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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TX2E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00329

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245382**
2.STATE VENDOR OR MEDICAID NO.
(L2) **134242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MADISON LUTHERAN HOME**
(L4) **900 SECOND AVENUE**
(L5) **MADISON, MN** (L6) **56256**

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)

6. DATE OF SURVEY **07/29/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Miriam Thornquist, HFE NEII 08/14/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Heath
Enforcement Specialist 09/24/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/24/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/22/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5382

A partial extended and a extended survey were completed at this facility. Conditions in the facility during both the partial extended and the extended survey constituted Substandard Quality of Care (SQC) to resident health or safety.

As a result of the survey findings, this Department recommended to the CMS Region V Office the following remedy for imposition:

-Mandatory Denial of Payment for New Mediare and Medicaide admissions, effective July 30, 2014

The facility would be subject to a two year loss of NATCEP beginning May 21, 2014 as a result of the extended and partial extended surveys, where SQC was identified.

On July 29, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 2, 2014 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 partial extended survey, completed on April 30, 2014 and an extended survey completed on May 21, 2014. Based on our revisit, the facility has corrected the deficiencies issued pursuant to the partial extended survey and the extended survey, effective July 29, 2014.

Since the facility attained substantial compliance, the remedy of Mandatory Denial of Payent for new Medicare and Medicaid admissions, effective July 30, 2014, will not be imposed.

However, The facility would be subject to a two year loss of NATCEP beginning May 21, 2014 as a result of the extended and partial extended surveys, where SQC was identified.

Refer to the CMS 2567b for the results of this visit.

Effectived July 29, 2014, the facility is certifitied for 80 skilled nursing facility beds.

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5382

August 14, 2014

Ms. Calista Bergerson, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

Dear Ms. Bergerson:

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 progra.

Effective July 29, 2014 the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

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

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 14, 2014

Ms. Calista Bergerson, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

RE: Project Number S5382023, H5382011

Dear Ms. Bergerson:

On June 16, 2014 this Department imposed the Category 1 rememdy of State monitoring, effective June 16, 2014.

On July 14, 2014, the CMS Region V office informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 30, 2014. (42 CFR 488.417 (b))

Also, CMS notified you in their letter of July 14, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 30, 2014.

This was based on the deficiencies cited by this Department for a partial extended survey completed on April 30, 2014 an an extended survey completed on May 21, 2014, where conditions in the facility at the time of both surveys constituted Substandard Quality of Care (SQC) to resident health or safety. The most serious deficiencies in your facility at the time of the partial extended survey completed on April 30, 2014 and the extended survey completed May 21, 2014 were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On July 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on July 2, 2014 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 partial extended survey, completed on April 30, 2014 and an extended survey completed on May 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 14, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our partial extended survey, completed on April 30, 20114

and our extended survey completed May 21, 2014, as of July 29, 2014.
As a result of the PCR findings, this Department discontinued the Category 1 remedy of State monitoring, effective July 29, 2014

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our their letter of July 14, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective July 30, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective July 30, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective July 30, 2014, is to be rescinded.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Madison Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective April 30, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

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

Sincerely,

Mark Meath

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

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

AH Form Approved
8/14/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00329	A. Building B. Wing	7/28/2014

Name of Facility	Street Address, City, State, Zip Code
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **21980** Reg. # **MN St. Statute 626.557 Subd. 3** LSC	**07/14/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/30/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

Health

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245382	A. Building B. Wing	7/29/2014

Name of Facility	Street Address, City, State, Zip Code
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **07/14/2014**
ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/14/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/14/2014**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/29/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **07/14/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **07/14/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/29/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **07/14/2014**	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GA/mm	08/14/2014	31593	07/29/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 5/21/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245382	A. Building B. Wing 01 - MAIN BUILDING 01	7/2/2014

Name of Facility	Street Address, City, State, Zip Code
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0029	**05/22/2014**	ID Prefix Reg. # **NFPA 101** LSC K0144	**05/21/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 08/14/2014	**Signature of Surveyor:** 22373	**Date:** 07/02/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 5/19/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

OHFC

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245382	A. Building B. Wing	7/28/2014

Name of Facility	Street Address, City, State, Zip Code
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (** LSC	**07/14/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	**07/14/2014**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 4/30/2014	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 9, 2014

Ms. Calista Bergerson, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

Re: Enclosed Reinspection Results - Complaint Number H5382011

Dear Ms. Bergerson:

On July 28, 2014 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on April 30, 2014. At this time these correction orders were found corrected.

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

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

Sincerely,

Mark Meath

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

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

cc: Licensing and Certification File

AH Form Approved
8/14/2014

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00329	A. Building B. Wing	7/29/2014

Name of Facility	Street Address, City, State, Zip Code
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **21980** Reg. # **MN St. Statute 626.557 Subd. 3** LSC	Correction Completed **07/14/2014**	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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By KL/mm	Date: 08/14/2014	Signature of Surveyor: 30339	Date: 07/29/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/30/2014		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: TX2E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00329

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245382**

2.STATE VENDOR OR MEDICAID NO.
(L2) **134242800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MADISON LUTHERAN HOME**
(L4) **900 SECOND AVENUE**
(L5) **MADISON, MN** (L6) **56256**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/21/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 07/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
07/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5382

On April 30, 2014 a partial extended survey (complaint investigation number H5382011) was completed at this facility. Conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. In addition, on May 21, 2014 an extended survey was completed at this facility. Conditions in the facility continued to constituted Substandard Quality of Care (SQC) to resident health or safety. As a result of continous non compliance, this Department recommended to the CMS Region V Office the following remedy for imposition:

-Mandatory Denial of Paymetn for New Mediare and Medicaide admissions, effective July 30, 2014

As a result of both the partial extended and extended surveys, the facility would be subject to a two year loss of NATCEP, effective April 30, 2014.

Furthermore, this Department recommended the following additional remedy for imposition:

- A Civil Money Penalty for deficiency cited at F226

Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

June 11, 2014

Ms Kathy Johnson, Administrator
Madison Lutheran Home
900 Second Avenue
Madison, Minnesota 56256

RE: Project Number S5382023, H5382011

Dear Ms. Johnson:

On May 6, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department's Office of Health Facility Complaints for a partial extended survey, completed on April 30, 2014. Conditions in the facility at the time of the partial extended survey constituted Substandard Quality of Care (SQC) to residents health or safety. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On May 21, 2014, the Minnesota Departments of Health and Public Safety completed an extended survey and determined conditions in the facility at the time of the extended survey continued to constitute SQC to residents health or safety. The extended survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm, with potential for more than minimal harm that was not immediate jeopardy (Level F), where corrections are required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, this Department is recommending to the CMS Region V Office the following remedy for imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 30, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify you o f their determination regarding the remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP).

Since findings during the partial extended survey verified deficiency cited a F226 with conditions in the facility that constituted Substandard Quality of Care (SQC) to resident health or safety, and new findings were found at the same deficiency cited F226 and conditions in the facility continued to constitute SQC to resident health or safety. This Department is imposing the Category 1 remedy of State monitoring, effective June 16, 2014.

Furthermore, this Department is recommending the following additional remedy to the CMS Region V Office for imposition:

- A Civil money penalty for deficiency cited at F226 (42 CFR 488.430 through 488.444)

As we notified you in our letter of May 6, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 30, 2014.

The CMS Region V Office will notify you of their determination regarding the remedies, Nursing Training and/or Compentency Evaluation Programs (NATCEP).

> **Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;**
>
> **Appeal Rights - the facility rights to appeal imposed remedies;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **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.**

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the**

following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.
Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Madison Lutheran Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective April 30, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be

in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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:

Gail Anderson, Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health

Phone: (218) 332-5140
Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review

and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 July 30, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 30, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited

deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

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

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

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

Sincerely,

Mark Meath

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245382	A. BUILDING _____ B. WING _____	05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

(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. An extended survey was conducted on 5/18/14 thru 5/21/14	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164		7/14/14

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

Electronically Signed | 06/20/2014

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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F 164	Continued From page 1 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medically prescribed diet textures for 10 of 18 residents (R29, R50, R42, R14, R49, R1, R17, R16, R28 and R15) who received meals in the station one dining room, remained confidential. Findings Include: During observation of the evening meal in the station-one dining room on 5/18/14, at 5:23 p.m. there were two, 8.5 by 11 inch, paper postings, one lime green colored and one white colored, taped to the outside of a window in front of the food service area. The lime green posting listed the names of eight residents (R29, R50, R42, R14, R49, R1, R17, and R16) and identified they were to receive a mechanical soft diet. The lime green posting also noted the resident names of R28 and R15, revealing they were to receive a pureed diet. In addition, the white posting listed the names of the same eight residents who were to receive a mechanical soft diet (R29, R50, R42, R14, R49, R1, R17 and R16), and noted those	F 164	MLH will ensure the resident has the right to personal privacy and confidentiality of his/her personal and clinical records. MLH will keep confidential all information contained in the resident's records, regardless of the form or storage methods. MLH removed the list of prescribed diet textures for 10 residents (R29, R50, R42, R14, R49, R1, R17, R16, R28 and R 15) from all public areas, including both dining rooms, to provide confidentiality per HIPPA policy. HIPPA policy will be reviewed in reagards to confidentiality with all dietary staff at July 1st in-serive and nursing staff at 6/16/14 and 6/20/14 meetings. Dietary Manager, or designee, will audit and record compliance at least 1 time per week. Reports of audits will be taken to	

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F 164	Continued From page 2 residents were not to receive toast due to their mechanical soft diet restriction. Both postings were able to be read by any resident, family or visitor who entered the food service area of the station one dining room. On 5/18/14, at 5:23 p.m. licensed practical nurse (LPN)-A stated the signs had been posted to ensure residents received the correct diet and to ensure the residents on mechanical soft diets, did not receive toast. She indicated dietary staff and nursing assistants were double checking the residents' diets for accuracy and the posted signs were the avenue with which they communicated this information. On 5/18/14, at 6:11 p.m. registered nurse (RN)-A reported the notes were posted because a resident had received the wrong diet in the past and staff began to question whether they had the correct, prescribed diet information. In addition to the lime green and white paper postings, the station one dining room had implemented various check-points to verify accurate food consistency. On 5/18/14, at approximately 7:30 p.m. the director of nursing (DON) verified the posted information, confirming the confidential, medically prescribed diet textures for R29, R50, R42, R14, R49, R1, R17, R16, R28 and R15 were exposed to any resident, family, or visitor who entered the station one dining room. The DON reported the information was posted in the station one food service area, earlier in the month, prior to 5/5/14. The DON reported she had noticed a couple of residents were receiving diet textures inconsistent with their medically prescribed diet.	F 164	QA on a quarterly basis.	
F 221	483.13(a) RIGHT TO BE FREE FROM	F 221		7/14/14

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F 221 SS=D	Continued From page 3 PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the use of a mechanical recliner with a built-in foot rest, was assessed as a potential restraint for 1 of 2 residents (R59) reviewed for restraints. Findings include: The quarterly Minimum Data Set (MDS) dated 2/28/14, indicated R59 had severely impaired cognition, with diagnoses including Alzheimer's disease and glaucoma. The MDS revealed R59 required extensive assistance from staff for all activities of daily living (ADLs), including transfers and ambulation, with the exception of eating. The MDS identified no restraints were used for R59. During observation on 5/18/14, at 3:10 p.m. R59 was observed to be seated alone, in a common area of the facility, in a mechanical recliner with the foot rest elevated. A remote control was attached to a spiral cord along the side of the chair, to her right side out of reach. At 3:40 p.m. R59 was assisted to transfer out of the recliner, to a wheelchair by nursing assistant (NA)-C and another nursing assistant. During interview on 5/18/14, at 3:36 p.m. nursing assistant (NA)-C confirmed R59 was unable to	F 221	Resident R59 had an Occupational Therapy evaluation for Lift Chair Safety completed on 6/16/14. Findings of the evaluation indicate that R59 cannot operate the chair alone and requires total assistance; the remote control is to be placed in the side pocket of the chair because the resident can not safely operate it. Initial Assessment for use of Restraint/Adaptive Equipment was completed on 6/18/14 and the resident will continue to have quarterly Restraint/Adaptive Assessments completed. After assessments were completed it was determined that the Electric Lift Chair is not a restraint device, rather an assistive device related to transfers and her request for comfort. Care plan was updated on 6/18/14 to reflect assessment findings on use of Electrical Lift Chair. R59 family was educated on residents inability to use the electric lift chair independently and agreed to sign an Electric Lift Chair Acknowledgment Form to allow the resident continued use of recliner on 6/19/14. MLH developed an Electrical Lift Chair	

