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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TNSP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00073

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245499**

2. STATE VENDOR OR MEDICAID NO. (L2) **190176100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CALEDONIA CARE AND REHABILITATION CENTER**
(L4) **425 NORTH BADGER STREET**
(L5) **CALEDONIA, MN** (L6) **55921**

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) **07/01/2004**

6. DATE OF SURVEY **6/24/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (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
	50			
(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 :
Gary Nederhoff, Unit Supervisor 06/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/24/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245499

June 24, 2016

Ms. Marian Rauk, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, MN 55921

Dear Ms. Rauk:

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

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

Effective June 10, 2016 the above facility is certified for:

50 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 50 skilled nursing facility.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 24, 2016

Ms. Marian Rauk, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, MN 55921

RE: Project Number S5499023

Dear Ms. Rauk:

On May 20, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 5, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On June 21, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 10, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 10, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 5, 2016, effective June 10, 2016 and therefore remedies outlined in our letter to you dated May 20, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245499 Y1	A. Building B. Wing Y2	6/21/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0166	Correction	ID Prefix	F0170	Correction	ID Prefix	F0225	Correction
Reg. #	483.10(f)(2)	Completed	Reg. #	483.10(i)(1)	Completed	Reg. #	483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed
LSC		06/10/2016	LSC		05/25/2016	LSC		06/07/2016
ID Prefix	F0226	Correction	ID Prefix	F0280	Correction	ID Prefix	F0282	Correction
Reg. #	483.13(c)	Completed	Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(k)(3)(ii)	Completed
LSC		06/10/2016	LSC		05/31/2016	LSC		06/10/2016
ID Prefix	F0309	Correction	ID Prefix	F0314	Correction	ID Prefix	F0323	Correction
Reg. #	483.25	Completed	Reg. #	483.25(c)	Completed	Reg. #	483.25(h)	Completed
LSC		06/10/2016	LSC		06/01/2016	LSC		06/10/2016
ID Prefix	F0431	Correction	ID Prefix	F0441	Correction	ID Prefix	F0504	Correction
Reg. #	483.60(b), (d), (e)	Completed	Reg. #	483.65	Completed	Reg. #	483.75(j)(2)(i)	Completed
LSC		06/01/2016	LSC		06/10/2016	LSC		06/10/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	6/24/2016	10160	6/21/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/5/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245499	A. Building 01 - THE LUTHERAN HOME CALEDONIA B. Wing	6/10/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0154	Correction Completed 06/10/2016	ID Prefix Reg. # NFPA 101 LSC K0155	Correction Completed 06/10/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 6/24/2016	SIGNATURE OF SURVEYOR 37008	DATE 6/10/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
5/3/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TNSP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00073

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245499**

2. STATE VENDOR OR MEDICAID NO. (L2) **190176100**

3. NAME AND ADDRESS OF FACILITY
(L3) **CALEDONIA CARE AND REHABILITATION CENTER**
(L4) **425 NORTH BADGER STREET**
(L5) **CALEDONIA, MN** (L6) **55921**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **07/01/2004**

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

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **50** (L18)

13.Total Certified Beds **50** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	50			
(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 :
Justin Main, HFE NE II 06/08/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 06/17/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 20, 2016

Ms. Marian Rauk, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, MN 55921

RE: Project Number S5499023

Dear Ms.. Rauk:

On May 5, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 15, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by August 5, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

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

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to resolve a grievance for 1 of 1 resident (R32) who's family member had verbalized a concern and there was no documentation on the grievance. Findings Include: R32's family member (FM)-A had been interviewed on 5/3/16, at 12:36 p.m. FM-A stated she had a concern with [R32's] clothes being washed by the facility despite the signs posted in her room indicating family will do laundry. FM-A	F 166	1. We will write out the grievance expressed in the findings and develop a plan for that specific issue. We will inform the staff of our plan and the implementation process. 2. Grievance forms will be placed in the admission packet and also at the central nursing desk. Staff will respond to verbal complaints in order to correct. If they let us know that it has not been corrected. We will offer family a written grievance form or will write out the complaint for further follow up. Family input will be	6/10/16

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

Electronically Signed | 05/25/2016

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	245499	A. BUILDING _____ B. WING _____	05/05/2016

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F 166	Continued From page 1 stated the staff did not read the signs and they washed her clothes in the laundry. FM-A stated she also finds R32's clothing draped over the chairs in her room. FM-A stated she has taken pictures of R32's room and she had shared these concerns with the facility staff and felt nothing was done about the concern. On 5/5/16, at 8:50 a.m. during the environmental tour with maintenance (M)-A verified there were pants draped over the back of the chair in R32's room. On 5/05/2016, at 10:37 a.m. the administrator stated she was aware of the family concern with R32's laundry and audits had been completed on the room to monitor to ensure the concern with clothing being draped over the chairs was addressed. The administrator stated she did not have written audits or documentation of the concern and stated there was nothing formally written regarding the family concerns but we have had meetings with the family. The administrator stated she expected R32's clothes to be placed in the hamper by the staff and not draped over the furniture. The administrator stated the facility had complaint forms, however a complaint form had not been completed by the facility or family at this time regarding the concerns with R32's laundry. The administrator stated we talk about the complaint forms upon admission and have at previous family council meetings. The administrator stated this family concern should have had a formal grievance filled out by the facility to address the concern. On 5/05/2016, at 11:29 a.m. nursing assistant (NA)-A stated she was not aware of any family concerns related to R32's clothing being draped	F 166	encouraged to resolve issues. 3. Policies will be updated on the new grievance procedure and admission packets will also be updated. 4. Audits will be done by Social Worker/designee on each grievance to determine follow up of the correction has been completed. Results of the audit will be shared at quarterly QAA Committee meetings.	

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F 166	Continued From page 2	F 166		

over the chair in her room. NA-A stated usually communication was completed by email to alert us of resident or family concerns. NA-S stated she was not aware of any concerns with R32's clothing other than family did her laundry.
On 5/05/2016, at 11:32 a.m. NA-B stated she was unaware of any concerns voiced by family regarding staff placing clothing over the back of R32's chairs in her room rather than putting them in the laundry hamper. NA-B stated actually just last night, "I learned family did her laundry" another nursing assistant had informed her. NA-B stated has worked at the facility since the end of November 2015 and stated she worked from 8:00 a.m. to 8:30 p.m. NA-B stated she, "Helped R32 get ready for bed and I always took her clothing to the laundry room." NA-B stated now that I know her family does her laundry, I put R32's clothing in the laundry basket in her closet. NA-B stated there were usually signs posted on closets in resident rooms that indicated family did laundry. NA-B verified by observation in R32's room with this writer, there were two signs, one on the closet door and one in the bathroom that indicated family did the laundry. NA-B stated she had "just not noticed these signs before." NA-B stated staff was informed of resident or family concerns through the internal email in the computer charting system.

On 5/05/2016, at 11:40 a.m. licensed practical nurse (LPN)-A stated she was unaware of any family concerns related to clothing being placed over the furniture instead of in the hamper for R32. LPN-A stated staff are notified of resident and family concerns by internal communication through email. LPN-A stated signs were are placed in residents' room to alert staff when family was going to complete the laundry. LPN-A

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F 166	Continued From page 3	F 166		

stated she was unaware of any concerns with R32's clothing or laundry.

The administrator provided an internal communication to staff dated 12/23/15, regarding FM-A's concerns that included, "...Remember that her room should be straightened up before you leave it. (Soiled products put in waste basket and taken out when you leave the room, cloths hung up or placed in the laundry area ect.)..."

An email from the administrator was received on 5/10/16, following the survey providing additional information regarding FM-A concerns that included: I was reminded that during a meeting with R32's family member on March 8, 2016, family member did ask me if I had written anything up regarding our conversations. I stated, "No, would you like me to do that?" Family member stated, "No."...The social worker was also present and stated we did not write anything up as this is not how we handle our grievance. They are informed in the admission agreement and it is discussed regarding how to proceed. The opportunity is there for them to initiate a grievance if needed.

The Caledonia Care and Rehab Administration Grievances and Complaints undated policy, indicated Caledonia Care and Rehab wanted the experience of each resident in its various programs to be a positive one. Persons who had concerns about the services and care given them are encouraged to report them to the employee who was caring for them. The employee to whom the concerns were reported would, whenever possible, resolve these concerns. If the concerns were not resolved, the resident, the employee or anyone aware of the concerns, is to refer to the

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F 166	Continued From page 4 Procedure for General Grievances. A grievance or complaint must be in writing, contain the name and address of the person filing it, and briefly describe the complaint.	F 166		
F 170 SS=C	483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened. This REQUIREMENT is not met as evidenced by: Based on interview the facility failed to provide United States postal mail on Saturdays according to an interview with 1 of 8 residents (R15) who was on the resident council. This had the potential to affect all 42 residents who may have had mail on Saturday's. Findings include: R15 was on of the residents provided when asked for all residents who attend the resident council meetings on a regular basis. This was asked for on 5/2/2016. R15's face sheet indicated the resident was admitted on 6/6/2014. R15's quarterly Minimum Data Set (MDS), dated 3/16/2016, indicated that the resident had a score of 15 on the Brief Interview for Mental Status (BIMS), which was used to assess cognitive status. A score of 15 indicated the resident was cognitively intact.	F 170	Maintenance hours have been changed to allow pick up of mail on Saturday and distribution. Audits will be completed on a weekly basis for four weeks; then monthly for three months and then quarterly by the DON/Administrator/designee. Findings will be reported to the QAA Committee on a quarterly basis.	5/25/16

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F 170	Continued From page 5 When interviewed on 5/4/2016, R15 stated that she could not remember if mail was delivered on Saturdays. When interviewed on 5/5/16 at 11:14 a.m., the Activities Director (AD) who facilitated the resident council meetings, stated that she was not aware if mail was delivered on Saturdays. The AD stated that previously on Saturdays, the facility management would take turns delivering the mail. This was divided up between the AD, the administrator and the dietary manager. The AD stated that all the managers were on-call to deliver the mail. The AD stated that she had not been delivering the mail on Saturdays even if she had to come in on Saturdays. When interviewed on 5/5/16 at 11:43 a.m., the administrator stated that the facility used to have a receptionist who delivered mail on Saturdays. She checked with the staff and stated that it had been months since mail had been delivered on Saturdays. The administrator said that mail delivery on Saturdays fell through the crack. Review of the facility policy titled, "Administration Policy: Mail' (5/2006), it stated that mail was to be delivered directly to the person's room except Sundays and holidays.	F 170		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		6/7/16

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F 225	Continued From page 6 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse/neglect were immediately reported to the State Agency and administrator for 2 of 4 residents (R44, R49) reviewed for abuse neglect	F 225	1. VA reports were made on R44 and R49 by the Social Worker. Education was provide on 3.15.16 to the nurse regarding reporting immediately to OHFC on R49 incident.	

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F 225	Continued From page 7 protocol and failed to report and investigate. Findings included: R44's had a fall on 4/26/16 at 11:45 p.m. according to fall progress notes. Progress notes report R44 had fallen in the bathroom, found face down on the floor bleeding from laceration to nose and chin, urine in the toilet, and no walker at the time. R44 was then transferred by ambulance to the hospital. A progress note dated, 4/27/16, at 4:10 a.m. indicated R44 had returned from the hospital, "left knee purple in color, right knee red in color, around right eye purple in color, around left eye slightly purple in color, laceration, above top lip has 1 stitch laceration to nose with dermabond applied, bottom right chin and right side of jaw purple in color with swelling, bottom right shin purple in color, has fractured nose." R44's vulnerable adult investigation form dated 4/26/16 indicated the administrator was notified on 4/27/16 at 12:26 a.m., director of nursing (DON) notified at 9:00 a.m. and Social worker notified at 8:05 a.m. The form indicated the Stage Agency was notified on 4/27/16 at 8:30 a.m. via Internet, The first report to the state agency informed, "resident found in her bathroom on the floor during the night with laceration to nose and chin. Was sent to [hospital name] to be evaluated. Was found to have a broken nose." During an interview on 5/3/16, at 8:58 a.m. licensed social worker (LSW) (only one employed by facility) stated the report was made on 4/27/16 at 8:30 a.m. because that's when she was notified, and she had immediately reported. R49's incident report dated 3/12/16 at 5:18 p.m. reported, R49 had reported missing 30 dollars from his billfold from his top drawer. The report indicated a copy of the report would be given to the administrator and the social worker. The facility investigation form indicated the	F 225	2. Nurses Guide to Reporting has been updated and nursing staff will be re-trained at annual inservice. 3. Incident report will be revised to assist nursing to identify whether incident is reportable or not. Education on June 7, 2016 will be given at mandatory nurses meeting. Investigations may include chart review, resident interviews (as appropriate) staff interviews, and any other pertinent information to determine if any abuse or neglect occurred. 4. Audits will be done on incident reports and vulnerable adult reports to determine if completed appropriately and education provided if needed, by Social Worker/designee. The information collected in the audits will be shared at the QAA Meeting quarterly for one year.	

