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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: TXE1

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00353

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245238**
2.STATE VENDOR OR MEDICAID NO.
(L2) **739745302**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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 **02/24/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **32** (L18)
13.Total Certified Beds **32** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(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 :
Sherri Softing, HFE NEII 03/30/2017
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/19/2017
(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
08/04/1981
(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
03/03/2017
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5238

On February 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 24, 2017, the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 6, 2017. Based on our revisits, we have determined the facility has corrected deficiencies issued pursuant to the extended survey, effective February 9, 2017. As a result that the facility achieved compliance, the Department discontinued the Category 1 remedy of State monitoring as of February 9, 2017.

However, the Department recommended to the CMS Region V office the following actions related to the remedies recommended in our letter of March 30, 2107, for imposition:

- Civil money penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

Furthermore, 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), the facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 6, 2017, as a result of the extended survey that identified Substandard Quality of Care (SQC).

Effective February 9, 2017 the facility is certified for 32 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245238

June 18, 2017

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, MN 56557

Dear Mr. Kruger:

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

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

Effective February 9, 2017 the above facility is certified for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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
Health Regulation Division
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 30, 2017

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

RE: Project Number S5238027

Dear Mr. Kruger:

On January 24, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective January 29, 2017. (42 CFR 488.422)

In addition, on January 24, 2017, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies being imposed:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

Furthermore, this Department recommended to the CMS that the following additional enforcement remedy be imposed. CMS concurred and had authorized us to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 6, 2017. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on January 6, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On February 24, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on February 24, 2017, 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 an extended survey, completed on January 6, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 9, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on January 6, 2017, as of February 9, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective February 9, 2017.

However, as we notified you in our letter of January 24, 2017, 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 January 6, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of January 24, 2017:

- Civil money penalty for the deficiency cited at F309, be imposed. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 6, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 30, 2017

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

Re: Reinspection Results - Project Number S5238027

Dear Mr. Kruger:

On February 24, 2017 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 6, 2017, with orders reviewed electronically on January 25, 2017. 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
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: TXE1

Facility ID: 00353

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245238**
2.STATE VENDOR OR MEDICAID NO.
(L2) **739745302**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAHNOMEN HEALTH CENTER**
(L4) **414 WEST JEFFERSON AVENUE, PO BOX 396**
(L5) **MAHNOMEN, MN** (L6) **56557**

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 **01/06/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **32** (L18)
13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(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 :
Beth Nowling, HFE NEII 02/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/03/2017 (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
08/04/1981
(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 5238

On January 6, 2017 an extended survey was completed. Conditions in the facility constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to residents health and safety. CMS policy requires that facilities will not be given an opportunity to correct before remedies would be imposed when immediate jeopardy has been identified. The facility meets this criterion. Therefore, this Department imposed the following Category 1 remedy:

- State Monitoring effective January 29, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

Furthermore, 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 a facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 6, 2017. 42 CFR488.417 (b))

The facility would be subject to a two year loss of NATCEP, beginning January 6, 2017, as a result of the extended survey, that identified SQC. 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.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 24, 2017

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

RE: Project Number S5238027

Dear Mr. Kruger:

On January 6, 2017 an extended survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

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 6 months after the survey date; and

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on January 6, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective January 29, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F309. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

Furthermore, 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, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 6, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 6, 2017. (42 CFR 488.417 (b)). The will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 6, 2017. (42 CFR 488.417 (b)) . You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Futher, 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, Mahnomen Health Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective January 6, 2017. 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

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to: Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §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.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) 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. If you disagree with the findings 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 (formerly Health Care Financing Administration) 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-64
Washington, DC 20201

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.

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 1 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 remedy be imposed:

- 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 PoC 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 ePoC, 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

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 April 6, 2017 (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 July 6, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: 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
	245238	A. BUILDING _____ B. WING _____	01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on January 3, 2017 through January 6, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to comprehensively assess and effectively implement fall interventions of an alarm which resulted in the high potential for harm or death. The IJ began on September 20, 2016 and was removed on January 6, 2017. As a result of identification of the IJ at F323, an extended survey was conducted by the Minnesota Department of Health on January 5 and 6, 2017. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or	F 241		2/9/17

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

Electronically Signed | 02/01/2017

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F 241	Continued From page 1 her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents were dressed in a dignified manner for 1 of 2 residents (R22) reviewed for dignity concerns. Findings include: R22's annual Minimum Data Set (MDS) dated 11/16/16, indicated R22 had Parkinson's disease and Alzheimer's disease. The MDS identified R22 had severely impaired cognition, was incontinent of urine, and required extensive assistance for dressing and ambulation. R22's care plan dated 12/12/16, indicated R22 required the assistance of one to two staff, a gait belt, and walker for ambulation, and assistance of one staff for dressing needs and incontinence cares. On 1/3/17, at 5:00 p.m. R22 was observed seated in a recliner in the resident lounge area. R22 was observed wearing a pair of gray sweat pants that had a hole below the left front pocket approximately four inches long in the seam of the pants which exposed R22's left upper, outer thigh. A staff member was observed to assist R22 to stand, then instructed R22 to use the walker and ambulated from the resident lounge, down the hall, and into the dining room. Throughout the observation, staff and other residents were observed to walk near and around R22.	F 241	" On 01/06/2017 the hole in Resident 22□s grey sweat pants, below the left front pocket was repaired. " 01/25/2017 Nursing staff and Laundry staff were provided education by the Director of Nursing or Designee. The education included direction to inspect all resident clothing at the time of laundering and when assisting residents with dressing. If clothing is found to be in need of repair the clothing will be set aside for the seamstress to fix or if needed, family/representative will be notified to purchase new clothing. " By 02/03/2017 the same education will be discussed during one-on-one nursing home staff meeting. Staff not present during these meetings will be educated on their first shift worked after 02/03/2017. " By 02/03/2017 staff will receive education by the Director of Nursing or Designee on treating and caring for all residents in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident□s individuality. Staff not present during these meetings will be educated on their first shift worked after 02/03/2017. " The Director of Nursing (DON), or her designee, will monitor the residents□ appearance and condition of clothing every day x 2 weeks, then weekly x	

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F 241	Continued From page 2 On 1/3/17, at 5:49 p.m. R22 was seated in a stationary chair in the dining room outside of the serving door with his left side facing the dining room filled with residents. The hole in R22's pants gaped open and exposed R22's upper, outer left thigh and white incontinence brief. Throughout the dining observation on 1/3/17, from 4:58 p.m. to 5:49 p.m. multiple staff walked past R22 on the way to the serving door, with no attempts or offers to change R22's pants. On 1/5/17, at 7:51 a.m. nursing assistant (NA)-E verified R22 required extensive assistance with dressing, ambulation and incontinence cares. NA-E stated R22 had many pairs of sweat pants, and R22 should have had the sweat pants changed because it was not dignified to walk around with torn sweat pants that showed exposed skin. On 1/5/17, at 12:01 p.m. licensed practical nurse (LPN)-A verified R22's torn sweat pants should have been changed right away, and stated it was not dignified to be seated in the dining room with the leg and incontinent brief exposed. On 1/5/17, at 2:12 p.m. the dietary manager (DM)-A confirmed she observed the hole in R22's pants on 1/5/17. DM-A confirmed she could see skin of the left leg, and white material hanging out of the torn area of the sweat pants as R22 was seated in a chair in the dining room. DM-A confirmed staff was aware that R22's clothes were not in the best shape, and stated R22 had a history of picking at his clothing. On 1/5/17, 3:20 p.m. registered nurse (RN)-A found the pair of pants R22 was wearing on 1/3, and confirmed the hole was approximately four	F 241	1month until found to be compliant. The monitoring data will be brought through the Quality Assurance Performance Improvement by Nursing Home Quality Improvement designee (QAPI) until determined compliant. As of 02/09/2017 all residents clothing were inspected by director of nursing and MDS coordinator for defects. Clothing found to be defective were pulled and sent to laundry for repair. After this date, clothing will be inspected during laundering and examined by staff at the time of dressing.	

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F 241	Continued From page 3 inches long and stated R22 should not have been dressed in them. On 1/5/17, at 3:27 p.m. clinical manager (CM)-A confirmed the hole in R22's pants was not dignified, and would have expected staff to change R22's pants. The facility's Quality of Life-Dignity policy dated 3/2016, indicated each resident would be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.	F 241		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 care planned non-pharmacological interventions and ongoing monitoring of frequent moderate to severe pain for 1 of 3 residents (R18) reviewed for pain. Findings include: Review of R18's care plan dated 11/15/16, revealed R18 had complaints of chronic pain related to a history of alcohol abuse and falls with recent collar bone fracture. R18's care plan	F 282	" On 01/04/2017 a review of R18□s medication regime was conducted by the consulting pharmacist. The findings were for no recommendations at that time. " 01/06/2017 R18 was sent to clinic and was found to have an upper respiratory infection and was given an antibiotic and steroid. " 01/06/2017 BIMS□s and PHQ-9 were performed on R18. He scored a 6 which indicates some mild depression. " 01/10/2017 Primary care provider increased R 18□s gabapentin from	2/3/17

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F 282	Continued From page 4 revealed R18 had complained of pain with therapy, he had been educated to continue therapy despite the pain as he had not been using his arm due to pain. R18's care plan directed staff to provide R18 with pain medications, BioFreeze (an over the counter topical pain relieving medication) and non-pharmacological pain interventions of warm/cold packs. R18's care plan revealed PT has been ordered for shoulder pain and R18's MD had declined further pain medications or diagnostic testing of an MRI as of 11/8/16. The care plan further revealed R18 had enjoyed activities of trivia, reminiscing, and western movies shortly after he was admitted and R18's shoulder pain prevented him from attending activities. The care plan also revealed R18 preferred to lay in bed for comfort and had declined further activities due to pain. An identified care plan goal was for R18 to develop coping strategies to help adapt to pain. R18's admission Minimum Data Set (MDS) dated 11/2/16, R18 had frequent pain of a moderate level and had received as needed (prn) pain medications. The MDS identified R18 did not receive scheduled pain medications or non-medicinal interventions for pain within the seven day look back period. On 1/6/17, at 8:20 a.m. Registered Nurse Manager (NM) stated R18's cognition had improved since his admission assessment and no longer had moderate cognitive impairment. NM stated R18 would be a reliable source of information regarding his pain level. Review of R18's Pain Care Area Assessment (CAA) dated 11/2/16, identified R18 had many	F 282	300mg TID to 600mg TID in order to provide more pain control. Staff will monitor the effectiveness of the gabapentin increase through pain assessments and staff documentation of non-verbal cues. RN staff will report effectiveness to the Provider on Dr. Rounds or sooner if pain is not controlled tolerably. " 01/12/17 R18 was reassessed by Physical Therapy. He will continue with the functional maintenance program through rehab. " Resident was assessed on 01/17/2017 for activities of interests and abilities. The care plan was reviewed and revised. " On 01/13/2017 a reassessment of R18□s ability to perform Activities of Daily Living (ADLS), Range of Motion (ROM) of his right arm and implementation of non-pharmacological interventions was conducted by occupational therapy. The care plan was reviewed and revised as appropriate. " 01/17/2017 R18□s Ibuprofen (dose) was ordered to be administered 400mg TID scheduled instead of PRN and Tylenol will be PRN for breakthrough pain. Nursing staff will monitor the effectiveness of the Ibuprofen increase and report effectiveness to the Provider on Dr. Rounds or sooner if pain is not controlled or maintained at a tolerable level. " 01/17/2017 The IDT met to discuss R 18□s response to the increase in the medications. R18 has reported to OT and rehab that his pain is getting better and he can move his arm a lot better so it seems	

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F 282	Continued From page 5 complaints about shoulder, neck and back pain. The CAA identified R18 had a history of a broken collar bone. Review of R18's pain assessment dated 10/27/16, revealed R18 had stated upon staff interview he had frequent pain of the right shoulder and clavicle (collar bone) with onset with movement. The assessment revealed R18 had described the pain as an ache and was of a moderate intensity. The assessment revealed interventions were in place of Tylenol 650 milligrams (mg) by mouth (po) every four hours as needed (prn,) and a referral for physical therapy (PT) and occupational therapy (OT). On 1/4/17, at 12:40 p.m. R18 had his right arm guarded to his chest and a furrowed brow, clenched jaw and squinted eyes, with facial grimacing. On 1/4/17, at 2:37 p.m. R18 was observed with his right arm was tightly guarded to his chest. As he coughed, R18 grimaced with a furrowed brow. R18 stated the nurses offered him ibuprofen and Tylenol for the pain which was frequently ineffective. R18 stated the staff had offered ice packs right after he was admitted and that was also ineffective. Review of R18's medication administration record (MAR) for October, November and December 2016, revealed R18 was having inconsistant relief when prn medications were requested and administered. R18 reported ineffective, somewhat effective and effective relief after receiving the medication. In January 2017, revealed R18 had reported	F 282	that the increase in gabapentin has been effective. Staff will discuss R 18□s pain control and ability to perform ADLs at the weekly IDT meetings. Nursing staff and PT/OT will notify the DON if there is any indication by R18 that the resident□s pain is not controlled. " 01/26/2017 Follow up appointment was made with orthopedics for 02/01/2017 for a follow up to ensure proper healing of clavicle for pain management. " 01/26/2017 Family was notified of the plan to treat R18□s pain. Family was informed of the orthopedic appointment and the increase in the gabapentin and that the Ibuprofen is now scheduled " Beginning 01/26/2017 nursing staff will monitor facial expressions and behaviors of R 18 and document facial expressions that would be indicative of R 18 experiencing pain for example furrowed brow, taut jaw and cheeks, and pursed lips. Non-pharmacological interventions will be offered if R 18 is experiencing pain break through, prior to administering additional PRN pain medication per R18□s request. These interventions could include but are not limited to heat, cold pack, bio-freeze, repositioning etc. " On 01/27/2017 a depression reassessment was performed on R18 with a score of 3 which indicates minimal depression. Primary Care Provider was consulted for advisement. Plan: R18 clinic appointment made for 01/31/2017 regarding depression screening results. " On 01/27/2017 a reassessment of	

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F 282	Continued From page 6 moderate to severe pain and had received Tylenol 650 mg 3 times and out of the three times R18 had somewhat effective pain relief. The MAR revealed R18 received ibuprofen 400 mg eight times and out of the eight times two times R18 had somewhat effective pain relief and six times the ibuprofen was effective. Review of Therapy Assessment, OT evaluation form dated 10/28/16, revealed R18 was referred to the facility functional maintenance program (FMP) three times a week for ROM. Review of a Therapy Assessment, PT evaluation form dated 11/9/16, revealed R18 had shoulder pain from a fracture and had decreased ROM and pain. The assessment revealed PT had attempted seven visits with R18 from 11/11/16 to 12/1/16 and R18 had participated in therapy on three of the seven visits and had refused the rest. The assessment further revealed R18 continued to have pain in his shoulders. Review of facility progress notes from 10/27/16, to 1/4/17, revealed R18 consistently reported pain which was moderate to severe in intensity. R18 received prn medications upon request with inconsistent results. R18's medical record lacked any documentation of non-pharmacological interventions for pain having been offered or attempted for pain management. On 1/5/17, from 7:08 a.m. to 2:15 p.m. R18 was observed to have indicators of pain when attempting to utilize his right arm. Whenever possible, R18 utilized his left arm and held his right arm tightly guarded to his body. His face was	F 282	R18□s pain was conducted. His pain does not affect his ADL□s or his sleep. Scheduled medications will be given with non-pharmaceutical interventions and PRN Tylenol for breakthrough pain provided. The care plan was reviewed and revised. " By 02/03/2017 all Nursing staff was provided education on R18□s care plan. Those that are not working will be educated on their first shift worked after 02/03/2017. " 01/10/2017 maintenance fastened clips to all recliners for the alarms to be fastened too. " On 01/10/2017 the Medical Director met with the Administrator and DON to discuss the issue of pain management in the nursing home. Discussion included identifying the barriers to deal with chronic pain issues. The results of the discussion are: 1. Residents/patients with substance abuse and recent sobriety need to be treated conservatively. 2. There are those residents/patients with brain injuries from the substance abuse or have dementia which can lead to them being poor historians and can make it difficult to determine what the pain level is. 3. Providers should attempt therapy, non-pharmaceutical interventions and simple analgesics to be tried first. 4. Residents often refuse non-pharmaceutical interventions making it difficult to treat conservatively. 5. Providers will continue to treat pain more timely and aggressive.	

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F 282	Continued From page 7 consistently observed to have a furrowed brow, taut jaw and cheeks, and pursed lips. R18 stated he was not doing very well due to arm pain. R18 stated he could not sleep the previous night due to arm pain. R18 stated the nurse had given him Tylenol and it had not worked, and he continued to have severe pain. On 1/6/17, at 9:16 a.m. R18 walked down the hall independently toward his room, lips and jaw tight, forehead creased, brow furrowed. R18 stated he was in a lot of pain, had received some Tylenol that morning, and it had not been effective in reducing his pain. On 1/5/17, at 12:43 p.m. the PT stated R18 had refused to participate in therapy due to pain in his right shoulder. On 1/5/17, at 1:55 p.m. licensed practical nurse (LPN)-A stated R18 complained of right shoulder pain frequently. LPN-A stated R18 often reported to her both the Tylenol and ibuprofen were ineffective in relieving pain. LPN-A stated she had not offered R18 any other interventions for pain. On 1/5/17, at 2:39 p.m. nursing assistant (NA)-A stated she had seen R18 walk up to the nurses station and complain of pain on a routine basis. NA-A stated R18 had also frequently reported to her he had pain. On 1/5/17, at 3:18 p.m. NA- F stated R18 had reported to her he had been in pain though was unable to recall the most recent time. On 1/6/17, at 8:23 a.m. NA-D stated she completed resident restorative therapy daily and R18 was supposed to have upper and lower	F 282	6. Staff will communicate with the provider more frequently about pain and will discuss pain of residents at Inter-disciplinary meetings to determine what interventions seem to work best or what to try different. Staff will ensure medication administration is done timely, accurately and appropriately. " By 01/30/2017 a pain assessment with interviews were completed on all residents receiving pain medications. Those residents, who were not interviewable, will be observed for 5 days and will be determined from non-verbal cues if their pain is managed tolerably. Residents, whose pain is not managed at a tolerable level, will be brought to the Provider for further evaluation for pain management and their treatments will be adjusted accordingly. A pain reassessment will be performed in 60 days or sooner if needed. Care plans were adjusted accordingly. o 3 residents will be observed for 5 days for non-verbal cues as they are not interviewable. o 1 Resident refused to be interviewed. Will continue to try and interview. o 16 Residents were interviewed ¿ Of the 16 interviewed 5 stated that they didn□t have any pain. (RA, RB, RD, RE, RK) ¿ 10 complained of moderate pain (1-5 on a 1-10 scale). " RF-Plan increase gabapentin ordered at 100mg and continue with hydrocodone for breakthrough pain " RG-Plan: Ask resident in the AM if she would like a Tylenol for leg pain. Will	

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F 282	Continued From page 8 extremity exercises. NA-D stated she was to complete range of motion (ROM) exercises with R18's right arm three times a week which started in November. NA-D stated she had been unable to work with R18 the week of survey due to R18's complaints of pain. NA-D stated R18 had pain when he attempted to lift his right arm, moving his shoulder away from his body. NA-D stated she had not seen an improvement in R18's pain management or ROM since he was admitted. On 1/6/17, at 8:30 a.m. NA-C stated R18 frequently complained of pain in his right shoulder. On 1/6/17, at 2:23 p.m. during a follow up interview the NM stated she was aware R18 was not receiving routine relief with the current prn mediations of Tylenol and ibuprofen. The NM stated she felt R18 continued to experience pain and that his pain was not managed at that time. A care plan policy was requested and not provided.	F 282	re-evaluate 02/06/2017 to see if Tylenol should be scheduled. " RH-Plan: Declines further intervention. States his Tylenol BID is effective. " RI-Plan: Increase schedule Tylenol from BID to TID " RJ-Plan: Declines any medicine to treat pain. Performs his own exercises but would like a hot pack offered. Order entered to offer hot pack before bed, will re-evaluate in 2 weeks (02/13/2017) to see if this is effective. " RM-Plan: Resident states it is more anxiety related. Will plan to schedule Tylenol daily and continue with hydrocodone for breakthrough pain. " RN-Plan: Declines further intervention. States current treatment of Tylenol and Tramadol is effective. " RO-Plan: Tylenol was scheduled 01/24/2017 BID. Will continue to monitor for effectiveness. " RP-Plan: Continue gabapentin 400mg TID and Hydrocodone BID PRN. Will plan to schedule Tylenol in the AM. " RQ-Plan: Declines further intervention. State current medications are effective. ¿ 1 complained of severe pain (7 out of 10). RC-Plan: Has Doctor appointment 01/31/2017 will request for Tylenol to be scheduled and continue hydrocodone PRN for breakthrough pain. " 01/30/2017 care plan policy developed and put into place effective immediately. All staff will be educated on the policy by 02/03/2017 by the Director of Nursing or designee. Those staff not	