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F 221	Continued From page 4 get out of the recliner independently and required staff assistance to do so. During observation on 5/18/14, at 3:49 p.m. NA-G and NA-D transferred R59 from her wheelchair to the mechanical chair. NA-G used a remote control to elevate the foot rest. The remote control was then placed out of R59's reach, into a side pocket, at the bottom of the mechanical chair. At 3:51 p.m. NA-G and NA-D exited R59's room, with R59 reclined back in the recliner, legs elevated and remote control out of reach for R59. During interview on 5/20/14, at 11:34 a.m. NA-B reported R59 sat in mechanical recliners with her legs elevated in her resident room and in the lobby on a daily basis. NA-B then stated when R59 was not at a meal, she was most often in a recliner. NA-B reported R59 was not able to get out of the recliners without staff assistance. NA-B added, "I don't [do not] believe she would be able to move, we lay her way back." R59's clinical record was reviewed and lacked evidence to indicate mechanical recliners, with elevated foot rests, were identified and/or assessed as a restraint. During interview on 5/20/14, at 11:46 a.m. registered nurse (RN)-C stated R59 spent the majority of her time in mechanical recliners with her legs elevated, with the exception of mealtimes and/or activities. RN-C confirmed R59 had never attempted to get out of the recliners while reclined with her legs elevated. RN-C added that R59 had only attempted to get out of a wheelchair, which subsequently resulted in her falling. RN-C reported that staff were expected to leave the recliner's remote control with R59;	F 221	Policy on 6/14/14 and all current and future residents will follow the new policy. All current and future residents who use Electric Lift Chairs will have an evaluation from Occupational Therapy or a Registered Nurse along with an Initial Restraint/Adaptive Equipment Assessment completed by July 14th. Assessments will be done on a quarterly basis. Any resident found to be unable to appropriately use a lift chair will have an Acknowledgement Form signed by themselves, family or guardian before use. Use of Electric Lift Chair assessment finding will be reflected in their individual care plans. Audits of charts for any resident using an electric lift chair will be completed to verify that an OT evaluation for Lift Chair Safety, an Initial Assessment for use of Restraint/Adaptive Equipment and an Electric Lift Chair Acknowledgment Form has been signed, if indicated, is present in the chart. These audits will be completed by 7/11/14 and taken to QA for review. All staff will be educated on the new Electrical Lift Chair Policy, Restraint/Adaptive Equipment use and need for evaluations at all staff meetings held on June 16th & June 20th. Responsible Person Director of Nursing and/or Designee.	

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F 221	Continued From page 5 however, RN-C confirmed R59 would not have been able to operate the electronic remote control due to her impaired cognition. RN-C confirmed R59 was not able to get out of the mechanical recliner without assistance from staff, when reclined with the foot rests elevated. RN-C verified this meant R59 did not have freedom of movement while in the recliner. RN-C reported the therapy department needed to assess R59 for her use of the recliner with the electrical remote. RN-C confirmed there had been no therapy evaluation or restraint assessment completed to date. During interview on 5/20/14, at 12:45 p.m. the director of nursing (DON) reported R59 did not attempt to get out of the mechanical recliners and had not fallen from them. The DON stated occupational therapy (OT) evaluated residents for their use of mechanical recliners and remote controls, to determine whether they were a restraint. The DON was unable to confirm whether R59 was able to appropriately use a remote control for mechanical recliners. The facility's Physical Restraint and Devices Policy dated 11/11, directed the facility to strive for a restraint free environment. The policy defined a physical restraint as any manual method, physical or mechanical device, material, or equipment, attached or adjacent to a resident's body that could not be easily removed by the individual and restricted their freedom of movement or normal access to their body.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		7/14/14

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F 225	Continued From page 6 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 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	F 225	MLH will not employ individuals who have	

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F 225	Continued From page 7 facility failed to immediately report 3 of 3 incidents of potential resident-to-resident abuse and report of staff rough treatment to the facility administrator and State agency (SA) for 2 of 2 residents (R52 and R43) involved in the incidents reviewed. Findings include: R52's quarterly Minimum Data Set (MDS) dated 3/10/14, identified R52 was cognitively intact, with diagnoses which included persistent mental disorder. R43's quarterly MDS dated 4/21/14, identified R43 had severely impaired cognition, with diagnoses which included dementia with behavioral disturbances and depression. Review of the VA reports from 4/29/14 to 5/18/14 revealed the following: 1. Review of the vulnerable adult (VA) report dated 4/29/14, identified R52 experienced mistreatment identified as physical abuse. The VA identified R43 had pinched R52 on 4/28/14, while he was trying to pick up a shoe off the floor in the dining room. The pinch resulted in a U-shaped skin tear to R52's left forearm, measuring 15.5 centimeters long. R52 stated he did not know why R43 pinched him. The time of notification to the facility administrator was not specified on the report or progress notes and could not be identified by the facility. The SA was notified on 4/29/14, although the time of notification was not specified and could not be identified by the facility. The report included the investigation done by the facility determined R43 had behaviors and the facility would monitor for	F 225	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 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. MLH will 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 or their designee, the State Agency and to other officials in accordance with State law as outline in the facilities Vulnerable Adult and Elder Justice Policies that were reviewed and revised in May 2014 and again in June 2014 to further clarify immediately report. Documentation of immediate notification to the administrator or their designee will be kept with the VA report in the DON office. Folders with step-by-step direction for filing a VA, along with updated policies and algorithms for Injuries of Unknown Sources and Resident-to-Resident Altercations, were put at both nursing stations on 6/6/14 and nurses were educated on them on 6/16/14. Vulnerable Adult/Elder Justice information and examples/scenarios will continue to be discussed at all monthly meetings	

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F 225	Continued From page 8 further occurrences. 2. Review of the VA report dated 5/19/14, at 4:35 p.m. identified on 5/19/14, R43 had sustained physical abuse from R52. R52 was observed at breakfast hitting R43 and telling her to drink her juice. When questioned, R52 stated he was pushing on her arm to make her drink her juice. Staff witnessed the incident and verified R52 hit R43. The report had been submitted 7 hours after incident had occurred. The report did not indicate if and when the administrator had been notified of the potential resident to resident abuse. The report included the facility investigation identified R52 and R43 had a history of being rough with each other, and R52 had a history of hitting R43 and the facility would monitor for further occurrences. 3. Review of the VA report dated 5/20/14, at 2:35 p.m., identified on 5/18/14, R52 was observed with multiple bruises on mid and lower back. R52 stated he felt staff were too rough with him during cares and caused the bruises. The report identified the administrator had been notified on 5/20/14, at 10:50 a.m. (greater than 35 hours later) of the allegation of rough treatment by staff. The State agency had been notified greater than 39 hours after the incident occurred. During interview with DON on 5/20/14, she indicated the investigation was still in progress. Review of R52's progress notes from 4/28/14 to 5/20/14 revealed the following: - On 4/28/14, at 9:47 p.m. R52 was observed to have a large skin tear with moderate amount of blood on his arm. The skin tear measured 15.5 centimeters (cm) in length. R52 reported R43	F 225	beginning with the staff meetings on 6/16/14 and 6/20/14. MLH will plan to initiate the "Hand In Hand" Dementia training starting mid July. An IDT team including but not limited to the DON, Clinical Care Coordinator, Charge Nurse and Social Services will conduct a thorough investigation of all alleged violations and report the investigation findings to the administrator or their designee 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 allegation is verified, appropriate corrective action will be taken. The employee who is allegedly the abuser will be suspended during the investigation. Based on a thorough investigation, corrective action will be taken. All reporting and investigative documentation will be maintained by the Director of Nurses. The Director of Nurses and selected staff has begun, and will continue on a minimum of a quarterly basis, conducting face to face interviews with all residents to determine if there are concerns of safety in the facility. All concerns will be reported to the administrator or their designee and to other officials in accordance with State law and the IDT team will do a thorough investigation. The Director of Nurses will keep all interview documentation on file for seven years.	

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F 225	Continued From page 9 had pinched his arm, causing the skin tear. R52 reported he did not know why R43 had pinched his arm. The record lacked evidence the potential resident to resident abuse had been immediately reported to the administrator and SA. -On 5/18/14, at 10:32 p.m. revealed R52 had multiple large bruises throughout his back and upper chest. An open wound to his lower-left back, was also noted and was covered with a Tegaderm dressing (a medicated dressing used to promote healing of the skin). The progress note indicated the nurse manager was shown the bruises and nursing staff were to continue to monitor for further bruising. -On 5/18/14, at 11:03 p.m. while observing the bruises to his back and upper chest, R52 stated, "There are people here that are rough with me, but I'm not going to say names... They are not very careful." The progress note indicated a message was left with register nurse (RN)-B and R52's social worker regarding this statement. R52's clinical record lacked evidence to indicate the bruising with allegations of rough treatment by staff identified in the progress note on 5/18/14, at 11:03 p.m. were reported to the facility administrator and SA. -On 5/19/14, at 9:26 a.m. R52 was observed hitting R43 during the breakfast meal and telling her to drink her juice. When questioned R52 stated he was just pushing on her arm to make her drink her juice. The progress note identified staff had observed the incident and verified R52 hit R43. The record lacked documentation the resident-to-resident altercation had been reported	F 225	Resident R52 was interviewed on 5/21/14 by Social Services after he had c/o staff being rough. He did share with Social Services who the staff member was and stated she is so fast and doesn□t pay attention to my disabilities. The staff member has been put on a work improvement and is being mentored. The DON and Clinical Care Coordinators will continue to supervise that staff member. On 6-10-14, R52 was interviewed by Social Services at which time he stated that he felt safe here and he was not afraid of any staff members. Social Service or the DON (or designee) will continue to interview R52 on a weekly basis for one month. If R52 continues to deny c/o at that time we will extend the interviews to bi-weekly for one month and then proceed to quarterly interviews. Both R43 and R52 care plans have been reviewed on 6/17/14 and indicate interventions to defer resident to resident confrontation. All staff has been educated at staffing meeting on 6/16/14 and 6/20/14 on the importance of monitoring and preventing confrontation between these two residents. Family is well aware of issues and is notified with any concerns. Audits of incident reports and nurses notes on all residents will be completed daily for 1 month or until substantial compliance has been obtained at which time audits will be done randomly throughout the year. All information gathered at interviews and through audits will be reviewed at QA on a quarterly	

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F 225	Continued From page 10 immediately to the facility administrator and SA. The report was submitted to the SA on 5/19/14, at 4:35 p.m. (approximately seven hours after the incident occurred). The notification time to the facility administrator was not specified on the report and could not be identified. During interview on 5/20/14, at 9:06 a.m. the director of nursing (DON) confirmed the current facility policy and verified she was not sure what time the incident of potential resident-to-resident abuse, from 4/28/14, was reported to the SA. At 9:54 a.m. the DON indicated R52 and R43's family confirmed both residents had a long history of roughness with each other. The DON confirmed she was notified by staff of both incidents (from 5/18/14, and 5/19/14), on 5/19/14, but she had not immediately notified the administrator of the incidents. The DON stated that she did not routinely notify the administrator unless he was available. She added that if he was not available, she notified him the next day. The DON confirmed she re-interviewed R52 on 5/19/14, concerning staff roughness, but he would not identify any names during the investigation. The DON verified she had not reported the incident to the SA but would now report it. The DON stated, "We should of reported it," indicated notification to the administrator and the SA. She confirmed the facility had made observations of cares and interviewed R52, and the investigation was complete and indicated the facility should have reported the incident, then completed the investigation. During interview on 5/20/14, at 12:50 p.m. RN-B reported he was not notified of the resident-to-resident incident at breakfast,	F 225	basis. Responsible Person □ Director of Nursing and/or Designee.	

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F 225	Continued From page 11	F 225		

between R43 and R52 on 5/19/14, until sometime after the Noon meal on 5/19/14. RN-B verified he submitted the VA report to the SA for this incident on 5/19/14, at 4:35 p.m. RN-B stated, "It should be reported immediately." Furthermore, he reported that staff were confused about how to handle R52 and R43, so they tended to be more lenient.