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administrator, director of nursing, and social worker were not notified until 2 days later on 3/14/16 a.m. at 9:00 a.m. The incident was not reported to the State Agency until 2:30 p.m. on 3/14/16.
During an interview on 5/5/16, at 2:39 p.m. director of nursing stated, no staff investigations were performed to rule out abuse, and "I can't say why I followed up on this the next day."
The facility Vulnerable Adult Policy last reviewed 8/2014 included:
The policy informed staff, "At Caledonia Care & Rehab, report immediately, any incidents you feel may be abuse or neglect to the Director of Nursing, Social Worker, Administrator, or the Charge Nurse for the nursing home." The policy indicated staff may also report to the Common Entry Point and the sheriffs office.
The Abuse/Neglect policy explained designated reporters "will review the incident and determine if it is reportable under these policies and procedures. Incidents that are reportable will be reported immediately to the Minnesota Department of Health, Office of Health Facility Complaints (OHFC) via their secure website, and to the Common Entry Point (CEP) via fax, which is Houston County Human Service Department, (phone number).
"Any reports of suspected or witnessed abuse or neglect will promptly be made to the charge nurse or person in administrative authority," "The administrator will be notified of the alleged incident immediately." The policy explained if incidents are determined to be reportable they are immediately reported and then an internal investigation is conducted.
"All reports of abuse/neglect will be maintained including a record of the internal review and investigation of these cases. These records shall

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F 225	Continued From page 9 contain the incident/Accident Report, Investigation form, Initial OHFC report and the Investigative Report to OHFC."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their vulnerable adult policy to ensure allegations of abuse/neglect were immediately reported to the State Agency and administrator for 2 of 4 residents (R44, R49) reviewed for abuse neglect protocol and failed to report and investigate. Findings included: R44's had a fall on 4/26/16 at 11:45 p.m. according to fall progress notes. Progress notes report R44 had fallen in the bathroom, found face down on the floor bleeding from laceration to nose and chin, urine in the toilet, and no walker at the time. R44 was then transferred by ambulance to the hospital. A progress note dated, 4/27/16, at 4:10 a.m. indicated R44 had returned from the hospital, "left knee purple in color, right knee red in color, around right eye purple in color, around left eye slightly purple in color, laceration, above top lip has 1 stitch laceration to nose with dermabond applied, bottom right chin and right side of jaw purple in color with swelling, bottom right shin purple in color, has fractured nose."	F 226	1. Updated Policies and Procedures for reporting VA incidents and the Nurses' Guide to Reporting VA will also be updated to contain the same criteria. Investigation policies will also be updated to address process to determine if abuse/neglect occurred. 2. Training for all staff on vulnerable adult reporting policies will be provided by June 10, 2016. 3. Policy Handbook will be reviewed and updated by June 10, 2016 and annually thereafter or with any changes provided from state regulations.	6/10/16

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R44's vulnerable adult investigation form dated 4/26/16 indicated the administrator was notified on 4/27/16 at 12:26 a.m., director of nursing (DON) notified at 9:00 a.m. and Social worker notified at 8:05 a.m. The form indicated the Stage Agency was notified on 4/27/16 at 8:30 a.m. via Internet, The first report to the state agency informed, "resident found in her bathroom on the floor during the night with laceration to nose and chin. Was sent to [hospital name] to be evaluated. Was found to have a broken nose."
During an interview on 5/3/16, at 8:58 a.m. licensed social worker (LSW) (only one employed by facility) stated the report was made on 4/27/16 at 8:30 a.m. because that's when she was notified, and she had immediately reported.
R49's incident report dated 3/12/16 at 5:18 p.m. reported, R49 had reported missing 30 dollars from his billfold from his top drawer. The report indicated a copy of the report would be given to the administrator and the social worker.
The facility investigation form indicated the administrator, director of nursing, and social worker were not notified until 2 days later on 3/14/16 a.m. at 9:00 a.m. The incident was not reported to the State Agency until 2:30 p.m. on 3/14/16.
During an interview on 5/5/16, at 2:39 p.m. director of nursing stated, no staff investigations were performed to rule out abuse, and "I can't say why I followed up on this the next day."
The facility Vulnerable Adult Policy last reviewed 8/2014 included:
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F 226	Continued From page 11 Entry Point and the sheriffs office. The Abuse/Neglect policy explained designated reporters "will review the incident and determine if it is reportable under these policies and procedures. Incidents that are reportable will be reported immediately to the Minnesota Department of Health, Office of Health Facility Complaints (OHFC) via their secure website, and to the Common Entry Point (CEP) via fax, which is Houston County Human Service Department, (phone number). "Any reports of suspected or witnessed abuse or neglect will promptly be made to the charge nurse or person in administrative authority," "The administrator will be notified of the alleged incident immediately." The policy explained if incidents are determined to be reportable they are immediately reported and then an internal investigation is conducted. "All reports of abuse/neglect will be maintained including a record of the internal review and investigation of these cases. These records shall contain the incident/Accident Report, Investigation form, Initial OHFC report and the Investigative Report to OHFC."	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending	F 280		5/31/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 12 physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 2 of 5 residents (R8 & R130) who had a change in health status. Findings include: R8 had diagnoses that included: Dorsalgia, atrial fibrillation, hypertension, and benign positional vertigo. R8's quarterly Minimum Data Set (MDS) assessment dated 4/6/16, identified R8 required limited assistance of 1 for transfers, walking in room and supervision for toileting. The MDS further identified R8 with a Brief Interview for Mental Status (BIMS) score of 15/15, indicating she was cognitively intact. R8's care area assessment (CAA) dated 8/3/15, identified a risk of falling related to her need to rock body or push off on arms of chair when standing up from a chair and difficulty maintaining a standing position.	F 280	1. R8's care plan was updated. R 13's care plan was updated. 2. Careplans were reviewed and revised as needed. 3. Our system correction is on a quarterly basis and with a significant change to have the IDT (including DCPs (Direct Care Professionals) review the plan of care for each resident who is scheduled for a care conference. 4. Audits will be completed by DON/designee to assure system is maintained on a monthly basis for three months. Quarterly audits will be done for a year.	

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Although the CAA dated 8/3/15 identified a fall risk for R8, the current care plan dated 5/4/16, did not include interventions related to falls.

When interviewed on 5/4/26, at 10:15 a.m. R8 stated she had fallen in the bathroom about a month ago. She indicated she felt dizzy at the time and her knees "gave out".

During interview on 5/5/16, at 8:01 a.m. licensed practical nurse (LPN)-A stated dizziness is an on-going problem for R8. LPN-A further stated R8 had previously attended physical therapy (PT) for vestibular rehab to improve dizziness.

When interviewed on 5/5/16, at 10:45 a.m. registered nurse (RN)-A confirmed the current careplan had not been revised to include interventions related to R8's fall risks. RN-A further explained with change in computer software the fall interventions identified in the previous computer software system did not transition into current system.

R13 had diagnosis of traumatic brain injury (TBI).

R13's annual MDS assessment dated 3/9/16, identified R13 required extensive assistance for bed mobility, dressing, toilet use, and supervision for transfers and bathing. R13's BIMS score was 15/15, indicating he was cognitively intact. A Patient Health Questionnaire (PHQ-9) depressive screen was 0, indicating no depression. The MDS further identified R13 as having no behaviors.

When interview on 5/4/16, at 1:51 p.m. director of nursing (DON) stated R13 will "perseverate [Perseverate definition, to repeat something insistently or redundantly]" and has targeted

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F 280	Continued From page 14 different staff with complaints. DON indicated this had been an on-going issue and was not new. DON further explained R13 "goes in cycles" in reference to perseveration. During interview on 5/5/16, at 11:14 a.m. LPN-A stated she is aware R13 is currently upset with nursing assistant (NA)-C because NA-C makes him do his exercises. During interview on 5/5/16, at 11:16 a.m. RN-A stated she is aware that R13 has cursed at staff members and is verbal if he doesn't like them. When interviewed on 5/5/16, at 2:12 p.m. DON confirmed R13's careplan lacked evidence of a psychosocial or behavioral type of problem or development of intervention, and should have. The policy for Formulation of Resident Care Plans dated 4/2015, indicated each resident will have an interdisciplinary care plan meeting quarterly to review, revise, and update the plan of care.	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide oral care according to the plan of care for 1 of 4 residents	F 282	1. Careplans were reviewed for residents (R23; R29; R32; and R44)and revised as determined necessary.	6/10/16

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F 282	Continued From page 15 (R23), to identify non-pressure related skin concerns for 1 of 3 residents (R23) and to ensure safety devices were in place according to the care plan for 3 of 3 residents (R29, R32 &44) who utilized devices to promote safety. Findings include: R23 IMPAIRED SKIN INTEGRITY: R23's care plan dated for impaired skin integrity dated 4/28/16 included interventions of "skin assessment per policy (weekly and more often as needed)." The care plan for fragile skin dated 5/4/16 included, "report changes to nurse." R23 had been observed on 5/2/16, at 5:36 p.m. R23 was sitting in her reclining chair with her feet up with her eyes closed. Two large dark purple bruises observed on her left arm near elbow. One bruise appeared to be diameter of a small lime and the other more on the dorsal side just above the elbow appeared to be the size slightly larger than a half dollar. The left index finger was also noted to have lighter purple/green/yellow bruising from the distal to the proximal phalanx. The area between the proximal and medial phalanx showed slight swelling. R23's record reviewed from 4/19/16 through 5/2/16 lacked any identification or monitoring of the bruised areas. During an interview on 5/4/16, at 11:08 a.m. licensed practical nurse (LPN)-B explained documentation of bruises would be in nursing progress notes. LPN-B then observed the bruises on the R23's left arm and finger and reported the areas would be measured, documented, and would then notify the physician and family. LPN-B was not sure where the bruises came from. LPN-B stated weekly skin assessment were performed by licensed staff on bath days, however nursing assistants monitor daily with cares and alert nurse with changes.	F 282	2. DON/designee will re-educate nursing staff of the need to follow the resident care plan. 3. Our system correction is to input the order for the care needs in the electronic medical record under the DCP's flowsheet. 4. DON/designee will develop and implement an auditing system as part of our quality assurance program to maintain compliance. Audits will be completed monthly for three months and then quarterly for one year. Audit results will be shared at the QAA quarterly meeting.	

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During an interview on 5/4/16, at 3:06 p.m. director of nursing (DON) indicated nursing assistants inspect skin daily with cares of residents and if there is a change report to their nurse. DON further explained if the injury was from unknown origin the nurse needs to determine if the injury is suspicion of abuse or maltreatment and document possible causative factors that would rule out abuse.

R23 ORAL CARE:

R23's care plan intervention located on the treatment administration record (TAR) from April and May 2015 included nursing orders dated, 11/8/15 of, "Provide oral care after each meal three times a day," and "Check mouth at bedtime to make sure mouth is clean and seabond (denture adhesive) is removed from mouth." The TAR indicated on 5/4/16 oral care had been performed after breakfast by LPN-B.

During an interview on 5/3/16, at 2:46 p.m. family member (FM)-A questioned and voiced a concern if oral care was provided on a consistent basis related to the presence of denture adhesive visible in R23's mouth. FM-A reported R23 tends to pocket food in her mouth and often times had food left in her mouth after meal times during FM-A's visits.

During an observation on 5/4/16, at 11:22 a.m. R23 was sitting in a common area in wheelchair. Nursing assistant (NA)-D was asked to view R23's upper denture and bottom teeth. R23's upper denture showed pink debris in-between upper teeth and white debris on lower front teeth. NA-D stated, it doesn't look like her teeth were brushed after breakfast and didn't know if her teeth were supposed to be brushed after every meal.

During an interview on 5/4/16, at 11:29 a.m. licensed practical nurse (LPN)-B looked in her

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mouth and stated the pink debris appeared to be denture adhesive.
During an interview on 5/4/16, at 11:30 a.m. NA-E stated, "We are supposed to brush in the morning and at night for sure." NA-E stated she had access to the care plan on the computer. NA-E explained she worked all over the place and was not aware that R23 required oral care after each meal.
During an interview on 5/4/16, at 3:02 p.m. director of nursing indicated sometimes there is a problem with providing oral care, and staff should follow the care plan for oral care.
R29 Safety device:
R29's care plan provided by the facility on 5/5/16 reported R29 had potential for trauma falls related to history of falls, mental status, medications, and impaired gait and balance. The care plan directed staff to place sensor alarm on bed and chair; and to ensure they are on and in working order.
During an observation on 5/3/16, at 1:04 p.m. R29 was sitting in his room in a reclining chair, without safety alarm in place. Alarms observed to be on the wheelchair and bed. At 1:32 p.m. licensed practical nurse (LPN)-A verified the alarm was not on, and stated R29 should have an alarm on.

R32 safety device:
R32's care plan dated 1/19/16 included,"Sensor alarm: chair and bed."
During an observation on 5/3/16, at 8:10 a.m. R32's safety alarm was located in her wheelchair with R32 alone in bed, the safety alarm box was clipped to side of her bed but not connected to R32. At 8:20 a.m., R32 was in the dining room sitting in her wheelchair at a table without the safety alarm device.
During an observation on 5/3/16, at 1:48 p.m.

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F 282	Continued From page 18 R32 was lying in bed with the safety alarm box clipped to the side of the bed and not connected to R32. During an observation on 5/3/16, at 2:26 p.m. R32 was sitting in her wheelchair alone in her room without the safety alarm box clipped to her chair. Licensed practical nurse (LPN)-C verified the safety alarm was not on the wheelchair and indicated an unawareness if the safety alarm was supposed to be used when in the wheelchair. LPN-B and LPN-C then reviewed the electronic care plan and stated the safety alarm was supposed to be on R32's wheelchair. R44 Safety device: R44's care plan provided by the facility on 5/2/16 included call button in reach and bed alarm. During an observation on 5/2/16, at 5:22 p.m. R44's was lying in bed with eyes closed. R44 had extensive purple bruising to her face. Personal safety device was located on her wheel chair next to bed with the breaks unlocked, and call light was on the bedside table at the foot of the bed in-between a nebulizer machine and a napkin that had neb accessories on it. The call light was not in reach for R44 at this time. At 5:30 p.m. nursing assistant (NA)-H stated the sensor pad is supposed to be on her. At 5:45 p.m. the call light was in the same location on the table and again out of reach for R44. During an observation on 5/3/16, at 8:06 a.m. the call light was in the same location on the bedside table at the foot of the bed. R44 was in the dining room sitting at the table alone and without the safety alarm on. At 9:10 a.m. R44 was in her room alone sitting in wheelchair again without the safety alarm on and the call light was again out of	F 282		

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F 282	Continued From page 19 reach with it draped over a table. At 9:12 a.m. RN-B stated the chair alarm was supposed to be on when in wheelchair; RN-B then placed the sensor pad underneath R44 with the assistance of licensed practical nurse (LPN)-B. LPN-B placed the call light and explained R44 was not capable of using the call light for intended purpose but thought everyone should have a call light in place regardless.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess neurological status after a head injury due to falls for 1 of 1 resident (R44); failed to monitor and identify large areas of bruising for 1 of 3 resident/s (R23) reviewed for non-pressure related skin conditions; failed to administer oxygen as ordered for 1 of 5 residents (R22) reviewed. Findings included R44 NEUROLOGICAL EVALUATIONS: R44's diagnoses indicated on physician orders provided by the facility on 5/4/16 included;	F 309	Caledonia Care & Rehab (CCR) does assure that each resident receives and the facility does provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 1. According to Chen et al (2011) "Common terminology employed in the clinical literature to describe the pupillary light reflex and pupil size includes "unilateral" or "dilated pupils", as well as "brisk" "sluggish", and "nonreactive" pupils. These subjective terms are often	6/10/16