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F 282	Continued From page 9	F 282	working before 02/03/2017 will be educated on their next shift worked. " 01/30/2017 pain management policy developed and reviewed by Medical Director and put into effect immediately. All staff will be educated on the policy by 02/03/2017 by the Director of Nursing or designee. Those staff not working before 02/03/2017 will be educated on their next shift worked. " By 02/03/2017 nursing staff received education regarding pain management for residents. Staff not present during this meeting will be educated on their first shift worked after 02/03/2017. o This education included: 1. How to recognize a resident is experiencing pain by monitoring facial expressions, ability to perform ADLs, inability to sleep, presenting with behaviors, lack of appetite. 2. Monitoring and documentation of the effective of pain control medication. 3. Communication with providers regarding medication effectiveness and resident pain control. 4. Non pharmaceutical interventions and the importance of utilization prior to administration of PRN pain medication 5. Staff discussion and brainstorming of how to provide pain control and how to recognize resident pain. " By 02/03/17 Mahnomen Health Center Providers will evaluate residents in the nursing home with complaints of pain on a routine basis. " Weekly at the IDT meeting, each resident who receives pain medication or has pain concerns, the IDT will review the	

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F 282	Continued From page 10	F 282	effectiveness of the medications and interventions that are being utilized. If concerns are determined, the DON will follow up with the physician. " At the time of the Quarterly Assessment, the Minimum Data Set (MDS) coordinator, will interview staff and the resident if the assessment leads to pain concerns or if the resident is receiving pain medication. The MDS coordinator will follow up with the physician regarding the individual resident concerns. The MDS coordinator will review and revise the care plan as needed. " By 02/03/2017 all licensed staff will be educated on the process to document pain intensity rating pre/post administration for PRN medication in the EMAR. " The DON or her designee will monitor resident care plans for residents who utilize pain medication weekly to ensure the care plans are accurate as to interventions and resident status change. " The DON, or her designee, will monitor the documentation of the effective of PRN pain medications weekly to ensure the effectiveness is being monitored and communicated to the physician. " The DON, or her designee, will monitor weekly the documentation of facial expression or objective symptoms the resident who has pain concerns, is displaying that would indicated the resident was experiencing pain. " The monitoring data will be brought through the Quality Assurance	

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F 282	Continued From page 11	F 282	Performance Improvement (QAPI) until determined compliant. The next QAPI meeting is scheduled for February 21, 2017.	
F 309 SS=G	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions, monitor for efficacy and reassess the pain management program to relieve frequent moderate to severe pain following a fracture of	F 309	" On 01/04/2017 a review of R18□s medication regime was conducted by the consulting pharmacist. The findings were for no recommendations at that time. " 01/06/2017 R18 was sent to clinic and	2/3/17

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F 309	Continued From page 12 the right clavicle for 1 of 3 residents (R18) reviewed for pain. This deficient practice caused actual harm to R18. Findings Include: R18's admission Minimum Data Set (MDS) dated 11/2/16, identified R18 had moderate cognitive impairment and had diagnoses which included, pain of upper extremity, congestive heart failure (CHF) and seizure disorder. The MDS identified R18 had frequent pain of a moderate level and had received as needed (PRN) pain medications. The MDS identified R18 did not receive scheduled pain medications or non-medicinal interventions for pain within the seven day look back period. On 1/6/17, at 8:20 a.m. registered nurse manager (NM) stated R18's cognition had improved since his admission assessment and no longer had moderate cognitive impairment. At the time of the survey R18 had improved in cognition. NM stated R18 had minimal cognitive impairment and was able to verbalize his needs and wishes without difficulty. NM stated R18 would be a reliable source of information regarding his pain level. Review of R18's Pain Care Area Assessment (CAA) dated 11/2/16, identified R18 had many complaints about shoulder, neck and back pain. The CAA identified R18 had a history of a broken collar bone. The CAA revealed R18 was to be examined by his primary physician with nursing home rounds. Although R18 reported consistent, significant pain, there were no re-assessments of pain after this CAA. The facility failed to re-assess the pain and pain management program in order to determine efficacy of interventions and the	F 309	was found to have an upper respiratory infection and was given an antibiotic and steroid. " 01/06/2017 BIMS□s and PHQ-9 were performed on R18. He scored a 6 which indicates some mild depression. " 01/10/2017 Primary care provider increased R 18□s gabapentin from 300mg TID to 600mg TID in order to provide more pain control. Staff will monitor the effectiveness of the gabapentin increase through pain assessments and staff documentation of non-verbal cues. RN staff will report effectiveness to the Provider on Dr. Rounds or sooner if pain is not controlled tolerably. " 01/12/17 R18 was reassessed by Physical Therapy. He will continue with the functional maintenance program through rehab. " Resident was assessed on 01/17/2017 for activities of interests and abilities. The care plan was reviewed and revised. " On 01/13/2017 a reassessment of R18□s ability to perform Activities of Daily Living (ADLS), Range of Motion (ROM) of his right arm and implementation of non-pharmacological interventions was conducted by occupational therapy. The care plan was reviewed and revised as appropriate. " 01/17/2017 R18□s Ibuprofen (dose) was ordered to be administered 400mg TID scheduled instead of PRN and Tylenol will be PRN for breakthrough pain. Nursing staff will monitor the effectiveness of the Ibuprofen increase and report	

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F 309	Continued From page 13 need to modify any existing or implement new interventions. Review of R18's pain assessment dated 10/27/16, revealed R18 had stated upon staff interview he had frequent pain of the right shoulder and clavicle (collar bone) with onset of movement. The assessment revealed R18 had described the pain as an ache and was of a moderate intensity. The assessment revealed interventions were in place of Tylenol 650 milligrams (mg) by mouth (po) every four hours as needed (PRN) and a referral for physical therapy (PT) and occupational therapy (OT). Review of R18's care plan dated 11/15/16, revealed R18 had complaints of chronic pain related to a history of alcohol abuse and falls with recent collar bone fracture. R18's care plan revealed R18 had complained of pain with therapy, he had been educated to continue therapy despite the pain as he had not been using his arm due to pain. R18's care plan directed staff to provide R18 with pain medications, BioFreeze (an over the counter topical pain relieving medication) and non-pharmacological pain interventions of warm/cold packs. R18's care plan revealed PT had been ordered for shoulder pain and R18's MD had declined further pain medications or diagnostic testing of an MRI as of 11/8/16. The care plan further revealed R18 had enjoyed activities of trivia, reminiscing, and western movies shortly after he was admitted and R18's shoulder pain prevented him from attending activities. The care plan also revealed R18 preferred to lay in bed for comfort and had declined further activities due to pain. An identified care plan goal was for R18 to develop	F 309	effectiveness to the Provider on Dr. Rounds or sooner if pain is not controlled or maintained at a tolerable level. " 01/17/2017 The IDT met to discuss R 18□s response to the increase in the medications. R18 has reported to OT and rehab that his pain is getting better and he can move his arm a lot better so it seems that the increase in gabapentin has been effective. Staff will discuss R 18□s pain control and ability to perform ADLs at the weekly IDT meetings. Nursing staff and PT/OT will notify the DON if there is any indication by R18 that the resident□s pain is not controlled. " 01/26/2017 Follow up appointment was made with orthopedics for 02/01/2017 for a follow up to ensure proper healing of clavicle for pain management. " 01/26/2017 Family was notified of the plan to treat R18□s pain. Family was informed of the orthopedic appointment and the increase in the gabapentin and that the Ibuprofen is now scheduled " Beginning 01/26/2017 nursing staff will monitor facial expressions and behaviors of R 18 and document facial expressions that would be indicative of R 18 experiencing pain for example furrowed brow, taut jaw and cheeks, and pursed lips. Non-pharmacological interventions will be offered if R 18 is experiencing pain break through, prior to administering additional PRN pain medication per R18□s request. These interventions could include but are not limited to heat, cold pack, bio-freeze, repositioning etc.	

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F 309	Continued From page 14 coping strategies to help adapt to pain. On 1/4/17, at 12:40 p.m. R18 was lying on his left side in bed, facing the TV with his eyes open. R18 had his right arm guarded to his chest and a furrowed brow, clenched jaw and squinted eyes, with facial grimacing. On 1/4/17, at 2:37 p.m. R18 was seated on the edge of his bed, his feet on the floor. His right arm was tightly guarded to his chest. As he coughed, R18 grimaced with a furrowed brow. R18 stated he had been experiencing pain following a fall prior to admission to the facility in late October 2016. R18 continued to guard his right arm, and grimace. R18 stated he had sharp pain which started at his collar bone and radiated down to his hand. R18 stated at times the pain was severe, being at least an "8" on a pain scale of 0 to 10 with 10 being the worst imaginable pain. R18 stated he was right handed, so being independent with his cares and eating had been hard as he experienced pain whenever he moved his right arm. R18 stated at times it was hard for him to sleep at night and coughing significantly increased his pain level. R18 stated he told the nurses he had pain everyday. R18 stated the nurses offered him ibuprofen and Tylenol for the pain which was frequently ineffective. R18 stated he had been told by the nurses to work with therapy for the pain and stated he could not work with therapy due to it causing too much pain. R18 stated his physician had recently started him on the medication, gabapentin (a medication used to treat nerve pain from neuropathy). R18 stated he had been taking the gabapentin since December and had not had relief from the pain. R18 stated he felt he had a high pain tolerance as he was "no stranger to pain", and the nurses and doctor	F 309	" On 01/27/2017 a depression reassessment was performed on R18 with a score of 3 which indicates minimal depression. Primary Care Provider was consulted for advisement. Plan: R18 clinic appointment made for 01/31/2017 regarding depression screening results. " On 01/27/2017 a reassessment of R18□s pain was conducted. His pain does not affect his ADL□s or his sleep. Scheduled medications will be given with non-pharmaceutical interventions and PRN Tylenol for breakthrough pain provided. The care plan was reviewed and revised. " By 02/03/2017 all Nursing staff was provided education on R18□s care plan. Those that are not working will be educated on their first shift worked after 02/03/2017. " 01/10/2017 maintenance fastened clips to all recliners for the alarms to be fastened too. " On 01/10/2017 the Medical Director met with the Administrator and DON to discuss the issue of pain management in the nursing home. Discussion included identifying the barriers to deal with chronic pain issues. The results of the discussion are: 1. Residents/patients with substance abuse and recent sobriety need to be treated conservatively. 2. There are those residents/patients with brain injuries from the substance abuse or have dementia which can lead to them being poor historians and can make it difficult to determine what the pain level is.	

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F 309	Continued From page 15 should listen to him when he said the medications were not relieving his pain. R18 stated the staff had offered ice packs right after he was admitted and that was also ineffective. R18 continued to exhibit a furrowed brow, squinted eyes, and grimacing. R18 stated he felt the pain had affected his well being, he felt depressed and all he did was smoke and try to sleep the pain away but couldn't do it. R18 stated he felt his continued pain kept him isolated and he did not feel like himself. Review of R18's current physician orders signed 12/13/16, revealed the following orders for pain management: Tylenol 325 mg, take two tablets po every four hours for pain (start date 10/27/16), ibuprofen 400 mg three times a day (TID) po for right arm pain (start date 12/7/16). A hand written order dated 12/16/16, revealed an order for gabapentin 300 mgs by mouth TID for pain. Review of R18's medication administration record (MAR) for October, November and December 2016, revealed the following administration of PRN pain medications and the effectiveness: -October 2016, revealed R18 had reported moderate to severe pain and had received PRN Tylenol 650 mg 10 times and one out of 10 times R18 had received relief from the Tylenol. R18 had reported somewhat effective relief the other nine times. -November 2016, revealed R18 reported moderate to severe pain and had received PRN Tylenol 650 mg 44 times. The MAR revealed on 26 out of the 44 times R18 had received the Tylenol it had been somewhat effective and three out of 44 times it was ineffective in relieving R18's	F 309	3. Providers should attempt therapy, non-pharmaceutical interventions and simple analgesics to be tried first. 4. Residents often refuse non-pharmaceutical interventions making it difficult to treat conservatively. 5. Providers will continue to treat pain more timely and aggressive. 6. Staff will communicate with the provider more frequently about pain and will discuss pain of residents at Inter-disciplinary meetings to determine what interventions seem to work best or what to try different. Staff will ensure medication administration is done timely, accurately and appropriately. " By 01/30/2017 a pain assessment with interviews were completed on all residents receiving pain medications. Those residents, who were not interviewable, will be observed for 5 days and will be determined from non-verbal cues if their pain is managed tolerably. Residents, whose pain is not managed at a tolerable level, will be brought to the Provider for further evaluation for pain management and their treatments will be adjusted accordingly. A pain reassessment will be performed in 60 days or sooner if needed. Care plans were adjusted accordingly. o 3 residents will be observed for 5 days for non-verbal cues as they are not interviewable. o 1 Resident refused to be interviewed. Will continue to try and interview. o 16 Residents were interviewed ¿ Of the 16 interviewed 5 stated that they didn□t have any pain. (RA, RB, RD,	

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F 309	Continued From page 16 pain. R18 had reported effective results the other 15 times. -December 2016, revealed R18 had reported moderate to severe pain and had received PRN Tylenol 650 mg 32 times and out of the 32 times, 18 times R18 had reported the medication was somewhat effective and 3 times ineffective and 11 times was effective. The MAR also revealed R18 had received ibuprofen 400 mg 31 times during the month, out of the 31 times 10 times the ibuprofen was semi effective, three times not effective and 18 times was effective. -January 2017, revealed R18 had reported moderate to severe pain and had received Tylenol 650 mg 3 times and out of the three times R18 had somewhat effective pain relief. The MAR revealed R18 received ibuprofen 400 mg eight times and out of the eight times two times R18 had somewhat effective pain relief and six times the ibuprofen was effective. Review of an x-ray report dated 10/14/16, identified R18 had a displaced fracture of the distal third of the clavicle which appeared to be a healing subacute fracture. Review of R18's physician progress notes dated 11/8/16, revealed R18 had been seen for an initial visit. The note revealed R18 had attended therapy at the time of the note for right upper extremity and staff could apply moist heat 15 minutes per hour as able for the pain. The note revealed R18 had suffered a fracture of his right collarbone on 10/14/16 and had suffered constant, sharp pain which radiated from his collarbone down his right arm and occurred with any type of activity. The note revealed R18 had	F 309	RE, RK) ¿ 10 complained of moderate pain (1-5 on a 1-10 scale). " RF-Plan increase gabapentin ordered at 100mg and continue with hydrocodone for breakthrough pain " RG-Plan: Ask resident in the AM if she would like a Tylenol for leg pain. Will re-evaluate 02/06/2017 to see if Tylenol should be scheduled. " RH-Plan: Declines further intervention. States his Tylenol BID is effective. " RI-Plan: Increase schedule Tylenol from BID to TID " RJ-Plan: Declines any medicine to treat pain. Performs his own exercises but would like a hot pack offered. Order entered to offer hot pack before bed, will re-evaluate in 2 weeks (02/13/2017) to see if this is effective. " RM-Plan: Resident states it is more anxiety related. Will plan to schedule Tylenol daily and continue with hydrocodone for breakthrough pain. " RN-Plan: Declines further intervention. States current treatment of Tylenol and Tramadol is effective. " RO-Plan: Tylenol was scheduled 01/24/2017 BID. Will continue to monitor for effectiveness. " RP-Plan: Continue gabapentin 400mg TID and Hydrocodone BID PRN. Will plan to schedule Tylenol in the AM. " RQ-Plan: Declines further intervention. State current medications are effective. ¿ 1 complained of severe pain (7 out of 10). RC-Plan: Has Doctor appointment	

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F 309	Continued From page 17 significant deformity of his collarbone with tenderness over the joint. The note further revealed R18 was to be seen again in four weeks. Review of R18's physician note dated 12/7/16, revealed R18 was seen by an orthopedic physician regarding his right shoulder. The note revealed R18 had been having significant pain and had been unable to comply with therapy in the facility due to right arm pain. The note identified R18 had a healing right distal clavicle fracture with possible cuff dysfunction with his pain. The note further revealed R18 had weakness with external rotation, that may have been due to pain. Review of R18's physician progress note dated 12/13/16, revealed a nursing home note which identified R18 had a closed displaced fracture of acromial end of right clavicle (towards the shoulder) with malunion. The note revealed R18 complained of ongoing pain in the right shoulder. The note revealed R18 had significant right shoulder girdle atrophy with a marked deformity of the distal clavicle. The note further revealed R18's internal and external rotation were limited. The note also revealed R18 had tenderness to touch over the right shoulder. The note revealed R18 was to continue to receive heat application therapy and use Tylenol and ibuprofen for pain management. The note further revealed R18 was to continue with passive and active range of motion (ROM) exercises and the physician would consider adding additional pain medication if no improvement in R18's pain. Review of Therapy Assessment, OT evaluation form dated 10/28/16, revealed R18 had been	F 309	01/31/2017 will request for Tylenol to be scheduled and continue hydrocodone PRN for breakthrough pain. " 01/30/2017 care plan policy developed and put into place effective immediately. All staff will be educated on the policy by 02/03/2017 by the Director of Nursing or designee. Those staff not working before 02/03/2017 will be educated on their next shift worked. " 01/30/2017 pain management policy developed and reviewed by Medical Director and put into effect immediately. All staff will be educated on the policy by 02/03/2017 by the Director of Nursing or designee. Those staff not working before 02/03/2017 will be educated on their next shift worked. " By 02/03/2017 nursing staff received education regarding pain management for residents. Staff not present during this meeting will be educated on their first shift worked after 02/03/2017. o This education included: 1. How to recognize a resident is experiencing pain by monitoring facial expressions, ability to perform ADLs, inability to sleep, presenting with behaviors, lack of appetite. 2. Monitoring and documentation of the effective of pain control medication. 3. Communication with providers regarding medication effectiveness and resident pain control. 4. Non pharmaceutical interventions and the importance of utilization prior to administration of PRN pain medication 5. Staff discussion and brainstorming of how to provide pain control and how to	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 18 evaluated for therapy and had impaired upper ROM both active and passive of his right upper extremity. The assessment revealed R18 was referred to the facility functional maintenance program (FMP) three times a week for ROM. Review of a Therapy Assessment, PT evaluation form dated 11/9/16, revealed R18 had shoulder pain from a fracture and had decreased ROM and pain. The assessment identified R18 has constant pain which would shoot down his arm. The assessment revealed R18 had reported Tylenol was not effective in relieving his pain which he had rated an 8 out of 10. The assessment revealed R18 understood the need to move his arm around, though did not want to due to pain. The assessment revealed PT had attempted seven visits with R18 from 11/11/16 to 12/1/16 and R18 had participated in therapy on three of the seven visits and had refused the rest. The assessment further revealed R18 continued to have pain in his shoulders. Review of facility progress notes from 10/27/16, to 1/4/17, revealed the following: -A note on 10/27/16, revealed R18 was alert and oriented, had complained of shoulder pain rated a 7 out of 10, received Tylenol 650 mg. The note revealed R18 reported a tolerable level of pain was a 3 out of 10. - A note on 10/30/16, revealed R18 complained of pain rated 6 out of 10 and received Tylenol 650 mg. -A note on 11/04/16, revealed R18 complained of right shoulder pain rated a 7 out of 10 and had received Tylenol 650 mg.	F 309	recognize resident pain. " By 02/03/17 Mahnomen Health Center Providers will evaluate residents in the nursing home with complaints of pain on a routine basis. " Weekly at the IDT meeting, each resident who receives pain medication or has pain concerns, the IDT will review the effectiveness of the medications and interventions that are being utilized. If concerns are determined, the DON will follow up with the physician. " At the time of the Quarterly Assessment, the Minimum Data Set (MDS) coordinator, will interview staff and the resident if the assessment leads to pain concerns or if the resident is receiving pain medication. The MDS coordinator will follow up with the physician regarding the individual resident concerns. The MDS coordinator will review and revise the care plan as needed. " By 02/03/2017 all licensed staff will be educated on the process to document pain intensity rating pre/post administration for PRN medication in the EMAR. " The DON or her designee will monitor resident care plans for residents who utilize pain medication weekly to ensure the care plans are accurate as to interventions and resident status change. " The DON, or her designee, will monitor the documentation of the effective of PRN pain medications weekly to ensure the effectiveness is being monitored and communicated to the physician.	

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F 309	Continued From page 19 -A note on 11/5/16, revealed R18 complained of right shoulder pain, rated 8 out of 10 and received Tylenol 650 mg. The note revealed R18 had reported pain of 4 out of 10 after receiving the Tylenol. - A note on 11/6/16, revealed R18 complained of right shoulder pain, rated 6 out of 10 and received Tylenol 650 mg. The note revealed R18 had reported pain of 2 out of 10 after he received the Tylenol. - A note on 11/7/16, revealed R18 refused therapy due to right arm pain. - A note on 11/8/16, revealed R18 was not seen for restorative therapy for the week of November 2 - 8, due to right shoulder pain. Another note revealed R18 had been seen in the facility by his primary physician. The note revealed R18 complained of right shoulder pain and requested an MRI. The note further revealed R18's MD ordered PT for shoulder pain and ROM. -A note dated 12/2/16, as a late entry for 11/11/16, revealed R18 was seen by PT for right shoulder pain and completed ultrasound and therapeutic exercises which included passive ROM. -A note dated 12/2/16, as a late entry for 11/15/16, revealed R18 had been seen for 25 minutes by PT, received ROM exercises and reported continued pain of the right shoulder. -Review of notes dated 12/2/16, as late entries for 11/16/16, 11/18/16, revealed R18 refused therapy.	F 309	" The DON, or her designee, will monitor weekly the documentation of facial expression or objective symptoms the resident who has pain concerns, is displaying that would indicated the resident was experiencing pain. " The monitoring data will be brought through the Quality Assurance Performance Improvement (QAPI) until determined compliant. The next QAPI meeting is scheduled for February 21, 2017.	