During interview on 5/20/14, at 12:57 p.m. RN-B confirmed that he was notified by staff on 5/18/14, of R52's allegations of rough treatment and the bruising to his back and upper chest. RN-B stated, "I did not think abuse with [R52's bruising] because he is on Coumadin [an anti-coagulant/ blood-thinning medication]." RN-B confirmed that this should have been reported to the facility administrator and SA immediately, but had not been.

During interview on 5/21/14, at 10:18 a.m. the administrator confirmed facility staff were expected to notify one of the RNs who worked as a care coordinator or the DON immediately upon suspicion of abuse/mistreatment. The administrator confirmed that the former facility procedure for abuse allegations was to complete the investigation first; however, "[We] have discovered we need to report immediately." The administrator confirmed the policy was updated a year ago to reflect this change. The administrator confirmed staff were notifying him of abuse allegations within 24 hours, rather than immediately, as the current facility policy directed.

Review of the facility's Vulnerable Adult/Elder Justice Act policy revised on 12/11, indicated all residents residing in the facility were to be

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F 225	Continued From page 12 protected from mistreatment and the facility required that all suspected mistreatment be reported to the SA immediately. Furthermore, the policy indicated the DON was to notify the administrator of all suspected mistreatment as soon as possible.	F 225		
F 226 SS=F	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 develop and implement their abuse prohibition policy to include the immediate reporting of abuse/mistreatment and neglect of care to the facility administrator and State agency (SA), related to 3 of 3 incidents of potential resident-to-resident abuse and allegations of staff roughness for 2 of 2 residents (R52 and R43) involved in the incidents reviewed. Findings include: Review of the facility's Vulnerable Adult/Elder Justice Act policy revised on 12/11, indicated all residents residing in the facility were to be protected from mistreatment and the facility required that all suspected mistreatment be reported to the SA immediately. Furthermore, the policy indicated the director of nursing (DON) was to notify the administrator of all suspected	F 226	The facility will 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 or their designee and to other officials in accordance with State law as outline in the facilities Vulnerable Adult and Elder Justice Policies that were reviewed and revised in May 2014 and again in June 2014 to further clarify immediately report . The DON or her designee will report the incident to the administrator or their designee IMEMDIATELY. Documentation of the immediate notification to the administrator or their designee will be kept with the VA report in the DON office. Folders with step-by-step direction for	7/14/14

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F 226	Continued From page 13 mistreatment as soon as possible. During a group interview with registered nurse (RN)-A, RN-C and RN-B on 5/20/14, at 9:58 a.m. RN-A explained that for a report of potential abuse, the facility's procedure was to immediately begin an investigation to find the root cause, interviewing the resident involved and removing the resident(s) from immediate danger. RN-A stated, "Our policy states we have up to twenty four hours," but depending on the severity of the allegations or injuries, it may need to be immediately reported. RN-A further stated, "Physical harm would be immediate." However, RN-A added for verbal abuse, "tapping" a resident, or an incident that did not cause injury, "We have twenty four hours," to report. RN-A confirmed facility staff had received training on abuse prohibition policies and procedures, adding that training was provided facility-wide within the past couple of months. During the group interview, RN-C indicated a report to the SA was to be submitted immediately with the information available at the time, but further stated the SA notification could be reported within 24 hours if no harm was caused. Also during the group interview, RN-B confirmed his understanding was for a suspected abuse allegation to be reported immediately if harm was caused, however, more time was allowed if no injury had occurred. RN-B stated, for example, verbal abuse could be reported up to 72 hours after the incident occurred. During interview on 5/21/14, at 10:18 a.m. the administrator confirmed facility staff were expected to notify one of the RNs who worked as a care coordinator or the DON immediately upon suspicion of abuse/mistreatment. The	F 226	filing a VA, along with updated policies and algorithms for Injuries of Unknown Sources and Resident-to-Resident Altercations, were put at both nursing stations on 6/6/14 and nurses were educated on them at nurses meeting on 6/16/14. Vulnerable Adult/Elder Justice information and examples/scenarios will continue to be discussed at all monthly meetings beginning with the staffing meetings on 6/16/14 and 6/20/14. MLH will plan to initiate the "Hand In Hand" Dementia training starting mid July. All staff will be educated at the upcoming staffing meetings that with any incident, the resident needs to be safe and then they must be reported immediately. Staff will be encouraged to continue reviewing the folders at the station until they are comfortable with the policies and procedure. We will continue to review the VA/Elder Justice policy and steps to file at each monthly meeting for the next 6 months and at that time re-evaluate if continued monthly education is needed. All new employees will have training during orientation on both Vulnerable Adult Abuse and Elder Justice Act. Also, annual training by all staff is to be completed. This training will be monitor by the Human Resources Department. Audits of incident reports and nurses notes on all residents will be completed daily for 1 month or until substantial compliance has been obtained at which	

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F 226	Continued From page 14 administrator confirmed that the former facility procedure for abuse allegations was to complete the investigation first, however, "[We] have discovered we need to report immediately." The administrator confirmed the policy was updated a year ago to reflect this change. The administrator confirmed staff were notifying him of abuse allegations within 24 hours, rather than immediately, as the current facility policy directed. The administrator confirmed the plan was to have staff notify the administrator immediately with abuse allegations, however, he added not all staff had been informed of this. R52's quarterly Minimum Data Set (MDS) dated 3/10/14, identified R52 was cognitively intact, with diagnoses which included persistent mental disorder. R43's quarterly MDS dated 4/21/14, identified R43 had severely impaired cognition, with diagnoses which included dementia with behavioral disturbances and depression. Review of the VA reports from 4/29/14 to 5/18/14 revealed the following: 1. Review of the vulnerable adult (VA) report dated 4/29/14, identified R52 experienced mistreatment identified as physical abuse. The VA identified R43 had pinched R52 on 4/28/14, while he was trying to pick up a shoe off the floor in the dining room. The pinch resulted in a U-shaped skin tear to R52's left forearm, measuring 15.5 centimeters long. R52 stated he did not know why R43 pinched him. The time of	F 226	time audits will be done randomly throughout the year. All information gathered at interviews and through audits will be reviewed at QA on a quarterly basis. Responsible Person □ Director of Nursing and/or Designee.	

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F 226	Continued From page 15 notification to the facility administrator was not specified on the report or progress notes and could not be identified by the facility. The SA was notified on 4/29/14, although the time of notification was not specified and could not be identified by the facility. The report included the investigation done by the facility determined R43 had behaviors and the facility would monitor for further occurrences. 2. Review of the VA report dated 5/19/14, at 4:35 p.m. identified on 5/19/14, R43 had sustained physical abuse from R52. R52 was observed at breakfast hitting R43 and telling her to drink her juice. When questioned, R52 stated he was pushing on her arm to make her drink her juice. Staff witnessed the incident and verified R52 hit R43. The report had been submitted 7 hours after incident had occurred. The report did not indicate if and when the administrator had been notified of the potential resident to resident abuse. The report included the facility investigation identified R52 and R43 had a history of being rough with each other, and R52 had a history of hitting R43 and the facility would monitor for further occurrences. 3. Review of the VA report dated 5/20/14, at 2:35 p.m., identified on 5/18/14, R52 was observed with multiple bruises on mid and lower back. R52 stated he felt staff were too rough with him during cares and caused the bruises. The report identified the administrator had been notified on 5/20/14, at 10:50 a.m. (greater than 35 hours later) of the allegation of rough treatment by staff. The State agency had been notified greater than 39 hours after the incident occurred. During interview with DON on 5/20/14, she indicated the investigation was still in progress.	F 226		

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Review of R52's progress notes from 4/28/14 to 5/20/14 revealed the following:

- On 4/28/14, at 9:47 p.m. R52 was observed to have a large skin tear with moderate amount of blood on his arm. The skin tear measured 15.5 centimeters (cm) in length. R52 reported R43 had pinched his arm, causing the skin tear. R52 reported he did not know why R43 had pinched his arm. The record lacked evidence the potential resident to resident abuse had been immediately reported to the administrator and SA.

-On 5/18/14, at 10:32 p.m. revealed R52 had multiple large bruises throughout his back and upper chest. An open wound to his lower-left back, was also noted and was covered with a Tegaderm dressing (a medicated dressing used to promote healing of the skin). The progress note indicated the nurse manager was shown the bruises and nursing staff were to continue to monitor for further bruising.

-On 5/18/14, at 11:03 p.m. while observing the bruises to his back and upper chest, R52 stated, "There are people here that are rough with me, but I'm not going to say names... They are not very careful." The progress note indicated a message was left with register nurse (RN)-B and R52's social worker regarding this statement. R52's clinical record lacked evidence to indicate the bruising with allegations of rough treatment by staff identified in the progress note on 5/18/14, at 11:03 p.m. were reported to the facility administrator and SA.

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-On 5/19/14, at 9:26 a.m. R52 was observed hitting R43 during the breakfast meal and telling her to drink her juice. When questioned R52 stated he was just pushing on her arm to make her drink her juice. The progress note identified staff had observed the incident and verified R52 hit R43. The record lacked documentation the resident-to-resident altercation had been reported immediately to the facility administrator and SA. The report was submitted to the SA on 5/19/14, at 4:35 p.m. (approximately seven hours after the incident occurred). The notification time to the facility administrator was not specified on the report and could not be identified.

During interview on 5/20/14, at 9:06 a.m. the director of nursing (DON) confirmed the current facility policy and verified she was not sure what time the incident of potential resident-to-resident abuse, from 4/28/14, was reported to the SA. At 9:54 a.m. the DON indicated R52 and R43's family confirmed both residents had a long history of roughness with each other. The DON confirmed she was notified by staff of both incidents (from 5/18/14, and 5/19/14), on 5/19/14, but she had not immediately notified the administrator of the incidents. The DON stated that she did not routinely notify the administrator unless he was available. She added that if he was not available, she notified him the next day. The DON confirmed she re-interviewed R52 on 5/19/14, concerning staff roughness, but he would not identify any names during the investigation. The DON verified she had not reported the incident to the SA but would now report it. The DON stated, "We should of reported it," indicated notification to the administrator and the SA. She confirmed the

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F 226	Continued From page 18 facility had made observations of cares and interviewed R52, and the investigation was complete and indicated the facility should have reported the incident, then completed the investigation. During interview on 5/20/14, at 12:50 p.m. RN-B reported he was not notified of the resident-to-resident incident at breakfast, between R43 and R52 on 5/19/14, until sometime after the Noon meal on 5/19/14. RN-B verified he submitted the VA report to the SA for this incident on 5/19/14, at 4:35 p.m. RN-B stated, "It should be reported immediately." Furthermore, he reported that staff were confused about how to handle R52 and R43, so they tended to be more lenient. During interview on 5/20/14, at 12:57 p.m. RN-B confirmed that he was notified by staff on 5/18/14, of R52's allegations of rough treatment and the bruising to his back and upper chest. RN-B stated, "I did not think abuse with [R52's bruising] because he is on Coumadin [an anti-coagulant/ blood-thinning medication]." RN-B confirmed that this should have been reported to the facility administrator and SA immediately, but had not been.	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	F 280		7/14/14

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F 280	Continued From page 19 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise each resident's plan of care upon a change in condition, related to monitoring/treatment needs and additional interventions for 1 of 1 resident (R27) reviewed with a newly identified pressure ulcer. Findings include: R27's current plan of care revised 2/20/14, directed various interventions to maintain skin integrity, including keeping her skin clean and dry, along with utilization of a pressure relieving cushion to protect her skin while in her wheelchair. R27 required a Hoyer lift (total body mechanical lift) with assistance from two staff for transfers and required extensive assistance of one staff for use of a bedpan. The care plan did not identify R27 with a current pressure ulcer, therefore, did not include direction for monitoring, treatment and interventions to prevent further skin breakdown.	F 280	The current policy and procedure for Care Plans was reviewed and/or revised on 6/12/14 by the Director of Nursing. Nursing staff will be educated on the policy and procedure for care plan development, revision and following of a resident care plan on 6/16/14 nurses meeting. Nurse aids will be educated to review and carry their pocket worksheets at all times and/or review kardex on the Point of Care system at a meeting held on 6/20/14. Resident #R27 care plan was reviewed 5/20/14 to potential for impairment to skin integrity and identify monitoring and treatment along with an individualized repositioning plan of offering and attempting to reposition resident at least every 2 hours. Treatment and monitoring were updated onto the TAR on 5/20/14. Repositioning every 2 hours was verified	