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F 309	Continued From page 20 essential hypertension, dementia, polyosteoarthritis, urinary incontinence, and repeated falls. R44's quarterly Minimum Data Set (MDS) dated 4/6/16 indicated severe cognitive impairment with inattention and trouble focusing, was not steady and only able to stabilize with human assist, wondered 1-3 days during assessment period, and had 2 falls since previous assessment. R44's last fall occurred on 4/26/16 at 11:45 p.m. according to fall progress notes. Progress notes report R44 had fallen in the bathroom, found face down on the floor bleeding from laceration to nose and chin, urine in the toilet, and no walker at the time. R44 was then transferred by ambulance to the hospital. A progress note dated, 4/27/16, at 4:10 a.m. indicated R44 had returned from the hospital, "left knee purple in color, right knee red in color, around right eye purple in color, around left eye slightly purple in color, laceration, above top lip has 1 stitch laceration to nose with dermabond applied, bottom right chin and right side of jaw purple in color with swelling, bottom right shin purple in color, has fractured nose." Neurological assessments were initiated after R44 returned from the hospital on 4/27/16. Evaluations were all consistent with left and right pupil measurements of 2 millimeters (mm) until 4:13 p.m. when the record reflected a change in left pupil size of 1 mm with brisk response. At 8:00 p.m. pupil sizes now measured 1 mm bilaterally with sluggish reaction. The record did not reflect timely neurological assessment following the decline in pupil size and reactivity to light. The next neurological assessment was 4 hours later on 6/28/16 at 12:00 a.m. when the right pupil measured 2 mm and with brisk reaction and left measured 1 mm with sluggish reaction. Also the physician had not been	F 309	applied without a standard clinical protocol or definition. A more precise assessment of the pupil is problematic, since manual papillary assessment as part of the clinical routine is subject to compounded sources of inaccuracies and inconsistencies, and is characterized by large inter-examiner variability." According to Jarvis, (2012) a change in level of consciousness is the single most important factor in neurological rechecks (page 66). CCR has modified their "Notification of Physician Regarding Resident Change in Condition," to indicate they will be notified with a "significant change." Staff's skin assessment was completed prior to the departure of surveyors indicated R 23's bruising on left outer elbow area is a chronic condition related to frequent skin tears from resident's fragile skin condition. Bruising on "index finger" has resolved. Policy will be revised to indicate notification of administrator in the incident of a "suspicious bruise." Staff root cause analysis identified positioning of resident was difficult related to stiffness due to disease process. Re-education of staff was completed in regards to R22's oxygen titration to be maintained at 2L. Staff education was provided in regards to the importance of following physician orders and guidelines. 2. All residents were reviewed for the above issues with no findings found. 3. Re-education will be provided to staff on a on-going basis to assure that	

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F 309	Continued From page 21 contacted in regards to the decline in pupil size and reactivity to light. Neuro's were terminated after return to baseline on 4/28/16, at 4:00 a.m. During an interview on 5/5/16, at 8:10 a.m. licensed practical nurse (LPN)-A In response to the question, "how does the facility do neurological evaluations?" LPN-A stated for three days if they hit their head and if the fall is un-witnessed it depends on the resident and their mental status. Facility policy Notification of Physician Regarding Resident Change in Condition last reviewed, 5/2014 included, "the attending physician or his/her designee should be kept informed of changes in condition of a resident." and the nurse will notify an attending physician of a change in condition of a resident." R23 IMPAIRED SKIN INTEGRITY: R23 had been observed on 5/2/16, at 5:36 p.m. R23 was sitting in her reclining chair with her feet up with her eyes closed. Two large dark purple bruises were observed on her left arm near elbow. One bruise appeared to be diameter of a small lime and the other more on the dorsal side just above the elbow appeared to be the size slightly larger than a half dollar. The left index finger was also noted to have lighter purple/green/yellow bruising from the distal to the proximal phalanx. The area between the proximal and medial phalanx showed slight swelling. R23's quarterly Minimum Data Set (MDS) dated 1/27/16 (more recent MDS requested from the facility and not provided) indicated diagnoses of dementia and Parkinson's with severe cognitive impairment. The MDS indicated R23 had unclear speech and was totally dependent on one to two staff members for all activities of daily living. R23's care plan 4/2/16 for impaired skin integrity	F 309	physician orders are followed, notifications are completed appropriately, and staff are working successfully within the guidelines. 4. Random chart audits will be completed monthly for three months, quarterly for one year, and information and outcomes will be presented to the QAA Committee on a quarterly basis.	

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F 309	Continued From page 22 included interventions of "skin assessment per policy weekly and more often as needed." The care plan for fragile skin dated 5/4/16 included, "report changes to nurse." R23's skin evaluation dated 4/18/16 included, R23 was completely immobile, did not make even slight changes in body/extremity position without assistants, slides in bed and chair, and had constant friction and shear. The evaluation reported R23 was chair fast, could not bear weight, skin was often moist, and R23 can't always communicate pain or need to be reposition. The evaluation indicated a score of 12 indicating high risk for skin breakdown. R23's physician visit nursing progress note dated 5/2/16 indicated the physician had evaluated R23; summary of the visit did not remark on left upper extremity bruising and indicated R23 had fragile skin with fair turgor. R23's nursing progress note dated 5/4/16 at 12:06 p.m. after surveyor requested nurse evaluation of the bruised areas included, "index finger bruise measures 1 cm [centimeter] x 1.5 cm swelling noted to knuckle area, area of bruising noted to left outer elbow area measuring 2 cm x 4 cm purple color to middle fading brown to yellow noted. Bruising noted to anterior left arm measuring 2 cm x 4 cm above the elbow purple middle starting to fade on outer corners area not open to drainage noted also bruise to mid forearm measures 2 cm x 1 cm light purple in color. Family will be notified, placed note on Dr.s clipboard to be reviewed, will continue to monitor for changes. Resident does bruise easily from fragile skin." R23's record reviewed from 4/19/16 through 5/2/16 lacked initial assessment and ongoing monitoring of the bruised areas. During an interview on 5/4/16, at 11:08 a.m.	F 309		

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F 309	Continued From page 23 licensed practical nurse (LPN)-B explained documentation of bruises would be in nursing progress notes. LPN-B then observed the bruises on the R23's left arm and finger and reported the areas would be measured, documented, and would then notify the physician and family. LPN-B was not sure where the bruises came from. LPN-B stated weekly skin assessment were performed by licensed staff on bath days, however nursing assistants monitor daily with cares and alert nurse with changes. During an interview on 5/4/16, at 3:06 p.m. director of nursing (DON) indicated nursing assistants inspect skin daily with cares of residents and if there is a change report to their nurse. DON further explained if the injury was from unknown origin the nurse needs to determine if the injury is suspicion of abuse or maltreatment and document possible causative factors that would rule out abuse. A facility policy Notification of Bruising and Skin Tears not dated, did not reflect current standard of reporting injuries of unknown origin immediately to the administrator. The policy directed staff to fill out an incident report, administer appropriate treatment, and notify the physician and family. The policy indicated the incident report would be reviewed by the administrator, director of nursing, and the Social worker through computer charter, and then the director of nursing and social worker would complete a follow-up investigation on an individualized basis. R22's face sheet, dated 2/8/16, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease (COPD) with acute exacerbation (a progressive disease that makes it hard to breathe).	F 309		

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F 309	Continued From page 24 R22's physician orders, dated 3/2/16, indicated that the resident was to receive oxygen at 2 L (liters) per minute continuously during all shifts. R22's care plan, dated 2/9/16, indicated that the resident had an ineffective breathing pattern due to an altered respiratory status. The goal was to keep R22 adequately oxygenated. Interventions set in place to attain this goal were to administer oxygen as ordered and assess effectiveness. R22's progress notes, reviewed from 2/15/16 through 5/4/16, indicated that the resident's oxygen had been increased by the nursing staff a total of 11 times due to shortness of breath. The physician had not been notified in any of these instances. During an observation on 5/4/16 at 3:52 p.m., R22 was sitting in his reclining chair in his room. The oxygen concentrator was on and running; the nasal tubing was connected to the resident. The oxygen was set at 3 L/min (liters/minute). When interviewed on 5/4/16 at 3:56 p.m., registered nurse (RN)-B went in to R22's room, observed the oxygen running at 3 L/min and turned it down to 2 L/min. RN-B stated that R22's shortness of breath "comes and goes." She stated that if the resident was having shortness of breath she might have increased the oxygen to 3 L/min and checked to see if the resident had any relief; after that she would have let palliative care know and gotten the order changed. When interviewed on 5/5/16 at 8:13 a.m., nursing assistant (NA)-F stated that if R22 was going to leave the room and needed to switch the oxygen	F 309		

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source from his oxygen concentrator to a portable tank, she would keep the oxygen set at the same level she saw it was set on the concentrator even if it was on 3 L/min.

When interviewed on 5/5/16 at 8:39 a.m., registered nurse (RN)-A stated that due to the resident's COPD, standing orders would not apply regarding increasing oxygen usage. RN-A stated that the nursing staff should be following the physician's order.

When interviewed on 5/5/16 at 9:49 a.m., the director of nursing (DON) stated that the nursing staff should be following physician orders.

The American Thoracic Society recommends the following COPD Guidelines for use of oxygen:

"Oxygen is a medication prescribed by your healthcare provider. Optimally, the amount is carefully decided based on an ABG and then guided by oximetry. Once the amount of oxygen you need is decided, your provider will advise you of the rate at which the oxygen should be set. It is very important that you only use the amount that your doctor or nurse has prescribed, no more or no less. The treatment goal is to keep your oxygen at a level that meets your body ' s need for oxygen, usually above 89%. Taking too much oxygen sends a message to your brain to slow your breathing. Whereas too little may deprive the tissue in your brain and heart of oxygen and result in memory loss or changes in your heart."

Review of the facility policy titled, "Medication Orders of the Resident" (5.2015), it stated that medications would not be started without a physician's order.

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F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete a comprehensive skin assessment and then develop interventions to promote healing of new pressure ulcers and reduce the development of new ulcers. Also failed to follow physician ordered treatment/s to promote healing of pressure ulcers for 1 of 1 resident (R6) who had current multiple ulcers and a history of developing pressure ulcers and other skin related concerns. Findings include: R6 was admitted according to admission form with significant osteomyelitis of left heel and chronic wound, dysphagia, also has history of chronic skin breakdown due to immobility and decreased nutritional intake. R6 had been observed on 5/4/16, at 11:56 a.m. along with registered nurse (RN)-B and nursing assistant (NA)-E when R6's buttocks was observed to determine if any skin concerns were present. R6's Bilateral buttocks area showed a caked on thick layer of dried white paste, some areas of cracking of the paste noted, other areas of the white dried paste showed light yellowish	F 314	CCR does ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. 1. R6 care plan, physician orders, and treatment orders were reviewed and revised to promote optimum health. Weekly measurements were added to the treatment progress plan. 2. As there were no other pressure ulcers in the building, we re-educated the nursing staff on wound documentation presented by a wound nurse, BSN, CWON. 3. CCR has been selected for a nationwide study, On Time Pressure Ulcer Prevention Program, funded by the agency Healthcare Research and Quality	6/1/16

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F 314	Continued From page 27 discoloration. Due to the thick layer of caked on paste there was no visible skin concerns observed. On asking NA-E & RN-B regarding the caked on paste NA-E explained staff had been directed not to remove the previously applies cream as the cream was supposed to be left on and new paste was applied over the old. RN-B confirmed what NA-E had said however, stated "It should have come off, the area cleaned and [paste] reapplied." RN-B stated the direction to leave layers of cream on had come from the consulting wound nurse. A progress note written about 8 hour previously to observation was dated 5/4/16 at 3:32 a.m. and authored by Licensed practical nurse (LPN) read, "GENERAL SKIN CONDITION: no problems noted and none present." Entry same day at 12:58 p.m. authored by LPN read, "GENERAL SKIN CONDITION: skin issues noted chronic area of redness and irritation." Observation of wound care on 5/5/16, at 10:31 a.m., LPN-A had indicated the majority of the cream on R6 ' s bottom had been removed to allow better visualization of skin surface, however explained they were unable to remove all the dried cream related to resident discomfort and unintentional debridement of the wounds that were present. The director of nursing was also present at the time of observation of R6 ' s bottom. R6 ' s bilateral buttocks showed some remaining areas of pasty cream where skin integrity could not be fully visualized to get an accurate assessment of skin condition. However, the wounds that could be easily visualized (no paste present) included the following: a. One wound appeared to be unstageable and was covered with light brown eschar measuring 2 centimeters (cm) by 2.2 cm. b. Below that wound and towards the coccyx was	F 314	in partnership with Stratis Health. This program has showed a 59% reduction in the incidents of pressure ulcers. 4. Our facility implementation progress will be monitored monthly by an outside facilitator and reported in our QAA Meeting.	

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another unstageable wound with brown eschar measuring 3 cm by 0.6 cm.
c. The left buttock was observed to have several other unstageable wounds. One was covered with brown eschar that measured 2 cm by 0.8 cm.
d. Below the wound on left buttocks was an unstageable ulcer with brown eschar measuring 2.5 cm by 0.7 cm.
e. The upper coccyx/sacral region was observed to have multiple stage 2 pressure ulcerations measuring 1.7 cm by 7.0 cm, 1.2 cm by 0.6 cm
f. To the right of the coccyx/sacral ulcer and down was another open pressure ulcer measured 0.9 cm by 0.6 cm.
g. The right buttock also had a stage 2 pressure ulcer that measured 0.7 cm by 0.4 cm.
h. The mid-right buttock was observed to have a closed area that was raised and the skin appeared to be of a different texture, that area measured 2.2 cm by 1.9 cm but could not be assessed well related to presence of the cream.
The resident's bilateral buttocks were observed to appear overall irritated and red not including the areas where paste covered skin. The reddened areas on the right buttock showed sluggish profusion where there were underlying multiple small dark purple areas noted (appearance resembled bruises under the epithelial tissue). LPN-A performed light palpation over the purple and reddened areas, R31 reported discomfort and non-verbal signs of pain of flinching and facial grimaces during the palpation.
During an interview on 5/4/16, at 1:47 p.m. in regards to the caked on paste, RN-A stated nurses use their best judgement on what to treat a wound with or will get recommendations from the wound nurse.
During an interview on 5/4/16, at 2:49 p.m. on

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asking the DON for information from the consulting wound nurse the DON explained the wound nurse consulted did not come to the facility but viewed by video. Also there was not documentation because the wound nurse did not use the facilty electronic charting system and no documentation from the consulting nurse had been provided even though asked for several time. DON stated the consulting wound nurse had recommended using the zinc paste and to keep the first layer intact and to not wash off. DON indicated wound nurse had recommended. However, the Mayo Clinic wound recommended to stop the zinc oxide and use Vaseline or hydroqurad for wound with visit date of 4/12/16. DON indicated wounds were measured and assessed weekly by either LPN's or RN's, whoever was assigned at the time. DON stated the nurses would report to her if the wounds got worse and she would go look at it however would not document what was observed or assessed. When asked if the nurses who were responsible for performing the wound assessments and evaluations were completed accurately the DON responded the wound nurse was going to do training on 5/16/16 for the nurses. DON also explained R6 spends a lot of time on his back related to current condition and treatments. DON described interventions that were put into place were frequent repositioning (Even though only 2 hour repositioning was evident in records), air mattress, and pressure relieving cushion in chair. DON also indicated the resident was being treated by the wound clinic. When asked why the wound clinic orders were not followed, DON explained with use of the Vaseline the wound got worse and the wound was almost healed. DON indicated they went back to what the wound nurse had recommended for treatment previously.