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F 309	Continued From page 20 -A note dated 11/19/16, revealed R18 complained of shoulder pain rated 6 out of 10 and received Tylenol 650 mg. - A note dated 12/2/16, as a late entry for 11/22/16, revealed R18 refused therapy. -A note dated 12/2/16, as a late entry for 11/23/16, revealed R18 refused therapy. -A note dated 11/28/16, revealed R18 complained of shoulder pain rated 7 out of 10 and received Tylenol 650 mg. The note revealed R18 had rated his pain 4 out of 10 after he received the Tylenol. - A note dated 11/30/16, revealed R18 complained of shoulder pain rated a 7 out of 10 and received Tylenol. The note revealed R18 had rated his pain 3 out of 10 after he received the Tylenol. - A note dated 12/2/16, late entry for 12/1/16, revealed R18 was seen by PT, reported improved pain and completed 25 minutes of ROM exercises. - A care conference note dated 12/1/16, revealed R18 complained of right shoulder pain from a fall prior to admission. The note revealed R18 had not addressed his shoulder properly and the result was chronic pain. The note further revealed R18 resisted therapy despite the benefit. The note revealed R18 had been provided education on the benefits of therapy. - A note dated 12/1/16, revealed R18 complained of shoulder pain rated 6 out of 10, and received Tylenol 650 mg.	F 309		

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F 309	Continued From page 21 - A note dated 12/3/16, revealed R18 complained of shoulder pain rated 8 out of 10, and received Tylenol 650 mg. - A note dated 12/4/16, revealed R18 complained of shoulder pain rated 7 out of 10, and received Tylenol 650 mg. -A note dated 12/5/16, revealed R18 spoken with the NM twice and stated something needed to be done about his shoulder. The note revealed PT had planned to discontinue services. The note revealed the NM would speak with R18's MD. A further note revealed R18 complained of pain rated 7 out of 10 and received Tylenol 650 mg. The note revealed R18's pain level was 4 out of 10 after he received the Tylenol. - A note dated 12/8/16, a late entry for 12/6/16, revealed R18 received 2 out of 3 restorative sessions for the week of 11/30/16 through 12/6/16 and completed upper extremity (U/E) exercises. - A note dated 12/7/16, revealed R18 was seen by an orthopedic MD and received no new orders or interventions for pain relief. The note revealed NM encouraged R18 to take Tylenol. A further note revealed R18's MD had ordered ibuprofen 400 mg TID as needed for right arm pain. The note further revealed R18 was to keep using ice and heat to address pain with gentle ROM. - A note dated 12/8/16, revealed R18 complained of right shoulder pain and ibuprofen was given. A further note revealed R18's functional maintenance program (FMP) was updated to include gentle ROM to his right upper extremity	F 309		

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and lower extremities. A further note revealed R18 complained of pain rated a 7 out of 10 and received ibuprofen 400 mg. The note revealed R18's pain level was 3 out of 10 after he received the ibuprofen.

- A note dated 12/9/16, revealed R18 complained of pain rated 7 out of 10, and received ibuprofen 400 mg. The note revealed R18's pain level was rated 4 out of 10 after he received the ibuprofen.

- A note dated 12/11/16, revealed R18 complained of pain rated at 8 out of 10 and received ibuprofen 400 mg. The note revealed R18's pain level was rated 3 out of 10 after he received the ibuprofen.

-A note dated 12/13/16, revealed R18 had been seen by his primary MD on a routine visit. The note revealed R18 complained of continued shoulder pain. The note further revealed R18 was to use heat to his shoulder for pain 15 minute intervals.

-A note dated 12/15/16, revealed R18 complained of shoulder pain rated 8 out of 10 and had received Tylenol 650 mg. The note revealed R18 rated the pain level 4 out of 10 after he received the Tylenol.

- A note dated 12/16/16, revealed R18 approached NM and requested to be seen in the emergency room (ER) for continued shoulder pain. The note revealed NM encouraged R18 to be seen at the clinic in the afternoon. The note revealed NM had informed R18's MD of his continued complaints of pain. The note revealed R18's MD had sent an order for gabapentin 300 mg TID for increased pain and R18 was not seen

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in the clinic or ER.

-A note on 12/20/16, revealed R18 complained of pain in his arm and requested Tylenol. The note revealed R18 had become "impatient" when he had to wait for the pain medication.

- A note on 12/21/16, revealed R18 was observed to wear a pained look upon his face and was gently holding his his arm. The note further revealed R18 refused group activities and only wanted to smoke, eat and lay down.

- A note on 12/22/16, revealed R18 had trouble completing exercises due to pain and too much pressure on his right shoulder.

R18's medical record lacked any documentation of non-pharmacological interventions for pain having been offered or attempted for pain management.

On 1/5/17, at 7:08 a.m. R18 was seated in a stationary chair in the dining room, held a coffee cup in his left hand and his right arm was bent at the elbow resting on the armrest of the chair. R18 received scrambled eggs, two sausage links, toast and hot cereal. R18 lifted his right arm and reached for his fork. R18's eyes immediately shut, brow furrowed and R18 quickly put his right arm back down on the armrest. R18 used his left hand, grabbed the fork and proceeded to eat 4 fork bites of scrambled eggs. R18 then moved his fork to his right hand, pierced a sausage link guarded his right arm to his chest, bent his elbow and moved his head down to the fork to eat the sausage links. R18 did not raise his right arm/hand to eat the sausage. R18 picked up a spoon with his left hand and ate three bites of his

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hot cereal, and placed the spoon back on the table. R18 picked up a piece a toast with his left hand, ate two bites, and placed it back on his plate. R18 held the coffee cup in his left hand and drank all of his coffee. At 7:19 a.m. the director of nursing (DON) approached R18 and asked if he had enough to eat. R18 replied he was not feeling well and stated he was going to go back to bed. At 7:22 a.m. R18 independently walked out of the dining room with his right arm guarded to his right side, walked to the nurses station and obtained a cigarette and lighter. R18 walked toward the smoking room, pushed the button with his left hand to open the door, walked in the room and sat on a chair. R18 lit his cigarette with his left hand and proceeded to smoke with his left hand, while his right arm remained at his side. R18 then walked independently back to his room and sat on his bed, while his right arm remained guarded to his side, brow was furrowed, jaw tight and face taut.

On 1/5/17, at 7:26 a.m. R18 stated he was not doing very well due to arm pain. R18 stated he could not sleep the previous night due to arm pain. R18 stated the nurse had given him Tylenol and it had not worked, and he continued to have severe pain. R18 said he was "so tired" of the pain. R18 further admitted he felt frustrated and hopeless. R18 stated he would tell the nurse when he had pain and would tell the nurses when the Tylenol or ibuprofen was ineffective in relieving pain. R18 said he told his physician he was in pain and the Tylenol and ibuprofen were ineffective in easing the pain. R18 stated he had pain everyday and staff knew he was in pain.

On 1/5/17, at 12:14 p.m. R18 walked independently in the hallway toward his room, his

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right arm guarded tightly to his right side. R18's brow was furrowed, cheeks and jaw were taut, and lips were pursed.

On 1/5/17, at 2:15 p.m. R18 walked independently down the hall toward the nurses station, his right arm guarded toward his side, cheeks taut, brow furrowed, lips and jaw tight. R18 obtained a cigarette, smoked with his left hand in the facility smoking room and walked back to his room. R18's facial expression remained unchanged.

On 1/6/17, at 9:16 a.m. R18 walked down the hall independently toward his room, lips and jaw tight, forehead creased, brow furrowed. At that time R18 stated he was in a lot of pain, had received some Tylenol that morning, and it had not been effective in reducing his pain.

On 1/5/17, at 12:27 p.m. the dietary manager (DM) stated she was aware R18 had not been using his right arm consistently during meals. The DM stated she felt R18's use of his arm would improve with therapy. She stated R18 did not want to use his right arm like he used to and would not participate in therapy because of that.

On 1/5/17, at 12:43 p.m. the PT stated R18 had refused to participate in therapy due to pain in his right shoulder. The PT stated he felt R18 was a reliable source of information regarding his pain and was unsure of the last time PT was completed.

On 1/5/17, at 1:55 p.m. licensed practical nurse (LPN)-A stated she felt R18 was cognitively intact and able to voice his needs and wishes. LPN-A stated R18 complained of right shoulder pain

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frequently. LPN-A stated she would provide R18 with ordered PRN Tylenol and ibuprofen when he reported pain. LPN-A stated R18 often reported to her both the Tylenol and ibuprofen were ineffective in relieving pain. LPN-A stated she reported R18's continued pain to the NM as recently as a couple of weeks ago. LPN-A stated she had not offered R18 any other interventions for pain.

On 1/5/17, at 2:39 p.m. nursing assistant (NA)-A stated she had seen R18 walk up to the nurses station and complain of pain on a routine basis. NA-A stated R18 had also frequently reported to her he had pain, most recently that week. NA-A stated R18 had complained of right shoulder pain since admission a few months ago. NA-A stated she felt there were days R18 would stay in his room due to being in so much pain. NA-A stated R18 had also reported to her he often laid down due to pain and did not sleep well. NA-A stated she would inform the nurse when R18 would report pain to her. NA-A stated she routinely observed R18 grimacing when he moved his right arm on a routine basis.

On 1/5/17, at 3:18 p.m. NA- F stated R18 had reported to her he had been in pain though was unable to recall the most recent time. NA-F stated she felt R18 often held his right arm to his body due to being in pain. NA-F stated she had seen R18 walk up to the nurses station and complain of pain frequently. NA-F stated she had also reported to the nurses R18 had pain, though was unable to recall the most recent time.

On 1/6/17, at 1:59 p.m. the activity director (AD) stated she felt R18 was cognitively intact and able to voice his needs and wishes. The AD stated

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R18 had participated in activities briefly after he arrived at the facility. The AD stated R18 routinely complained of right shoulder/arm pain since admission and had stopped attending activities. The AD stated she completed 1:1 visits with R18 in his room per his preference. The AD stated R18 had stopped attending group activities due to his pain.

On 1/6/17, at 8:23 a.m. NA-D stated she completed resident restorative therapy daily and R18 was supposed to have upper and lower extremity exercises. NA-D stated she was to complete range of motion (ROM) exercises with R18's right arm three times a week which started in November. NA-D stated R18 complained of pain with movement of his right arm. NA-D stated R18 had a fractured collar bone on the right side which she felt affected his range of motion. NA-D stated she had been unable to work with R18 the week of survey due to R18's complaints of pain and not feeling well. NA-D stated R18 had pain when he would bear weight with his right arm and when he attempted to lift his right arm, moving his shoulder away from his body. NA-D stated she had not seen an improvement in R18's pain management or ROM since he was admitted.

On 1/6/17, at 8:30 a.m. NA-C stated R18 frequently complained of pain in his right shoulder. NA-C stated she frequently observed R18 guarding his right arm by holding it against his body. NA-C stated when R18 reported pain in his shoulder she would immediately tell the nurse.

On 1/6/17, at 8:46 a.m. a phone call was placed to R18's primary physician, who was also the facility's medical director. R18's primary MD was not in the office and would not return until 1/9/17,

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a message was left with MD's nurse line for MD to call back. MD did not return phone call prior to survey exit. A phone call was received by MD on 1/10/17, at 4:20 p.m. During the phone interview MD stated he was aware R18 had ongoing pain, especially in his right shoulder. MD stated he was not aware of the overall ineffectiveness of R18's current pain regimen. MD stated he had thought R18's Tylenol and ibuprofen were already given to him on a scheduled basis. MD stated the usual practice was to schedule PRN pain medication if they routinely received it. MD stated he had referred R18 to an orthopaedic MD and he had felt an MRI was not necessary. MD stated he had considered adding Tramadol (non-opiate prescription pain medication) to R18's medication regimen but had not at that time. MD stated he was very reluctant to order opioid and/or narcotic pain medications due to the monitoring involved in prescribing those medications. MD stated he would only order opioid and/or narcotic pain medications in cases of acute injury or pain, which he felt R18 did not meet that criteria. MD stated he had also ordered gabapentin for R18's pain in December some time and had hoped that would improve. MD stated R18 could have had heat and cold therapy, but was not sure if the staff had tried them or their effectiveness.

On 1/6/17, at 1:56 p.m. LPN-B stated R18 had an old fracture to his right collar bone which she felt continued to cause R18 frequent pain. LPN-B stated R18 received Tylenol and ibuprofen for pain, which were overall not effective. LPN-B stated she had reported to the NM, R18 was not receiving relief from pain with the current prn medications, most recently as the previous week.

On 1/6/17, at 2:23 p.m. during a follow up

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F 309	Continued From page 29 interview the NM stated she was aware R18 was not receiving routine relief with the current PRN medications of Tylenol and ibuprofen. The NM stated she had been unable to complete another cognition assessment as requested by the surveyor due to R18 not feeling well with a cough. The NM stated she felt R18 was overall cognitively intact and may have minimal memory loss. The NM stated she felt R18 was a reliable source of information regarding his pain. The NM stated she had reported to R18's primary MD the current pain medication overall was not effective. The NM stated she would routinely struggle with R18's MD regarding R18's pain management due to an unwillingness to try other pain medications. The NM stated R18's MD has started him on gabapentin and only saw minimal improvement. The NM stated she felt R18 continued to experience pain and that his pain was not managed at that time. A facility policy titled, Pain, reviewed 5/2016, revealed it was the facility's policy to ensure patients were free of pain or would receive pain management that would allow them to maintain the highest degree of functioning and well being, enhance comfort. The policy directed facility licensed staff to complete an initial and ongoing pain assessment of prn medications. The policy directed licensed staff to monitor the effectiveness of medications and to evaluate if a need to schedule prn pain medications.	F 309		
F 323 SS=J	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		2/9/17

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F 323	Continued From page 30 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively re-assess, thoroughly investigate causal factors and implement effective interventions in order to minimize the risk of falls and injury for 1 of 3 residents (R32) who sustained harm following a fractured wrist and has had continued falls. The facility was utilizing a care planned intervention related to use of a chair alarm, however, did not follow manufacturer instructions rendering the intervention ineffective when the device was not affixed properly. This resulted in an immediate jeopardy situation for R32. Findings include:	F 323	ABATEMENT PLAN AS APPROVED BY MDH ON 1/6/2017: 1.) What are you going to do to remove the immediacy of the risk. a. Switched the Tab alarm and replaced it with a mat alarm in the wheelchair based on root cause analysis and resident assessment. It was determined that the mat alarms would be more sensitive to the repositioning of the resident and the box does not need to be secured to any of the chairs in order for the alarm to function. b. Staff on duty on 1/5/and 1/6/2017 were educated by the RN and DON on the SMART chair alarm utilizing the	

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F 323	Continued From page 31 The Immediate Jeopardy (IJ) began on 9/20/16, related to the facility's failure to complete a comprehensive assessment to determine causal factors related to risk for falls and implement effective interventions for R32. The facility administrator and director of nursing (DON) were notified of the IJ on 1/5/17, at 10:15 a.m. which began on 9/20/16, when R32 had fallen and the facility failed to complete a comprehensive assessment of causal factors related to R32's continued falls, in a effort to implement interventions to minimize the risk of R32's risk for further falls. The IJ was removed on 1/6/17, at 4:00 p.m., however, non-compliance remained at a scope and severity level of G, which indicated actual harm for R32 due to a left wrist fracture sustained during a fall which required medical assessment and intervention. R32's diagnosis list dated 1/5/17, indicated R32's diagnoses included dementia, limitation of activities due to disability, difficulty in walking, history of encephalopathy (acute changes in awareness), fracture of the right arm, rheumatoid arthritis, osteoarthritis and osteoporosis. R32's admission Minimum Data Set (MDS) dated 7/26/16, indicated R32's history of falls, or fall risk could be determined. R32's MDS identified R32 had severely impaired cognition, required extensive assistance with activities of daily living (ADLs), was occasionally incontinent of urine, was not on a toileting program, received antibiotic medication and had a urinary tract infection (UTI) which increased R32's risk for falls. R32's MDS further identified R32 had hallucinations and wandered which put R32 at significant risk for injury. R32's Falls Care Area Assessment (CAA) dated	F 323	manufacturer□s instructions. Staff educated did confirm they understood correct placement of the alarm ensuring that proper placement and testing were performed so the alarm is able to function properly. Staff that was not on duty on 1/5 and 1/6 will receive education as they come on duty. Staff educated on when to use the mat alarms according to the individualized care plan. c. A comprehensive assessment was completed on 1/5/2017 by RN and based on the assessment there was no change in the resident□s status since the last quarterly assessment done in October of 2016. Findings of the specific assessment requested are: i. Recliner assessment: 1. According to the definition of a restraint the chair when reclined causes difficulty for this resident to transfer independently. Resident requests to be seated in the recliner with her feet elevated and her legs covered. She is able to cue staff by waving, asking and has obvious agitation that she wants to be repositioned or moved out of the recliner. 2. Plan: a. Resident will be asked if she would like to be placed in the recliner and if she would like her feet reclined or not. b. Staff will continue with hourly rounding while in the recliner. c. A Staff member will be monitoring the commons area at all times when residents with alarms are present in the commons area. d. A mat alarm will be used at all times when seated in the recliner in the	

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F 323	Continued From page 32 8/2/16, indicated R32 had 1 fall. R32 was found on the floor in her room in front of her recliner. She had an x-ray which was negative for a fracture, and R32 remained a high fall risk. R32's Cognitive Loss/Dementia CAA dated 8/2/16, indicated R32 had obtained a bladder infection during her first week of admission and remained very confused and delirious at times. R32's Falls Risk Acuity report dated 7/21/16, indicated R32 had poor safety awareness, required the use of assistive devices, was up ad lib and was continent. The report indicated R32 took antihypertensive and laxative medications that increased R32's risk for falls. The report further indicated R32 had cognitive impairment with a decline in cognitive function, delirium, depression and dementia. The report identified R32 was at risk for falls and was to be seen by PT and occupational therapy (OT) and a falls care plan would be initiated. R32's care plan dated 12/30/16, indicated R32 had memory and cognitive problems that seemed to worsen with UTI's. R32 had a physical decline in all of her ADLs since the UTI, and signs of delirium as she reached for things she saw in the air. R32's care plan indicated the goals were to be safe in her surroundings, needs would be met and R32 would be monitored for safety concerns. R32's care plan identified R32 had been incontinent of bowel and bladder since admission and incontinence was possibly related to her recent UTI and fall. R32 was to be toileted every 2 hours. R32's care plan indicated as of 11/21/16, staff was not to leave R32 alone in the bathroom	F 323	commons area as directed in the plan of care specifically for this resident. ii. Bowel and Bladder assessment completed to determine resident□s toileting pattern. 1. RN has reviewed bathroom patterns over the last 7 days. This is a detailed record in real time based on nursing assistant records. This was taken based on actual times the resident was toileted or changed. Jan 5th, 2017: 6 am void, dressed and up for the day, was incontinent of bladder. 7am dry, 9am dry, 11am dry, 3pm dry, 5pm, 8pm void washed up for bed, then went to bed. 11pm dry awake in bed, placed in her recliner for supervision and night shift reported that she slept all night. Jan 4th 2017: 6am up and dressed, void but pad was wet, 8am dry void with a BM; 10 am dry void, 12pm dry void, 4pm dry void, 8pm dry void and dressed for bed, placed in her bed but was awake on rounds, placed in recliner during the night, slept remaining night shift. Jan 3rd 2017: 12 am placed in recliner, dry, 6am void but pad was wet, dressed for the day. 8am dry void, 9am dry void, 12pm dry void, 3 pm dry void, 5pm dry void, 8 pm dry void and dressed for bed. Jan 2nd 2017: Up in her recliner around 12-1am due to being awake in bed, 5am wet, void and dressed for the day, wanted to get up. 7am dry void, 10am dry void, 12pm dry void, 4pm dry void, 8pm dry	