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F 280	Continued From page 20 R27's quarterly Minimum Data Set (MDS) dated 5/2/14, identified she was cognitively intact, with diagnoses including dementia, chronic pain and schizophrenia. Review of R27's Braden Scale (a tool used to predict pressure ulcer risk) dated 5/2/14, identified she was at moderate risk for the development of pressure ulcers, with the following risk factors: very moist skin, activity level, and very limited mobility, with friction and shear. Review of a progress note for R27 on 5/16/14, revealed an open area (blister) was identified on her left coccyx, in the lower crease (inner aspect of left buttocks). The note indicated the area was cleansed and an Allevyn dressing (a dressing used for wound care) applied. The note indicated the area was to be monitored. Review of R27's physician order dated 5/16/14, directed the open area to her left coccyx was to be monitored and checked upon rising and at bedtime. The order instructed, "Change Allevyn every 3 [three] days & [and] as needed to open area on left coccyx area until healed." R27's medication administration record (MAR) for 5/14, lacked the Allevyn dressing application and changes, along with routine monitoring of her open area. During observation in R27's resident room on 5/20/14, at 9:05 a.m., nursing assistant (NA)-F and NA-E used the Hoyer lift to transfer R27 from her wheelchair to her bed, for use of her bedpan. Upon observation of her skin, R27 was noted to have a brownish, scabbed area on her coccyx, which measured approximately one centimeter	F 280	in the Point of Care system on 5/20/14 for the CNA□s and updated on the CNA pocket worksheet on 6/18/14. All residents care plans will be reviewed and updated on a quarterly schedule and as needed to reflect current Braden Assessment and MDS information. Audits on all residents with skin breakdown and resident with risk of potential for impaired skin breakdown will be conducted to monitor appropriate treatment plan is in place along with care plan completion/updating. These audits will be completed by the DON or her designee on a weekly basis and then monthly basis until compliance has been met at which time will be continued on a quarterly basis. Audits results will be reported to the QA committee quarterly. Responsible Person □ Director of Nursing and/or Designee.	

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(cm) by one cm, with a pinpoint opening in the center of the scab.

On 5/20/14, at 9:10 a.m. NA-F confirmed R27 did not have a dressing over her coccyx and was not aware of an open are on her coccyx.

On 5/20/14, at 9:25 a.m. licensed practice nurse (LPN)-B stated she was not aware R27 had an open area on her coccyx and reported she did not have an order for a dressing change or monitoring of an open area for R27. At 9:30 a.m. LPN-B stated she had just been notified that R27 had an open area by NA-F. LPN-B confirmed the MAR did not include directions for dressing changes or monitoring of the pressure ulcer. LPN-B stated she reviewed R27's medical record and found an order for a dressing change on 5/16/14, which had not been transcribed to the medication administration record. LPN-B then proceeded to apply an Allevyn dressing over R27's pressure ulcer.

On 5/20/14, at 12:11 p.m. registered nurse (RN)-C stated she was not aware R27 had an open area on her coccyx until LPN-B notified her just a few minutes prior to this interview. RN-C stated she expected R27's pressure ulcer to be monitored at least daily, with interventions put in place to promote healing and to prevent further breakdown. RN-C added, documenting on every shift to determine treatment effectiveness was also expected for residents with pressure ulcers. RN-C verified that no new interventions were put into place upon initial discovery of R27's pressure ulcer on 5/16/14.

During interview on 5/20/14, at 12:35 p.m. R27 stated she had recently developed a "blister" on

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F 280	Continued From page 22 her buttocks. R27 confirmed staff had not applied a dressing or routinely looked at the open area. On 5/21/14, at 9:04 a.m. the director of nursing (DON) stated she expected staff to immediately notify a nurse when a pressure ulcer was identified. The nurse was then expected to evaluate the area, including measurement, staging, implementation of treatments and implementation of additional care plan interventions. The DON confirmed no evaluation or treatment of further interventions had been initiated since R27 developed the pressure ulcer.	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 implement fall prevention interventions as directed per the written plan of care, for 4 of 5 residents (R21, R49, R59 and R34) reviewed with a history of falls and 1 of residents (R21) who required assistance with oral cares. Findings include: R21's care plan revised on 4/17/14, identified her as a high fall risk, related to safety needs, vision, confusion and fall history. The care plan directed	F 282	The current policy and procedure for Care Plans, Fall Prevention including use of TAB's alarms and Oral Cares were reviewed and/or revised on 6/12/14 by the Director of Nursing. Nursing staff will be educated on the policy and procedure for care plan development, revision and following of a resident care plan on 6/16/14 nurses meeting. Nurse aids will be educated to review and carry their pocket worksheets at all times and/or review kardex on the Point of Care system and the importance of attending	7/14/14

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F 282	Continued From page 23 safety interventions were to include alarms for her chair and bed, appropriate foot wear and "Do NOT leave alone in the bathroom. Resident does not always remember to use call light when finished and has a sig (significant) fall history." On 5/20/14, at 6:56 a.m. R21 was observed sitting in a wheelchair in her private resident room, with a personal safety alarm sounding from her bed. The blanket and sheet on R21's bed were lying askew. A blue pressure alarm pad (a pad that alarmed when weight was removed) was partially on the bed, with a third of the pad hanging off the edge of the bed. R21 was observed in her wheelchair, wearing flannel pajamas, with no shoes/footwear. The wheelchair was noted to have a TABS alarm (an alarm mounted to the back of a chair, which sounded when a pin, attached to a string that was typically clipped to a resident's back, was pulled out of the alarm box). The string and clip from R21's TABS alarm, was observed hanging from the alarm, not attached to R21. At 6:57 a.m., R21 stood from her wheelchair, but was unable to maintain her balance and returned to a seated position. At 6:58 a.m., R21 again attempted to stand from the wheelchair. Being unable to stand, R21 sat down abruptly/hard in her wheelchair, which caused the front wheels of the chair to rise slightly off of the floor. At 6:59 a.m., trained medical aide (TMA)-B arrived and assisted R21 to the bathroom. TMA-B confirmed R21 had self transferred herself from the bed and seated herself in the wheelchair. At 7:02 a.m. nursing assistant (NA)-A entered the room, and TMA-B left the room, R31 remained seated on the toilet. At 7:08 a.m., NA-A left the room with R21 remained seated on the toilet with no alarm was in place. R21's wheelchair was two feet from	F 282	shift change report at a meeting held on 6/20/14. Resident R49, R21, R59 and R34 care plans was reviewed and/or revised on 6/14/14 to identify appropriate falls prevention is in place. Residents Safety Risk assessments will be completed on a minimum of a quarterly basis and changes will be made as appropriate for fall preventions. Care plans will be reviewed and/or revised at that time. CNA Pocket worksheets were reviewed on 6/18/14. Resident R21 care plan was reviewed on 6/14/14 to identify appropriate assistance for oral cares was care planned. CNA Pocket worksheets were reviewed on 6/18/14 to verify proper need for assistance with oral cares was included. Pocket worksheets will be reviewed and/or revised minimally of bi-weekly. All residents, who utilize personal safety alarms and need physical assistance with oral cares, care plans have been reviwed for appropiateness. Appropriate assessments will be completed and care plans are reviewed and updated quarterly in accordance MDS schedule. Spot check audits will be conducted on all residents to monitor placement of tabs alarms at all times and oral cares by the DON and/or her designee on a weekly and PRN basis until they reach a substantial compliance. Audit results will be reported to the QA committee	

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F 282	Continued From page 24 the toilet, without the brakes applied. At 7:09 a.m., NA-A returned to R21's bathroom and continued morning cares. During interview on 5/20/14, at 7:16 a.m., NA-A stated R21 routinely self transferred and confirmed she had left R21 alone on the toilet. During interview on 5/21/14, at 1:21 p.m. registered nurse (RN)-A confirmed R21 had poor vision related to macular degeneration and confusion, with a history of falls. RN-A indicated R21 was at risk for further falls and confirmed R21'a current care plan interventions. She confirmed R21 had fallen in the bathroom in the past, and would expect staff to stay with her in the bathroom to prevent further falls. During interview on 5/21/14, at 3:20 p.m. the director of nursing (DON) confirmed the care plan interventions noted above were current and accurate. The DON verified staff were expected to follow R21's written plan of care. R49's care plan reviewed 5/9/14, indicated she was at risk for falls. Fall interventions included a chair/bed alarm and directed staff to ensure the device is in place. An undated NA care sheet indicated R49 was to have an alarm on when in a recliner or wheelchair. During continuous observation on 5/18/14, from 3:10 p.m. to 4:14 p.m. R49 did not have her TABS/chair alarm in place while seated in a recliner in the lobby. R49's wheelchair was placed to the right of her recliner. The TABS alarm was observed attached to the wheelchair, however, not clipped to R49.	F 282	quarterly. Responsible Person □ Director of Nursing and/or Designee.	

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F 282	Continued From page 25 During interview on 5/18/14, at 4:14 p.m., NA-D confirmed the TABS alarm was not attached to R49 and was left on her wheelchair. NA-D reported R49 was fairly immobile and used the alarm in her wheelchair because she leaned forward. During interview on 5/18/14, at 4:18 p.m., licensed practical nurse (LPN)-D confirmed R49 was supposed to have the TABS alarm attached while in the recliner. R59's care plan revised on 5/19/14, indicated she was at risk for falls. Fall interventions included a TABs alarm to be used when in her wheelchair and bed. The care plan directed staff to ensure the device was in place as needed. An undated NA care sheet indicated R59 was to have an alarm on while in bed and while in her wheelchair. During continuous observation on 5/20/14, from 11:31 a.m. to 11:42 a.m. R59 did not have a TABS/chair alarm in place. At 11:31 a.m., NA-B assisted R59 from a recliner to her wheelchair. NA-B did not attach the TABS alarm to R59. NA-B then assisted R59 to the dining room in her wheelchair, after which NA-B left the dining room. At 11:34 a.m. NA-B stated she was not sure whether R59 had any recent falls. NA-B added, "I just fill in." When NA-B was asked how the staff were made aware of resident needs, NA-B replied that they were informed through report; however, NA-B stated she did not receive report on 5/20/14. NA-B confirmed that she did not carry an NA care sheet. NA-B then stated, "I just go into the resident's room and look around to see what they may need." NA-B stated R59 only required alarms when in her bed or recliner.	F 282		

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F 282	Continued From page 26 When asked whether an alarm was needed while in her wheelchair, NA-B stated, "No." At 11:42 a.m., NA-B returned to the dining room with a TABS alarm unit. NA-B secured the alarm to the wheelchair and attached the clip to the back of R59's shirt. NA-B then stated, "[R59] is supposed to have it [the alarm] on the wheelchair." During interview on 5/20/14, at 12:45 p.m. the DON confirmed that "casual" staff were expected to have the NA care sheets readily available to direct the appropriate care for each resident. The DON verified that staff were expected to follow the interventions identified on the care plans and NA care sheets. R34's care plan reviewed 5/6/14, identified she was at risk for falls, related to her limited awareness of safety needs. The care plan interventions included use of a TABS alarm while in her wheelchair and use of a pressure alarm while in bed. The care plan directed staff to ensure the device was in place as needed. An undated NA care sheet identified R34 was to have a bed and wheelchair alarm. The care sheet noted R34 required staff assistance with transfers and ADLs. On 5/18/14, at 3:10 p.m. R34 was observed in a lounge area of the facility, seated in her wheelchair. A TABS alarm was observed on the back of her wheelchair, with the string and clip hanging off of the alarm. The alarm was not attached to her. R34 repeatedly propelled herself back and forth in the lounge area, picking up various objects and moving the objects to another table or counter in the lounge. A clicking noise could heard while R34 propelled herself in	F 282		

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lounge, from the metal clip hanging down the back of her wheelchair hitting the wheel of the wheelchair. R34 was observed from 3:10 p.m. to 3:20 p.m., at which time a NA asked R34 if she needed to use the restroom. Two staff members were noted to walk by R34 during this observation period, without checking or attaching the alarm. At 3:20 p.m. NA-D confirmed the TABS alarm was not attached to R34. NA-D confirmed that without the clip attached to R34, the alarm would not have sounded if she had stood up from her wheelchair. NA-D stated R34 had a TABS alarm due to her frequent attempts to self-transfer. NA-D added, "Every chance she gets."