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F 314	Continued From page 30 R6's hospital discharge summary dated 2/18/16 included diagnoses of diabetes type II, dysphagia, urinary incontinence, and indicated right heal decubitus ulcers were present on hospital admission. The summary indicated a below the knee amputation (BKA) was performed on 2/15/16, related to significant osteomyelitis (infection of the bone) of the left heel and chronic wound. The hospital discharge summary included orders; "Wound care to buttock is barrier cream 3 times a day after washing with soap and water." R6 ' s progress notes were reviewed since the time of admission 2/18/16 to 5/3/16, progress note dated 2/22/16 identified a new stage 2 pressure ulcer on the right buttock. Progress notes indicate worsening of the pressure ulcer to a stage 3 and the development of a new stage 2 pressure ulcer on the left buttock on 3/1/16. The record lacked ongoing assessment and monitoring of the left buttock ulcer; 3/1/16 is the only date that ulcer is mentioned in nursing assessments and progress notes. R6 ' s record indicated the pressure ulcer was healing until 4/26/16 when the resident went to the wound clinic. On asking for a comprehensive assessment of these pressure ulcers as they developed and was given progress notes included some of the pressure ulcers being comprehensively assessed and others no assessment noted. Also the pressure ulcers were not given location so ongoing monitoring included "wound healing" but not sure which wound or when the wound healed. R6's progress note dated on 4/23/16 indicated the abrasions were nicely healing. R6's wound clinic note dated 4/26/16 reported, "Wound care to right and left medical buttock today with acetic acid 0.25% soak to help remove what appeared to be old pieces of dressing	F 314		

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material or possible tape. There is a significant amount of friction shearing injury to medial bilateral buttocks evidenced by jagged skin edges. Photograph taken today. Please cleanse the buttocks gently with soap and water with each brief change and prior to replicating the zinc barrier based cream to open areas. Cleanse to help reduce build up of barrier cream. Return to wound clinic in 2 weeks for follow-up to reevaluate."
R6's physician note dated 4/27/16 included, "follow up visit 4/26/16 with wound nurse over at [hospital name]. I did get a call from wound nurse. She reports that she had to remove a lot of "old tape/dressing/from the wounds ...that they look so much worse." That they had to soak it [zink paste] off with acidic acid x [times] 10 minutes. She reports that she did take a photo of the skin on his bottom. She asks that we make sure we wash the bottom before applying the creams, either with soap and water or wipes. She requests that a 'zinc based' cream be applied. That we could cover it with an ABD pad or non adherent pad to protect it. I did report to [wound nurse] that resident is on his bottom more these days whether in bed or chair. She was pleased to see he had a cushion in the chair" and "Nursing staff did discuss residents daily activities since tube feeding started. He is on his bottom more. Tube feeding 4 x day where he has to be upright. Up in chair to eat which can take an hour just to do this. Then therapy works with him at least 2 hours a day. Staff do try to put him on his side when possible."
R6's admission Minimum Data Set (MDS) dated 2/25/16, indicated the resident had severe cognitive impairment with a brief interview for mental status score of 6, was totally dependent on staff for activities of daily living that involved

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mobility, had range of motion impairments of both upper and lower extremities, was always incontinent of bowel, and had an indwelling Foley catheter.
R6's care area assessment (CAA) dated 2/27/16 included, pressure ulcer presents on right buttock, right great toe and heel. The CAA identified risk factors including friction and shear, "slides down in the bed, moved by sliding rather than lifting," and pressure related to "requires staff assistance to move sufficiently to relieve pressure over any one site confined to bed or chair most of the time. Requires pressure reducing mattress or seat cushion." Additional risk factors were identified as immobility, cognitive loss, newly admitted, bedfast or wheelchair bound, dependent on staff for all mobility, and recent history of pressure ulcers. The CAA reported, "Will develop care plan-staff to change position every 2 hours. Encourage him to lay on side when in bed. Consult with the wound nurse."
R6's care plan for pressure ulcers dated 2/19/16 included skin interventions however, they were generalized and not resident specific. Also the resident's care plan did not include revision following completion of a CAA on 2/27/16, to include presence and location of ulcers, risk factors or interventions. Interventions identified on the CAA included the use of the pressure reducing mattress or seat cushions, and reposition schedule of every 2 hours.
Facility policy Treatment and Prevention of Pressure Ulcers last reviewed 5/2015 included: "It is the policy of this facility to properly identify and assess resident whose clinical conditions increase the risk for the development skin issues, and pressure ulcers, to implement preventative measures, and to provide appropriate treatment

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F 314	Continued From page 33 measures for pressure ulcers according to the AHCPR [Agency for Health Care Policy and Research] guidelines." The policy addresses risk identification and instructs to complete assessments to determine the risk, implement prevention protocols and develop the care plan. The policy also included direction for pressure ulcer treatment: "initiate skin and wound care protocols, implement care plan for treatment and prevention pressure ulcers, and initiate a weekly wound progress sheet with the onset of any skin condition," and "Documentation in the nurse notes and on the weekly wound progress sheet at a minimum weekly, to include specific wound description, size, depth, character of drainage, odor, character of tissue in wound and surrounding tissue." The policy instructed staff to use the prescribed treatment and update the care plan as needed. The policy also indicated the facility's quality assurance committee was responsible for pressure ulcer prevention, monitoring, evaluation, and staff education.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		6/10/16

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F 323	Continued From page 34 Based on observation, interview, and document review, the facility failed to complete a comprehensive falls assessment which included root cause analysis, to evaluate care plan interventions to determine if they were affective, and to consistently use falls interventions to promote safety for 4 of 4 residents (R44, R29, R32 & R2) reviewed for falls. Findings included: R44 had falls: R44 had been observed on 5/2/16, at 5:22 p.m. R44's was lying in bed with eyes closed. R44 had extensive purple bruising to her face. Personal safety device was located on her wheel chair next to bed with the breaks unlocked, and call light was on the bedside table at the foot of the bed in-between a nebulizer machine and a napkin that had neb accessories on it and not in reach of resident. At 5:30 p.m. nursing assistant (NA)-H stated the sensor pad is supposed to be used even if in bed. At 5:45 p.m. the call light was in the same location on the table and not in reach of resident. During an observation on 5/3/16, at 8:06 a.m. R44 was in the dining room sitting at the table alone without the safety alarm in use. At 9:10 a.m. R44 was in her room alone sitting in wheelchair, without the safety alarm on and the call light in the same position draped over the table. At 9:12 a.m. RN-B stated the alarm was supposed to be on when in wheelchair; RN-B then placed the sensor pad underneath R44 with the assistance of licensed practical nurse (LPN)-B. LPN-B placed the call light and explained R44 was not capable of using the call light for intended purpose but thought everyone	F 323	CCR will provide an environment that remains free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents. 1. According to Guildermann (2012), evidence indicates elimination of alarms can lead to a decrease in falls and can create a more tranquil, homelike environment. R44, R29, and R32 were evaluated via the above program for appropriateness of alarm usage. R29 and R32 will have their alarms removed because of non-falls in the last thirty days. R44 will have her alarm removed related to that it appears to cause increased confusion and did not prevent a fall. Re-education and monitoring will be done for appropriate call light usage. 2. All resident will be reviewed that currently have alarms for the appropriateness of them. We are using the above criteria to eliminate alarms in our building. Call lights will be monitored for all residents. 3. Education will be provided to the staff and families regarding alarm through family council, newsletter, conversation, etc. Trending of falls will be monitored to assure that fall levels are maintained or decreased. Re-education on call light monitoring will be done. 4. Audits will be completed on alarm and call light usage on a weekly basis for one month, then monthly for three months and then quarterly by DON/designee and presented at our quarterly QAA Meeting.	

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should have a call light in place regardless.
R44's diagnoses indicated on physician orders provided by the facility on 5/4/16 included; essential hypertension, dementia, polyosteoarthritis, urinary incontinence, and repeated falls.
R44's quarterly Minimum Data Set (MDS) dated 4/6/16 indicated severe cognitive impairment with inattention and trouble focusing, was not steady and only able to stabilize with human assist, wondered 1-3 days during assessment period, and had 2 falls since previous assessment.
R44's fall care area assessment (CAA) dated 7/28/15 included R44's history of falling prior to facility admission indicated use of antidepressant medication, and reported risk diagnoses of COPD. The CAA also included R44 had visual impairment and Alzheimer's disease. The CAA informed "will develop care plan."
R44's care plan provided by the facility on 5/2/16 included call button in reach. The care plan indicated R44 used a walker for mobility and indicated a revision on 4/29/16 from independent with ambulation and transfers to supervision. The fall care plan informed of potential for trauma falls related to mental status gait/balance and history of falls manifested by impaired balance, unsteady gait, and shortness of breath. Fall interventions dated 4/29/16 included bed alarm, and transferred independently. The care plan also informed R44 had behavior of wondering and to monitor whereabouts.
R44's care guide (used by nursing assistants to provide resident centered interventions) instructed to have call light within reach, however did not include bed alarm or monitor whereabouts related to wondering.
R44's fall progress note report on 3/31/16 indicated a fall was unwitnessed and R44 found

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in the education room on the floor, without assistive device. The report indicated R44 was reminded to use call light, instructed on device use and safe transfers, and more frequent room checks as interventions. A progress note indicated R44 had sustained multiple falls since starting Seroquel and plan to discontinue and discontinue bed alarms. According to physician's orders the Seroquel was discontinued on 4/1/16. However, there was no thorough investigation to determine the root cause of the fall and even though care plan fall interventions were not based on the root cause analysis of the fall in the education room.

R44's care plan was requested and received, no date, the care plan did not reflect revision to include more frequent room checks or discontinuation of the bed alarm as described in fall progress note report dated 3/31/16.

R44's next fall occurred on 4/7/16. The incident report indicated R44 had an unwitnessed fall, no time or location of incident was indicated. The incident report informed the possible cause of the fall was indicated as "no device used." The report indicated no new interventions were added, and reported Seroquel had been discontinued and the power of attorney was educated.

Corresponding progress notes indicated R44 fell in her bathroom by her sink at 7:10 a.m. and sustained a laceration to upper lip and bruising to left upper eyelid and cheek bone, with root cause being lost balance. The progress note indicated the preventative action taken was consideration of alarm on bed to alert staff when up. Staff to check and assist up if awake at 7:00 a.m. and on 4/8/16 note indicated a therapy screen was requested.

R44's care plan was reviewed and again there were no revision for staff to check and assist R44

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if up and awake at 7:00 a.m. In addition, the record did not reflect an evaluation of current falls interventions to determine if they are affective or not.
R44's next fall occurred on 4/18/16. The incident report reported the possible cause of the fall was "found down" with no time, date, or location indicated. The report indicated the fall was unwitnessed and no injuries sustained and indicated the intervention action to be, "referral to therapy-balance?" The corresponding progress note reported the fall occurred in an unlocked utility room at 11:44 a.m. with the intervention to lock the utility room door and referred to therapy for re-evaluation.
R44's physical therapy record reflected on 4/20/16 an order for physical therapy evaluation was obtained to develop strength and endurance, range of motion and flexibility, balance with gait, transfer training 3 times a week for 4 weeks. Physical therapy note dated 4/20/16 reported, "patient has had 5 falls in the last 2 weeks."
R44's record only revealed two falls had occurred during that period of time. The physical therapy goals included, "patient to be independent with transfers and ambulate throughout the facility with 2 wheeled walker without loss of balance and minimal fall risk," and "patient to be independent with all transfers and gait with wheeled walker throughout facility with min [minimum] fall risk as she was prior to this last couple of weeks."
R44's last fall occurred on 4/26/16 at 11:45 p.m. according to fall progress notes. Progress notes report R44 had fallen in the bathroom, found face down on the floor bleeding from laceration to nose and chin, urine in the toilet, and no walker at the time. R44 was then transferred by ambulance to the hospital. A progress note dated, 4/27/16, at 4:10 a.m. indicated R44 had returned

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from the hospital, "left knee purple in color, right knee red in color, around right eye purple in color, around left eye slightly purple in color, laceration, above top lip has 1 stitch laceration to nose with dermabond applied, bottom right chin and right side of jaw purple in color with swelling, bottom right shin purple in color, has fractured nose." The intervention put into place was, "alarms placed" even though safety alarms already on the care plan.
Again there was no comprehensive assessment of the fall to determine the root cause of fall and then develop interventions to reduce or prevent further falls based on the comprehensive assessment.
During an interview on 5/4/16, at 3:26 p.m. DON was asked, "Where is the investigations and root cause analysis for the falls?" DON stated, "Oh, I wish I had time to do that, it's on my to do list." The DON stated interventions are developed from staff opinions and ideas, the nurses come back with things to try. In response to the question, "What did you put into place after each fall had occurred?", DON indicated they had started Seroquel because of the hollering out and falling, so we stopped it because she was falling more. We added Tylenol to the regimen to see if pain was a factor, we tried to implement a walker but she doesn't use it safely. In response to the question, "Has the resident had a comprehensive exam done by the doctor in relation to all the falls.?" DON responded, "he saw her yesterday [5/3/16].

R29 use of safety devices:
During an observation on 5/3/16, at 1:04 p.m. R29 was sitting in his room in a reclining chair, without safety alarm in place. Alarms observed to be on the wheelchair and bed. At 1:32 p.m.