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F 323	Continued From page 33 and watch for her trying to go to the bathroom by herself. The care plan identified R32 had bed and chair alarms placed 7/27/16, due to R32 self transferring, a tab alarm placed 9/20/16, due to standing without purpose, all items were to be within reach, no clutter on the floor, call light within reach, fall mat placed, bed in low position and lipped mattress. R32's care plan further identified R32 fell on 7/27/16, and had no injury, another fall 9/20/16, with skin tear and left wrist fracture, and fell again on 11/21/16, with no injury. The care plan failed to identify R32's falls on 8/27/16, and 10/9/16. There were no injuries. R32's undated North Assignment sheet (tool nursing assistants use to direct care), indicated R32 required the assistance of 1-2 staff for ADLs which included transfers and toileting, and identified R32 had a bed and chair alarm. Fall events: 1. R32's Fall Safety Event report indicated R32 fell on 7/27/16, at 7:30 p.m. after she attempted to self transfer and was found on the floor in her room. The report indicated R32 had complaints of pain in her buttocks and right thigh, had a fever and UTI. The report identified neurological checks (neuros) and vital signs (vitals) were checked and fall interventions included analgesics (pain medication), bed alarm and rest. R32's progress note (PN) dated 7/27/16, at 7:30 p.m. indicated R32 was found on the floor in her room in a sitting position with both legs off to her right side. R32 stated her butt and right leg and thigh hurt. The note identified R32 denied hitting her head and referred to the fall safety event report.	F 323	void and dressed for bed. Jan 1st 2017: Resident slept fair but was awake at 4 am, wet and void placed in recliner, 7am void, dressed for the day, 11am dry void, 12pm dry void, 4pm, dry void, 7pm dry void, 8pm dry void and dressed for bed. Dec 31 2016: Up and void at 5am, was wet and placed in recliner, 9am dry void, 12pm dry void, 3pm dry void, 7pm dry void, 9pm dressed for bed, dry. Dec 30th 2016: Up at 4am wet and up in her recliner, 7am dry void, 10 am dry void, 12pm dry void, 3pm dry void, 5 pm dry void, 8pm dry void and dressed for bed. RN has reviewed the bathroom patterns and Resident□s incontinence pattern has been determined to improve since her admission on 7/20/16. During the day she is kept continent and the assessment date indicates the Resident is only incontinent at night. There are very few occasions when she is incontinent, she does have some urge tendencies but she seems to be able to hold her bladder and have a continent void and BM. We do not wake her to toilet her due to her dementia and it can cause her to get her days and nights mixed up. This has been discussed with the family and they are in agreement. Staff attempts to place her in her bed at night, but during rounds the night staff find her awake often and due to her fall risks they get her up and assist the Resident to the recliner in the commons area for	

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F 323	Continued From page 34 R32's pelvic and hip X-ray report dated 7/31/16, at 5:02 p.m. identified R32 had abnormal bony projections throughout her pelvis and degenerative changes without definite fracture. 2. R32's Fall Safety Event report indicated R32 fell on 8/27/16, at 10:21 a.m. The report indicated R32's chair alarm sounded after she attempted to self transfer from her wheelchair to the commode. R32 was observed to slip and fall on the floor on her butt and hit her head on the bathroom door knob. The report indicated R32 complained of slight pain in her lower back and her vitals signs were taken. The report failed to identify R32's mental status, possible contributing factors, if current interventions were effective, or any new interventions implemented after the fall. R32's PN dated 8/27/16, at 10:38 a.m. indicated R32 slipped and fell on her butt and bumped her head on the door knob. R32 complained about slight pain in the middle of her back. R32's vitals were taken and the new intervention was to ensure R32 had her shoes on. 3. R32's Fall Safety Event report indicated R32 fell on 9/20/16, at 10:30 p.m. after R32 attempted to self-transfer. She was found on the floor in her room facing her bed with a skin tear to her right forearm. The report indicated neuros and vitals were completed, there were no possible contributing factors, current interventions were effective and an additional intervention was a floor mat. The record lacked a reassessment of R32's risk for falls. R32's PN dated 9/20/16, at 10:30 p.m. indicated R32 was found seated on her floor with her back	F 323	closer monitoring. The RN has notified the family about bringing the Resident to the commons area to rest in the recliner and be monitored. The family stated that that is fine as long as she is getting enough sleep. The RN and staff assured the family that she does sleep well in the recliner, but staff will continue to attempt to have her sleep in her bed. The RN and nursing will continue to monitor the Resident sleeping in the recliner and in her bed. Looking at a possible pattern for the resident□s toilet habits, it seems that after she gets up for the day she asks to use the bathroom about 1-2 hours after arising. There is not a definite pattern from breakfast through lunch; she has many voiding times that do not correlate from day to day. After lunch the Resident□s habits has been to either roam in her wheel chair and be with staff at the desk or she often requests to sit in the recliner and rest. She does rest well in her recliner and does usually nap for a few hours. The Resident is toileted before supper or asked if she needs to use the bathroom. Her afternoon routine is also not a pattern she doesn't seem to use the bathroom after 5pm until around 7-8pm, this is usually when she is getting ready for bed. If the Resident is roaming in her wheel chair or appears to be agitated, staff is	

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F 323	Continued From page 35 against the bed. R32 stated she scooted down. The note indicated vitals were taken and would be monitored every 4 hours per facility policy. R32 had no complaints of pain. The report identified R32 sustained a skin tear to her right forearm, neuros were at baseline and a floor mat would be requested. A PN dated 9/21/16 at 10:23 a.m. identified R32 complained of wrist pain while in therapy. Swelling was noted in the wrist and facial grimacing when touched. R32 was seen by the physician and an x-ray was ordered. R32's left wrist X-ray report dated 9/21/16, at 4:03 p.m. identified a left wrist fracture. 4. R32's Fall Safety Event Report indicated R32 fell on 10/9/16, at 1:53 p.m. after she self-transferred from a wheelchair to the toilet in her bathroom. R32 slid onto her butt. The report indicated R32 did not hit her head, had no complaints of pain and vitals were completed. The report failed to identify if current interventions were effective or any new interventions. R32's PN dated 10/9/16, at 1:45 p.m. identified R32 was found on the bathroom floor after she slid off the toilet onto the floor. The report indicated R32 had not hit her head, had no complaints of pain and her vital signs were taken. The note failed to identify any new interventions after R32 fell. R32's Falls Risk Acuity report dated 10/25/16, indicated R32 was disoriented with diminished safety awareness, required the use assistive devices, had impaired mobility and was continent with staff assistance. The report indicated R32 took antihypertensive, narcotic and laxative medications that increased R32's risk for falls. The report further indicated R32 had 3 or more	F 323	aware that she needs to be monitored more closely for bathroom or any other needs to be met. The Resident is fully capable of letting staff know that she needs to use the restroom; she may not come out and ask all the time but when asked she does say yes or no. Plan: Care rounding has been implemented as of 01/05/2017 which involves staff asking Charlotte every hour from 6AM to 10PM if she has any pain, if she requires or requests positioning, if she needs to utilize the bathroom, and to ensure that her personal items are within reach her needs are met. From 10PM to 6 AM staff observes her and meet her needs every two hours. 2. RN's have reviewed and talked about her bowel and bladder. She does seem to have a better control of her bladder since her admission. She seems that she is having less brief changes through the day. Due to the risk of falls she will be placed on a rounding program (rounding every hour during the day and every 2 hours at noc) for toileting, to try to anticipate her needs to use the bathroom in attempts to try and decrease falls and attempted self-transfers. iii. Fall risk assessment completed 1/5/2017for an updated score risk. The risk assessment score is 13 which is the same as the quarterly score done in October 2016. We will continue to use the bed and chair alarms but will use mat alarms instead of tab alarms for Charlotte and all residents that have been assessed	

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F 323	Continued From page 36 falls in the last 3 months, loss of limb movement, decline in physical status, incontinence, hypotension (low blood pressure), cerebrovascular accident (stroke) and weakness to 1 side of her body. The report identified R32 was at risk for falls, no referrals were necessary and they were to continue current plan of care. 5. R32's Fall Safety Event Report indicated R32 fell on 11/21/16, at 12:33 p.m. after she self-transferred from the wheelchair to the toilet in the east bathroom. R32 slid down between the toilet and the wall. The report indicated neuros and vitals were taken and R32 complained of pain on the right top of her hand. The report failed to identify if current interventions were effective and any new interventions added after the fall. R32's PN dated 11/21/16, at 12:11 p.m. identified R32 self transferred from her wheelchair to the toilet in the bathroom before staff could get to her and she slid down between the toilet and the wall. The note indicated R32 complained her right hand was sore and she was emotionally upset. The report further indicated vitals were taken and R32's care plan would be updated. The note failed to identify any new interventions implemented after R32 fell. On 1/3/17, at 1:44 p.m. R32 was observed seated in a recliner in the common area with a TABS alarm (fall prevention monitor) adjustable cord clipped to the back of R32's shirt. The unit was not attached to the recliner but placed between arm chair cushions, which may have prevented it from sounding if R32 attempted to stand independently. When the TABS unit was not secured, the cord can stay attached to the unit. If it does not separate, the alarm will not sound	F 323	to utilize an alarm. 1. Fall risk assessment completed due to removal of the Tab alarms. Resident remains a high risk for falls. Care Plan has been updated to include: Tab alarm was removed due to risk of improper placement and delayed alarm. Mat alarm implemented in place of the tab alarm because it is more sensitive to change in position and will sound faster when resident is attempting to self-transfer. 2. Falls: a. July 27th 2016 1930 Resident was found on the floor in her room: Fall was unwitnessed. She was sitting in her chair prior to her fall with call light within reach. b. 08-27-2016 1021 Resident was in her room alarm went off and staff entered room and resident was standing next to the commode and was witnessed as she slid to the floor. c. 09/20/16 2230 Resident was in bed and stated I was scooting down staff found her on the floor. (fx occurred during this fall). d. 10/09/2016 1353 Resident was found in the north bathroom and as staff entered the bathroom she was witnessed to slide off the toilet. e. 10/21/2016 1230 Resident was followed into the bathroom by staff and they were unable to reach her before she stood up. Staff witnessed her slide against wall to the floor. i. The time line indicates that there is no pattern associated with time of day. Two of the falls were in the bathroom, but they were both witnessed falls and one fall was next to her commode. The other two	

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F 323	Continued From page 37 alerting staff to the independent transfer. The foot rest was up on the recliner. R32 made no attempts to stand. Review of the User Instructions for the Personal Sentry Fall Monitoring System (TABS style unit) identified the monitor was to be mounted to either a chair or bed using the clip on the back of the monitor, the magnetic disc from the pull string was to be secured to the monitor magnet, and the locking clip attached to the resident's garment at the top of the shoulder or back of the neck with the appropriate cord length determined in order for the person to activate alarm. When a resident moved beyond the determined length of the cord, the disc pulled from the monitor and the alarm would sound. The user instructions directed staff to follow the installation instructions, particularly the warnings and cautions when using the fall monitoring system and failure to do so could result in injury or death. On 1/4/17, at 8:34 a.m. R32 was observed seated in a recliner in the common area with a TABS alarm cord clipped to the back of R32's shirt. The TABS unit was not attached to the recliner. It was on the right arm of the recliner chair. The footrest on the recliner was elevated. R32 made no attempt to stand. -8:45 a.m. R32 was observed seated in a recliner in the common area with a TABS alarm cord clipped to the back of R32's shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. R32's right arm was in front of alarm unit. R32 made no attempts to stand. The recliner footrest remained up. -9:27 a.m. R32 was observed seated in a recliner	F 323	were in her room, but her motives are not clear because they were not witnessed and the resident could not verbalize her intent. Only on one occasion could the resident verbalize what she was doing. One of the falls occurred 7 days after admission and she did have a difficult time adjusting to her new living arrangement. She has had 5 falls, once a month, but she hasn□t fallen since 11/21/2016. As of today, the resident seems more content with her environment with the exception of more stimulation in the facility, her anxiety and agitation increase. ii. As we look at this data, it is determined that we will implement the care rounding to try and anticipate any need she may have to decrease her incidents of self-transferring. iii. Due to this data, we will be implementing a root cause analysis after each fall through the falls prevention program. 3. Root cause Analysis: a. Current Reality: Resident attempts independent transfer but has fallen due to dementia, mobility issues, anxiety, and acclamation to unfamiliar living environment. b. Desired Result: Resident will not attempt to self-transfer and Resident will not fall. c. Recommendations/Implementation plan: i. Care rounding-hourly and every 2 hours to meet resident needs ii. Root cause analysis (RCA) done after each fall	

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F 323	Continued From page 38 in the common area with a TABS alarm cord clipped to the back of R32's shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. The footrest remained up on the recliner. R32 made no attempts to stand. -9:35 a.m. R32 was observed seated in a recliner in the common area with a TABS alarm cord clipped to the back of her shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. The footrest on the recliner remained elevated. R32 made no attempts to stand. -10:05 a.m. after asking nursing assistant (NA)-B about R32's toileting schedule NA-B stated, "I was just about to do that." NA-B asked R32 if she wanted to use the bathroom. R32 said yes. R32 reached forward and grabbed the seat of her wheelchair with both hands, patted the seat, and picked at the wheelchair arms with her right hand. NA-B applied the gait belt and removed the TABS alarm unit from the recliner and R32's shirt and placed them in the storage pouch on the back of her wheelchair. NA-B cued R32 to stand up. R32 stood up slowly and held on to both arms of the wheelchair. R32 was stooped over and very unsteady. NA-B assisted R32, holding on to her with the gait belt and assisting her to turn around and sit down in her wheelchair. R32 took small steps during transfer remaining stooped over and moving slowly. -11:15 a.m. R32 was observed seated in a recliner in the common area. The footrest was up on the recliner. The TABS alarm cord was clipped to the back of R32's shirt. The unit was not attached to the recliner but was sitting on the right arm of the recliner chair. R32 made no attempts	F 323	iii. Closer monitoring of resident involving activities of interest iv. Bring to nurses station for activities v. Supervision in dining room and common areas. vi. Assist to recliner and elevate feet upon request. vii. Apply mat alarm viii. Educate staff on updated care plan ix. Monitoring of supervision x. January 9th the falls prevention program will meet to implement RCA d. Analysis: (complete this quarterly □) i. Reviewed 5 falls: determined no trend as of time of day. ii. Determined probable cause to be toileting needs to be met by care rounding. iii. Bowel and bladder assessment which indicated improvement since admission iv. Fall risk assessment remained at 13 same as upon admission. v. Resident has been here 6 months and has become more familiar with her environment and staff making her more comfortable and less anxious. vi. We did 3 root cause analysis based on issues identified by the surveyors related to the deficiency which lead to staff education, change in the alarm, and processes in place for closer observation. d. RN updated Resident□s care plans on 1/5 and 1/6/2017and staff were educated via the communication board and verbal instruction per the RN and DON to review care plans. e. OT/PT evaluation/assessment conducted on 1/5/2017 to review self-transfer and self-ambulation mobility.	

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F 323	Continued From page 39 to stand. -12:27 p.m. NA-B transferred R32 from her wheelchair to the recliner using a gait belt, cueing and physical assistance. R32 leaned forward in her recliner when NA-B attempted to elevate her feet with the recliner leg rest. R32 became upset and stated loudly and harshly, "I don't want that up." NA-B said ok and clipped the TABS alarm cord to the back of R32's shirt and placed the alarm unit loosely under the right recliner arm cushion. The unit was not attached to R32's chair. R32 leaned forward, lifted her bottom off the recliner seat and plopped herself back down in recliner. R32 scooted herself back in the chair. The alarm did not sound during this activity. NA-B had left the area. -12:33 p.m. R32 leaned forward in the recliner, looked around the area and leaned back in the chair. No staff were present in area. -12:36 p.m. No staff were present in area. R32 leaned forward and pulled some of the alarm unit cord forward with the unit. The alarm did not sound. There was too much slack in the cord and the unit was unattached making the alarm ineffective. R32 attempted to get up from the recliner. R32 was able to get her bottom to the edge of the recliner chair. She was then able to lift her bottom approximately 2 inches from the chair. Although the cord pulled slightly with R32 as she moved, there was too much slack for the alarm to sound. R32 then attempted to self transfer. R32 leaned forward, pushed off of the recliner chair arms with both hands and attempted to stand. No staff was present, and the alarm failed to sound, so one surveyor remained with R32 while another surveyor left to find staff to	F 323	i. PT determined to continue with the same Functional Maintained Program (FMP) and ambulation to and from meals with assistance of staff and assistive device. f. Care rounding has been implemented as of 01/05/2017 which involves staff asking Charlotte every hour from 6AM to 10PM if she has any pain, if she requires or requests positioning, if she needs to utilize the bathroom, and to ensure that her personal items are within reach her needs are met. From 10PM to 6 AM staff observes her and meet her needs every two hours. i. Staff was educated by the RN on 1/5 and 1/6/2017 and as the staff begin their shifts will be educated by the charge nurse. g. A staff member will be present in the dining area at all times when residents are in the dining room. Staff was educated via communication board and verbal instruction per the RN and DON. 2.) Identify which residents are at risk for the deficient practice and how they could be affected. a. There was only one resident that was using the Tab alarm which was the deficient practice when the IJ was issued. After a root cause analysis and this resident assessment, the use and placement of tab alarms was to be no longer be used and a mat alarm would be the best option as they are more sensitive to movement and do not required to be secured to a chair to function properly. 3.) Corrective measures to resolve and prevent further risk to the identified	

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F 323	Continued From page 40 assist R32. NA-C was found running water for a bath. NA-C was alerted to R32's attempts at self transferring in the day room. NA-C called for NA-A to help her in the day area. They physically assisted R32 with cues and a gait belt from the recliner to her wheelchair. NA-C confirmed the TABS alarm was not attached to R32's chair and should have been. On 1/4/17, at 12:41 p.m. NA-B stated they usually put the TABS alarm on the side of the bed or chair. She stated there was a clip on the unit to be attached to her chair. NA-B confirmed R32's alarm should have been attached to her chair and not resting on the arms of the recliner. NA-B confirmed she had received education on how to operate and place the alarm when she was hired. On 1/5/17 , at 9:13 a.m. R32 was observed self propelling from the day room to the east bathroom using only her feet. R32 leaned forward and opened the bathroom door when the alarm sounded. R32 continued to push herself through the doorway and was scooting forward in her chair. NA-D intervened and redirected R32, wheeling R32 out of the bathroom into the hallway. NA-D and R32 had a brief conversation in the hallway and NA-D assisted her into the bathroom and closed the door. On 1/5/17, at 9:33 a.m. NA-D and NA-C were observed standing in the north hallway. R32 was seated in her wheelchair. NA-D stated they were going to assist R32 with ambulation. NA-D applied a gait belt around R32's waist and NA-D and NA-C cued R32 and physically assisted her to stand up. R32 pushed herself up with her hands on the wheelchair arms a couple times to gain momentum and NA-D and NA-C assisted	F 323	resident and other residents at risk. a. Discontinue the utilization of Tab alarms in our facility. b. Education to staff on the use of mat alarms per manufacturer instructions, the proper placement of the mat, checking the mat to ensure proper functioning and monitoring and supervision of residents. c. All residents who utilize mat alarms were reviewed by the RN. d. Resident who utilize mat alarms, the care plans were reviewed by the RN. 4.) Provided Evidence of corrective measures. a. Comprehensive assessments completed in Matrix b. PT evaluation completed in Matrix c. Staff education information and log d. Root Cause Analysis data e. Removal of Tab alarms from facility use f. Care Plan review/revision updates g. Care Rounding Logs at the Nurses Station 5.) How will we educate staff to prevent further accident and injury. a. All staff who provide direct care to resident, who were on duty received education on 1/5 and 1/6 2016 by the RN and DON. Staff who was not on duty will receive education prior to providing care as they come on duty. Staff not present at this time, individual signature pages will be made and attached to the education binder and the charge nurse will review packet of information with them before they step on the floor and have them sign the sheet once education has been provided and they verbalize	

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F 323	Continued From page 41 her to stand. NA-D provided R32 with a walker and NA-C followed R32 and NA-D with a wheelchair. R32 was confused and grabbed the left arm handle of the walker and the front bar of her walker. NA-D cued R32 to grab the right walker handle with her right hand. R32's left foot swung in front of her right foot, R32 was leaned forward and her legs were weak. NA-D confirmed R32 had walked 100 feet and that was the farthest she ever walked. NA-D later confirmed she walked an additional 80 feet and stated R32 wanted to walk even more. On 1/4/17 at 2:16 p.m. R32's falls including fall event reports, progress notes, care plan and interventions implemented were reviewed with the DON. The DON stated the following: The DON verified the fall information and stated she were not aware staff was not placing R32's TABS alarm correctly. She stated she just assumed they affixed it to her chair or recliner. The DON stated she used a communication board and R32's care plan to ensure staff understood how to care for her. She also stated the NAs had an assignment sheet that summarized R32's care plan and stated some NA's chose not to carry it with them. She stated she expected staff to rely on their "best judgement" and R32's care plan to determine whether or not to apply R32's TABS alarm in a common area. The DON stated she expected the TABS alarm to be affixed if she was in her room or in her wheelchair. For the fall of 7/27/16, at 7:30 p.m. the DON verified the fall information and stated she thought R32 tried to self-transfer and get out of bed. She stated the fall was unwitnessed and	F 323	understanding. b. This education will be provided by both verbal and written instructions. c. Up dated Care plans d. Manufacturer□s instructions were reviewed and placed in communication book. e. Orientation information will include utilization of mat alarms. This will be presented to all new staff and travel staff. f. Education regarding the utilization of mat alarms will be presented annually to staff. 6.) Evidence of audits and monitoring a. Care rounding sheet will show hourly/2 hourly monitoring the resident b. Education log will indicated which staff have received education. c. Maintenance staff will check the condition of the mat alarms monthly and document the check. d. Four observations per week of staff presence in the dining room will be made by facility leadership. e. Charge nurse will monitor presence of staff when resident is in the common□s area. This will be documented in the EMR. 7.) Policy and Procedures reviewed and changed. a. Bed and chair alarm policy updated b. Care planning policy reviewed c. Fall prevention program Meeting scheduled January 9, 2017 for program review.	