On 5/20/14, at 1:30 p.m. DON confirmed R34's care plan indicated the use of alarms for her safety. DON stated the expectation was to have alarms attached to residents, otherwise the alarm was ineffective for its purpose.

The facility's Fall Prevention Policy dated 10/13, directed staff to identify all residents who were at risk for falls and develop/implement a care plan that protected the resident against falls to the maximum potential.

R21 did not receive assistance with oral cares as directed by the care plan.

R21's care plan revised on 4/17/14, identified she required extensive assistance with hygiene and assist with oral cares.

During observation of morning cares on 5/20/14, from 7:05 a.m. to 7:15 a.m., NA-A assisted R21 with morning cares which included washing her face, perineal cares and dressing. R21 was not assisted with or offered the opportunity for

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F 282	Continued From page 28 completion of oral cares. R21 was noted to have white colored debris at the gum-line of the lateral and cusped (the second and third tooth from the front of the mouth), on the upper right side of her mouth. During interview on 5/20/14, at 11:52 a.m. nursing assistant (NA)-A confirmed oral care had not been completed or offered to R21 during her morning cares, nor was it completed or offered after breakfast. During interview on 5/21/14, at 4:58 p.m. the director of nursing (DON) confirmed R21's current care plan and stated she expected staff to provide the appropriate oral care for residents, in accordance with the resident's care plan. The facility policy titled Teeth Brushing revised on 10/11, identified the purpose of oral care was to clean and freshen the mouth, preventing infections of the mouth, and maintaining the teeth/gums in healthy condition.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide daily oral cares for 1 of 2 residents (R21) reviewed who	F 312	Current Oral Cares policy was reviewed and/or updated on 6/14/14 by the DON. Nursing staff will be educated on the	7/14/14

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F 312	Continued From page 29 required extensive assistance with oral cares. Findings include: R21's quarterly Minimum Data Set (MDS) dated 4/17/14, identified she was moderately cognitively impaired, with diagnoses including dementia. The MDS indicated R21 required extensive assistance for completion of personal hygiene tasks. R21's care plan revised on 4/17/14, identified she required extensive assistance with hygiene and assist with oral cares. During observation of morning cares on 5/20/14, from 7:05 a.m. to 7:15 a.m. nursing assistant (NA)-A assisted R21 with morning cares which included washing her face, perineal cares and dressing. R21 was not assisted with or offered the opportunity for completion of oral cares. R21 was noted to have white colored debris at the gum-line of the lateral and cusped (the second and third tooth from the front of the mouth), on the upper right side of her mouth. During interview on 5/20/14, at 11:52 a.m. NA-A confirmed oral care had not been completed or offered to R21 during her morning cares, nor was it completed or offered after breakfast. During interview on 5/21/14, at 4:58 p.m. the director of nursing (DON) confirmed R21's current care plan and stated she expected staff to provide the appropriate oral care for residents in accordance with the resident's care plan. The facility policy titled Teeth Brushing revised on 10/11, identified the purpose of oral care was to	F 312	policy and procedure for Oral Cares at the 6/16/14 and 6/20/14 staff meetings. Nurse aids will be educated to review and carry their pocket worksheets at all times and/or review kardex on the Point of Care system and the importance of attending shift change report at a meeting held on 6/20/14. Resident R21 care plan was reviewed on 6/14/14 to identify appropriate assistance for oral cares was care planned. CNA Pocket worksheets were reviewed on 6/16/14 to verify proper need for assistance with oral cares was included. Pocket worksheets will be reviewed and/or revised minimally of bi-weekly. All residents, who need physical assistance with oral cares, care plans have been reviwed for appropiateness. Appropriate assessments will be completed and care plans are reviewed and updated quarterly in accordance MDS schedule. Audits of all residents will be conducted to monitor oral cares by the DON and/or her designee on a weekly basis until substantial compliance has been reached, at which point audits will be done randomly throughout the year. Audits results will be reported to the QA committee quarterly. Responsible Person □ Director of Nursing and/or Designee.	

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F 312	Continued From page 30 clean and freshen the mouth, preventing infections of the mouth, and maintaining the teeth/gums in healthy condition.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess each resident's repositioning needs to minimize the risk for development of pressure ulcers, and failed to monitor and provide treatment for an identified pressure ulcer for 1 of 2 residents (R27) reviewed who were at risk for the development of pressure ulcers. Findings include: R27's quarterly Minimum Data Set (MDS) dated 5/2/14, identified she was cognitively intact, with diagnoses including dementia, chronic pain and schizophrenia. The MDS identified R27 required extensive assistance with all activities of daily living (ADLs), was frequently incontinent of bladder and bowel, and was dependent on staff for repositioning. Further, the MDS revealed R27	F 314	Resident R27 care plan was reviewed on 6/17/14. Resident is cognitively intact. She is to be offered toileting and repositioning at a minimum of every 2 hour per Point Of Care system but does have the right to refuse. Staff will be educated on importance of offering toileting and need of repositioning every 2 hours at staff meetings on 6/16/14 and 6/20/14. Refer to F280 regarding pressure ulcer for R27. All residents care plans are reviewed and updated on a quarterly schedule and as needed to reflect current Braden Assessment and MDS information. Audits on all residents will be conducted	7/14/14

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F 314	Continued From page 31 was at risk for the development of pressure ulcers, but was not on a scheduled repositioning program. R27's annual MDS dated 8/2/13, identified R27 was cognitively intact, required extensive assistance with all ADLs, was frequently incontinent of bowel and bladder and was dependent on staff for repositioning. The Care Area Assessment (CAA) dated 8/9/13, identified R27 was at risk for developing a pressure ulcer, required extensive assistance with transfers and bed mobility. The CAA identified R27 required a regular schedule of turning, and was to be on a two hour T&R (turning and reposition)/toileting program. Review of R27's Braden Scale (a tool used to predict pressure ulcer risk) dated 5/2/14, identified she was at moderate risk for the development of pressure ulcers, with the following risk factors: very moist skin, activity level, and very limited mobility, with friction and shear. R27's current plan of care revised 2/20/14, directed various interventions to maintain skin integrity, including keeping her skin clean and dry, along with utilization of a pressure relieving cushion to protect her skin while in her wheelchair. R27 required a Hoyer lift (total body mechanical lift) with assistance from two staff for transfers and required extensive assistance of one staff for use of a bedpan. The care plan did not identify R27 with a current pressure ulcer and did not direct a turning/repositioning schedule for her nor did the care plan include treatments for the care of the current pressure ulcer.	F 314	to monitor assessments are completed according to their MDS schedule and as needed and appropriate repositioning needs are identified on the care plan and on the CNA pocket worksheets. These audits will be completed by the DON or her designee on a weekly basis until compliance has been met. Audits results will be reported to the QA committee quarterly. Audits will be conducted for appropriate repositioning on all residents with skin breakdown or risk for altered skin by the DON and/or her designee on a weekly and PRN basis until substantial compliance has been reached, at which point audits will be done randomly throughout the year. Audits results will be reported to the QA committee quarterly. Responsible Person □ Director of Nursing and/or Designee.	

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Review of a progress note for R27 from 5/15/14 to 5/20/14 revealed on 5/16/14, R27 was found to have an open area (blister) on her left coccyx, in the lower crease (inner aspect of left buttocks). The note indicated the area was cleansed and an Allevyn dressing (a dressing used for wound care) applied. The note indicated the area was to be monitored.

Review of R27's physician order dated 5/16/14, directed the open area to her left coccyx was to be monitored and checked upon rising and at bedtime. The order instructed, "Change Allevyn every 3 [three] days & [and] as needed to open area on left coccyx area until healed."

R27's medication administration record (MAR) for 5/14, did not include the Allevyn dressing application and changes, along with routine monitoring of her open area.

During observation on 5/20/14, at 6:45 a.m. R27 was seated in a wheelchair in her resident room. R27 was seated on a blue canvas-type sling (used with the total mechanical lift), with a black gel-type cushion under the sling on the seat of the wheelchair. R27 remained seated in her wheelchair in her room until 7:58 a.m., when nursing assistant (NA)-F entered the room and wheeled her to the dining room for breakfast. NA-F did not offer or encourage R27 to reposition or toilet prior to assisting her to the dining room. R27 remained seated in her wheelchair in the dining room until 8:57 a.m., when she began to slowly propel her wheelchair out of the dining room, down the hallway and toward her room.

At 8:45 a.m. NA-F confirmed R27 was not able to reposition herself, and utilized a total mechanical

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lift for transferring and repositioning. She stated R27 had been up, in her wheelchair since her shift began at approximately 6:00 a.m. NA-F confirmed R27 had not been repositioned or offered repositioning since she began work at 6:45 a.m. NA-F stated R27 was not on a routine repositioning schedule and stated R27 "self-directed" her own repositioning schedule and let staff know when she had to use the bedpan.

At 8:58 a.m., NA-F and NA-E offered to assist R27 to use her bedpan. At 9:05 a.m., NA-F and NA-E attached the straps of the blue canvas sling under R27's buttocks and proceeded to lift her. R27 was not repositioned or offered repositioning from 6:00 a.m. (as was confirmed by NA-F), until 9:05 a.m., a total of three hours and five minutes. Upon observation of her skin, R27 was noted to have a brownish, scabbed area on her coccyx, which measured approximately one centimeter (cm) by one cm, with a pinpoint opening in the center of the scab. At 9:10 a.m. NA-F confirmed R27 did not have a dressing over her coccyx and stated she was not aware of an open area on her coccyx.

On 5/20/14, at 9:25 a.m. licensed practice nurse (LPN)-B stated she was not aware R27 had an open area on her coccyx and reported she did not have an order for a dressing change or monitoring of an open area for R27. At 9:30 a.m. LPN-B stated she had just been notified that R27 had an open area by NA-F. LPN-B confirmed the MAR did not include directions for dressing changes or monitoring of the pressure ulcer. LPN-B stated she reviewed R27's medical record and found an order for a dressing change on 5/16/14, which had not been transcribed to the

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medication administration record. At 9:35 a.m., during examination of R27's skin, LPN-B verified R27 had an open area on the coccyx and the skin on her coccyx was not blanchable (loses all redness when pressed). LPN-B measured the open area on the coccyx and confirmed the open area measured one cm by one cm. LPN-B then proceeded to apply an Allevyn dressing over R27's pressure ulcer.

On 5/20/14, at 12:11 p.m. registered nurse (RN)-C stated she was not aware R27 had an open area on her coccyx until LPN-B notified her just a few minutes prior to this interview. RN-C confirmed R27's care plan lacked direction for a repositioning schedule and treatment of the current pressure ulcer. She stated, "As a general rule," every resident in the facility was to be repositioned every two hours. RN-C stated she expected R27's pressure ulcer to be monitored at least daily, with interventions put in place to promote healing and to prevent further breakdown. RN-C added, documenting on every shift to determine treatment effectiveness was also expected for residents with pressure ulcers. RN-C verified that no new interventions were put into place upon initial discovery of R27's pressure ulcer on 5/16/14. RN-C indicated the typical facility protocol was to conduct an assessment to determine the frequency of turning/repositioning needed to maintain skin integrity on admission and quarterly. RN-C confirmed R27's medical record lacked documentation of such an assessment for more than one year.