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licensed practical nurse (LPN)-A verified the alarm was not being used, and stated R29 should have an alarm on.
R29 fall progress note dated 11/12/15 indicated R29 fell outside his room in the hallway and was last seen sitting in wheelchair. The possible cause indicated for the fall was "stood without assist " and the intervention of, "make sure the alarms are actually working although they were just checked this shift."
R29's record lacked a comprehensive fall investigation to determine individualized interventions to prevent or decrease the risk for falls.
R29's quarterly Minimum Data Set (MDS) dated 1/27/16 included diagnoses of dementia, and anxiety and depression disorders. The MDS indicated severe cognitive impairment with inattention and disorganized thinking. The MDS reported R29 required extensive assistance from one to two staff, did not ambulate with impaired balance for transfers.
R29's fall care area assessment (CAA) reported prior history of several falls prior to admission, and identified risk factors for falling as; incontinence, Parkinson's disease, peripheral neuropathy, impaired vision, depression, and cognitive impairment. The CAA reported, "Will develop Care plan."
R29's care plan provided by the facility on 5/5/16 reported R29 had potential for trauma falls related to history of falls mental status, medications, and impaired gait and balance. The care plan directed staff to place sensor alarm on bed and chair; and to ensure they are on and in working order.
R32 use of safety devices:
During an observation on 5/3/16, at 8:10 a.m. R32's safety alarm was sitting in her wheelchair alone in her room, a safety alarm box was clipped

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to side of her bed. At 8:20 a.m., R32 was in the dining room sitting in her wheelchair, at a table in her wheelchair without a safety alarm device.
During an observation on 5/3/16, at 1:48 p.m. R32 was lying in bed with the safety alarm box clipped to the side of the bed.
During an observation on 5/3/16, at 2:26 p.m. R32 was sitting in her wheelchair alone in her room without the safety alarm box clipped to her chair. Licensed practical nurse (LPN)-C verified the safety alarm was not on the wheelchair and indicated an unawareness if the safety alarm was supposed to be in on the wheelchair. LPN-B and LPN-C then reviewed the electronic care plan and stated the safety alarm was supposed to be on R32's wheelchair.
R32's quarterly Minimum Data Set (MDS) dated 1/20/16 and 4/13/16 indicated moderate cognitive impairment, adequate vision, impaired balance, and urinary incontinence. The MDS's indicated R32 was extensive assist with activities of daily living that involved mobility.
R32's physician order sheet provided by the facility on 5/4/16 included diagnoses of: essential hypertension, polyosteoarthritis, constipation, osteoporosis, glaucoma, diabetes type II, and pulmonary hypertension.
R32's care plan provided by the facility on 5/5/16 indicated, R32 required extensive assistance from one staff member for bed mobility, dressing, and toileting. Care plan revision on 3/22/16 indicated required extensive assist from one staff person with walker. 4/22/16 care plan revision on 4/22/16 indicated, "AMBULATION: **Do Not Walk**" and transferring with walker
R32's fall care plan included, Potential for trauma falls. The care plan instructed staff to transfer with assistance and instruct to call for help, use assistive devices: wheelchair walker and EZ

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F 323	Continued From page 41 stand when weak for transferring. The care plan also informed staff to toilet per bowel/bladder plan, sensor alarm on chair and bed on at all times, low bed with wheels locked, encourage to assistance, and non-skid foot wear. R32's care guide (not dated) provided by the facility on 5/5/16 did not reflect fall interventions including application of the sensor alarm however, indicated the R32 was at risk for falling. R32's Fall risk assessment dated 1/19/16 indicated the resident had a fall within the last month, was alert and orientated, reliably aware of safety, ambulatory and incontinent at times mainly overnight. The fall risk assessment indicated R32 used assistive devises and had poor vision. The assessment indicated the R32 did not have any falls within the last 3 months even though the assessment indicated R32 had a fall within the last month. The assessment indicated R32 received antihypertensive, hypoglycemic agents, and narcotics medications, and had arthritis. The assessment indicated the risk score as 13 and "resident is at risk for falling." The assessment did not identify R32's medication regimen included cathartics. The risk assessment conflicted with the MDS dated 1/20/16 that indicated vision was adequate, had a level of cognitive impairment that would affect recall and judgement, and failed to include impaired balance. The hand written incident report indicated R32 had a fall on 3/5/16, at 3:30 a.m. the hand written incident report, reported conflicting information. First described resident found sitting on the floor with back up against the bed and then described the resident was found lying on her back, head towards the bed. The report indicated one-half rails used and there was not environmental	F 323		

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hazards at the time of the fall. The incident account indicated the reason for the fall was the safety alarm did not sound. The intervention was to place alarm properly, vital signs and range of motion were performed. The incident report did not identify diagnoses and conditions or medications that could have contributed to the fall.
R32's fall on 3/5/16 was recorded into the electronic medical record on 3/7. The information that was recorded indicated the resident was observed sitting on the floor and had slipped after removing her bed alarm. The report indicated a new alarm was applied and resident educated on using the call light. The report did not indicate what the resident slipped on. The paper incident report indicated there were no environmental hazards at the time of the fall.
The record lacked a post fall assessment to determine the level of risk.
R32's fall risk assessment dated 4/11/16 indicated R32 did not have a fall within the last 30 days, had one to two falls within the last 3 months, indicated vision was adequate, had poor recall and judgement, safety awareness, impaired mobility/continent assist with toileting, balance problem, when standing, balance problem when walking, and uses assistive devises. The assessment indicated a risk score of 15 and "resident is at risk for falling." Again the assessment did not identify the level of risk. Also the assessment did not identify R32's medication regiment that included antihypertensive, narcotics, or hypoglycemic medications and indicated her vision improved since the last assessment. The assessment also did not identify the condition of arthritis. The risk assessment conflicted with the quarterly MDS dated 4/13/16 that indicated R32 was

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occasionally incontinent of urine.
Review of the facility policy titled, "Assessment, Document and Reporting Falls" (6.2015), it stated that licensed staff would assess all residents for injuries after any and all falls and report these assessments to physicians and families as needed. It stated that follow up for falls would be implemented at that time and monitored.
R2 comprehensive falls assessment:

R2's face sheet, dated 12/22/15, indicated that the resident had a diagnosis of a cerebral infarction due to thrombosis of the right vertebral artery (stroke).

R2's quarterly Minimum Data Set (MDS), dated 2/10/16, indicated that the resident had a Brief Interview for Mental Status (BIMS) score of 5, which meant the resident had severe cognitive impairment.

R2's physician orders, dated 11/7/2015, indicated that the resident was to have a bed alarm in place due to the resident's unsteadiness related to her confusion. On 2/18/16, an order was placed for a physical therapy (PT) evaluation: the resident was to participate in therapeutic exercises to develop strength and endurance, range of motion and flexibility, gait training.

R2's treatment sheet, reviewed from 4/1/16 through 4/5/16, indicated that the nursing staff were checking the placement of the bed alarm during the evening and night shifts.

R2's care plan, dated 11/11/15, indicated that the resident was at risk for falls related to impaired balance and a history of falls. It advised to report pain indicators; report a change in ability; provide

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activities; encourage physical activity; offer fluids during activity. On 12/1/15, the care plan was updated. It required a sensor alarm on R2's bed and wheelchair; the resident was to use an EZ stand for transfers; R2's bed was to be in the low position with the wheels locked; R2 was to wear non-skid footwear; R2's glasses were to be within reach. On 2/18/16, the care plan was updated: it advised the nursing staff to ask R2 if she would like to get out of bed regardless of the time of day if she were to appear restless.

R2's incident reports from 12/1/15 through 5/2/2016 were provided by the facility.

R2's incident report notes, reviewed from 12/1/15 through 5/2/16, indicted that the resident had a total of 6 falls. The falls occurred on 12/4/15, 12/7/15, 1/8/16, 2/4/16, 3/4/16 and 4/22/16. Every fall described that R2 was found in her room in a sitting position by her bed. As a possible cause in the post-fall investigation, every fall report stated that the resident slid out of bed. As a preventative action to prevent further falls, each follow up post-fall investigation recommended to teach the resident to use the call light before trying to get out of bed.

When interviewed on 5/4/16 at 11:06 a.m., nursing assistant (NA)-G stated that R2 was not able to use the call light (due to her mental capacity).

When interviewed on 5/4/16 at 11:50 a.m., licensed practical nurse (LPN)-C and nursing assistant (NA)-C stated that they would be very surprised if R2 was able to use the call light (due to her mental capacity).

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When interviewed on 5/5/16 at 8:53 a.m., registered nurse (RN)-A stated that when a fall occurred an independent report was filled out; there was follow-up within 24 hours and a follow-up falls report was to be filed within 24 hours. That report was then to be printed out and given to the Director of Nursing (DON). The DON would then review with the interdisciplinary team in order to come up with interventions. When asked what interventions had been instituted after R2's falls, RN-A stated that the facility did get a new bed which ensured that the bed in its lowest position possible when the resident was in bed. RN-A stated that she was not sure when that was put in place.

When interviewed on 5/5/16 at 9:31 a.m., the Director of Nursing (DON) stated that it was probably after the third fall by R2 that the facility instituted the low bed intervention. The DON stated that R2 would get up at night and so they got a new bed that was lower to the ground. She stated that they spoke with R2's family member who suggested that if the resident was moving around in bed to just go ahead and get the resident up. The DON stated that she recently hired someone who would take over addressing falls. Lately, the responsibility had been up to the on-duty nurses and the DON. The DON stated that there could have been better root cause analysis as to what caused the falls. She stated she did not know what more interventions could have been in place, though.

Review of the facility policy titled, "Assessment, Document and Reporting Falls" (6.2015), it stated that licensed staff would assess all residents for injuries after any and all falls and report these assessments to physicians and families as

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F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		6/1/16

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F 431	Continued From page 47 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medication refrigerator temperature was maintained within an acceptable range for 1 of 2 medication refrigerators revived for medication storage. This had the potential to affect 4/4 residents (R15, R36, R5, and R9) who had medications stored in the south medication refrigerator. Findings include: On 5/5/16, at 8:23 a.m. the south medication refrigerator temperature was 48 degrees Fahrenheit (F). registered nurse (RN)-A verified this reading on the thermometer, and stated it was 2 degrees above the acceptable range for the insulin stored in there. RN-A was unable to find a current temperature log for the refrigerator to identify when temperature became unacceptable in refrigerator. The refrigerator contained: Two Novolog insulin pens (used to treat diabetes) dispensed 3/9/16 for R15 Five Lantus SoloStar insulin pens (used to treat diabetes) dispensed 4/18/16 for R15 Five Lantus SoloStar insulin pens dispensed 5/2/16 for R36 Five Novolog insulin pens dispensed 3/28/16 for R36 Two Lantus SoloStar insulin pens dispensed 5/3/16 for R5 Three Lantus SoloStar insulin pens dispensed 5/3/16 for R9	F 431	1. Implement temperature log with daily verification of 36-46 F. range, staff to notify maintenance if not within the appropriate range. 2. DON/designee will monitor weekly for one month, monthly for three months and then quarterly. Quarterly RPh check will ensure compliance. Re-educate nursing staff on policies and procedures.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	05/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CALEDONIA CARE AND REHABILITATION CENTER	425 NORTH BADGER STREET CALEDONIA, MN 55921

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F 431	Continued From page 48 During interview on 5/5/16, at 1:22 p.m. RN-A stated she verified with facility pharmacist any insulin out of the recommended temperature of 36-46 degree F is only good for 28 days or 28 days from dispense date. RN-A stated insulin pens within the 28 days all dated as opened with dispense date now and those past the 28 days disposed of.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441		6/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING _____ B. WING _____	05/05/2016

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F 441	Continued From page 49 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly clean and store nebulizer equipment between uses for 1 of 1 resident (R22) reviewed for infection control practices. Findings include: R22's face sheet, dated 2/8/16, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease with acute exacerbation (a progressive disease that makes it hard to breathe). R22's physician orders, dated 4/06/16, indicated that the resident had been prescribed Albuterol Sulfate 2.5 mg (milligrams)/3 ml (milliliters) 0.083% Nebulization solution: 1 inhalation three times a day (a medication used to relax the airway muscles and increase airflow to the lungs). R22's care plan, dated 2/9/16, indicated that the resident had an ineffective breathing pattern related to an altered respiratory status. Interventions set in place to address this problem was to administer R22's medications as ordered; the care plan also advised to address infection	F 441	1. Re-education of nursing staff of the need to rinse and dry the nebulizer after each treatment for R22. 2. Education was provided regarding the rinsing and drying of the nebulizer after each treatment for other residents who use this treatment. 2. Audits will be completed on a weekly basis for one month, then a monthly basis for three months and then quarterly for one year by DON/designee.	

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F 441	Continued From page 50 precautions. R22's medication summary report, reviewed from 4/6/16 through 5/2/16, indicated that the resident had been receiving the Albuterol Sulfate nebulization solution as prescribed. During an observation on 5/2/16 at 5:18 p.m., R22 was sitting in his room in his reclining chair. At the resident's table next to his recliner there was a nebulizer machine. The tubing was connected to the machine; a mask and canister (where the medication is placed) were connected to the tubing. There was condensation in the canister. Upon closer inspection, there appeared to be a small amount of fluid at the bottom of the canister. R22 stated that there was a "little bit" of fluid in the bottom of the canister. R22 explained that staff would set up the medication for him to take; they would leave the room while he took the medication. During an observation with the Director of Nursing (DON) on 5/2/16 at 8:00 p.m., R22 was in his room sitting in his reclining chair. The nebulizer machine was on a table next to the resident's recliner. The tubing was connected to the machine and the mask and canister were connected to the tubing. There was condensation in the canister where medication is placed. There was a small amount of liquid in the bottom of the canister. The DON stated there was a small amount of liquid on the bottom of the canister. R22 stated that he had last used the nebulizer machine to administer the medication around 4:00 p.m. The DON stated that the nebulizer equipment should have been cleaned out after its use and stored properly.	F 441		

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F 441	Continued From page 51 Review of the facility policy titled, "Nursing Policy: Cleaning a Nebulizer" (April 2004), it stated that the facility would maintain the cleanliness of the nebulizer equipment. It stated that cleaning the nebulizer equipment would help prevent germs that could cause infection.	F 441		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure a laboratory study was completed according to physician's orders for 1 of 5 residents (R8) reviewed for unnecessary medications. Findings included: R8's signed physician's orders dated 5/3/16 included Simvastin (cholesterol lowering medication) 40 milligrams (mg) by mouth daily for hyperlipidemia (high cholesterol). R8's physician orders also included, "11/08/15 Lab: lipid panel annually September." R8's physician progress note dated 2/1/16 reported, "is overdue for fasting lipid panel, in reviewing her annual labs will add annual lipid panel to be done in March." R8's record did not reflect a lipid panel on file since 2014. During an interview on 5/5/16, at 9:30 a.m. licensed practical nurse (LPN)-A called the clinic to request history of lipid panels performed. LPN-A reported the clinic verified April of 2014	F 504	1. A new pharmacy consultant was hired. His initial visit was May 19-20 to establish his records and review all charts. He addressed each resident's lab orders and needs and made recommendations. 2. A conversation was held with medical director and labs standing orders will be removed and labs will be ordered on an individualized basis from attending physicians and pharmacy review. 3. Audits of the labs will be completed on a weekly basis for one month, monthly for three months and then quarterly for one year. Findings will be shared at the quarterly QAA Meeting.	6/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 504	Continued From page 52 was the last lipid panel performed. During an interview on 5/4/16, at 2:46 p.m. director of nursing (DON) explained the health unit coordinators schedule the labs. DON stated the medication monitoring labs are individualized for each resident. DON indicated the lab should have been obtained. A facility policy for Lab Monitoring not dated included, "will monitor all residents' labs per medical director, pharmacy, attending physician's discretion."	F 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245499	A. BUILDING **01 - THE LUTHERAN HOME CALEDONIA** B. WING _____	**05/03/2016**

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K 000	INITIAL COMMENTS 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Caledonia Care and Rehab was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		06/07/2016

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

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K 000	Continued From page 1 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. Caledonia Care and Rehab is a 1-story building. The building was constructed at 3 different times. The original building was constructed in 1961 and was determined to be of Type II(000)construction, with a full basement. In 1971, addition was constructed and was determined to be of Type II(000) construction, with no basement. In 1975, addition was constructed and was determined to be of Type II(000) construction, with no basement. Because the original building and the 2 additions are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is partially sprinklered as noted in K56 tag. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 42 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 154	NFPA 101 LIFE SAFETY CODE STANDARD	K 154		6/10/16

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K 154 SS=D	Continued From page 2 Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 This STANDARD is not met as evidenced by: K-154: Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch system is provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1 On facility tour between 11:00 AM and 1:30 PM on 05/03/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire sprinkler system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 154	A service plan was written up to assure there is a watch system in place if the automatic sprinkler system is out of service. At the 6.7.2016, the staff were educated on the plan.	
K 155 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 This STANDARD is not met as evidenced by: K-155	K 155	A fire watch plan was written in case the	6/10/16

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K 155	Continued From page 3 Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction is notified, and the building is evacuated or an approved fire watch is provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8 On facility tour between 11:00 AM and 1:30 PM on 05/03/2016, observation and documentation reviewed revealed that there was not a single plan for the out of service plan for the fire alarm system. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery	K 155	fire alarm system is out of service for more than four hours in a 24-hour period. At the 6.7.2016 inservice, staff were educated on the plan.	