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F 323	Continued From page 42 after the fall R32 had complained of a sore butt and pain in her right thigh. The DON stated sometimes R32 could not make sense of things. She stated bed and chair alarms were added to R32's care plan. The DON verified the fall information dated 8/27/16, at 10:21 a.m. She stated R32 tried to self-transfer. R32 got herself up, slipped and fell when she tried to go to the bathroom. She stated the fall was witnessed and the intervention was to make sure R32's shoes were on. The DON stated the fall on 9/20/16, at 10:30 p.m. resulted from R32 self transferring, attempting to get out of bed, and stated she wasn't sure why R32 was trying to transfer. The DON verified the documentation was accurate. She stated R32 sustained a left wrist fracture after the unwitnessed fall and it was reported to the State Agency. She stated a floor matt was added after the fall. The DON verified the information documented for the fall on 10/9/16, at 1:53 p.m. She stated R32 self transferred to the toilet and slipped and fell on the bathroom floor. She stated the fall was unwitnessed, vitals were completed and R32 did not hit her head. The DON confirmed there were no new interventions added after R32's fall. The DON stated the fall information on 11/21/16, at 12:33 p.m. was accurate. R32 was in the bathroom and stood up from her wheelchair trying to get to the toilet. She said R32 fell between the toilet and the wall in the bathroom. The DON stated after one of her falls staff tried to keep her at the nurses station and give her things to do. She stated the new intervention added was not	F 323	ADDITIONAL INFORMATION REGARDING ABOVE PLAN OF CORRECTION: " Staff education began 01/05/2017 and continues with all staff upon coming on their first shift worked after 01/05/2017. A binder with all the education and a list of employees has been created and kept at the nurse□s desk that is available for all staff at all times. The staff education includes Charlottes updated care plan, updated care plans for all the other residents who have mat alarms, education on care rounding, information on the mat alarms (manufacturer□s instructions), a review of all residents on bed and chair alarms. Education includes communication on the requirements of someone being available in the dining room during meal times and in the commons area at all time when a resident with a recliner or wheelchair alarms are present. Education is provided by the Director of Nursing or designee. " Audits began 01/05/2017 of the dining room and commons area. The dining room will be observed by administrative staff 4 times a week to ensure that there is someone in the dining room at all times during meals. The commons area will be audited by DON at least twice a week to ensure that it is being supervised when residents with recliner alarms are present. The monitoring data will be brought through the Quality Assurance Performance Improvement (QAPI) until determined compliant " 01/09/2017 the Mahnomen Health Center orientation check list was updated	

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F 323	Continued From page 43 leaving R32 alone in the bathroom. The DON stated R32 had moderate to severe cognitive impairment and R32 had no concept of time, or where she was at. She confirmed R32's last fall assessment was completed on 10/25/16. There were no other fall assessments. The DON stated R32 was at high risk for falls due to the amount of assistance and cueing she required with ADLs. R32 had forgotten she wasn't as mobile as she used to be and would try to stand up. She stated she had not considered doing a bowel and bladder assessment on R32, and stated those were only done quarterly. She stated she had not considered any other fall prevention interventions for R32. The DON stated they also tried to keep R32 in their line of vision, give her something to do at the nurses desk, and did not like to leave her alone in her room for extended periods of time. The DON confirmed they do not have a, "Falls," policy and would continue to use the current fall event form in Matrix (clinical documentation system) until they developed a preventative program and new plan. On 1/4/17, at 12:48 p.m. NA-A stated R32 was at risk for falls because she wandered, tried to stand up and reached forward in her chair. NA-A stated the last time she observed R32 get up from her wheelchair was a couple of days ago. She stated she thought R32 had only fallen once on the first day she was admitted. NA-A stated she thought she slid out of her bed and had to wear a cast after the fall. NA-A stated she was not aware of any other falls for R32. She stated R32's fall interventions were the TABS alarm and to keep R32 busy. She stated they tried to keep R32 by	F 323	to include orientation to the mat alarms. " 01/27/2017 all Residents care plans were reviewed for appropriate fall interventions and care plans were adjusted accordingly. By 02/03/2017 Staff will be educated by the Director of Nursing or designee of the changes and those staff not working during this time frame will be educated on their first working shift after 02/03/17. " 01/27/2017 all Residents with mat alarms were re-assessed for appropriateness and care plans were adjusted accordingly. By 02/03/2017 Staff will be educated by the Director of Nursing or designee of the changes and those staff not working during this time will be educated on their first working shift after 02/03/17. " Fall prevention program meeting was held 01/09/2017. o 01/09/2017A falls tracker tool was identified and will be used to track falls for patterns and risks associated with falls and data will be brought through QAPI. o A falls prevention coordinator will attend IDT meetings to aid in the prevention and intervention of all falls as of 01/09/2016. o 01/10/2017 the Falls Prevention Program Committee policy was updated and finalized. o The Falls Prevention committee was developed by 01/16/2016 comprising of someone from each discipline. The committee will meet once a month. The next meeting is scheduled for 02/20/2016. o 01/29/2017 falls prevention committee members have been invited to the next	

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F 323	Continued From page 44 them otherwise her alarm was going off. She stated R32's tab alarm was not attached to the recliner today and should have been. On 1/4/17, at 12:53 p.m. clinical manager (CM)-A stated a fall intervention for R32 was to have a tab alarm in place secured to her recliner or chair. She stated R32 had the tab alarm because she had a history of self transferring and R32 had sustained an injury as a result. She stated R32 was at risk for falls because she had no safety awareness. CM-A stated she expected the nurse on duty to make sure her alarm was placed correctly. On 1/4/17, at 1:06 p.m. licensed practical nurse (LPN)-A stated R32's TABS alarm should be secured. She stated she hated to see the NA's wedge the alarm unit in the arm of the recliner chair. LPN-A stated she had previously educated the NA's to secure R32's TABS alarm. On 1/5/17, at 8:56 a.m. NA-D stated R32 started a restorative program on 8/15/15. NA-D stated she was currently working with R32 on both upper and lower extremity exercises and ambulation about 3 times per week as tolerated. NA-D stated she felt R32 had moderate cognitive impairment and some day's R32 was really confused. She stated R32 was at risk for falling and required extensive assistance with ADLs. She stated she could walk 86-89 feet with staff assistance but R32's legs got tired. NA-D stated she felt R32 didn't attempt to get up that often except when her cognition was, "off" that day. She stated the last time she observed R32 try to stand up was 2-3 weeks ago. On 1/5/17, at 9:25 a.m. the activities director (AD)	F 323	committee meeting scheduled for 02/20/2017 via outlook calendar and posters. o A falls policy is being formed and will be completed by 02/08/2017. o A Post Fall Huddle Form will be developed and completed by 02/08/2017. o Education for staff will be completed by 02/20/2017 on the falls prevention program. All staff that is not working during this time frame will receive education on their next working shift. o The Falls prevention coordinators will attend QAPI and bring forward findings to the QAPI group in regards to falls and fall prevention education. As of 02/09/2017 the MDS coordinator on 01/27/2017 interviewed staff including restorative aid, nursing assistants, activities and therapy staff and reviewed progress notes to determine that interventions for falls were appropriate and care plans were updated according to the findings. As of 02/08/2017 a fall risk assessments is performed on admission, quarterly and with significant change. As of 02/09/2017 a fall risk assessment will be done after each fall. As of 02/08/2017 a post fall hall huddle is being conducted utilizing the Post Fall Investigation tool which includes a root cause analysis portion. As of 02/08/2017 all Post Fall	

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F 323	Continued From page 45 stated she felt R32 was at moderate risk for falls when she was alone in her room and when she tried to stand up from her wheelchair. The AD stated the last time she saw R32 try to get up on her own was 1/3/16 when R32 wheeled herself into the east bathroom. She stated whenever R32 tried to stand up on her own they would remind her not to and she would reply, "I know." On 1/5/17, at 12:34 p.m. physical therapist (PT)-A stated he did not complete an initial physical therapy evaluation when PT started on 8/2/16. PT-A confirmed he did not complete a PT discharge summary for R32 when she was discharged from PT on 9/2/16. He stated R32's cognition dropped significantly within the first couple weeks of admission. It was difficult to get her up to walk even with cueing and assistance from staff. He stated R32 was discharged from PT because of severe cognitive and balance impairment. He further stated R32 did not make any progress during PT and continued to be at risk for falls. On 1/6/17, at 9:59 a.m. the occupational therapist (OT) confirmed R32's OT evaluation on 7/22/16. The OT stated R32 had been discharged from OT on 8/12/16. The OT confirmed she had not completed a discharge evaluation for R32 and stated she must have overlooked it. She stated when R32 began therapy she was confused and required supervision and physical assistance from staff with bed mobility and transfers and used a walker. She stated after R32 fell on 7/27/16, it became difficult for R32 to go from a sitting to standing position. The OT stated at that point R32 could not be left unattended because she would lose her balance. The OT confirmed R32 was at risk for falling because she required	F 323	Investigations will be reviewed at weekly IDT meetings and the data will be entered into the Falls Tracker Tool. As of 02/09/2017 Care plans will be reviewed quarterly and with each fall to ensure the care plans are current and interventions are appropriate. On 02/09/2017A Falls Tracker tool was developed and will be used to track falls for patterns and risks associated with falls. The Falls Coordinator will input the data and present the data to the Falls Prevention Committee monthly IDT meetings weekly and QAPI quarterly. If patterns are identified, interventions and care plans will be adjusted and updated accordingly. As of 02/09/2017, the DON or designee will make observations of interventions that are identified on resident care plans to ensure the interventions are being properly implemented. The observations will be conducted daily x 2 weeks, then weekly for one month, then monthly until determined compliant through Quality Assurance Performance Improvement (QAPI). The next QAPI meeting is scheduled for February 21, 2017. As of 02/09/2017, all resident with a mat alarm will have an order for the nurses to check for proper placement and proper functioning of the mat alarm. Residents with mat alarms the orders will be reviewed at weekly IDT meetings to ensure order is appropriate and the nurses are documenting that the mat is properly placed and functioning.	

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physical assistance of staff for ADLs, had weakness in her legs and had a difficult time transitioning from sitting to standing. She stated when R32 was discharged from OT on 8/12/16, she was more confused, and had increased difficultly following directions. She further stated pain was a limiting factor for OT progress after her fall on 7/27/16.

The OT stated they started OT with R32 again on 11/7/16, after R32's splint had been removed and she was able to use her left wrist for ADLs. The OT stated R32 was discharged again from OT on 11/23/16, and R32's left hand was swollen, had limited flexion and some pain. She stated R32's limiting factors and reason for discharge from OT on 11/23/16, was due to poor cognition. She stated R32 required staff assistance and cues to ambulate with her walker. The OT stated R32 continued to be at risk for falls because she required assistance with ADLs and cognition. The OT additionally stated the last time she saw her, R32 was able to self propel herself in the wheelchair using only her feet.

The immediate jeopardy which started on 9/20/16, was removed on 1/6/17, at 4:00 p.m. after the facility completed the following interventions as part of their removal plan:
-R32 was comprehensively assessed for falls
-R32's care plan was updated to reflect R32's assessment for current risks for falls and fall interventions
-Staff were educated on R32's fall interventions
-On 1/6/17 from 3:00 p.m. to 4:00 p.m. direct care staff, including licensed nursing staff were interviewed regarding R32's safety risks. All of the interviewed staff were aware of R32's risk for falls, and the fall interventions to ensure R32's

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MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

(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 323	Continued From page 47 safety.	F 323		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS (d) Influenza and pneumococcal immunizations (1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. (2) Pneumococcal disease. The facility must	F 334		2/9/17

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F 334	Continued From page 48 develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the Pneumococcal Conjugate Vaccine -13 (PCV13) vaccines were offered to 4 of 5 residents (R1, R5, R13, R19) as recommended by the Centers for Disease Control and Prevention (CDC) and failed to develop guidelines for PCV13.	F 334	" All residents□ vaccines were reviewed and were updated with the pneumonia vaccines 23 and 13 by 01/17/2017 with the exception of two residents. Those residents were scheduled with White Earth Home Health and received the vaccination on 01/26/2017. All residents are now	

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F 334	Continued From page 49 Findings include: The CDC guidelines updated 7/16/14, identified the pneumococcal conjugate vaccine (PCV13), protected against the 13 most common types of pneumonia, and the Advisory Committee on Immunization Practices (ACIP) recommended all adults 65 years of age or older receive a dose of PCV13. R1's Complete Immunization Record printed 1/6/17, indicated the 68 year old had received 2 doses of the pneumococcal polysaccharide vaccine (PPV23) on 11/26/09. R1's Resident Face Sheet indicated R1 received the PPV23 last on 10/13/14. R1's medical record lacked evidence the PCV13 vaccination had been offered. R5's Complete Immunization Record printed 1/6/17, indicated the 94 year old had received the PPV23 on 9/13/11, and 11/3/05. R5's Resident Face Sheet indicated her most recent Pneumovax vaccine was received 11/03/05. R1's medical record lacked evidence the PCV13 vaccination had been offered. R13's Complete Immunization Record printed 1/6/17, indicated the 92 year old had received the PPV23 on 11/01/1999. R1's medical record lacked evidence the PCV13 vaccination had been offered. R19's Complete Immunization Record printed 1/6/17, and R19's Resident Face Sheet lacked evidence the 74 year old had received any Pneumovax vaccine. However, the medical record also lacked evidence R19 was offered the PCV-13 as recommended by the CDC.	F 334	updated with the pneumonia vaccines. " 01/09/2017 the admission checklist was updated to ensure that the pneumonia shots (both PVC 13 and PPSV-23) have been administered and if not, offered upon admission. If they choose not to receive the vaccination a declination form will be filled out and signed. " As of 01/27/2017, all immunizations will be reviewed quarterly by the RN unit coordinator to ensure all recommended vaccines are administered or offered and will be brought through QAPI. " 01/27/2017 education provided by the Director of Nursing to the admission staff on recommended vaccinations and plans to monitor. " This will be monitored by the Director of Nursing or designee and brought through QAPI until determined compliant. As of 02/09/2017 at the time of admission, nursing will review each resident□s immunization history to ensure the immunizations are current. On 01/09/2017, the admission checklist was updated to ensure that the pneumonia vaccinations (both PVC 13 and PPSV-23) have been administered. If the resident has no record of receiving the immunizations, the vaccines will be offered. If resident chooses not to receive the vaccination, a declination form will be filled out and signed and placed in the resident□s medical record. As of 02/08/2017 the Director of Nursing (DON) or designee will monitor the	

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F 334	Continued From page 50 On 1/06/17, at 3:10 pm, nurse manager (NM)-A who was currently responsible for the facility's infection control program while the infection control nurse was unavailable confirmed she was aware many residents in the facility had not received the PCV-13 vaccine. NM-A stated the facility had received a list from the clinic of residents in the facility that required the vaccine, but they had not begun to offer them. The facility's LTC Influenza & Pneumonia Vaccines policy reviewed and revised 11/16/15 indicated Administration of the pneumococcal vaccinations would be made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.	F 334	immunizations for new admissions, at weekly IDT meeting to verify that immunizations are current. As of 01/26/2017 all resident immunizations are current. As of 01/27/2017, all resident immunizations will be reviewed quarterly (first quarter Jan-March 2017) by the Registered Nurse (RN) unit coordinator to ensure all recommended vaccines have been administered or are offered. The monitoring data will be brought through the Quality Assurance Performance Improvement (QAPI) until determined compliant. The next QAPI meeting is scheduled for February 21, 2017.	

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	245238	A. BUILDING **01 - 1969 BUILDING WITH 1975 ADDITION** B. WING _____	**01/05/2017**

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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. At the time of this survey, Mahnomen Health Center (Nursing Home) 01 Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of the Health Care Facilities Code (NFPA 99). PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/01/2017

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 and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Mahnomen Health Center (Nursing Home) was built at three different times. In 1969 the main building was added to the east of the Mahnomen Hospital. It is 1-story, without a basement and is Type II(111) construction. In 1996 an addition to the north of the kitchen was added, is 1-story, no basement and Type II (111) construction, In 2000, additions of 1-story, without basements and of Type II(000) construction were built to the west of the 1969 building and to the north of the 1996 building, The 1969 building is separated by a 2-hour fire barrier from the Hospital building and from the 2000 east addition. The facility has 3 smoke compartments separated by at least 30 minute fire barriers. The facility is protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler	K 000		

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K 000	Continued From page 2 Systems with quick response heads. The facility has a fire alarm system with corridor smoke detection, sleeping room smoke detection, and smoke detection in common areas in accordance with NFPA 72 "The National Fire Alarm Code" . The facility has a capacity of 32 beds and had a census of 25 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 353 SS=F	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The	K 353	" 4 residents□ room sprinkler heads were cleaned on 01/17/17 by Allied Fire Protection. " Main resident dining sprinkler head	1/17/17

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K 353	Continued From page 3 standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 32 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 1:00 pm on 01/04/2017 observations and staff interview revealed 5 sprinkler heads not properly maintained in the following locations. 1. Resident rooms 41 & 43, 4 heads covered with lint 2. Main resident dining area, one head with clear liquid in the frangible bulb instead of red. This deficient condition was confirmed by the Facility Operations Manager.	K 353	was replaced by allied fire protection by 01/17/17 " Sprinkler system and sprinkler heads will continue to be monitored by Facility Director on a quarterly a year time frame and annual by Allied Fire Protection The monitoring data will be brought through the Quality Assurance Performance Improvement (QAPI) until determined compliant. See Attached work order for sprinkler head replacement from Allied Fire Protection Form A.	
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on	K 363		1/12/17

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K 363	Continued From page 4 corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS, details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide two corridor doors with a means suitable for keeping the door closed and resist the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5. This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 17 of the 32 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 1:00 pm on 01/04/2017 observations and staff interview revealed resident room door 31,does not fit tightly in the frame and resident room door 24 does not latch.	K 363	" Fire and smoke seal was installed on the frame in resident room door 31 room. 31 door now fits tight and seals completed on 01/12/2017. " A new latch was installed on resident room door 24. Room 24 now latches per code. Completed on 01/12/2017. Continue to be monitored by Facility Director monthly. The monitoring data will be brought through the Quality Assurance Performance Improvement (QAPI) until determined compliant	

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K 363	Continued From page 5 This deficient condition was confirmed by the Facility Operations Manager	K 363		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 24, 2017

Mr. Dale Kruger, Administrator
Mahnomen Health Center
414 West Jefferson Avenue, PO Box 396
Mahnomen, Minnesota 56557

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5238027

Dear Mr. Kruger:

The above facility was surveyed on January 3, 2017 through January 6, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burkman at (218) 308-2104 or email: lyla.burkman@state.mn.us.**

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

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

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
Health Regulation Division
Minnesota Department of Health

Email: 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
	00353	A. BUILDING: _____ B. WING _____	01/06/2017

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 1/3/2107, through 1/6/2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement fall interventions related to the placement of a fall prevention monitor (tabs alarm) as directed by the care plan for 1 of 3 (R32) residents reviewed for accidents, and observed to have incorrect placement of their tabs alarm. Findings include: R32's care plan dated 12/30/16 indicated R32 had memory and cognitive problems, physical decline and had signs of delirium as she reached for things she saw in the air. R32's care plan further indicated R32's goals was to be safe in her surroundings, her needs would be met and R32 would be monitored for safety concerns. The care plan identified R32 had bed and chair alarms placed 7/27/16 due to R32 self transferring, and R32 had a tabs alarm placed 9/20/16 due to standing without purpose. R32's care plan further	2 565	corrected	1/6/17

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identified R32 fell on 7/27/16 and had no injury, another fall 9/20/16 with skin tear and left wrist fracture, and fell again on 11/21/16 and had no injury. The care plan failed to identify R32's falls on 8/27/16 and 10/9/16.

R32's North Assignment sheet, undated (tool nursing assistants use to direct care), indicated R32 required the assistance of 1-2 staff for ADLs which included transfers and toileting, and identified R32 had a bed and chair alarm.

On 1/3/17, at 1:44 p.m. R32 was observed seated in a recliner in the common area with a tabs alarm adjustable cord clipped to the back of R32's shirt and the unit was not attached to the recliner but placed between arm chair cushions. R32 made no attempt to stand.

On 1/4/17, at 8:34 a.m. R32 was observed seated in a recliner in the common area with a tabs alarm cord clipped to the back of R32's shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. R32 made no attempt to stand.

-8:45 a.m. R32 was observed seated in a recliner in the common area with a tabs alarm cord clipped to the back of R32's shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. R32's right arm was in front of alarm unit. R32 made no attempt to stand.

-9:27 a.m. R32 was observed seated in a recliner in the common area with a tabs alarm cord clipped to the back of R32's shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. R32 made no attempt to stand.