During interview on 5/20/14, at 12:35 p.m. R27 stated she had recently developed a "blister" on her buttocks. R27 confirmed staff had not applied a dressing or routinely looked at the open

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F 314	Continued From page 35 area on her coccyx. On 5/21/14, at 9:04 a.m. the director of nursing (DON) confirmed R27 was at risk for developing pressure ulcers, had significant mobility issues and required use of a Hoyer lift for repositioning for greater than one year. She stated her expectation was for R27 to have an individualized repositioning program to prevent development of pressure ulcers. The DON stated she expected staff to immediately notify a nurse when a pressure ulcer was identified. The nurse was then expected to evaluate the area, including measurement, staging, implementation of treatments and implementation of additional care plan interventions. The DON stated that an assessment to determine the frequency of turning/repositioning needed to maintain skin integrity was completed on all residents upon admission and every quarter, along with a Braden Scale (skin risk assessment). The DON verified no assessment of turning/repositioning needs had been completed for R27 in the past year. Further, the DON confirmed no evaluation or treatment of further interventions had been initiated since R27 developed the pressure ulcer. The DON confirmed R27 had very limited mobility, utilized a total mechanical lift for more than one year and due to immobility and location, the DON considered the open area a stage-two pressure ulcer. The facility's Pressure Ulcers Prevention/Management Program policy revised 10/10, directed use of the Braden scale to identify risk factors for pressure ulcer development included mobility, activity impairment and moisture/incontinence. The policy also instructed early interventions for prevention of skin	F 314		

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F 314	Continued From page 36 breakdown were to be implemented, with reassessment upon condition changes.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement fall prevention interventions related to the ineffective use of personal safety alarms for 4 of 5 residents (R21, R49, R59 and R34) reviewed with a history of falls. In addition, the facility failed to secure hazardous chemicals, ensuring they were inaccessible for resident safety. This had the potential to affect 7 of 7 residents (R53, R34, R41, R42, R61, R69 and R48) who were identified to wander throughout the facility. Findings include: FALLS R21's quarterly Minimum Data Set (MDS) dated 4/17/14, identified her with moderately impaired cognition and diagnoses including dementia and vision impairment. The MDS revealed R21 required extensive assistance for most activities of daily living (ADLs), including transfers and ambulation.	F 323	See F282 regarding Falls for R21, R49, R59, R34. MLH will ensure that the residents environment remains free of hazardous materials. An Accient Prevention/Hazardous Materials Policy and Procedure will be developed by the DON or her designee. All staff will be educated on the new policy during July staffing meetings. All hazardous materials will be placed in locked areas so that residents are unable to access them. Staff will be educated on the importance to keep these types of materials in a locked area to prevent an accident to our residents at the staffing meetings that will be held on 6/16/14 and 6/20/14.	7/14/14

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F 323	Continued From page 37 R21's care plan revised on 4/17/14, identified her as a high fall risk, related to safety needs, vision, confusion and fall history. The care plan directed safety interventions were to include alarms for her chair and bed, appropriate foot wear and "Do NOT leave alone in the bathroom. Resident does not always remember to use call light when finished and has a sig [significant] fall history." On 5/20/14, at 6:56 a.m. R21 was observed sitting in a wheelchair in her private resident room, with a personal safety alarm sounding from her bed. The blanket and sheet on R21's bed were lying askew. A blue pressure alarm pad (a pad that alarmed when weight was removed) was partially on the bed, with a third of the pad hanging off the edge of the bed. R21 was observed in her wheelchair, wearing flannel pajamas, with no shoes/footwear. The wheelchair was noted to have a TABS alarm (an alarm mounted to the back of a chair, which sounds when a pin, attached to a string that is typically clipped to a resident's back, is pulled out of the alarm box). The string and clip from R21's TABS alarm, was observed hanging from the alarm, not attached to R21. At 6:57 a.m., R21 stood from her wheelchair, but was unable to maintain her balance and returned to a seated position. At 6:58 a.m., R21 again attempted to stand from the wheelchair. Being unable to stand, R21 sat down abruptly/hard in her wheelchair, which caused the front wheels of the chair to rise slightly off of the floor. At 6:59 a.m., trained medical aide (TMA)-B arrived and assisted R21 to the bathroom. During interview on 5/20/14, at 7:01 a.m. TMA-B	F 323	Audits will be conducted to monitor placement of hazardous materials by the DON and/or her designee on a weekly basis until substantial compliance has been met, at which point audits will be done randomly throughout the year. Continuous monitoring will be completed on a monthly facility safety walk through with the DON and the Environmental Services Manager. Audit results will be reported to the QA committee quarterly. Responsible Person □ Director of Nursing and/or Designee.	

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confirmed R21 self-transferred to her wheelchair. TMA-B stated R21 had recently become dependent upon staff and did not remember to use her call light or wait for staff assistance.

During continued observation on 5/20/14, at 7:02 a.m. nursing assistant (NA)-A relieved TMA-B, taking over R21's care. At 7:08 a.m., NA-A left the room while R21 sat on the toilet. No alarm was in place. R21's wheelchair was two feet from the toilet, without the brakes applied. At 7:09 a.m., NA-A returned to R21's bathroom and continued morning cares.

During interview on 5/20/14, at 7:16 a.m., NA-A confirmed R21 was left alone on the toilet. NA-A stated it was acceptable to leave R21 alone on the toilet because she did not attempt to self-transfer from the toilet.

During interview on 5/21/14, at 1:21 p.m. registered nurse (RN)-A confirmed R21 had poor vision related to macular degeneration and confusion, with a history of falls. RN-A confirmed the care plan interventions noted above were current and accurate. RN-A added, after a fall on 4/28/14, attempting to self-transfer from the toilet, R21 was not to be left alone while toileting.

During interview on 5/21/14, at 3:20 p.m. the director of nursing (DON) confirmed the care plan interventions noted above were current and accurate. The DON verified staff were expected to follow R21's written plan of care.

R49's annual MDS dated 5/8/14, identified she was at risk for falls and required extensive assistance for all ADLs. R49's diagnoses

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included Alzheimer's disease. The Care Area Assessment (CAA) worksheet dated 5/11/13, indicated R49 had impaired balance during transfers and most of her falls were due to self-transfer attempts.

The care plan reviewed 5/9/14, indicated R49 was at risk for falls. Fall interventions included a chair/bed alarm and directed staff to ensure the device is in place. An undated NA care sheet indicated R49 was to have an alarm on when in a recliner or wheelchair.

During continuous observation on 5/18/14, from 3:10 p.m. to 4:14 p.m. R49 did not have her TABS/chair alarm in place while seated in a recliner in the lobby. R49's wheelchair was placed to the right of her recliner. The TABS alarm was observed attached to the wheelchair, however, not clipped to R49.

During interview on 5/18/14, at 4:14 p.m., NA-D confirmed the TABS alarm was not attached to R49 and was left on her wheelchair. NA-D reported R49 was fairly immobile and used the alarm in her wheelchair because she leaned forward.

During interview on 5/18/14, at 4:18 p.m., licensed practical nurse (LPN)-D confirmed R49 was supposed to have the TABS alarm attached while in the recliner.

R59's quarterly MDS dated 2/28/14, indicated R59 had diagnoses including Alzheimer's disease, osteoporosis and glaucoma. The MDS also indicated R59 was unable to be interviewed, had both short term and long term memory

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MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

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problems and had severely impaired cognitive skills for daily decision making, at risk for falls and required extensive assistance with transfers. The CAA worksheet dated 12/12/13, indicated R59 had physical limitations that included weakness, limited range of motion, poor coordination, poor balance, visual impairment, pain, weakness and unsteady gait.

The care plan revised on 5/19/14, indicated R59 was at risk for falls. Fall interventions included a TABs alarm to be used when in her wheelchair and bed. The care plan directed staff to ensure the device was in place as needed. An undated NA care sheet indicated R59 was to have an alarm on while in bed and while in her wheelchair.

During continuous observation on 5/20/14, from 11:31 a.m. to 11:42 a.m. R59 did not have a TABS/chair alarm in place. At 11:31 a.m., NA-B assisted R59 from a recliner to her wheelchair. NA-B did not attach the TABS alarm to R59. NA-B then assisted R59 to the dining room in her wheelchair, after which NA-B left the dining room. At 11:34 a.m. NA-B was not sure whether R59 had any recent falls. NA-B added, "I just fill in." When NA-B was asked how the staff were made aware of resident needs, NA-B replied that they were informed through report, however, NA-B stated she did not receive report on 5/20/14. NA-B confirmed that she did not carry an NA care sheet. NA-B then stated, "I just go into the resident's room and look around to see what they may need." NA-B stated R59 only required alarms when in her bed or recliner. When asked whether an alarm was needed while in her wheelchair, NA-B stated, "No." At 11:42 a.m., NA-B returned to the dining room with a TABS alarm unit. NA-B secured the alarm to the

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wheelchair and attached the clip to the back of R59's shirt. NA-B then stated, "[R59] is supposed to have it [the alarm] on the wheelchair."

During interview on 5/20/14, at 11:46 a.m. RN-C stated all of R59's falls had occurred from her wheelchair. RN-C confirmed R59 was to have an alarm attached at all times when in her bed or wheelchair.

During interview on 5/20/14, at 12:45 p.m. the DON confirmed that "casual" staff were expected to have the NA care sheets readily available to direct the appropriate care for each resident. The DON verified that staff were expected to follow the interventions identified on the care plans and NA care sheets.

R34's quarterly MDS dated 5/5/14, identified she was severely cognitively impaired, with diagnoses including dementia. The MDS revealed R34 required extensive assistance with all ADLs and was dependent on staff for mobility to and from destinations with her wheelchair. The MDS further identified R34 was not steady during transitions (moving from seated to standing position, moving on and off the toilet, and surface to surface transfers) and was only able to stabilize with staff assistance.

R34's care plan reviewed 5/6/14, identified she was at risk for falls, related to her limited awareness of safety needs. The care plan interventions included use of a TABS alarm while in her wheelchair and use of a pressure alarm while in bed. The care plan directed staff to ensure the device was in place as needed. An undated NA care sheet identified R34 was to have a bed and wheelchair alarm. The care

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F 323	Continued From page 42 sheet noted R34 required staff assistance with transfers and ADLs. On 5/18/14, at 3:10 p.m. R34 was observed in a lounge area of the facility, seated in her wheelchair. A TABS alarm was observed on the back of her wheelchair, with the string and clip hanging off of the alarm and not attached to her. R34 repeatedly propelled herself back and forth in the lounge area, picking up various objects and moving the objects to another table or counter in the lounge. A clicking noise could heard while R34 propelled herself in lounge, from the metal clip hanging down hitting the wheel of the wheelchair. R34 was observed from 3:10 p.m. to 3:20 p.m., at which time a NA asked R34 if she needed to use the restroom. Two staff members were noted to walk by R34 during this observation period, without checking or attaching the alarm. At 3:20 p.m. NA-D confirmed the TABS alarm was not attached to R34. NA-D confirmed that without the clip attached to R34, the alarm would not have sounded if she had stood up from her wheelchair. NA-D stated R34 had a TABS alarm due to her frequent attempts to self-transfer. NA-D added, "Every chance she gets." On 5/20/14, at 1:05 p.m. LPN-B confirmed R34 had history of self-transfers attempts. On 5/20/14, at 1:10 p.m. R34 stated she was able to take herself to bed and to the bathroom. R34 stated that sometimes someone helped, but she was able to do it on her own. On 5/20/14, at 1:30 p.m. DON confirmed R34's care plan indicated the use of alarms for her safety. DON stated the expectation was to have alarms attached to residents, otherwise the alarm	F 323		

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F 323	Continued From page 43 was ineffective for its purpose. The facility's Fall Prevention Policy dated 10/13, directed staff to identify all residents who were at risk for falls and develop/implement a care plan that protected the resident against falls to the maximum potential. CHEMICALS During the environmental tour on 5/21/14, at 9:45 a.m. with the director of environmental services (DES), disinfecting wipes (Cavi Wipes and Epi-clenz + Hand Sanitizing wipes) were observed in numerous, unlocked areas of facility which were easily accessible to residents. DES verified both the Cavi Wipes and Epi-clenz were to be stored in locked areas, outside of resident reach, as the wipes could have been harmful to residents if swallowed or applied to the skin. DES also confirmed there were residents who wandered throughout the facility and would have been able to access the disinfecting wipe products in each of the unlocked areas they were stored. A total of eleven containers of Cavi Wipes and seven containers of Epi-Clenz were observed as unsecured and accessible to residents. Review of Material Safety Data Sheets (MSDS) for both cleansing wipes, revealed the following: ·The MSDS for Epi-clenz + Hand Sanitizing wipes issued 2/19/08, noted warnings to keep the product out of reach to children as it was hazardous to their health. Health hazard data indicated the wipes caused eye irritation, respiratory irritation, and may have been harmful if absorbed through the skin. The product was noted as harmful if inhaled and harmful or fatal if swallowed.	F 323		