MDH
Minnesota
Department
of Health
Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
May 20, 2016

Ms. Marian Rauk, Administrator
Caledonia Care And Rehabilitation Center
425 North Badger Street
Caledonia, MN 55921

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5499023

Dear Ms. Rauk:

The above facility was surveyed on May 2, 2016 through May 5, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Gary Nederhoff, Unit Supervisor at (507) 206-2731.

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,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00073	A. BUILDING: _____ B. WING _____	05/05/2016

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On May 2, 3, 4, 5, & 6, 2016 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.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by	2 555		6/10/16

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	00073	A. BUILDING: _____ B. WING _____	05/05/2016

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CALEDONIA CARE AND REHABILITATION CEN	425 NORTH BADGER STREET CALEDONIA, MN 55921

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2 555	Continued From page 2 the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 2 of 5 residents (R8 & R130) who had a change in health status. Findings include: R8 had diagnoses that included: Dorsalgia, atrial fibrillation, hypertension, and benign positional vertigo. R8's quarterly Minimum Data Set (MDS) assessment dated 4/6/16, identified R8 required limited assistance of 1 for transfers, walking in room and supervision for toileting. The MDS further identified R8 with a Brief Interview for Mental Status (BIMS) score of 15/15, indicating she was cognitively intact. R8's care area assessment (CAA) dated 8/3/15, identified a risk of falling related to her need to rock body or push off on arms of chair when standing up from a chair and difficulty maintaining a standing position. Although the CAA dated 8/3/15 identified a fall risk for R8, the current care plan dated 5/4/16, did not include interventions related to falls. When interviewed on 5/4/26, at 10:15 a.m. R8 stated she had fallen in the bathroom about a month ago. She indicated she felt dizzy at the time and her knees "gave out".	2 555	corrected	

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2 555	Continued From page 3	2 555		

During interview on 5/5/16, at 8:01 a.m. licensed practical nurse (LPN)-A stated dizziness is an on-going problem for R8. LPN-A further stated R8 had previously attended physical therapy (PT) for vestibular rehab to improve dizziness.

When interviewed on 5/5/16, at 10:45 a.m. registered nurse (RN)-A confirmed the current careplan had not been revised to include interventions related to R8's fall risks. RN-A further explained with change in computer software the fall interventions identified in the previous computer software system did not transition into current system.

R13 had diagnosis of traumatic brain injury (TBI).

R13's annual MDS assessment dated 3/9/16, identified R13 required extensive assistance for bed mobility, dressing, toilet use, and supervision for transfers and bathing. R13's BIMS score was 15/15, indicating he was cognitively intact. A Patient Health Questionnaire (PHQ-9) depressive screen was 0, indicating no depression. The MDS further identified R13 as having no behaviors.

When interview on 5/4/16, at 1:51 p.m. director of nursing (DON) stated R13 will "perseverate [Perseverate definition, to repeat something insistently or redundantly]" and has targeted different staff with complaints. DON indicated this had been an on-going issue and was not new. DON further explained R13 "goes in cycles" in reference to perseveration.

During interview on 5/5/16, at 11:14 a.m. LPN-A stated she is aware R13 is currently upset with nursing assistant (NA)-C because NA-C makes him do his exercises.

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2 555	Continued From page 4 During interview on 5/5/16, at 11:16 a.m. RN-A stated she is aware that R13 has cursed at staff members and is verbal if he doesn't like them. When interviewed on 5/5/16, at 2:12 p.m. DON confirmed R13's careplan lacked evidence of a psychosocial or behavioral type of problem or development of intervention, and should have. The policy for Formulation of Resident Care Plans dated 4/2015, indicated each resident will have an interdisciplinary care plan meeting quarterly to review, revise, and update the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring care plan for revisions are made timely when a change in health status is noted. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 555		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide oral care	2 565	corrected	6/10/16

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2 565	Continued From page 5 according to the plan of care for 1 of 4 residents (R23), to identify non-pressure related skin concerns for 1 of 3 residents (R23) and to ensure safety devices were in place according to the care plan for 3 of 3 residents (R29, R32 &44) who utilized devices to promote safety. Findings include: R23 IMPAIRED SKIN INTEGRITY: R23's care plan dated for impaired skin integrity dated 4/28/16 included interventions of "skin assessment per policy (weekly and more often as needed)." The care plan for fragile skin dated 5/4/16 included, "report changes to nurse." R23 had been observed on 5/2/16, at 5:36 p.m. R23 was sitting in her reclining chair with her feet up with her eyes closed. Two large dark purple bruises observed on her left arm near elbow. One bruise appeared to be diameter of a small lime and the other more on the dorsal side just above the elbow appeared to be the size slightly larger than a half dollar. The left index finger was also noted to have lighter purple/green/yellow bruising from the distal to the proximal phalanx. The area between the proximal and medial phalanx showed slight swelling. R23's record reviewed from 4/19/16 through 5/2/16 lacked any identification or monitoring of the bruised areas. During an interview on 5/4/16, at 11:08 a.m. licensed practical nurse (LPN)-B explained documentation of bruises would be in nursing progress notes. LPN-B then observed the bruises on the R23's left arm and finger and reported the areas would be measured, documented, and would then notify the physician and family. LPN-B was not sure where the bruises came from. LPN-B stated weekly skin assessment were performed by licensed staff on bath days, however nursing assistants monitor daily with cares and alert nurse with changes.	2 565		

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2 565	Continued From page 6 During an interview on 5/4/16, at 3:06 p.m. director of nursing (DON) indicated nursing assistants inspect skin daily with cares of residents and if there is a change report to their nurse. DON further explained if the injury was from unknown origin the nurse needs to determine if the injury is suspicion of abuse or maltreatment and document possible causative factors that would rule out abuse. R23 ORAL CARE: R23's care plan intervention located on the treatment administration record (TAR) from April and May 2015 included nursing orders dated, 11/8/15 of, "Provide oral care after each meal three times a day," and "Check mouth at bedtime to make sure mouth is clean and seabond (denture adhesive) is removed from mouth." The TAR indicated on 5/4/16 oral care had been performed after breakfast by LPN-B. During an interview on 5/3/16, at 2:46 p.m. family member (FM)-A questioned and voiced a concern if oral care was provided on a consistent basis related to the presence of denture adhesive visible in R23's mouth. FM-A reported R23 tends to pocket food in her mouth and often times had food left in her mouth after meal times during FM-A's visits. During an observation on 5/4/16, at 11:22 a.m. R23 was sitting in a common area in wheelchair. Nursing assistant (NA)-D was asked to view R23's upper denture and bottom teeth. R23's upper denture showed pink debris in-between upper teeth and white debris on lower front teeth. NA-D stated, it doesn't look like her teeth were brushed after breakfast and didn't know if her teeth were supposed to be brushed after every meal. During an interview on 5/4/16, at 11:29 a.m. licensed practical nurse (LPN)-B looked in her mouth and stated the pink debris appeared to be	2 565		

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2 565	Continued From page 7	2 565		

denture adhesive.
During an interview on 5/4/16, at 11:30 a.m. NA-E stated, "We are supposed to brush in the morning and at night for sure." NA-E stated she had access to the care plan on the computer. NA-E explained she worked all over the place and was not aware that R23 required oral care after each meal.
During an interview on 5/4/16, at 3:02 p.m. director of nursing indicated sometimes there is a problem with providing oral care, and staff should follow the care plan for oral care.
R29 Safety device:
R29's care plan provided by the facility on 5/5/16 reported R29 had potential for trauma falls related to history of falls, mental status, medications, and impaired gait and balance. The care plan directed staff to place sensor alarm on bed and chair; and to ensure they are on and in working order.
During an observation on 5/3/16, at 1:04 p.m. R29 was sitting in his room in a reclining chair, without safety alarm in place. Alarms observed to be on the wheelchair and bed. At 1:32 p.m. licensed practical nurse (LPN)-A verified the alarm was not on, and stated R29 should have an alarm on.

R32 safety device:
R32's care plan dated 1/19/16 included,"Sensor alarm: chair and bed."
During an observation on 5/3/16, at 8:10 a.m. R32's safety alarm was located in her wheelchair with R32 alone in bed, the safety alarm box was clipped to side of her bed but not connected to R32. At 8:20 a.m., R32 was in the dining room sitting in her wheelchair at a table without the safety alarm device.
During an observation on 5/3/16, at 1:48 p.m. R32 was lying in bed with the safety alarm box clipped to the side of the bed and not connected

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2 565	Continued From page 8 to R32. During an observation on 5/3/16, at 2:26 p.m. R32 was sitting in her wheelchair alone in her room without the safety alarm box clipped to her chair. Licensed practical nurse (LPN)-C verified the safety alarm was not on the wheelchair and indicated an unawareness if the safety alarm was supposed to be used when in the wheelchair. LPN-B and LPN-C then reviewed the electronic care plan and stated the safety alarm was supposed to be on R32's wheelchair. R44 Safety device: R44's care plan provided by the facility on 5/2/16 included call button in reach and bed alarm. During an observation on 5/2/16, at 5:22 p.m. R44's was lying in bed with eyes closed. R44 had extensive purple bruising to her face. Personal safety device was located on her wheel chair next to bed with the breaks unlocked, and call light was on the bedside table at the foot of the bed in-between a nebulizer machine and a napkin that had neb accessories on it. The call light was not in reach for R44 at this time. At 5:30 p.m. nursing assistant (NA)-H stated the sensor pad is supposed to be on her. At 5:45 p.m. the call light was in the same location on the table and again out of reach for R44. During an observation on 5/3/16, at 8:06 a.m. the call light was in the same location on the bedside table at the foot of the bed. R44 was in the dining room sitting at the table alone and without the safety alarm on. At 9:10 a.m. R44 was in her room alone sitting in wheelchair again without the safety alarm on and the call light was again out of reach with it draped over a table. At 9:12 a.m. RN-B stated the chair alarm was supposed to be on when in wheelchair; RN-B then placed the sensor pad underneath R44 with the assistance	2 565		

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2 565	Continued From page 9 of licensed practical nurse (LPN)-B. LPN-B placed the call light and explained R44 was not capable of using the call light for intended purpose but thought everyone should have a call light in place regardless. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could re-educate staff on following resident care plan. The DON or designee could develop and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to assess neurological status after a	2 830	corrected	6/10/16

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2 830	Continued From page 10 head injury due to falls for 1 of 1 resident (R44); failed to monitor and identify large areas of bruising for 1 of 3 resident/s (R23) reviewed for non-pressure related skin conditions; failed to administer oxygen as ordered for 1 of 5 residents (R22) reviewed. Findings included R44 NEUROLOGICAL EVALUATIONS: R44's diagnoses indicated on physician orders provided by the facility on 5/4/16 included; essential hypertension, dementia, polyosteoarthritis, urinary incontinence, and repeated falls. R44's quarterly Minimum Data Set (MDS) dated 4/6/16 indicated severe cognitive impairment with inattention and trouble focusing, was not steady and only able to stabilize with human assist, wondered 1-3 days during assessment period, and had 2 falls since previous assessment. R44's last fall occurred on 4/26/16 at 11:45 p.m. according to fall progress notes. Progress notes report R44 had fallen in the bathroom, found face down on the floor bleeding from laceration to nose and chin, urine in the toilet, and no walker at the time. R44 was then transferred by ambulance to the hospital. A progress note dated, 4/27/16, at 4:10 a.m. indicated R44 had returned from the hospital, "left knee purple in color, right knee red in color, around right eye purple in color, around left eye slightly purple in color, laceration, above top lip has 1 stitch laceration to nose with dermabond applied, bottom right chin and right side of jaw purple in color with swelling, bottom right shin purple in color, has fractured nose." Neurological assessments were initiated after R44 returned from the hospital on 4/27/16. Evaluations were all consistent with left and right	2 830		

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2 830	Continued From page 11 pupil measurements of 2 millimeters (mm) until 4:13 p.m. when the record reflected a change in left pupil size of 1 mm with brisk response. At 8:00 p.m. pupil sizes now measured 1 mm bilaterally with sluggish reaction. The record did not reflect timely neurological assessment following the decline in pupil size and reactivity to light. The next neurological assessment was 4 hours later on 6/28/16 at 12:00 a.m. when the right pupil measured 2 mm and with brisk reaction and left measured 1 mm with sluggish reaction. Also the physician had not been contacted in regards to the decline in pupil size and reactivity to light. Neuro's were terminated after return to baseline on 4/28/16, at 4:00 a.m. During an interview on 5/5/16, at 8:10 a.m. licensed practical nurse (LPN)-A In response to the question, "how does the facility do neurological evaluations?" LPN-A stated for three days if they hit their head and if the fall is un-witnessed it depends on the resident and their mental status. Facility policy Notification of Physician Regarding Resident Change in Condition last reviewed, 5/2014 included, "the attending physician or his/her designee should be kept informed of changes in condition of a resident." and the nurse will notify an attending physician of a change in condition of a resident." R23 IMPAIRED SKIN INTEGRITY: R23 had been observed on 5/2/16, at 5:36 p.m. R23 was sitting in her reclining chair with her feet up with her eyes closed. Two large dark purple bruises were observed on her left arm near elbow. One bruise appeared to be diameter of a small lime and the other more on the dorsal side just above the elbow appeared to be the size slightly larger than a half dollar. The left index finger was also noted to have lighter	2 830		