-9:35 a.m. R32 was observed seated in a recliner

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2 565	Continued From page 4 in the common area with a tabs alarm cord clipped to the back of R32's shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. R32 made no attempt to stand. -10:05 a.m. after asking nursing assistant (NA-B) about R32's toileting schedule she stated I was just about to do that. NA-B asked R32 is she wanted to use the bathroom. R32 said yes. R32 reached forward and grabbed the seat of her wheelchair with both hands and patted the seat, and picked at the wheelchair arms with her right hand. NA-B applied R32's gait belt and removed the tabs alarm unit from the recliner and R32's shirt and put them in the back of her wheelchair storage pouch. NA-B cued R32 to stand up on the count of 3, R32 stood up slowly and held on to both arms of the wheelchair. R32 was stooped over and very unsteady. NA-B assisted R32 and held onto to her with the gait belt and assisted her to turn around and sit down in her wheelchair from a standing position. R32 took small steps during transfer and her legs appeared weak. -11:15 a.m. R32 was observed seated in a recliner in the common area with a tabs alarm cord clipped to the back of R32's shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. R32 made no attempt to stand. -12:27 p.m. NA-B transferred R32 from her wheelchair to recliner using gait belt, cueing and physical assistance. R32 leaned forward in her recliner when NA-B attempted to elevate R32's feet with the recliner leg rest. R32 became upset and stated out loud and gruff, "I don't want that up." NA-B said ok and clipped the tabs alarm cord to the back of R32's shirt and put the alarm unit loosely under the right recliner arm cushion,	2 565		

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and did not attach it to R32's chair. Resident leaned forward and lifted up her bottom up off the recliner and plopped herself back down in recliner. R32 appeared to scoot herself back in the chair and alarm didn't sound. NA-B left the area.

-12:33 p.m. R32 leaned forward in the recliner, looked around the area and sat back in the chair. No staff were present in area.

-12:36 p.m. No staff were present in area. R32 leaned forward and pulled some of the alarm unit cord forward with the unit. The alarm did not sound. There appeared to be too much slack ion the cord and the unit was unattached making the alarm ineffective. R32 attempted to get up off the recliner. R32 was able to get her bottom a couple inches off the chair and her bottom was on the edge of the recliner chair. The cord pulled slightly with R32 as she moved but the cord had too much slack to alert staff R32 attempted to self transfer. R32 leaned forward, pushed off of the recliner chair arms with both hands and attempted to stand up. Surveyor #32603 went to get help. Surveyor #32603 found NA-C who was running water for a bath and was waiting for a resident to come out of her room. NA-C was alerted to R32's attempts of self transfer in the day room. NA-C called out for NA-A to help her in the day area and they physically assisted R32 with gait belt and cues from the recliner into her wheelchair. NA-C confirmed tabs alarm was not attached to R32's chair and should have been.

On 1/04/17, at 12:41 p.m. NA-B stated they usually put the tabs alarm on the side of the bed or chair. She stated there is a clip for the unit to be attached to her chair. NA-B confirmed R32's tabs alarm should have been attached to her

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chair and not rested on the arms of the recliner. NA-B confirmed she had received education on how to operate and place the alarm when she was hired.

On 01/4/17, at 12:48 p.m. NA-A stated R32 was at risk for falls because she wandered, tried to stand up and reached forward in her chair. She stated the last time she observed R32 get up from her wheelchair was a couple days ago. She stated R32's fall interventions were the tabs alarm and to keep R32 busy. She stated they tried to keep R32 by them otherwise her alarm was going off. She stated R32's tabs alarm was not attached to the recliner today and should have been.

On 1/04/17, at 12:53 p.m. clinical manager (CM-A) stated a fall intervention for R32 was to have a tabs alarm in place and and be secured to her recliner or chair. She stated R32 had the tabs alarm because she had a history of self transferring and R32 had sustained an injury due to this. She stated R32 was at risk for falls because she had no safety awareness and stated she expected the nurse on duty to make sure her alarm was placed correctly.

On 1/04/17, at 1:06 p.m. licensed practical nurse (LPN-A) stated R32's tabs alarm should be secured. She stated she hated to see the NA's wedge the alarm unit in the arm of the recliner chair. She stated she had educated the NA's in the past to secure R32's tabs alarm.

On 1/4/17, at 2:16 p.m. Director of Nursing (DON) confirmed R32's care plan. DON stated she expected staff to follow R32's care plan, and affix R32's tabs alarm to her recliner when in use.

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2 565	Continued From page 7 Review of the User Instructions for the Personal Sentry Fall Monitoring System identified the monitor was to be mounted to either a chair or bed using the clip on the back of the monitor, the magnetic disc from the pull string was to be secured to the monitor magnet, and the locking clip attached to the resident's garment at the top of the shoulder or back of the neck with the appropriate cord length determined in order for the person to activate alarm. When a resident moved beyond the determined length of the cord, the disc pulled from the monitor and the alarm would sound. The user instructions directed staff to follow the installation instructions, particularly the warnings and cautions when using the fall monitoring system and failure to do so could result in injury or death. A copy of the facility's care planning policy was requested and was not provided. In addition the facility failed to implement care planned non-pharmacological interventions and ongoing monitoring of frequent moderate to severe pain for 1 of 3 residents (R18) reviewed for pain. R18's admission Minimum Data Set (MDS) dated 11/2/16, identified R had moderate cognitive impairment and had diagnoses which included, pain of upper extremity, congestive heart failure (CHF) and seizure disorder. The MDS identified R18 had frequent pain of a moderate level and had received as needed (prn) pain medications. The MDS identified R18 did not receive scheduled pain medications or non-medicinal interventions for pain within the seven day look back period. On 1/6/17, at 8:20 a.m. Registered Nurse	2 565		

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Manager (RNM) stated R18's cognition had improved since his admission assessment and no longer had moderate cognitive impairment at the time of the survey and had improved in cognition. RNM stated she felt R18 had minimal cognitive impairment and R18 was able to verbalize his needs and wishes without difficulty. RNM stated R18 would be a reliable source of information regarding his pain level.

Review of R18's Pain Care Area Assessment (CAA) dated 11/2/16, identified R18 had many complaints about shoulder, neck and back pain. The CAA identified R18 had a history of a broken collar bone. The CAA revealed R18 was to be examined by his primary physician upon nursing home rounds.

Review of R18's pain assessment dated 10/27/16, revealed R18 had stated upon staff interview he had frequent pain of the right shoulder and clavicle (collar bone,) with an onset with movement. The assessment revealed R18 had described the pain as an ache and was of a moderate intensity. The assessment revealed interventions were in place of Tylenol 650 milligrams (mgs) by mouth (po) every four hours as needed (prn,) and a referral for PT and occupational therapy (OT.)

Review of R18's care plan dated 11/15/16, revealed R18 had complaints of chronic pain related to a history of alcohol abuse and falls with recent collar bone fracture. R18's care plan revealed R18 had complained of pain with therapy, he had been educated to continue therapy despite the pain as he had not been using his arm due to pain. R18's care plan directed staff to provide R18 with pain medications, BioFreeze (an over the counter

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topical pain relieving medication,) and non-pharmacological pain interventions as warm/cold packs. R18's care plan revealed physical therapy (PT) has been ordered for shoulder pain and R18's MD had declined further pain medications or diagnostic testing of an MRI as of 11/8/16. The care plan further revealed R18 had enjoyed activities of trivia, reminiscing, western movies shortly after he was admitted and R18's shoulder pain had prevented him from attending activities. The care plan also revealed R18 preferred to lay in bed for comfort and had declined further activities due to pain.

On 1/4/17, at 12:40 p.m. R18 was lying on his left side in bed, facing the TV with his eyes open. R18 had his right arm guarded to his chest and had a furrowed brow, clenched jaw and squinted eyes, grimacing.

On 1/4/17, at 2:37 p.m. R18 was seated on the edge of his bed, his feet on the floor, his right arm was guarded to his chest as he coughed and grimaced with a furrowed brow. R18 stated he had been experiencing pain following a fall prior before he was admitted to the facility in late October. R18 continued to guard his right arm, grimaced and stated he had sharp pain which started at his collar bone and radiated down to his hand. R18 stated all over his shoulder from his collar bone to his hand. R18 stated at times the pain was severe, being at least an "8" on a numeric pain scale (pain scale sued to assess pain with 0 being no pain and 10 being the worst imaginable.) R18 stated he was right handed, was independent with his cares and eating had been hard as he experienced pain whenever he moved his right arm. R18 stated at times it was hard for him to sleep at night and it coughing significantly increased his pain level. R18 stated

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he told the nurses he had pain everyday. R18 stated the nurses offered him ibuprofen and Tylenol for the pain and was frequently ineffective. R18 stated he had been told by the nurses to work with therapy for the pain and stated he could not work with therapy due to it causing too much pain. R18 stated his MD had recently started him on another medication of gabapentin (a medication used to treat nerve pain from neuropathy.) R18 stated he had been taking the gabapentin since December and had not had relief from the pain. R18 stated he felt he had a high pain tolerance as he was not stranger to pain, and he felt the nurses and his MD should listen to him when he said the medications were not reliving his pain. R18 stated the staff had offered ice packs right after he was admitted and it was also ineffective. R18 continued to exhibit a furrowed brow, squinted eyes, grimaced and stated he felt the pain had affected his well being, he felt depressed and all he did was smoke and tried to sleep the pain away but couldn't. R18 stated he felt his continued pain kept him isolated and he did not feel like himself.

-R18's medical record lacked any documentation of non-pharmacological interventions for pain having been offered or attempted for pain management.

On 1/5/17, at 7:08 a.m. R18 was seated in a stationary chair in the dining room, held a coffee cup in his left hand and his right arm was bent at the elbow rested on the armrest of the chair. R18 received his breakfast meal of scrambled eggs, two sausage links, toast and hot cereal. R18 proceeded to lift his right arm and reached for his fork. At that time, R18's eyes shut, brow had furrowed and R18 immediately put his right arm back down on the armrest. R18 used his left

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hand, grabbed the fork and proceeded to eat 4 fork bites of scrambled eggs. R18 then moved his fork to his right hand, pierced the sausage links and proceeded to guard his right arm to his chest, bent his elbow and moved his head down towards the fork and ate the sausage links. R18 then picked up a spoon with his left hand and ate three bites of his hot cereal, then placed the spoon back onto the table. R18 picked up a piece a toast with his left hand and ate two bites, placed it back onto his plate. R18 held the coffee cup in his left hand and drank all of his coffee. At 7:19 a.m. the director of nursing (DON) approached R18 and asked if he had had enough to eat. R18 replied he was not feeling well and stated he was going to go back to bed. At 7:22 a.m. R18 independently walked out of the dining room with his right arm guarded to his right side, walked to the nurses station and obtained a cigarette and a lighter. R18 walked towards the smoking room, pushed to button with his left hand to open the door, walked into the room and sat on a chair. R18 lit his cigarette with his left hand and proceeded to smoke with his left hand, while his right arm remained at his side. R18 then walked independently back to his room and sat on his bed, while his right arm remained guarded to his side, brow was furrowed, jaw was tight and face was taunt.

On 1/5/17, at 7:26 a.m. R18 stated he was not doing good that day due to arm pain. R18 stated he could not sleep the previous night due to arm pain. R18 stated the nurse had given him Tylenol and id had not worked, he stated he continued to have severe pain which he was so tired of. R18 further stated he felt frustrated and felt hopeless. R18 stated he would tell the nurse when he had pain and would tell the nurses when the Tylenol or ibuprofen was ineffective in relieving pain. R18

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stated he had told his MD he was in pain and the Tylenol and ibuprofen were ineffective in easing the pain. R18 stated he had pain everyday and stated he felt the staff knew he was in pain.

On 1/5/17, at 12:14 p.m. R18 walked independently in the hallway towards his room, his right arm was held guarded to his right side. R18's brow was furrowed, cheeks were taunt, jaw was tight and lips were pursed.

On 1/5/17, at 2:15 p.m. R18 walked independently down the hall towards the nurses station, his right arm was guarded towards his side, cheeks taunt, brow furrowed, lips and jaw were tight. R18 proceeded to obtain a cigarette, smoked with his left hand in the facility smoking room and walked back to his room. R18's facial expression remained unchanged.

On 1/6/17, at 9:16 a.m. R18 walked down the hall independently towards his room, lips and jaw were tight, forehead was creased, brow furrowed. At that time R18 stated he was in a lot of pain, had received some Tylenol that morning and stated it had not been effective in reducing his pain.

On 1/5/17, at 12:27 p.m. the dietary manager (DM) stated she was aware R18 had been not been using his right arm consistently during meals. DM stated she felt R18's use of his arm would improve with therapy. DM stated she felt R18 did not want to use his right arm like he used to and would not participate in therapy due to that.

On 1/5/17, at 12:43 p.m. PT stated R18 had refused to participate in therapy due to pain in his

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2 565	Continued From page 13 right shoulder. PT stated he felt R18 was a reliable source of information regarding his pain and was unsure when PT was last completed. On 1/5/17, at 1:55 p.m. licensed practical nurse (LPN)-A stated she felt R18 was cognitively intact and was able to voice his needs and wishes. LPN-A stated R18 complained of right shoulder pain frequently. LPN-A stated she would provide R18 with ordered prn Tylenol and Ibuprofen when he reported pain. LPN-A stated R18 often reported to her both the Tylenol and Ibuprofen were ineffective in relieving pain. LPN-A stated she had reported to the NM of R18's continued pain as recently as a couple of weeks ago. LPN-A stated she had not offered R18 any other interventions for pain. On 1/5/17, at 2:39 p.m. nursing assistant (NA)-A stated she had seen R18 walk up to the nurses station and complain of pain on a routine basis. NA-A stated R18 had also reported to her he had pain frequently, with the most recent time that week. NA-A stated R18 had complained of right shoulder pain since admission a few months ago. NA-A stated she felt there were days R18 would stay in his room due to being in so much pain. NA-A stated R18 had also reported to her he often laid down due to pain and did not sleep well. NA-A stated she would inform the nurse when R18 would report pain to her. NA-A stated she had observed R18 grimacing when he moved his right arm on a routine basis. On 1/5/17, at 3:18 p.m. NA- F stated R18 had reported to her he had been in pain though was unable to recall the most recent time. NA-F stated she felt R18 often held his right arm to his body due to being in pain. NA-F stated she had seen R18 walk up to the nurses station and complain	2 565		

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2 565	Continued From page 14 of pain frequently. NA-F stated she had also reported to the nurses R18 had pain, though was unable to recall the most recent time. On 1/6/17, at 1:59 p.m. activity director (AD) stated she felt R18 was cognitively intact and was able to voice his needs and wishes. AD stated R18 had participated in activities briefly after he arrived at the facility. AD stated R18 had routinely complained of right shoulder/arm pain since admission and had stopped attending activities. AD stated she completed 1:1 visits with R18 in his room per his preference. AD stated she felt R18 had stopped attending group activities due to his pain. On 1/6/17, at 8:23 a.m. NA-D stated she completed resident restorative therapy daily which R18 was supposed to have upper and lower extremity exercises. NA-D stated she was to complete range of motion (ROM) exercises with R18's right arm three times a week which started in November. NA-D stated R18 complained of pain with movement of his right arm. NA-D stated R18 had a fractured collar bone on the right side which she felt affected his range of motion. NA-D stated she had been unable to work with R18 the week of survey due to R18's complaints of pain and not feeling well. NA-D stated R18 had pain when he would bear weight with his right arm and when he attempted to lift his right arm, moving his shoulder away from his body. NA-D stated she had not seen an improvement in R18's pain management or ROM since he was admitted. On 1/6/17, at 8:30 a.m. NA-C stated R18 frequently complained of pain in his right shoulder. NA-C stated she frequently observed R18 guarding his right arm by holding it against	2 565		

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2 565	Continued From page 15	2 565		

his body. NA-C stated when R18 reported pain in his shoulder she would immediately tell the nurse.

On 1/6/17, at 8:46 a.m. a phone call was placed to R18's primary physician, who was also the facilities medical director. R18's primary MD was not in the office would not return until 1/9/17, a message was left with MD's nurse line for MD to call back. MD did not return phone call prior to survey exit. A phone call was received by MD on 1/10/17, at 4:20 p.m. During the phone interview MD stated he was aware R18 had ongoing pain, especially in his right shoulder. MD stated he was not aware of the overall ineffectiveness of R18's current pain regimen. MD stated he had thought R18's Tylenol and ibuprofen were already given to him on a scheduled basis. MD stated the usual practice was to schedule prn pain medication if they routinely received it. MD stated he had referred R18 to an orthopaedic MD and he had felt an MRI was not necessary. MD stated he had considered adding Tramadol (non-opiate prescription pain medication) to R18's medication regimen but had not at that time. MD stated he was very reluctant to order opioid and/or narcotic pain medications due to the monitoring involved in prescribing those medications. MD stated he would only order opioid and/or narcotic pain medications in cases of acute injury or pain, which he felt R18 did not meet that criteria. MD stated he had also ordered gabapentin for R18's pain in December some time and had hoped that would improve. MD stated R18 could have had heat and cold therapy, but was not sure if the staff had tried them or their effectiveness.

On 1/6/17, at 1:56 p.m. LPN-B stated R18 had an old fracture to his right collar bone which she felt continued to cause R18 frequent pain. LPN-B stated R18 received Tylenol and ibuprofen for

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2 565	Continued From page 16	2 565		

pain, which were overall not effective. LPN-B stated she had reported to the NM, R18 was not receiving relief from pain with the current prn medications, most recently as the previous week.

On 1/6/17, at 2:23 p.m. during a follow up interview NM stated she was aware R18 was not receiving routine relief with the current prn mediations of Tylenol and ibuprofen. NM stated she had been unable to complete another cognition assessment as requested by surveyor sue to R18 not feeling well with a cough. NM stated she felt R18 was overall cognitively intact and may have minimal memory loss. NM stated she felt R18 was a reliable source of information regarding his pain. NM stated she had reported to R18's primary MD the current pain medication was overall not effective. NM stated she would routinely struggle with R18's MD regarding R18's pain management due to unwillingness to try other pain medications. NM stated R18's MD has started him on gabapentin and only saw minimal improvement. NM stated she felt R18 continued to experience pain and that is pain was not managed at that time.

A facility policy titled, Pain, reviewed 5/2016, revealed it was the facilities policy to ensure patients were free of pain or would receive pain management that would allow them to maintain the highest degree of functioning and well being, enhance comfort. The policy directed facility licensed staff to complete an initial and ongoing pain assessment of prn medications. The policy directed licensed staff to monitor the effectiveness of medications and to evaluate if a need to schedule prn pain medications.

A care plan policy was requested and not provided.