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F 323	Continued From page 44 ·The MSDS for Cavi Wipes, prepared 1/11, noted warnings to keep the product out of reach to children as it was hazardous to their health. Health hazard data indicated contact with eyes could cause reversible damage. The emergency first aid procedures directed that in case of ingestion, large amounts of water were to be consumed and medical attention was to be sought. The MSDS also revealed the product could cause irritation if inhaled. On 5/21/14, at 11:30 a.m. the DON verified both chemical wipes should have been locked away from resident reach. The DON also confirmed that there were a number of residents in the facility with wandering behaviors for whom accessible hazardous chemicals posed safety risks. The DON identified R53, R34, R41, R42, R61, R69 and R48 as residents with wandering behaviors who could have accessed the disinfecting wipes.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		7/14/14

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F 329	Continued From page 45 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop, implement and evaluate the effectiveness of non-pharmacological interventions for the continued use of antipsychotic medications for 2 of 5 residents (R21 and R29) reviewed who were prescribed antipsychotic medication. Findings include: R21's quarterly Minimum Data Set (MDS) dated 4/17/14, identified R21 had moderately impaired cognition and diagnoses including Alzheimer disease, anxiety and depression. R21's Behavior Summary Reports from 12/2/13, through 5/22/14, identified the following throughout the period of over five months: Four instances of wandering, four instances of repetitive movements, eight instances of crying, two instances of threatening behavior and two instances of yelling/ screaming. Review of nursing progress notes from 4/1/14, through 5/3/14, identified 18 entries of confused, angry or tearful episodes. However, the reports lacked	F 329	MLH policy and procedure for Psychotropic Drug Monitoring has been reviewed and/or revised on 6/14/14 by the DON. Policy and Procedure will be reviewed with staff on 6/16/14 and 6/20/14 staffing meetings along with importance of documenting behaviors and non-pharmalogical interventions attempted before use of medications. R21 care plan and Point of Care was reviewed on 6/16/14 and has individualized target behaviors noted on it along with non-pharmalogical interventions to the Point of Care system. R21□s had a quarterly AIMS and Psychotropic Medication Assessment completed on 4/18/14 and has one completed minimally on a quarterly basis. R29 care plan and Point of Care was reviewed on 6/16/14 and has individualized target behaviors noted on it along with non-pharmalogical interventions to the Point of Care system.	

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F 329	Continued From page 46 documentation of non pharmacological interventions utilized when the behaviors occurred and R21's response to those interventions. Review of the physician progress notes from 10/1/13 to 4/17/14 revealed a physician progress note dated 12/5/13, identified R21 received a routine dose of Seroquel (an antipsychotic medication) 25 mg each morning and would decrease the dose to 12.5 mg each night for hallucinations and confusion. The note revealed R21's mood, hallucinations and confusion were currently very stable. R21's care plan reviewed on 5/5/14, identified R21 received Seroquel, with a goal to remain free of drug related complications through the next review date. The care plan listed target behaviors which included wandering, disrobing, inappropriate response to verbal communication and violence/aggression. However, the care plan lacked non pharmacological interventions for staff to utilize when the target behaviors occurred. During interview on 5/21/14, at 4:51 p.m. registered nurse (RN)-A confirmed there were no non-pharmacological interventions in place for R21 and if any interventions had been attempted, there was no documentation to determine whether they were effective. During interview on 5/21/14, at 4:58 p.m. the director of nursing (DON) confirmed she expected staff to develop and implement individualized, non-pharmacological interventions for residents, to minimize the use of antipsychotic medications.	F 329	R29 had a quarterly AIMS completed on 4/1/14 and a comprehensive Psychotropic Medication Assessment completed on 6/17/14 and will have one completed minimally on a quarterly basis. All residents receiving psychotropic medications will have appropriate targeted behaviors and monitoring added to their care plans. These residents will also have psychotropic medication assessment, AIMS, PHQ-9 and Point of Care tasks reviewed and revised by 7/14/14 and then on a quarterly basis. Consulting pharmacy reviews all charts on a monthly basis. Gradual Dose Reductions will be attempted as determined appropriate and documented in the doctors dictation. Dose reductions will be monitored by licensed staff and reported to the doctor for further determinations. MLH has developed a MDS Assessment Checklist to be used by the Care Coordinators and used for quarterly audits to determine that appropriate resident assessments are being completed as scheduled. Audits will be conducted monthly by the DON or designee to ensure Psychotropic Medication Assessments are completed as due per quarter. Review of these audits will be done with Consulting Pharmacist each month to ensure we are identifing problems. Monitoring of Point of Care behaviors will also be conducted. Audits will be taken to QA for review	

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F 329	Continued From page 47 During a telephone interview on 5/22/14, at 10:50 a.m. the consulting pharmacist (CP) confirmed facility staff should have documented their use of and the effectiveness of non-pharmacological interventions for R21 in effort to decrease the need for these medications and to justify the use of Seroquel. R29's quarterly MDS dated 3/20/14, identified R29 had severely impaired cognition and diagnoses including dementia with behavioral disturbances, unspecified psychosis, cognitive deficits related to cerebrovascular disease and depressive disorder. The MDS indicated R29 had exhibited no behaviors during the assessment period. R29's current physician orders dated 5/19/14, included Zyprexa (an atypical antipsychotic medication), 2.5 mg daily, started on 11/26/12, for unspecified psychosis. Review of the physician progress notes from 11/22/13 to 3/25/14, revealed a note dated 3/25/14 which identified R29 continued on Zyprexa 2.5mg daily for a history of aggression and the physician indicated R29 had no new problems at this time. Review of the facility's behavior tracking system for R29 (The daily Follow Up Question Report) from 12/1/13, through 3/30/14, revealed a generic list of target behaviors that were being monitored. The report did not include any data regarding non-pharmacological interventions utilized nor the effectiveness of those interventions. The care plan dated 4/30/14, directed staff to monitor R29's target behaviors which included	F 329	quarterly and continued until a substantial compliance is reached. Responsible Person □ Director of Nursing and/or Designee.	

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wandering and disrobing, inappropriate response to verbal communication, violence and aggression and to implement various interventions including monitoring for side effects of psychoactive medications and validating/ acknowledging R29's feelings. The care plan lacked additional non-pharmacological interventions for staff to utilize in an attempt to minimize or alleviate the behavior.

On 5/21/14, at 11:01 a.m. nursing assistant (NA)-A reported R29 liked to yell and if he was angry he would hit staff, but staff were typically able to predict when he might strike out at them.

On 5/21/14, at 1:26 p.m. licensed practical nurse (LPN)-B indicated R29 did get mad, but his behavior had improved and he had not seen any other types of behaviors from him.

On 5/21/14, at 3:12 p.m. RN-B said he was not aware of routine monitoring for target behaviors or use of non-pharmacological interventions for R29. RN-B confirmed he had not assessed R29's for continued need of antipsychotic medications.

On 5/21/14, at 3:39 p.m. DON confirmed the current facility policy. She stated that residents with as needed (PRN) antipsychotic medications would routinely have specific interventions specified to decrease the need to administer the medication. However, the DON indicated that scheduled antipsychotic medications did not routinely have identified non-pharmacological interventions.

The facility's Psychotropic Drug Monitoring policy reviewed on 5/13, directed staff to put forth effort

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F 329	Continued From page 49 to identify factors that may have been responsible for behavior changes within a resident. The policy recommended consideration for the use of non-drug interventions or alternate means to intervene/treat those factors.	F 329		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		7/14/14

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F 356	Continued From page 50 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nurse staffing information was posted on a daily basis. This had the potential to affect all visitors and all 61 residents who resided in the facility. Findings include: During the initial tour of the facility on 5/18/14, at 2:51 p.m. the Hours Report of Nursing Staff Directly Responsible for Resident Care form dated 5/16/14, was observed to be posted on the wall next to the doctor's exam room. The nurse staffing information for the current date of 5/18/14, was not observed to be posted anywhere in the facility. During interview on 5/18/14, at 2:51 p.m. licensed practical nurse (LPN)-B confirmed the posting dated 5/16/14, had been the only nurse staffing information posted since 5/16/14. LPN-B reported the staffing coordinator typically gave nursing staff the postings for the weekend, then the weekend nurses were to post them on the correct dates and make changes as necessary. LPN-B confirmed the nursing department had not received any postings to post for the weekend of 5/17/14, and 5/18/14. During interview on 5/20/14, at 8:11 a.m. the staffing coordinator (SC) confirmed the nurse staffing postings were posted daily during the week. SC confirmed the postings for the weekend were typically left with the nurses in the medication room on Fridays, and the weekend nurses posted the nurse staffing information	F 356	MLH will post the following information on a daily basis: Facility name, current date, census, total number and actual hours worked by licensed (RN & LPN) and unlicensed (CNA) nursing staff directly responsible for resident care per shift. This information will be posted in a clear & readable format in a prominent place readily accessible to residents & visitors. The facility will provide data to the public upon request at no cost and will maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. The Director of Nursing has reviewed and/or revised the Posting of Nursing Hours Policy on 6/14/14. The staffing coordinator and nurses will be educated on the Policy and Procedure on 6/16/14. A bi-weekly audit will be conducted by the DON or her designee and taken to the QA on a quarterly basis. Audits will continue until a substantial compliance is reached. Responsible Person Director of Nursing and/or Designee.	

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F 356	Continued From page 51 throughout the weekend. The SC confirmed the postings for the dates of 5/17/14, and 5/18/14, were not left with the nursing staff on 5/16/14. SC stated, "It was only the second time it was forgotten in three years." During interview on 5/20/14, at 8:08 a.m. the director of nursing (DON) reported the SC completed the nurse staffing information and posted them daily during the week. The DON was unable to verify the process or expectations for posting the nurse staffing information on the weekends. The facility's Posting of Direct Care Daily Staffing Numbers Policy dated 9/05, directed the facility to post the Hours Report of Nursing Staff Directly Responsible for Resident Care on a daily bases for each day.	F 356		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store food in a safe and sanitary manner in the main kitchen of the	F 371	MLH will procure food from sources approved or considered satisfactory by Federal, State or local authorities. MLH	7/14/14

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F 371	Continued From page 52 facility, failed to ensure food storage containers were covered and dated/labeled when opened. This had the potential to affect all 61 residents who ate food prepared by the facility kitchen. Findings include: On 5/18/14, at 2:50 p.m. during an initial tour of the facility kitchen with cook-A, the following concerns were identified: · The kitchen refrigerator was observed with water dripping from the ceiling. The water was dripping into a large, rectangular pan, located on the top shelf of the refrigerator. The pan was noted to contain approximately one-half inch of stagnant water and one unopened bag of shredded lettuce. · The kitchen freezer was observed with a frozen stock of celery, lying on a large, metal tray. The celery was not covered or dated. · Two single sized dishes containing orange sherbet were observed to be undated in the facility freezer. · A 32-ounce plastic bag of diced onions was observed in the kitchen freezer as half-full, with no date to identify when it was opened. · A 32-ounce plastic bag of green peppers was observed in the kitchen freezer as one-quarter full, with no date to identify when it was opened. · Two single-sized bowls of mixed fruit were observed in the walk-in cooler, without covers or dates to identify when they were originally stored. · Two single-sized bowls of pureed fruit were observed in the walk-in cooler, without covers or dates to identify when they were originally stored. · Frosted chocolate bars were observed in an undated food storage container in the walk-in cooler. · Mini-muffins were observed in the walk-in	F 371	will also store, prepare, distribute and serve food under saitary conditions. Policy on proper labeling of food will be reviewed/revised. Dietary staff performed a walk through of the kitchen including the walk-in cooler on 5/20/14 and removed all uncovered, outdated and undated materials. MLH maintenance staff investigated the dripping water and has consulted for repairs vs replacement. A new policy and procedure was developed for repair and replacement of kitchen equipment on 5/22/14 and all dietary and mainenance staff will be educated on it. All staff will be educated on proper storage and labeling of foods at July 1st in-service. Dietary manager or designee will audit compliance to policies and record compliance at least 1 time a week and results will be taken to quarterly QA meetings.	