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2 830	Continued From page 12 purple/green/yellow bruising from the distal to the proximal phalanx. The area between the proximal and medial phalanx showed slight swelling. R23's quarterly Minimum Data Set (MDS) dated 1/27/16 (more recent MDS requested from the facility and not provided) indicated diagnoses of dementia and Parkinson's with severe cognitive impairment. The MDS indicated R23 had unclear speech and was totally dependent on one to two staff members for all activities of daily living. R23's care plan 4/2/16 for impaired skin integrity included interventions of "skin assessment per policy weekly and more often as needed." The care plan for fragile skin dated 5/4/16 included, "report changes to nurse." R23's skin evaluation dated 4/18/16 included, R23 was completely immobile, did not make even slight changes in body/extremity position without assistants, slides in bed and chair, and had constant friction and shear. The evaluation reported R23 was chair fast, could not bear weight, skin was often moist, and R23 can't always communicate pain or need to be reposition. The evaluation indicated a score of 12 indicating high risk for skin breakdown. R23's physician visit nursing progress note dated 5/2/16 indicated the physician had evaluated R23; summary of the visit did not remark on left upper extremity bruising and indicated R23 had fragile skin with fair turgor. R23's nursing progress note dated 5/4/16 at 12:06 p.m. after surveyor requested nurse evaluation of the bruised areas included, "index finger bruise measures 1 cm [centimeter] x 1.5 cm swelling noted to knuckle area, area of bruising noted to left outer elbow area measuring 2 cm x 4 cm purple color to middle fading brown to yellow noted. Bruising noted to anterior left arm measuring 2 cm x 4 cm above the elbow purple middle starting to fade on outer corners area not	2 830		

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2 830	Continued From page 13 open to drainage noted also bruise to mid forearm measures 2 cm x 1 cm light purple in color. Family will be notified, placed note on Dr.s clipboard to be reviewed, will continue to monitor for changes. Resident does bruise easily from fragile skin." R23's record reviewed from 4/19/16 through 5/2/16 lacked initial assessment and ongoing monitoring of the bruised areas. During an interview on 5/4/16, at 11:08 a.m. licensed practical nurse (LPN)-B explained documentation of bruises would be in nursing progress notes. LPN-B then observed the bruises on the R23's left arm and finger and reported the areas would be measured, documented, and would then notify the physician and family. LPN-B was not sure where the bruises came from. LPN-B stated weekly skin assessment were performed by licensed staff on bath days, however nursing assistants monitor daily with cares and alert nurse with changes. During an interview on 5/4/16, at 3:06 p.m. director of nursing (DON) indicated nursing assistants inspect skin daily with cares of residents and if there is a change report to their nurse. DON further explained if the injury was from unknown origin the nurse needs to determine if the injury is suspicion of abuse or maltreatment and document possible causative factors that would rule out abuse. A facility policy Notification of Bruising and Skin Tears not dated, did not reflect current standard of reporting injuries of unknown origin immediately to the administrator. The policy directed staff to fill out an incident report, administer appropriate treatment, and notify the physician and family. The policy indicated the incident report would be reviewed by the administrator, director of nursing, and the Social worker through computer charter, and then the	2 830		

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	00073	A. BUILDING: _____ B. WING _____	05/05/2016

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2 830	Continued From page 14 director of nursing and social worker would complete a follow-up investigation on an individualized basis. R22's face sheet, dated 2/8/16, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease (COPD) with acute exacerbation (a progressive disease that makes it hard to breathe). R22's physician orders, dated 3/2/16, indicated that the resident was to receive oxygen at 2 L (liters) per minute continuously during all shifts. R22's care plan, dated 2/9/16, indicated that the resident had an ineffective breathing pattern due to an altered respiratory status. The goal was to keep R22 adequately oxygenated. Interventions set in place to attain this goal were to administer oxygen as ordered and assess effectiveness. R22's progress notes, reviewed from 2/15/16 through 5/4/16, indicated that the resident's oxygen had been increased by the nursing staff a total of 11 times due to shortness of breath. The physician had not been notified in any of these instances. During an observation on 5/4/16 at 3:52 p.m., R22 was sitting in his reclining chair in his room. The oxygen concentrator was on and running; the nasal tubing was connected to the resident. The oxygen was set at 3 L/min (liters/minute). When interviewed on 5/4/16 at 3:56 p.m., registered nurse (RN)-B went in to R22's room, observed the oxygen running at 3 L/min and turned it down to 2 L/min. RN-B stated that R22's shortness of breath "comes and goes." She stated that if the resident was having shortness of	2 830		

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2 830	Continued From page 15 breath she might have increased the oxygen to 3 L/min and checked to see if the resident had any relief; after that she would have let palliative care know and gotten the order changed. When interviewed on 5/5/16 at 8:13 a.m., nursing assistant (NA)-F stated that if R22 was going to leave the room and needed to switch the oxygen source from his oxygen concentrator to a portable tank, she would keep the oxygen set at the same level she saw it was set on the concentrator even if it was on 3 L/min. When interviewed on 5/5/16 at 8:39 a.m., registered nurse (RN)-A stated that due to the resident's COPD, standing orders would not apply regarding increasing oxygen usage. RN-A stated that the nursing staff should be following the physician's order. When interviewed on 5/5/16 at 9:49 a.m., the director of nursing (DON) stated that the nursing staff should be following physician orders. The American Thoracic Society recommends the following COPD Guidelines for use of oxygen: "Oxygen is a medication prescribed by your healthcare provider. Optimally, the amount is carefully decided based on an ABG and then guided by oximetry. Once the amount of oxygen you need is decided, your provider will advise you of the rate at which the oxygen should be set. It is very important that you only use the amount that your doctor or nurse has prescribed, no more or no less. The treatment goal is to keep your oxygen at a level that meets your body ' s need for oxygen, usually above 89%. Taking too much oxygen sends a message to your brain to slow your breathing. Whereas too little may deprive the	2 830		

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2 830	Continued From page 16 tissue in your brain and heart of oxygen and result in memory loss or changes in your heart." Review of the facility policy titled, "Medication Orders of the Resident" (5.2015), it stated that medications would not be started without a physician's order. SUGGESTED METHOD OF CORRECTION: The facility could review their policies and procedures for reporting injuries of unknown origin, fall investigations and evaluation, and neurological evaluations after head trauma. The facility could then and re-educate staff and test for competency. The facility could then develop a monitoring system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent	2 900		6/10/16

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2 900	Continued From page 17 new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete a comprehensive skin assessment and then develop interventions to promote healing of new pressure ulcers and reduce the development of new ulcers. Also failed to follow physician ordered treatment/s to promote healing of pressure ulcers for 1 of 1 resident (R6) who had current multiple ulcers and a history of developing pressure ulcers and other skin related concerns. Findings include: R6 was admitted according to admission form with significant osteomyelitis of left heel and chronic wound, dysphagia, also has history of chronic skin breakdown due to immobility and decreased nutritional intake. R6 had been observed on 5/4/16, at 11:56 a.m. along with registered nurse (RN)-B and nursing assistant (NA)-E when R6's buttocks was observed to determine if any skin concerns were present. R6's Bilateral buttocks area showed a caked on thick layer of dried white paste, some areas of cracking of the paste noted, other areas of the white dried paste showed light yellowish discoloration. Due to the thick layer of caked on paste there was no visible skin concerns observed. On asking NA-E & RN-B regarding the caked on paste NA-E explained staff had been directed not to remove the previously applies cream as the cream was supposed to be left on and new paste was applied over the old. RN-B confirmed what NA-E had said however, stated "It should have come off, the area cleaned and [paste] reapplied." RN-B stated the direction to leave layers of cream on had come from the	2 900	corrected	

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2 900	Continued From page 18 consulting wound nurse. A progress note written about 8 hour previously to observation was dated 5/4/16 at 3:32 a.m. and authored by Licensed practical nurse (LPN) read, "GENERAL SKIN CONDITION: no problems noted and none present." Entry same day at 12:58 p.m. authored by LPN read, "GENERAL SKIN CONDITION: skin issues noted chronic area of redness and irritation." Observation of wound care on 5/5/16, at 10:31 a.m., LPN-A had indicated the majority of the cream on R6 ' s bottom had been removed to allow better visualization of skin surface, however explained they were unable to remove all the dried cream related to resident discomfort and unintentional debridement of the wounds that were present. The director of nursing was also present at the time of observation of R6 ' s bottom. R6 ' s bilateral buttocks showed some remaining areas of pasty cream where skin integrity could not be fully visualized to get an accurate assessment of skin condition. However, the wounds that could be easily visualized (no paste present) included the following: a. One wound appeared to be unstageable and was covered with light brown eschar measuring 2 centimeters (cm) by 2.2 cm. b. Below that wound and towards the coccyx was another unstageable wound with brown eschar measuring 3 cm by 0.6 cm. c. The left buttock was observed to have several other unstageable wounds. One was covered with brown eschar that measured 2 cm by 0.8 cm. d. Below the wound on left buttocks was an unstageable ulcer with brown eschar measuring 2.5 cm by 0.7 cm. e. The upper coccyx/sacral region was observed to have multiple stage 2 pressure ulcerations measuring 1.7 cm by 7.0 cm, 1.2 cm by 0.6 cm	2 900		

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2 900	Continued From page 19 f. To the right of the coccyx/sacral ulcer and down was another open pressure ulcer measured 0.9 cm by 0.6 cm. g. The right buttock also had a stage 2 pressure ulcer that measured 0.7 cm by 0.4 cm. h. The mid-right buttock was observed to have a closed area that was raised and the skin appeared to be of a different texture, that area measured 2.2 cm by 1.9 cm but could not be assessed well related to presence of the cream. The resident's bilateral buttocks were observed to appear overall irritated and red not including the areas where paste covered skin. The reddened areas on the right buttock showed sluggish profusion where there were underlying multiple small dark purple areas noted (appearance resembled bruises under the epithelial tissue). LPN-A performed light palpation over the purple and reddened areas, R31 reported discomfort and non-verbal signs of pain of flinching and facial grimaces during the palpation. During an interview on 5/4/16, at 1:47 p.m. in regards to the caked on paste, RN-A stated nurses use their best judgement on what to treat a wound with or will get recommendations from the wound nurse. During an interview on 5/4/16, at 2:49 p.m. on asking the DON for information from the consulting wound nurse the DON explained the wound nurse consulted did not come to the facility but viewed by video. Also there was not documentation because the wound nurse did not use the facilty electronic charting system and no documentation from the consulting nurse had been provided even though asked for several time. DON stated the consulting wound nurse had recommended using the zinc paste and to keep the first layer intact and to not wash off. DON indicated wound nurse had recommended. However, the Mayo Clinic wound recommended	2 900		

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2 900	Continued From page 20	2 900		

to stop the zinc oxide and use Vaseline or hydroqurad for wound with visit date of 4/12/16. DON indicated wounds were measured and assessed weekly by either LPN's or RN's, whoever was assigned at the time. DON stated the nurses would report to her if the wounds got worse and she would go look at it however would not document what was observed or assessed. When asked if the nurses who were responsible for performing the wound assessments and evaluations were completed accurately the DON responded the wound nurse was going to do training on 5/16/16 for the nurses. DON also explained R6 spends a lot of time on his back related to current condition and treatments. DON described interventions that were put into place were frequent repositioning (Even though only 2 hour repositioning was evident in records), air mattress, and pressure relieving cushion in chair. DON also indicated the resident was being treated by the wound clinic. When asked why the wound clinic orders were not followed, DON explained with use of the Vaseline the wound got worse and the wound was almost healed. DON indicated they went back to what the wound nurse had recommended for treatment previously.
R6's hospital discharge summary dated 2/18/16 included diagnoses of diabetes type II, dysphagia, urinary incontinence, and indicated right heal decubitus ulcers were present on hospital admission. The summary indicated a below the knee amputation (BKA) was performed on 2/15/16, related to significant osteomyelitis (infection of the bone) of the left heel and chronic wound. The hospital discharge summary included orders; "Wound care to buttock is barrier cream 3 times a day after washing with soap and water."
R6 ' s progress notes were reviewed since the time of admission 2/18/16 to 5/3/16, progress note dated 2/22/16 identified a new stage 2

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2 900	Continued From page 21	2 900		

pressure ulcer on the right buttock. Progress notes indicate worsening of the pressure ulcer to a stage 3 and the development of a new stage 2 pressure ulcer on the left buttock on 3/1/16. The record lacked ongoing assessment and monitoring of the left buttock ulcer; 3/1/16 is the only date that ulcer is mentioned in nursing assessments and progress notes. R6 ' s record indicated the pressure ulcer was healing until 4/26/16 when the resident went to the wound clinic. On asking for a comprehensive assessment of these pressure ulcers as they developed and was given progress notes included some of the pressure ulcers being comprehensively assessed and others no assessment noted. Also the pressure ulcers were not given location so ongoing monitoring included "wound healing" but not sure which wound or when the wound healed.
R6's progress note dated on 4/23/16 indicated the abrasions were nicely healing.
R6's wound clinic note dated 4/26/16 reported, "Wound care to right and left medical buttock today with acetic acid 0.25% soak to help remove what appeared to be old pieces of dressing material or possible tape. There is a significant amount of friction shearing injury to medial bilateral buttocks evidenced by jagged skin edges. Photograph taken today. Please cleanse the buttocks gently with soap and water with each brief change and prior to replicating the zinc barrier based cream to open areas. Cleanse to help reduce build up of barrier cream. Return to wound clinic in 2 weeks for follow-up to reevaluate."
R6's physician note dated 4/27/16 included, "follow up visit 4/26/16 with wound nurse over at [hospital name]. I did get a call from wound nurse. She reports that she had to remove a lot of "old tape/dressing/from the wounds ...that they look so

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2 900	Continued From page 22 much worse." That they had to soak it [zink paste] off with acidic acid x [times] 10 minutes. She reports that she did take a photo of the skin on his bottom. She asks that we make sure we wash the bottom before applying the creams, either with soap and water or wipes. She requests that a 'zinc based' cream be applied. That we could cover it with an ABD pad or non adherent pad to protect it. I did report to [wound nurse] that resident is on his bottom more these days whether in bed or chair. She was pleased to see he had a cushion in the chair" and "Nursing staff did discuss residents daily activities since tube feeding started. He is on his bottom more. Tube feeding 4 x day where he has to be upright. Up in chair to eat which can take an hour just to do this. Then therapy works with him at least 2 hours a day. Staff do try to put him on his side when possible." R6's admission Minimum Data Set (MDS) dated 2/25/16, indicated the resident had severe cognitive impairment with a brief interview for mental status score of 6, was totally dependent on staff for activities of daily living that involved mobility, had range of motion impairments of both upper and lower extremities, was always incontinent of bowel, and had an indwelling Foley catheter. R6's care area assessment (CAA) dated 2/27/16 included, pressure ulcer presents on right buttock, right great toe and heel. The CAA identified risk factors including friction and shear, "slides down in the bed, moved by sliding rather than lifting," and pressure related to "requires staff assistance to move sufficiently to relieve pressure over any one site confined to bed or chair most of the time. Requires pressure reducing mattress or seat cushion." Additional risk factors were identified as immobility, cognitive loss, newly admitted, bedfast or	2 900		