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2 565	Continued From page 17 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. To ensure ongoing compliance, the DON or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, thoroughly investigate causal factors and implement interventions in order to minimize the risk of falls and injury for 1 of 3 residents (R32)	2 830	corrected	1/6/17

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2 830	Continued From page 18 who had repeated falls with serious injury which required medical intervention. This resulted in an immediate jeopardy situation for R32. Findings include: The Immediate Jeopardy (IJ) began on 9/20/16, related to the facility's failure to complete a comprehensive assessment to determine causal factors and implement interventions for R32 who sustained a significant injury from a fall which occurred on 9/20/16. The lack of assessment placed R32 at significant risk for serious injury and/or death. The facility administrator and director of nursing (DON) were notified of the IJ on 1/5/17, at 10:15 a.m. which began on 9/20/16, when R23 had fallen and the facility failed to complete a comprehensive assessment of causal factors related to R23's continued falls, in a effort to implement interventions to minimize the risk of R23's risk for further falls. The IJ was removed on 1/6/17, at 4:00 p.m. however, non-compliance remained at a scope and severity level of G, which indicated actual harm for R32 due to a left wrist fracture sustained during a fall which required medical assessment and interventions. R32's diagnosis list dated 1/5/17, indicated R32's diagnoses included dementia, limitation of activities due to disability, difficulty in walking, history of encephalopathy (acute changes in awareness), fracture of the right arm, rheumatoid arthritis, osteoarthritis and osteoporosis. R32's admission Minimum Data Set (MDS) dated 7/26/16, indicated R32's history of falls, or fall risk could be determined. R32's MDS identified R32 had severely impaired cognition, required extensive assistance with activities of daily living	2 830		

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2 830	Continued From page 19 (ADLs), was occasionally incontinent of urine, was not on a toileting program, received antibiotic medication and had a urinary tract infection (UTI) which increased R32's risk for falls. R32's MDS further identified R32 had hallucinations and wandered which put R32 at significant risk for injury. R32's Falls Care Area Assessment (CAA) dated 8/2/16, indicated R32 had 1 fall. R32 was found on the floor in her room in front of her recliner. She had an x-ray which was negative for a fracture, and R32 remained a high fall risk. R32's Cognitive Loss/Dementia CAA dated 8/2/16, indicated R32 had obtained a bladder infection during her first week of admission and remained very confused and delirious at times. The CAA further indicated R32's cognition would be monitored through the first month of admission. On 1/5/17, at 12:34 p.m. physical therapist (PT)-A confirmed he did not complete an initial physical therapy evaluation when PT started on 8/2/16. PT-A confirmed he did not complete a PT discharge summary for R32 when she was discharged from PT on 9/2/16. He stated R32's cognition dropped significantly within the first couple weeks of admission. It was difficult to get her up to walk even with cueing and assistance from staff. He stated R32 was discharged from PT because of severe cognitive and balance impairment. He further stated R32 did not make any progress during PT and continued to be at risk for falls.	2 830		

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2 830	Continued From page 20 R32's care plan dated 12/30/16, indicated R32 had memory and cognitive problems that seemed to worsen with UTI's. R32 had a physical decline in all of her ADLs since the UTI, and signs of delirium as she reached for things she saw in the air. R32's care plan indicated the goals were to be safe in her surroundings, needs would be met and R32 would be monitored for safety concerns. R32's care plan identified R32 had been incontinent of bowel and bladder since admission and incontinence was possibly related to her recent UTI and fall. R32 was to be toileted every 2 hours. R32's care plan indicated as of 11/21/16, staff was not to leave R32 alone in the bathroom and watch for her trying to go to the bathroom by herself. The care plan identified R32 had bed and chair alarms placed 7/27/16, due to R32 self transferring, a tab alarm placed 9/20/16, due to standing without purpose, all items were to be within reach, no clutter on the floor, call light within reach, fall mat placed, bed in low position and lipped mattress. R32's care plan further identified R32 fell on 7/27/16, and had no injury, another fall 9/20/16, with skin tear and left wrist fracture, and fell again on 11/21/16, with no injury. The care plan failed to identify R32's falls on 8/27/16, and 10/9/16. There were no injuries. R32's undated North Assignment sheet (tool nursing assistants use to direct care), indicated R32 required the assistance of 1-2 staff for ADLs which included transfers and toileting, and identified R32 had a bed and chair alarm. R23's Falls Risk Acuity report dated 7/21/16, indicated R32 had poor safety awareness,	2 830		

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2 830	Continued From page 21 required the use of assistive devices, was up ad lib and was continent. The report indicated R32 took antihypertensive and laxative medications that increased R32's risk for falls. The report further indicated R32 had cognitive impairment with a decline in cognitive function, delirium, depression and dementia. The report identified R32 was at risk for falls and was to be seen by PT and occupational therapy (OT) and a falls care plan would be initiated. Fall events: 1. R32's Fall Safety Event report indicated R32 fell on 7/27/16, at 7:30 p.m. after she attempted to self transfer and was found on the floor in her room. The report indicated R32 had complaints of pain in her buttocks and right thigh, had a fever and UTI. The report identified neurological checks (neuro's) and vital signs (vitals) were checked and fall interventions included analgesics (pain medication), bed alarm and rest. R32's PN dated 7/27/16, at 7:30 p.m. indicated R32 was found on the floor in her room in a sitting position with both legs off to her right side. R32 stated her butt and right leg and thigh hurt. The note identified R32 denied hitting her head and referred to the fall safety event report. R32's pelvic and hip X-ray report dated 7/31/16, at 5:02 p.m. identified R32 had abnormal bony projections throughout her pelvis and degenerative changes without definite fracture. 2. R32's Fall Safety Event report indicated R32 fell on 8/27/16, at 10:21 a.m. The report indicated R32's chair alarm sounded after she attempted to	2 830		

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2 830	Continued From page 22 self transfer from her wheelchair to the commode. R32 was observed to slip and fall on the floor on her butt and hit her head on the bathroom door knob. The report indicated R32 complained of slight pain in her lower back and her vitals signs were taken. The report failed to identify R32's mental status, possible contributing factors, if current interventions were effective, or any new interventions implemented after the fall. R32's PN dated 8/27/16, at 10:38 a.m. indicated R32 slipped and fell on her butt and bumped her head on the door knob. R32 complained about slight pain in the middle of her back. R32's vitals were taken and the new intervention was to ensure R32 had her shoes on. 3. R32's Fall Safety Event report indicated R32 fell on 9/20/16, at 10:30 p.m. after R32 attempted to self-transfer. She was found on the floor in her room facing her bed with a skin tear to her right forearm. The report indicated neuro's and vitals were completed, there were no possible contributing factors, current interventions were effective and an additional intervention was a floor mat. R32's PN dated 9/20/16, at 10:30 p.m. indicated R32 was found seated on her floor with her back against the bed. R32 stated she scooted down. The note indicated vitals were taken and would be monitored every 4 hours per facility policy. R32 had no complaints of pain. The report identified R32 sustained a skin tear to her right forearm, neuro's were at baseline and a floor mat would be requested. A PN dated 9/21/16 at 10:23 a.m. identified R32 complained of wrist pain while in therapy. Swelling was noted in the wrist and facial grimacing when touched. R32 was seen by	2 830		

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2 830	Continued From page 23 the physician and an x-ray was ordered. R32's left wrist X-ray report dated 9/21/16, at 4:03 p.m. identified a left wrist fracture. 4. R32's Fall Safety Event Report indicated R32 fell on 10/9/16, at 1:53 p.m. after she self-transferred from a wheelchair to the toilet in her bathroom. R32 slid onto her butt. The report indicated R32 did not hit her head, had no complaints of pain and vitals were completed. The report failed to identify if current interventions were effective or any new interventions. R32's PN dated 10/9/16, at 1:45 p.m. identified R32 was found on the bathroom floor after she slid off the toilet onto the floor. The report indicated R32 had not hit her head, had no complaints of pain and her vital signs were taken. The note failed to identify any new interventions after R32 fell. R32's Falls Risk Acuity report dated 10/25/16, indicated R32 was disoriented with diminished safety awareness, required the use assistive devices, had impaired mobility and was continent with staff assistance. The report indicated R32 took antihypertensive, narcotic and laxative medications that increased R32's risk for falls. The report further indicated R32 had 3 or more falls in the last 3 months, loss of limb movement, decline in physical status, incontinence, hypotension (low blood pressure), cerebrovascular accident (stroke) and weakness to 1 side of her body. The report identified R32 was at risk for falls, no referrals were necessary and they were to continue current plan of care. 5. R32's Fall Safety Event Report indicated R32	2 830		

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2 830	Continued From page 24 fell on 11/21/16, at 12:33 p.m. after she self-transferred from the wheelchair to the toilet in the east bathroom. R32 slid down between the toilet and the wall. The report indicated neuro's and vitals were taken and R32 complained of pain on the right top of her hand. The report failed to identify if current interventions were effective and any new interventions added after the fall. R32's PN dated 11/21/16, at 12:11 p.m. identified R32 self transferred from her wheelchair to the toilet in the bathroom before staff could get to her and she slid down between the toilet and the wall. The note indicated R32 complained her right hand was sore and she was emotionally upset. The report further indicated vitals were taken and R32's care plan would be updated. The note failed to identify any new interventions implemented after R32 fell. On 1/3/17, at 1:44 p.m. R32 was observed seated in a recliner in the common area with a tabs alarm (fall prevention monitor) adjustable cord clipped to the back of R32's shirt. The unit was not attached to the recliner but placed between arm chair cushions, which may have prevented it from sounding if R32 attempted to stand independently. When the tabs unit is not secured, the cord can stay attached to the unit. If it does not separate, the alarm will not sound alerting staff to the independent transfer. R32 made no attempts to stand. On 1/4/17, at 8:34 a.m. R32 was observed seated in a recliner in the common area with a tabs alarm cord clipped to the back of R32's shirt. The tabs unit was not attached to the recliner. It was on the right arm of the recliner chair. R32 made no attempt to stand.	2 830		

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2 830	Continued From page 25 -8:45 a.m. R32 was observed seated in a recliner in the common area with a tabs alarm cord clipped to the back of R32's shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. R32's right arm was in front of alarm unit. R32 made no attempts to stand. -9:27 a.m. R32 was observed seated in a recliner in the common area with a tabs alarm cord clipped to the back of R32's shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. R32 made no attempts to stand. -9:35 a.m. R32 was observed seated in a recliner in the common area with a tabs alarm cord clipped to the back of her shirt and the unit was not attached to the recliner but on the right arm of the recliner chair. R32 made no attempts to stand. -10:05 a.m. after asking nursing assistant (NA)-B about R32's toileting schedule NA-B stated "I was just about to do that." NA-B asked R32 is she wanted to use the bathroom. R32 said yes. R32 reached forward and grabbed the seat of her wheelchair with both hands, patted the seat, and picked at the wheelchair arms with her right hand. NA-B applied the gait belt and removed the tabs alarm unit from the recliner and R32's shirt and placed them in the storage pouch on the back of her wheelchair. NA-B cued R32 to stand up. R32 stood up slowly and held on to both arms of the wheelchair. R32 was stooped over and very unsteady. NA-B assisted R32, holding on to her with the gait belt and assisting her to turn around and sit down in her wheelchair. R32 took small steps during transfer remaining stooped over and moving slowly.	2 830		

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2 830	Continued From page 26 -11:15 a.m. R32 was observed seated in a recliner in the common area. The tabs alarm cord was clipped to the back of R32's shirt. The unit was not attached to the recliner but was sitting on the right arm of the recliner chair. R32 made no attempts to stand. -12:27 p.m. NA-B transferred R32 from her wheelchair to the recliner using a gait belt, cueing and physical assistance. R32 leaned forward in her recliner when NA-B attempted to elevate her feet with the recliner leg rest. R32 became upset and stated loudly and harshly, "I don't want that up." NA-B said ok and clipped the tabs alarm cord to the back of R32's shirt and placed the alarm unit loosely under the right recliner arm cushion. The unit was not attached to R32's chair. R32 leaned forward, lifted her bottom off the recliner seat and plopped herself back down in recliner. R32 scooted herself back in the chair. The alarm did not sound during this activity. NA-B had left the area. -12:33 p.m. R32 leaned forward in the recliner, looked around the area and leaned back in the chair. No staff were present in area. -12:36 p.m. No staff were present in area. R32 leaned forward and pulled some of the alarm unit cord forward with the unit. The alarm did not sound. There was too much slack in the cord and the unit was unattached making the alarm ineffective. R32 attempted to get up from the recliner. R32 was able to get her bottom to the edge of the recliner chair. She was then able to lift her bottom approximately 2 inches from the chair. Although the cord pulled slightly with R32 as she moved, there was too much slack for the alarm to sound. R32 then attempted to self	2 830		

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2 830	Continued From page 27	2 830		

transfer. R32 leaned forward, pushed off of the recliner chair arms with both hands and attempted to stand. No staff was present, and the alarm failed to sound, so one surveyor remained with R32 while another surveyor left to find staff to assist R32. NA-C was found running water for a bath. NA-C was alerted to R32's attempts at self transferring in the day room. NA-C called for NA-A to help her in the day area. They physically assisted R32 with cues and a gait belt from the recliner to her wheelchair. NA-C confirmed the tabs alarm was not attached to R32's chair and should have been.

On 1/4/17, at 12:41 p.m. NA-B stated they usually put the tabs alarm on the side of the bed or chair. She stated there was a clip on the unit to be attached to her chair. NA-B confirmed R32's alarm should have been attached to her chair and not resting on the arms of the recliner. NA-B confirmed she had received education on how to operate and place the alarm when she was hired.

On 1/5/17 , at 9:13 a.m. R32 was observed self propelling from the day room to the east bathroom using only her feet. R32 leaned forward and opened the bathroom door when the alarm sounded. R32 continued to push herself through the doorway and was scooting forward in her chair. NA-D intervened and redirected R32, wheeling R32 out of the bathroom into the hallway. NA-D and R32 had a brief conversation in the hallway and NA-D assisted her into the bathroom and closed the door.

On 1/5/17, at 9:33 a.m. NA-D and NA-C were observed standing in the north hallway. R32 was seated in her wheelchair. NA-D stated they were

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2 830	Continued From page 28 going to assist R32 with ambulation. NA-D applied a gait belt around R32's waist and NA-D and NA-C cued R32 and physically assisted her to stand up. R32 pushed herself up with her hands on the wheelchair arms a couple times to gain momentum and NA-D and NA-C assisted her to stand. NA-D provided R32 with a walker and NA-C followed R32 and NA-D with a wheelchair. R32 was confused and grabbed the left arm handle of the walker and the front bar of her walker. NA-D cued R32 to grab the right walker handle with her right hand. R32's left foot swung in front of her right foot, R32 was leaned forward and her legs were weak. NA-D confirmed R32 had walked 100 feet and that was the farthest she ever walked. NA-D later confirmed she walked an additional 80 feet and stated R32 wanted to walk even more. On 1/4/17 at 2:16 p.m. R32's falls including fall event reports, progress notes, care plan and interventions implemented were reviewed with the DON. The DON stated the following: The DON verified the fall information and stated she was not aware staff was not placing R32's tabs alarm correctly. She stated she just assumed they affixed it to her chair or recliner. The DON stated she used a communication board and R32's care plan to ensure staff understood how to care for her. She also stated the NA's had an assignment sheet that summarized R32's care plan and stated some NA's chose not to carry it with them. She stated she expected staff to rely on their "best judgement" and R32's care plan to determine whether or not to apply R32's tabs alarm in a common area. The DON stated she expected the	2 830		

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2 830	Continued From page 29 tabs alarm to be affixed if she was in her room or in her wheelchair. For the fall of 7/27/16, at 7:30 p.m. the DON verified the fall information and stated she thought R32 tried to self-transfer and get out of bed. She stated the fall was unwitnessed and after the fall R32 had complained of a sore butt and pain in her right thigh. The DON stated sometimes R32 couldn't make sense of things. She stated bed and chair alarms were added to R32's care plan. The DON verified the fall information dated 8/27/16, at 10:21 a.m. She stated R32 tried to self-transfer. R32 got herself up, slipped and fell when she tried to go to the bathroom. She stated the fall was witnessed and the intervention was to make sure R32's shoes were on. The DON stated the fall on 9/20/16, at 10:30 p.m. resulted from R32 self transferring, attempting to get out of bed, and stated she wasn't sure why R32 was trying to transfer. The DON verified the documentation was accurate. She stated R32 sustained a left wrist fracture after the unwitnessed fall and it was reported to the State Agency. She stated a floor matt was added after the fall. The DON verified the information documented for the fall on 10/9/16, at 1:53 p.m. She stated R32 self transferred to the toilet and slipped and fell on the bathroom floor. She stated the fall was unwitnessed, vitals were completed and R32 did not hit her head. The DON confirmed there were no new interventions added after R32's fall. The DON stated the fall information on 11/21/16, at 12:33 p.m. was accurate. R32 was in the	2 830		

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bathroom and stood up from her wheelchair trying to get to the toilet. She said R32 fell between the toilet and the wall in the bathroom. The DON stated after one of her falls staff tried to keep her at the nurses station and give her things to do. She stated the new intervention added was not leaving R32 alone in the bathroom.

The DON stated R32 had moderate to severe cognitive impairment and R32 had no concept of time, or where she was at. She confirmed R32's last fall assessment was completed on 10/25/16. The DON stated R32 was at high risk for falls due to the amount of assistance and cueing she required with ADLs. R32 had forgotten she wasn't as mobile as she used to be and would try to stand up. She stated she had not considered doing a bowel and bladder assessment on R32, and stated those were only done quarterly. She stated she had not considered any other fall prevention interventions for R32. The DON stated they also tried to keep R32 in their line of vision, give her something to do at the nurses desk, and did not like to leave her alone in her room for extended periods of time.

The DON confirmed they do not have a, "Falls," policy and would continue to use the current fall event form in Matrix (clinical documentation system) until they developed a preventative program and new plan.

On 1/4/17, at 12:48 p.m. NA-A stated R32 was at risk for falls because she wandered, tried to stand up and reached forward in her chair. NA-A stated the last time she observed R32 get up from her wheelchair was a couple of days ago. She stated she thought R32 had only fallen once on the first day she was admitted. NA-A stated she thought

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2 830	Continued From page 31 she slid out of her bed and had to wear a cast after the fall. NA-A stated she was not aware of any other falls for R32. She stated R32's fall interventions were the tabs alarm and to keep R32 busy. She stated they tried to keep R32 by them otherwise her alarm was going off. She stated R32's tab alarm was not attached to the recliner today and should have been. On 1/4/17, at 12:53 p.m. clinical manager (CM)-A stated a fall intervention for R32 was to have a tab alarm in place secured to her recliner or chair. She stated R32 had the tab alarm because she had a history of self transferring and R32 had sustained an injury as a result. She stated R32 was at risk for falls because she had no safety awareness. CM-A stated she expected the nurse on duty to make sure her alarm was placed correctly. On 1/4/17, at 1:06 p.m. licensed practical nurse (LPN)-A stated R32's tabs alarm should be secured. She stated she hated to see the NA's wedge the alarm unit in the arm of the recliner chair. LPN-A stated she had previously educated the NA's to secure R32's tabs alarm. On 1/5/17, at 8:56 a.m. NA-D stated R32 started a restorative program on 8/15/15. NA-D stated she was currently working with R32 on both upper and lower extremity exercises and ambulation about 3 times per week as tolerated. NA-D stated she felt R32 had moderate cognitive impairment and some day's R32 was really confused. She stated R32 was at risk for falling and required extensive assistance with ADLs. She stated she could walk 86-89 feet with staff assistance but	2 830		

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2 830	Continued From page 32 R32's legs got tired. NA-D stated she felt R32 didn't attempt to get up that often except when her cognition was, "off" that day. She stated the last time she observed R32 try to stand up was 2-3 weeks ago. On 1/5/17, at 9:25 a.m. the activities director (AD) stated she felt R32 was at moderate risk for falls when she was alone in her room and when she tried to stand up from her wheelchair. The AD stated the last time she saw R32 try to get up on her own was 1/3/16 when R32 wheeled herself into the east bathroom. She stated whenever R32 tried to stand up on her own they would remind her not to and she would reply, "I know." On 1/6/17, at 9:59 a.m. the occupational therapist (OT) confirmed R32's OT evaluation on 7/22/16. The OT stated R32 had been discharged from OT on 8/12/16. The OT confirmed she had not completed a discharge evaluation for R32 and stated she must have overlooked it. She stated when R32 began therapy she was confused and required supervision and physical assistance from staff with bed mobility and transfers and used a walker. She stated after R32 fell on 7/27/16, it became difficult for R32 to go from a sitting to standing position. The OT stated at that point R32 could not be left unattended because she would lose her balance. The OT confirmed R32 was at risk for falling because she required physical assistance of staff for ADLs, had weakness in her legs and had a difficult time transitioning from sitting to standing. She stated when R32 was discharged from OT on 8/12/16, she was more confused, and had increased difficultly following directions. She further stated pain was a limiting factor for OT progress after	2 830		

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2 830	Continued From page 33 her fall on 7/27/16. The OT stated they started OT with R32 again on 11/7/16, after R32's splint had been removed and she was able to use her left wrist for ADLs. The OT stated R32 was discharged again from OT on 11/23/16, and R32's left hand was swollen, had limited flexion and some pain. She stated R32's limiting factors and reason for discharge from OT on 11/23/16, was due to poor cognition. She stated R32 required staff assistance and cues to ambulate with her walker. The OT stated R32 continued to be at risk for falls because she required assistance with ADLs and cognition. The OT additionally stated the last time she saw her, R32 was able to self propel herself in the wheelchair using only her feet. Review of the User Instructions for the Personal Sentry Fall Monitoring System identified the monitor was to be mounted to either a chair or bed using the clip on the back of the monitor, the magnetic disc from the pull string was to be secured to the monitor magnet, and the locking clip attached to the resident's garment at the top of the shoulder or back of the neck with the appropriate cord length determined in order for the person to activate alarm. When a resident moved beyond the determined length of the cord, the disc pulled from the monitor and the alarm would sound. The user instructions directed staff to follow the installation instructions, particularly the warnings and cautions when using the fall monitoring system and failure to do so could result in injury or death. The immediate jeopardy which started on 9/20/16, was removed on 1/6/17, at 4:00 p.m.	2 830		

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2 830	Continued From page 34 after the facility completed the following interventions as part of their removal plan: -R32 was comprehensively assessed for falls -R32's care plan was updated to reflect R32's assessment for current risks for falls and fall interventions -Staff were educated on R32's fall interventions -On 1/6/17 from 3:00 p.m. to 4:00 p.m. direct care staff, including licensed nursing staff were interviewed regarding R32's safety risks. All of the interviewed staff were aware of R32's risk for falls, and the fall interventions to ensure R32's safety Based on observation, interview and document review, the facility failed to monitor and implement interventions to relieve frequent moderate to severe pain following a fracture of the right clavicle for 1 of 3 residents (R18) reviewed for pain. This deficient practice caused actual harm to R18. Findings Include: R18's admission Minimum Data Set (MDS) dated 11/2/16, identified R18 had moderate cognitive impairment and had diagnoses which included, pain of upper extremity, congestive heart failure (CHF) and seizure disorder. The MDS identified R18 had frequent pain of a moderate level and had received as needed (prn) pain medications. The MDS identified R18 did not receive scheduled pain medications or non-medicinal interventions for pain within the seven day look back period. On 1/6/17, at 8:20 a.m. Registered Nurse Manager (NM) stated R18's cognition had	2 830		