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	245382	A. BUILDING _____ B. WING _____	05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MADISON LUTHERAN HOME	900 SECOND AVENUE MADISON, MN 56256

(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 371	Continued From page 53 cooler, inside a cardboard box, with the plastic covering pulled back, exposing half of the container. The muffins were not effectively covered and were undated. · Pizza was observed in a cardboard box, with a quarter of the container left uncovered. Each of these concerns were verified by cook-A during the initial kitchen tour on 5/18/14, at 2:50 p.m. During a subsequent kitchen observation on 5/20/14, at 1:22 p.m. the pan of water which dripped from the ceiling of the kitchen refrigerator was again observed. Certified dietary manager (CDM) verified there was one inch of water in the metal pan, which remained on the top shelf of the kitchen refrigerator. CDM reported the refrigeration service personnel had inspected the refrigerator in the past, but could not figure out why it was dripping. The CDM was unsure when water began to drip from the ceiling of the kitchen refrigerator. CDM said she needed to talk to the facility maintenance staff to inquire as to whether it could be fixed or needed to be replaced. Upon interview at this time, CDM stated that all food storage items noted above should have been covered and dated when opened. Review of the facility's Kitchen Procedures policy, reviewed 12/11, indicated procedures were to be maintained in order to prevent transmission of disease. The policy did not indicate that open food items need to be covered and dated when opened. On 5/21/14, at 7:45 p.m. the CDM confirmed the facility did not have a policy for maintenance or repairing of equipment for the kitchen.	F 371		

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F 428	Continued From page 54	F 428		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist (CP) failed to identify the need for the development, implementation and evaluation of non-pharmacological interventions for residents who received antidepressant and antipsychotic medication. Findings include: R21's quarterly Minimum Data Set (MDS) dated 4/17/14, identified her with moderately impaired cognition and diagnoses including Alzheimer disease, anxiety and depression. R21's Behavior Summary Reports from 12/2/13, through 5/22/14, identified the following throughout the period of over five months): Four instances of wandering, four instances of repetitive movements, eight instances of crying, two instances of threatening behavior and two instances of yelling/ screaming. Review of nursing progress notes from 4/1/14, through	F 428	Refer to F329 for corrective action for R 21 and R 29.	7/14/14

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F 428	Continued From page 55 5/3/14, identified 18 entries of confused, angry or tearful episodes. Review of the physician progress notes from 10/1/13 to 4/17/14 revealed a physician progress note dated 12/5/13, identified R21 to continue the with Seroquel (an antipsychotic medication) 25 mg each morning and would decrease the dose to 12.5 mg each night for hallucinations and confusion. The note revealed R21's mood, hallucinations and confusion were currently very stable. R21's care plan reviewed on 5/5/14, identified R21 received Seroquel, with a goal to remain free of drug related complications through the next review date. The care plan listed target behaviors which included wandering, disrobing, inappropriate response to verbal communication and violence/aggression. However, the care plan lacked non pharmacological interventions for staff to utilize when the target behaviors occurred. R21's medication regimen review, revealed the CP had reviewed his medications for irregularities on a monthly basis, with the most recent review on 5/12/14, with no irregularities identified. During a telephone interview on 5/22/14, at 10:50 a.m. the CP confirmed facility staff should have documented their use of and the effectiveness of non-pharmacological interventions for R21, in effort to decrease the need for these medications and to justify the use of Seroquel. R29's quarterly MDS dated 3/20/14, identified R29 had severely impaired cognition and diagnoses including dementia with behavioral disturbances, unspecified psychosis, cognitive deficits related to cerebrovascular disease and	F 428		

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F 428	Continued From page 56 depressive disorder. R29's current physician orders dated 5/19/14, included Zyprexa (an atypical antipsychotic medication), 2.5 mg daily, started on 11/26/12, for unspecified psychosis. Review of the facility's behavior tracking system for R29 (The daily Follow Up Question Report) from 12/1/13, through 3/30/14, revealed a generic list of target behaviors that were being monitored. The report did not include any data regarding non-pharmacological interventions and the effectiveness of those interventions. The care plan dated 4/30/14, directed staff to monitor R29's target behaviors and implement various interventions including monitoring for side effects of psychoactive medications and validating/ acknowledging R29's feelings. The care plan lacked additional non-pharmacological interventions for staff to utilize in an attempt to minimize or alleviate the behavior. R29's medication regimen review, revealed the CP had reviewed his medications for irregularities on a monthly basis, with the most recent review on 5/12/14, with no irregularities identified. On 5/31/14, at 10:45 a.m. the CP confirmed R29's monthly reviews and reported R29's target behaviors included anger and combativeness, which was his most significant behavior. The CP indicated that he had talked to an interim director of nursing (DON) about psychotropic medication monitoring, including review of target behavior documentation and non-pharmacological interventions attempted; however, the CP revealed he was not sure if he had passed that	F 428		

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F 428	Continued From page 57 information on to the facility's current DON.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		7/14/14

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F 441	Continued From page 58 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement an infection control surveillance plan which identified, documented and monitored infections within the facility to minimize the spread of infection. This had the potential to affect all 61 residents that reside in the facility. In addition, the facility failed to follow proper infection control practices for 2 of 5 residents (R56 and R21) observed during personal cares. Findings include: Review of Infection Control (IC) Report forms from 1/14, through 5/19/14, revealed the facility's system of surveillance lacked evidence for tracking/trending signs/symptoms of infections for residents (prior to diagnosis/ antibiotic use), identification of the specific infectious organisms, and tracking/trending of employee illnesses. Facility was unable to provide IC forms prior to 1/14. On 5/21/14, at 1:00 p.m. registered nurse (RN)-B confirmed the contents of the monthly resident infection logs. He stated the logs were completed at the end of each month. RN-B confirmed the facility did not routinely review employee illnesses to assess for correlation with resident infections. RN-B confirmed he did not routinely monitor specific organisms of resident infections and stated the hospital lab personnel kept a log of all cultures done and he would have been notified from the lab of any unusual occurrences. RN-B	F 441	MLH will 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. MLH Use of Gloves Policy and Employee Health, Infection Control Policy was reviewed by the DON on 6/14/14. Education with the staff will take place at staffing meetings on 6/16/14 and 6/20/14. A new Infection Control Coordinator was assigned to oversee the Infection Control Program starting on 6/16/14. Policies, procedures, ongoing surveillance of the facility employees and residents, and monthly auditing tools will be implemented with this new position. Audits will be conducted monthly by the DON or her designee until substantial compliance has been met. Audits will be taken to the QA on a quarterly basis. Audits will be taken over by the new coordinator beginning July 2014. Responsible Person Director of Nursing and/or Designee.	

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F 441	Continued From page 59	F 441		

confirmed gastrointestinal illnesses were not tracked in the facility and stated he did not need to track any illness or infection that did not require antibiotic use. RN-B indicated he reviewed the logs at the end of each month and confirmed he did not routinely report analysis of resident and staff illnesses at the facility's quality assessment and assurance (QA&A) meetings. RN-B indicated that hospital lab personnel would have reported any unusual infections in the last quarter for the QA&A meeting. RN-B confirmed he had not routinely analyzed or reviewed resident and staff illness/ infections within the facility.

On 5/21/14, 1:10 p.m. the director of nursing (DON) confirmed the monthly tracking forms utilized by the facility. She indicated she was aware the current the infection control program was not effective and stated the facility would be working on the infection control program for improvement. DON verified no formal report was provided for QA meetings.

R56's quarterly Minimum Data Set (MDS) dated 4/8/14, indicated she had moderately impaired cognition and required extensive assistance of one staff to perform personal hygiene tasks.

R56's dental hygiene was observed on 5/20/14, at 7:34 a.m. with nursing assistant (NA)-A. NA-A brought R56 over to the bathroom sink in her wheelchair and positioned her in front of the sink. NA-A began by washing her hands in the sink, then gathering her supplies to perform oral hygiene. NA-A then picked-up R56's partial denture out of the denture cup and began to brush it, without donning gloves. After cleaning the partial denture it was laid atop a paper towel on the bathroom vanity. NA-A then proceeded to

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perform oral cares on R56 without gloved hands, brushing the inside of her mouth with the toothbrush. When NA-A completed oral cares, she picked-up the partial denture and applied it into R56's mouth. NA-A then went into R56's resident room and returned with her glasses. NA-A cleaned the glasses and applied them to R56's face. NA-A continued to clean around the bathroom sink, then collected the garbage and dirty laundry. NA-A did not don gloves throughout all of these tasks. NA-A left the room and took the garbage and dirty linen to the soiled utility room. NA-A then washed her hands.

During interview on 5/21/14, at 5:40 p.m. the DON confirmed that NA-A should have worn gloves during oral cares and should not have used her bare hands. The DON also stated, "This is not proper protocol and not good infection control measures."

During observation of morning cares on 5/20/14, beginning at 7:05 a.m. nursing assistant (NA)-A removed R21's pajama top and pants, placing them directly on the floor. Following cares, NA-A gathered all the soiled linens for washing.

During an interview on 5/20/14, at 7:16 a.m. NA-A confirmed the pajamas were placed on the floor and stated, "We are not to put anything on the floor."

During interview on 5/21/14, at 4:58 p.m. the DON confirmed she expected staff to place resident clothing and linens in plastic bags and bring them to laundry. The DON stated, "Linens should not go on the floor... nothing should touch the floor."

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F 441	Continued From page 61 Review of the facility's Infection Control Program policy revised 3/12, identified the facility was to collect and analyze data concerning infections for residents and staff. The program was to include analysis of the data to identify trends or outbreaks in a timely manner. Further, the policy identified changes were to be made promptly in the event there were any conditions that allowed an infection to occur. The policy instructed that ongoing surveillance and analysis of the surveillance were to be brought to the quality improvement committee on a routine basis. Review of the facility's Teeth Brushing policy revised 10/11, revealed staff were to wash their hands thoroughly and put on gloves prior to teeth brushing. Review of the facility's General Handwashing policy revised 3/03, directed staff were to wear gloves when it was reasonably anticipated that contact might occur with blood or other potentially infectious materials, such as mucous membranes and open skin lesions.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on May 19, 2014. At the time of this survey, Madison Lutheran Home was found not to be 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

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

Electronically Signed | 06/20/2014

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

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Madison Lutheran Home is a 3-story building with partial basement, and is fully fire sprinkler protected. The original building was constructed in 1914 and was determined to be of Type I(322) construction. The 1952 addition was determined to be of Type I(332) construction. The 1968 addition was determined to be of Type II(111) construction. The 1977 addition was determined to be of Type II(111) construction. The 1991 addition was determined to be of Type II(111) construction. Because the original building and the four additions met the construction types allowed for existing buildings, the facility was surveyed as one building. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, and is monitored for automatic fire department notification. The facility has a capacity of 80 beds and had a census of 67 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain a hazardous area door in accordance with NFPA 101 (00), Chapter 19, Section 19.3.2.1 and 19.3.6.3.2, and Chapter 8, Section 8.2.3.2.3.2. In a fire emergency, this deficient practice could adversely affect 20 of 80 residents. FINDINGS INCLUDE: On 05/19/2014 at 11:50 AM, observation revealed the corridor door leading into the Laundry Chute Termination Room in the basement of the 1952 building failed to self-close, as the door leaf was not equipped with automatic door closing hardware. This finding was confirmed with the director of environmental services at the time of discovery.	K 029	Maintenance Technician, Bill Kells, installed an automatic door closer hardware on the 1952 building clothes chute room. Completion date was 5-22-14. Paul Engesmoe, Director of Plant Engineering will monitor this door to make sure the auto closer and door latch works properly at all times.	5/22/14

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MADISON LUTHERAN HOME	**900 SECOND AVENUE** **MADISON, MN 56256**

(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
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility failed to maintain the emergency generators in accordance with the requirements at NFPA 101 (2000) Chapter 9, Section 9.1.3 and NFPA 110 (1999). In a fire or other emergency, this deficient practice could adversely affect 80 of 80 residents. FINDINGS INCLUDE: On 05/19/2014 at 10:55 AM, during a review of the monthly inspection and testing logs for the facility's two (2) emergency generators, no documentation could be provided verifying that each generator had been exercised at not less than 30% of their EPS nameplate ratings, during the previous calendar year. This finding was confirmed with the director of environmental services.	K 144	On 5/21/14 the MLH maintenance staff started logging KW load when running all emergency generators. Paul Engesmoe, Director of Plant Engineering will monitor the KW load for both generator sets.	5/21/14