag for Plan of Correction.	
	Findings include:			
	R6's admission Minimum Data Set (MDS) dated 1/15/18, identified diagnoses which included hypertension and weakness.			
	R6's Progress Notes dated 2/1/18, at 9:42 a.m. indicated R6 began having emesis on 1/31/18, symptoms worsened, and R6 had been admitted to the hospital at that time.			
	R124's quarterly MDS dated 3/1/18, identified			

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diagnoses which included diabetes mellitus, hypertension and chronic obstructive pulmonary disease (COPD).

R124's Progress Notes dated 3/14/18, R124 presented with weakness and decreased oxygen saturation of 83%, had been sent R124 to hospital emergency room (ER) for evaluation. At 10:25 p.m. facility received a phone call informing them R124 had been transferred to St. Cloud hospital for admission for pneumonia and congestive heart failure (CHF).

R22's Admission Record identified diagnoses which included anoxic brain damage, seizures and chronic obstructive pulmonary disease.

R22's Progress Notes on 3/4/18, indicated R22 had been sent to emergency department and admitted for aspiration pneumonia.

Review of R6, R124 and R22's medical records lacked documentation the notification of the facility initiated emergency transfer/discharge had been sent to the Long-Term Care (LTC) Ombudsman.

On 3/28/18, at 1:10 p.m. licensed social worker (LSW)-A confirmed she had not notified the ombudsman of R6, or R124's hospital transfers. LSW-A confirmed her usual practice did not include notifying the ombudsman of discharges, unless it was a "reportable" kind of discharge.

On 3/28/18, at 1:41 p.m. during a group interview with the regional director of clinical services (RDCS), administrator and director of nursing (DON), they indicated they was unaware of the need to notify the ombudsman of transfers and discharges. The administrator indicated they

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21925	Continued From page 45 would update their policy to include notification of the ombudsman. SUGGESTED METHOD OF CORRECTION: The Director of Social Work or designee could review facility policies and procedures for transfer and discharge notification, and develop a system to ensure the ombudsman is given notice when the facility initiates a resident transfer. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		