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2 900	Continued From page 23 wheelchair bound, dependent on staff for all mobility, and recent history of pressure ulcers. The CAA reported, "Will develop care plan-staff to change position every 2 hours. Encourage him to lay on side when in bed. Consult with the wound nurse." R6's care plan for pressure ulcers dated 2/19/16 included skin interventions however, they were generalized and not resident specific. Also the resident's care plan did not include revision following completion of a CAA on 2/27/16, to include presence and location of ulcers, risk factors or interventions. Interventions identified on the CAA included the use of the pressure reducing mattress or seat cushions, and reposition schedule of every 2 hours. Facility policy Treatment and Prevention of Pressure Ulcers last reviewed 5/2015 included: "It is the policy of this facility to properly identify and assess resident whose clinical conditions increase the risk for the development skin issues, and pressure ulcers, to implement preventative measures, and to provide appropriate treatment measures for pressure ulcers according to the AHCPR [Agency for Health Care Policy and Research] guidelines." The policy addresses risk identification and instructs to complete assessments to determine the risk, implement prevention protocols and develop the care plan. The policy also included direction for pressure ulcer treatment: "initiate skin and wound care protocols, implement care plan for treatment and prevention pressure ulcers, and initiate a weekly wound progress sheet with the onset of any skin condition," and "Documentation in the nurse notes and on the weekly wound progress sheet at a minimum weekly, to include specific wound description, size, depth, character of drainage, odor, character of tissue in wound and	2 900		

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2 900	Continued From page 24 surrounding tissue." The policy instructed staff to use the prescribed treatment and update the care plan as needed. The policy also indicated the facility's quality assurance committee was responsible for pressure ulcer prevention, monitoring, evaluation, and staff education. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review their policies and procedure in reporting pressure ulcers to the physician, and could review procedures for pressure ulcer prevention and treatment. The DON or designee could then educate staff and test for compentency. The DON or designee could then develop a routine auditing system as part of the quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly clean and store nebulizer equipment between uses for 1 of 1 resident (R22) reviewed for infection control practices.	21375	corrected	6/10/16

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21375	Continued From page 25 Findings include: R22's face sheet, dated 2/8/16, indicated that the resident had a diagnosis of chronic obstructive pulmonary disease with acute exacerbation (a progressive disease that makes it hard to breathe). R22's physician orders, dated 4/06/16, indicated that the resident had been prescribed Albuterol Sulfate 2.5 mg (milligrams)/3 ml (milliliters) 0.083% Nebulization solution: 1 inhalation three times a day (a medication used to relax the airway muscles and increase airflow to the lungs). R22's care plan, dated 2/9/16, indicated that the resident had an ineffective breathing pattern related to an altered respiratory status. Interventions set in place to address this problem was to administer R22's medications as ordered; the care plan also advised to address infection precautions. R22's medication summary report, reviewed from 4/6/16 through 5/2/16, indicated that the resident had been receiving the Albuterol Sulfate nebulization solution as prescribed. During an observation on 5/2/16 at 5:18 p.m., R22 was sitting in his room in his reclining chair. At the resident's table next to his recliner there was a nebulizer machine. The tubing was connected to the machine; a mask and canister (where the medication is placed) were connected to the tubing. There was condensation in the canister. Upon closer inspection, there appeared to be a small amount of fluid at the bottom of the canister. R22 stated that there was a "little bit" of fluid in the bottom of the canister. R22 explained that staff would set up the medication for him to	21375		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 26 take; they would leave the room while he took the medication. During an observation with the Director of Nursing (DON) on 5/2/16 at 8:00 p.m., R22 was in his room sitting in his reclining chair. The nebulizer machine was on a table next to the resident's recliner. The tubing was connected to the machine and the mask and canister were connected to the tubing. There was condensation in the canister where medication is placed. There was a small amount of liquid in the bottom of the canister. The DON stated there was a small amount of liquid on the bottom of the canister. R22 stated that he had last used the nebulizer machine to administer the medication around 4:00 p.m. The DON stated that the nebulizer equipment should have been cleaned out after its use and stored properly. Review of the facility policy titled, "Nursing Policy: Cleaning a Nebulizer" (April 2004), it stated that the facility would maintain the cleanliness of the nebulizer equipment. It stated that cleaning the nebulizer equipment would help prevent germs that could cause infection. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could inservice employees who are responsible for the cleaning and sanitizing of nebulizer units to store them according to manufactures instructions. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage	21610		6/10/16

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	00073	A. BUILDING: _____ B. WING _____	05/05/2016

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21610	Continued From page 27 Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medication refrigerator temperature was maintained within an acceptable range for 1 of 2 medication refrigerators revived for medication storage. This had the potential to affect 4/4 residents (R15, R36, R5, and R9) who had medications stored in the south medication refrigerator. Findings include: On 5/5/16, at 8:23 a.m. the south medication refrigerator temperature was 48 degrees Fahrenheit (F). registered nurse (RN)-A verified this reading on the thermometer, and stated it was 2 degrees above the acceptable range for the insulin stored in there. RN-A was unable to find a current temperature log for the refrigerator to identify when temperature became unacceptable in refrigerator. The refrigerator contained: Two Novolog insulin pens (used to treat diabetes) dispensed 3/9/16 for R15 Five Lantus SoloStar insulin pens (used to treat diabetes) dispensed 4/18/16 for R15 Five Lantus SoloStar insulin pens dispensed 5/2/16 for R36 Five Novolog insulin pens dispensed 3/28/16 for R36 Two Lantus SoloStar insulin pens dispensed	21610	corrected	

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21610	Continued From page 28 5/3/16 for R5 Three Lantus SoloStar insulin pens dispensed 5/3/16 for R9 During interview on 5/5/16, at 1:22 p.m. RN-A stated she verified with facility pharmacist any insulin out of the recommended temperature of 36-46 degree F is only good for 28 days or 28 days from dispense date. RN-A stated insulin pens within the 28 days all dated as opened with dispense date now and those past the 28 days disposed of. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper temperature for storing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21610		
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	21880		6/10/16

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21880	Continued From page 29 Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to resolve a grievance for 1 of 1 resident (R32) who's family member had verbalized a concern and there was no documentation on the grievance. Findings Include:	21880	corrected	

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21880	Continued From page 30 R32's family member (FM)-A had been interviewed on 5/3/16, at 12:36 p.m. FM-A stated she had a concern with [R32's] clothes being washed by the facility despite the signs posted in her room indicating family will do laundry. FM-A stated the staff did not read the signs and they washed her clothes in the laundry. FM-A stated she also finds R32's clothing draped over the chairs in her room. FM-A stated she has taken pictures of R32's room and she had shared these concerns with the facility staff and felt nothing was done about the concern. On 5/5/16, at 8:50 a.m. during the environmental tour with maintenance (M)-A verified there were pants draped over the back of the chair in R32's room. On 5/05/2016, at 10:37 a.m. the administrator stated she was aware of the family concern with R32's laundry and audits had been completed on the room to monitor to ensure the concern with clothing being draped over the chairs was addressed. The administrator stated she did not have written audits or documentation of the concern and stated there was nothing formally written regarding the family concerns but we have had meetings with the family. The administrator stated she expected R32's clothes to be placed in the hamper by the staff and not draped over the furniture. The administrator stated the facility had complaint forms, however a complaint form had not been completed by the facility or family at this time regarding the concerns with R32's laundry. The administrator stated we talk about the complaint forms upon admission and have at previous family council meetings. The administrator stated this family concern should have had a formal grievance filled out by the	21880		

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21880	Continued From page 31 facility to address the concern. On 5/05/2016, at 11:29 a.m. nursing assistant (NA)-A stated she was not aware of any family concerns related to R32's clothing being draped over the chair in her room. NA-A stated usually communication was completed by email to alert us of resident or family concerns. NA-S stated she was not aware of any concerns with R32's clothing other than family did her laundry. On 5/05/2016, at 11:32 a.m. NA-B stated she was unaware of any concerns voiced by family regarding staff placing clothing over the back of R32's chairs in her room rather than putting them in the laundry hamper. NA-B stated actually just last night, "I learned family did her laundry" another nursing assistant had informed her. NA-B stated has worked at the facility since the end of November 2015 and stated she worked from 8:00 a.m. to 8:30 p.m. NA-B stated she, "Helped R32 get ready for bed and I always took her clothing to the laundry room." NA-B stated now that I know her family does her laundry, I put R32's clothing in the laundry basket in her closet. NA-B stated there were usually signs posted on closets in resident rooms that indicated family did laundry. NA-B verified by observation in R32's room with this writer, there were two signs, one on the closet door and one in the bathroom that indicated family did the laundry. NA-B stated she had "just not noticed these signs before." NA-B stated staff was informed of resident or family concerns through the internal email in the computer charting system. On 5/05/2016, at 11:40 a.m. licensed practical nurse (LPN)-A stated she was unaware of any family concerns related to clothing being placed over the furniture instead of in the hamper for R32. LPN-A stated staff are notified of resident	21880		

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21880	Continued From page 32	21880		

and family concerns by internal communication through email. LPN-A stated signs were are placed in residents' room to alert staff when family was going to complete the laundry. LPN-A stated she was unaware of any concerns with R32's clothing or laundry.

The administrator provided an internal communication to staff dated 12/23/15, regarding FM-A's concerns that included, "...Remember that her room should be straightened up before you leave it. (Soiled products put in waste basket and taken out when you leave the room, cloths hung up or placed in the laundry area ect.)..."

An email from the administrator was received on 5/10/16, following the survey providing additional information regarding FM-A concerns that included: I was reminded that during a meeting with R32's family member on March 8, 2016, family member did ask me if I had written anything up regarding our conversations. I stated, "No, would you like me to do that?" Family member stated, "No."...The social worker was also present and stated we did not write anything up as this is not how we handle our grievance. They are informed in the admission agreement and it is discussed regarding how to proceed. The opportunity is there for them to initiate a grievance if needed.

The Caledonia Care and Rehab Administration Grievances and Complaints undated policy, indicated Caledonia Care and Rehab wanted the experience of each resident in its various programs to be a positive one. Persons who had concerns about the services and care given them are encouraged to report them to the employee who was caring for them. The employee to whom the concerns were reported would, whenever

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21880	Continued From page 33 possible, resolve these concerns. If the concerns were not resolved, the resident, the employee or anyone aware of the concerns, is to refer to the Procedure for General Grievances. A grievance or complaint must be in writing, contain the name and address of the person filing it, and briefly describe the complaint. SUGGESTED METHOD OF CORRECTION: The Director of Nursing and/or designee could review and revise policies pertaining to handling resident grievances, educate staff on these policies and perform audits to ensure each resident grievance has been addressed by the facility. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21880		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or	21980		6/10/16

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21980	Continued From page 34 (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of missing monies had been immediately reported to the State Agency for 1 of 4 residents (R49) who made an allegation of monies stolen. Findings included:	21980	corrected	

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21980	Continued From page 35 R49's incident report dated 3/12/16 at 5:18 p.m. reported, R49 had reported missing 30 dollars from his billfold from his top drawer. The report indicated a copy of the report would be given to the administrator and the social worker. The facility investigation form indicated the administrator, director of nursing, and social worker were not notified until 2 days later on 3/14/16 a.m. at 9:00 a.m. The incident was not reported to the State Agency until 2:30 p.m. on 3/14/16. During an interview on 5/5/16, at 2:39 p.m. director of nursing stated, no staff investigations were performed to rule out abuse, and "I can't say why I followed up on this the next day." The facility Vulnerable Adult Policy last reviewed 8/2014 included: The policy informed staff, "At Caledonia Care & Rehab, report immediately, any incidents you feel may be abuse or neglect to the Director of Nursing, Social Worker, Administrator, or the Charge Nurse for the nursing home." The policy indicated staff may also report to the Common Entry Point and the sheriffs office. The Abuse/Neglect policy explained designated reporters "will review the incident and determine if it is reportable under these policies and procedures. Incidents that are reportable will be reported immediately to the Minnesota Department of Health, Office of Health Facility Complaints (OHFC) via their secure website, and to the Common Entry Point (CEP) via fax, which is Houston County Human Service Department, (phone number). "Any reports of suspected or witnessed abuse or neglect will promptly be made to the charge nurse or person in administrative authority," "The administrator will be notified of the alleged incident immediately." The policy explained if incidents are determined to be reportable they	21980		

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21980	Continued From page 36 are immediately reported and then an internal investigation is conducted. "All reports of abuse/neglect will be maintained including a record of the internal review and investigation of these cases. These records shall contain the incident/Accident Report, Investigation form, Initial OHFC report and the Investigative Report to OHFC." SUGGESTED METHOD OF CORRECTION: The facility could review their policies and reporting systems to ensure sustainability and make modifications where needed. The facility could then educate staff on their reporting responsibilities and test for competency. The facility could then develop and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21980		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by:	21995		6/10/16

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21995	Continued From page 37 Based on interview and document review, the facility failed to implement their vulnerable adult policy to ensure allegations maltreatment are immediately reported to the State Agency for 1 of 4 residents (R49) reviewed for abuse neglect protocol and failed to report and investigate. Findings included: R49's incident report dated 3/12/16 at 5:18 p.m. reported, R49 had reported missing 30 dollars from his billfold from his top drawer. The report indicated a copy of the report would be given to the administrator and the social worker. The facility investigation form indicated the administrator, director of nursing, and social worker were not notified until 2 days later on 3/14/16 a.m. at 9:00 a.m. The incident was not reported to the State Agency until 2:30 p.m. on 3/14/16. During an interview on 5/5/16, at 2:39 p.m. director of nursing stated, no staff investigations were performed to rule out abuse, and "I can't say why I followed up on this the next day." The facility Vulnerable Adult Policy last reviewed 8/2014 included: The policy informed staff, "At Caledonia Care & Rehab, report immediately, any incidents you feel may be abuse or neglect to the Director of Nursing, Social Worker, Administrator, or the Charge Nurse for the nursing home." The policy indicated staff may also report to the Common Entry Point and the sheriffs office. The Abuse/Neglect policy explained designated reporters "will review the incident and determine if it is reportable under these policies and procedures. Incidents that are reportable will be reported immediately to the Minnesota Department of Health, Office of Health Facility Complaints (OHFC) via their secure website, and to the Common Entry Point (CEP) via fax, which is Houston County Human Service Department,	21995	corrected	

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21995	Continued From page 38 (phone number). "Any reports of suspected or witnessed abuse or neglect will promptly be made to the charge nurse or person in administrative authority," "The administrator will be notified of the alleged incident immediately." The policy explained if incidents are determined to be reportable they are immediately reported and then an internal investigation is conducted. SUGGESTED METHOD OF CORRECTION: The facility could review their policies and reporting systems to ensure sustainability and make modifications where needed. The facility could then educate staff on their reporting responsibilities and test for competency. The facility could then develop and implement an auditing system as part of their quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Three (3) days.	21995		