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2 830	Continued From page 35 improved since his admission assessment and no longer had moderate cognitive impairment. At the time of the survey R18 had improved in cognition. NM stated R18 had minimal cognitive impairment and was able to verbalize his needs and wishes without difficulty. NM stated R18 would be a reliable source of information regarding his pain level. Review of R18's Pain Care Area Assessment (CAA) dated 11/2/16, identified R18 had many complaints about shoulder, neck and back pain. The CAA identified R18 had a history of a broken collar bone. The CAA revealed R18 was to be examined by his primary physician with nursing home rounds. Review of R18's pain assessment dated 10/27/16, revealed R18 had stated upon staff interview he had frequent pain of the right shoulder and clavicle (collar bone) with onset with movement. The assessment revealed R18 had described the pain as an ache and was of a moderate intensity. The assessment revealed interventions were in place of Tylenol 650 milligrams (mg) by mouth (po) every four hours as needed (prn,) and a referral for physical therapy (PT) and occupational therapy (OT). Review of R18's care plan dated 11/15/16, revealed R18 had complaints of chronic pain related to a history of alcohol abuse and falls with recent collar bone fracture. R18's care plan revealed R18 had complained of pain with therapy, he had been educated to continue therapy despite the pain as he had not been using his arm due to pain. R18's care plan directed staff to provide R18 with pain medications, BioFreeze (an over the counter topical pain relieving medication) and	2 830		

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2 830	Continued From page 36 non-pharmacological pain interventions of warm/cold packs. R18's care plan revealed PT has been ordered for shoulder pain and R18's MD had declined further pain medications or diagnostic testing of an MRI as of 11/8/16. The care plan further revealed R18 had enjoyed activities of trivia, reminiscing, and western movies shortly after he was admitted and R18's shoulder pain prevented him from attending activities. The care plan also revealed R18 preferred to lay in bed for comfort and had declined further activities due to pain. An identified care plan goal was for R18 to develop coping strategies to help adapt to pain. On 1/4/17, at 12:40 p.m. R18 was lying on his left side in bed, facing the TV with his eyes open. R18 had his right arm guarded to his chest and a furrowed brow, clenched jaw and squinted eyes, with facial grimacing. On 1/4/17, at 2:37 p.m. R18 was seated on the edge of his bed, his feet on the floor. His right arm was tightly guarded to his chest. As he coughed, R18 grimaced with a furrowed brow. R18 stated he had been experiencing pain following a fall prior to admission to the facility in late October. R18 continued to guard his right arm, and grimace. R18 stated he had sharp pain which started at his collar bone and radiated down to his hand. R18 stated at times the pain was severe, being at least an "8" on a pain scale of 0 to 10 with 10 being the worst imaginable pain. R18 stated he was right handed, so being independent with his cares and eating had been hard as he experienced pain whenever he moved his right arm. R18 stated at times it was hard for him to sleep at night and coughing significantly increased his pain level. R18 stated he told the nurses he had pain everyday. R18 stated the	2 830		

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nurses offered him ibuprofen and Tylenol for the pain which was frequently ineffective. R18 stated he had been told by the nurses to work with therapy for the pain and stated he could not work with therapy due to it causing too much pain. R18 stated his physician had recently started him on the medication, gabapentin (a medication used to treat nerve pain from neuropathy). R18 stated he had been taking the gabapentin since December and had not had relief from the pain. R18 stated he felt he had a high pain tolerance as he was "no stranger to pain", and the nurses and doctor should listen to him when he said the medications were not reliving his pain. R18 stated the staff had offered ice packs right after he was admitted and that was also ineffective. R18 continued to exhibit a furrowed brow, squinted eyes, and grimacing. R18 stated he felt the pain had affected his well being, he felt depressed and all he did was smoke and try to sleep the pain away but couldn't do it. R18 stated he felt his continued pain kept him isolated and he did not feel like himself.

Review of R18's current physician orders signed 12/13/16, revealed the following orders for pain management: Tylenol 325 mg, take two tablets po every four hours for pain (start date 10/27/16), Ibuprofen 400 mg three times a day (tid) po for right arm pain (start date 12/7/16). A hand written order dated 12/16/16, revealed an order for gabapentin 300 mgs by mouth tid for pain.

Review of R18's medication administration record (MAR) for October, November and December 2016, revealed the following administration of prn pain medications and the effectiveness:

-October 2016, revealed R18 had reported moderate to severe pain and had received prn

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2 830	Continued From page 38 Tylenol 650 mg 10 times and one out of 10 times R18 had received relief from the Tylenol. R18 had reported somewhat effective relief the other nine times. -November 2016, revealed R18 reported moderate to severe pain and had received prn Tylenol 650 mg 44 times. The MAR revealed on 26 out of the 44 times R18 had received the Tylenol it had been somewhat effective and three out of 44 times it was ineffective in relieving R18's pain. R18 had reported effective results the other 15 times. -December 2016, revealed R18 had reported moderate to severe pain and had received prn Tylenol 650 mg 32 times and out of the 32 times, 18 times R18 had reported the medication was somewhat effective and 3 times ineffective and 11 times was effective. The MAR also revealed R18 had received ibuprofen 400 mg 31 times during the month, out of the 31 times 10 times the ibuprofen was semi effective, three times not effective and 18 times was effective. -January 2017, revealed R18 had reported moderate to severe pain and had received Tylenol 650 mg 3 times and out of the three times R18 had somewhat effective pain relief. The MAR revealed R18 received ibuprofen 400 mg eight times and out of the eight times two times R18 had somewhat effective pain relief and six times the ibuprofen was effective. Review of an x-ray report dated 10/14/16, identified R18 had a displaced fracture of the distal third of the clavicle which appeared to be a healing subacute fracture. Review of R18's physician progress notes dated	2 830		

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2 830	Continued From page 39 11/8/16, revealed R18 had been seen for an initial visit. The note revealed R18 had attended therapy at the time of the note for right upper extremity and staff could apply moist heat 15 minutes per hour as able for the pain. The note revealed R18 had suffered a fracture of his right collarbone on 10/14/16 and had suffered constant, sharp pain which radiated from his collarbone down his right arm and occurred with any type of activity. The note revealed R18 had significant deformity of his collarbone with tenderness over the joint. The note further revealed R18 was to be seen again in four weeks. Review of R18's physician note dated 12/7/16, revealed R18 was seen by an orthopedic physician regarding his right shoulder. The note revealed R18 had been having significant pain and had been unable to comply with therapy in the facility due to right arm pain. The note identified R18 had a healing right distal clavicle fracture with possible cuff dysfunction with his pain. The note further revealed R18 had weakness with external rotation, that may have been due to pain. Review of R18's physician progress note dated 12/13/16, revealed a nursing home note which identified R18 had a closed displaced fracture of acromial end of right clavicle (towards the shoulder) with malunion. The note revealed R18 complained of ongoing pain in the right shoulder. The note revealed R18 had significant right shoulder girdle atrophy with a marked deformity of the distal clavicle. The note further revealed R18's internal and external rotation were limited. The note also revealed R18 had tenderness to touch over the right shoulder. The note revealed R18 was to continue to receive heat application	2 830		

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2 830	Continued From page 40 therapy and use Tylenol and ibuprofen for pain management. The note further revealed R18 was to continue with passive and active range of motion (ROM) exercises and the physician would consider adding additional pain medication if no improvement in R18's pain. Review of Therapy Assessment, OT evaluation form dated 10/28/16, revealed R18 had been evaluated for therapy and had impaired upper ROM both active and passive of his right upper extremity. The assessment revealed R18 was referred to the facility functional maintenance program (FMP) three times a week for ROM. Review of a Therapy Assessment, PT evaluation form dated 11/9/16, revealed R18 had shoulder pain from a fracture and had decreased ROM and pain. The assessment identified R18 has constant pain which would shoot down his arm. The assessment revealed R18 had reported Tylenol was not effective in relieving his pain which he had rated an 8 out of 10. The assessment revealed R18 understood the need to move his arm around, though did not want to due to pain. The assessment revealed PT had attempted seven visits with R18 from 11/11/16 to 12/1/16 and R18 had participated in therapy on three of the seven visits and had refused the rest. The assessment further revealed R18 continued to have pain in his shoulders. Review of facility progress notes from 10/27/16, to 1/4/17, revealed the following: -A note on 10/27/16, revealed R18 was alert and oriented, had complained of shoulder pain rated a 7 out of 10, received Tylenol 650 mg. The note revealed R18 reported a tolerable level of pain was a 3 out of 10.	2 830		

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2 830	Continued From page 41 - A note on 10/30/16, revealed R18 complained of pain rated 6 out of 10 and received Tylenol 650 mg. -A note on 11/04/16, revealed R18 complained of right shoulder pain rated a 7 out of 10 and had received Tylenol 650 mg. -A note on 11/5/16, revealed R18 complained of right shoulder pain, rated 8 out of 10 and received Tylenol 650 mg. The note revealed R18 had reported pain of 4 out of 10 after receiving the Tylenol. - A note on 11/6/16, revealed R18 complained of right shoulder pain, rated 6 out of 10 and received Tylenol 650 mg. The note revealed R18 had reported pain of 2 out of 10 after he received the Tylenol. - A note on 11/7/16, revealed R18 refused therapy due to right arm pain. - A note on 11/8/16, revealed R18 was not seen for restorative therapy for the week of November 2 - 8, due to right shoulder pain. Another note revealed R18 had been seen in the facility by his primary physician. The note revealed R18 complained of right shoulder pain and requested an MRI. The note further revealed R18's MD ordered PT for shoulder pain and ROM. -A note dated 12/2/16, as a late entry for 11/11/16, revealed R18 was seen by PT for right shoulder pain and completed ultrasound and therapeutic exercises which included passive ROM. -A note dated 12/2/16, as a late entry for	2 830		

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2 830	Continued From page 42 11/15/16, revealed R18 had been seen for 25 minutes by PT, received ROM exercises and reported continued pain of the right shoulder. -Review of notes dated 12/2/16, as late entries for 11/16/16, 11/18/16, revealed R18 refused therapy. -A note dated 11/19/16, revealed R18 complained of shoulder pain rated 6 out of 10 and received Tylenol 650 mg. - A note dated 12/2/16, as a late entry for 11/22/16, revealed R18 refused therapy. -A note dated 12/2/16, as a late entry for 11/23/16, revealed R18 refused therapy. -A note dated 11/28/16, revealed R18 complained of shoulder pain rated 7 out of 10 and received Tylenol 650 mg. The note revealed R18 had rated his pain 4 out of 10 after he received the Tylenol. - A note dated 11/30/16, revealed R18 complained of shoulder pain rated a 7 out of 10 and received Tylenol. The note revealed R18 had rated his pain 3 out of 10 after he received the Tylenol. - A note dated 12/2/16, late entry for 12/1/16, revealed R18 was seen by PT, reported improved pain and completed 25 minutes of ROM exercises. - A care conference note dated 12/1/16, revealed R18 complained of right shoulder pain from a fall prior to admission. The note revealed R18 had not addressed his shoulder properly and the result was chronic pain. The note further revealed R18 resisted therapy despite the benefit. The	2 830		

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2 830	Continued From page 43 note revealed R18 had been provided education on the benefits of therapy. - A note dated 12/1/16, revealed R18 complained of shoulder pain rated 6 out of 10, and received Tylenol 650 mg. - A note dated 12/3/16, revealed R18 complained of shoulder pain rated 8 out of 10, and received Tylenol 650 mg. - A note dated 12/4/16, revealed R18 complained of shoulder pain rated 7 out of 10, and received Tylenol 650 mg. -A note dated 12/5/16, revealed R18 spoken with the NM twice and stated something needed to be done about his shoulder. The note revealed PT had planned to discontinue services. The note revealed the NM would speak with R18's MD. A further note revealed R18 complained of pain rated 7 out of 10 and received Tylenol 650 mg. The note revealed R18's pain level was 4 out of 10 after he received the Tylenol. - A note dated 12/8/16, a late entry for 12/6/16, revealed R18 received 2 out of 3 restorative sessions for the week of 11/30/16 through 12/6/16 and completed upper extremity (U/E) exercises. - A note dated 12/7/16, revealed R18 was seen by an orthopedic MD and received no new orders or interventions for pain relief. The note revealed NM encouraged R18 to take Tylenol. A further note revealed R18's MD had ordered ibuprofen 400 mg tid as needed for right arm pain. The note further revealed R18 was to keep using ice and heat to address pain with gentle ROM.	2 830		

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2 830	Continued From page 44 - A note dated 12/8/16, revealed R18 complained of right shoulder pain and ibuprofen was given. A further note revealed R18's functional maintenance program (FMP) was updated to include gentle ROM to his right upper extremity and lower extremities. A further note revealed R18 complained of pain rated a 7 out of 10 and received ibuprofen 400 mg. The note revealed R18's pain level was 3 out of 10 after he received the ibuprofen. - A note dated 12/9/16, revealed R18 complained of pain rated 7 out of 10, and received ibuprofen 400 mg. The note revealed R18's pain level was rated 4 out of 10 after he received the ibuprofen. - A note dated 12/11/16, revealed R18 complained of pain rated at 8 out of 10 and received ibuprofen 400 mg. The note revealed R18's pain level was rated 3 out of 10 after he received the ibuprofen. -A note dated 12/13/16, revealed R18 had been seen by his primary MD on a routine visit. The note revealed R18 complained of continued shoulder pain. The note further revealed R18 was to use heat to his shoulder for pain 15 minute intervals. -A note dated 12/15/16, revealed R18 complained of shoulder pain rated 8 out of 10 and had received Tylenol 650 mg. The note revealed R18 rated the pain level 4 out of 10 after he received the Tylenol. - A note dated 12/16/16, revealed R18 approached NM and requested to be seen in the emergency room (ER) for continued shoulder pain. The note revealed NM encouraged R18 to be seen at the clinic in the afternoon. The note	2 830		

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revealed NM had informed R18's MD of his continued complaints of pain. The note revealed R18's MD had sent an order for gabapentin 300 mg tid for increased pain and R18 was not seen in the clinic or ER.

-A note on 12/20/16, revealed R18 complained of pain in his arm and requested Tylenol. The note revealed R18 had become "impatient" when he had to wait for the pain medication.

- A note on 12/21/16, revealed R18 was observed to wear a pained look upon his face and was gently holding his his arm. The note further revealed R18 refused group activities and only wanted to smoke, eat and lay down.

- A note on 12/22/16, revealed R18 had trouble completing exercises due to pain and too much pressure on his right shoulder.

R18's medical record lacked any documentation of non-pharmacological interventions for pain having been offered or attempted for pain management.

On 1/5/17, at 7:08 a.m. R18 was seated in a stationary chair in the dining room, held a coffee cup in his left hand and his right arm was bent at the elbow resting on the armrest of the chair. R18 received scrambled eggs, two sausage links, toast and hot cereal. R18 lifted his right arm and reached for his fork. R18's eyes immediately shut, brow furrowed and R18 quickly put his right arm back down on the armrest. R18 used his left hand, grabbed the fork and proceeded to eat 4 fork bites of scrambled eggs. R18 then moved his fork to his right hand, pierced a sausage link guarded his right arm to his chest, bent his elbow and moved his head down to the fork to eat the

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2 830	Continued From page 46 sausage links. R18 did not raise his right arm/hand to eat the sausage. R18 picked up a spoon with his left hand and ate three bites of his hot cereal, and placed the spoon back on the table. R18 picked up a piece a toast with his left hand, ate two bites, and placed it back on his plate. R18 held the coffee cup in his left hand and drank all of his coffee. At 7:19 a.m. the director of nursing (DON) approached R18 and asked if he had enough to eat. R18 replied he was not feeling well and stated he was going to go back to bed. At 7:22 a.m. R18 independently walked out of the dining room with his right arm guarded to his right side, walked to the nurses station and obtained a cigarette and lighter. R18 walked toward the smoking room, pushed to button with his left hand to open the door, walked in the room and sat on a chair. R18 lit his cigarette with his left hand and proceeded to smoke with his left hand, while his right arm remained at his side. R18 then walked independently back to his room and sat on his bed, while his right arm remained guarded to his side, brow was furrowed, jaw tight and face taut. On 1/5/17, at 7:26 a.m. R18 stated he was not doing very well due to arm pain. R18 stated he could not sleep the previous night due to arm pain. R18 stated the nurse had given him Tylenol and it had not worked, and he continued to have severe pain. R18 said he was "so tired" of the pain. R18 further admitted he felt frustrated and hopeless. R18 stated he would tell the nurse when he had pain and would tell the nurses when the Tylenol or ibuprofen was ineffective in relieving pain. R18 said he told his physician he was in pain and the Tylenol and ibuprofen were ineffective in easing the pain. R18 stated he had pain everyday and staff knew he was in pain. On 1/5/17, at 12:14 p.m. R18 walked	2 830		

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independently in the hallway toward his room, his right arm guarded tightly to his right side. R18's brow was furrowed, cheeks and jaw were taut, and lips were pursed.

On 1/5/17, at 2:15 p.m. R18 walked independently down the hall toward the nurses station, his right arm guarded toward his side, cheeks taut, brow furrowed, lips and jaw tight. R18 obtained a cigarette, smoked with his left hand in the facility smoking room and walked back to his room. R18's facial expression remained unchanged.

On 1/6/17, at 9:16 a.m. R18 walked down the hall independently toward his room, lips and jaw tight, forehead creased, brow furrowed. At that time R18 stated he was in a lot of pain, had received some Tylenol that morning, and it had not been effective in reducing his pain.

On 1/5/17, at 12:27 p.m. the dietary manager (DM) stated she was aware R18 had not been using his right arm consistently during meals. The DM stated she felt R18's use of his arm would improve with therapy. She stated R18 did not want to use his right arm like he used to and would not participate in therapy because of that.

On 1/5/17, at 12:43 p.m. the PT stated R18 had refused to participate in therapy due to pain in his right shoulder. The PT stated he felt R18 was a reliable source of information regarding his pain and was unsure of the last time PT was completed.

On 1/5/17, at 1:55 p.m. licensed practical nurse (LPN)-A stated she felt R18 was cognitively intact and able to voice his needs and wishes. LPN-A stated R18 complained of right shoulder pain

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frequently. LPN-A stated she would provide R18 with ordered prn Tylenol and ibuprofen when he reported pain. LPN-A stated R18 often reported to her both the Tylenol and ibuprofen were ineffective in relieving pain. LPN-A stated she reported R18's continued pain to the NM as recently as a couple of weeks ago. LPN-A stated she had not offered R18 any other interventions for pain.

On 1/5/17, at 2:39 p.m. nursing assistant (NA)-A stated she had seen R18 walk up to the nurses station and complain of pain on a routine basis. NA-A stated R18 had also frequently reported to her he had pain, most recently that week. NA-A stated R18 had complained of right shoulder pain since admission a few months ago. NA-A stated she felt there were days R18 would stay in his room due to being in so much pain. NA-A stated R18 had also reported to her he often laid down due to pain and did not sleep well. NA-A stated she would inform the nurse when R18 would report pain to her. NA-A stated she routinely observed R18 grimacing when he moved his right arm on a routine basis.

On 1/5/17, at 3:18 p.m. NA- F stated R18 had reported to her he had been in pain though was unable to recall the most recent time. NA-F stated she felt R18 often held his right arm to his body due to being in pain. NA-F stated she had seen R18 walk up to the nurses station and complain of pain frequently. NA-F stated she had also reported to the nurses R18 had pain, though was unable to recall the most recent time.

On 1/6/17, at 1:59 p.m. the activity director (AD) stated she felt R18 was cognitively intact and able to voice his needs and wishes. The AD stated R18 had participated in activities briefly after he

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2 830	Continued From page 49	2 830		

arrived at the facility. The AD stated R18 routinely complained of right shoulder/arm pain since admission and had stopped attending activities. The AD stated she completed 1:1 visits with R18 in his room per his preference. The AD stated R18 had stopped attending group activities due to his pain.

On 1/6/17, at 8:23 a.m. NA-D stated she completed resident restorative therapy daily and R18 was supposed to have upper and lower extremity exercises. NA-D stated she was to complete range of motion (ROM) exercises with R18's right arm three times a week which started in November. NA-D stated R18 complained of pain with movement of his right arm. NA-D stated R18 had a fractured collar bone on the right side which she felt affected his range of motion. NA-D stated she had been unable to work with R18 the week of survey due to R18's complaints of pain and not feeling well. NA-D stated R18 had pain when he would bear weight with his right arm and when he attempted to lift his right arm, moving his shoulder away from his body. NA-D stated she had not seen an improvement in R18's pain management or ROM since he was admitted.

On 1/6/17, at 8:30 a.m. NA-C stated R18 frequently complained of pain in his right shoulder. NA-C stated she frequently observed R18 guarding his right arm by holding it against his body. NA-C stated when R18 reported pain in his shoulder she would immediately tell the nurse.

On 1/6/17, at 8:46 a.m. a phone call was placed to R18's primary physician, who was also the facilities medical director. R18's primary MD was not in the office would not return until 1/9/17, a message was left with MD's nurse line for MD to

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	00353	A. BUILDING: _____ B. WING _____	01/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAHNOMEN HEALTH CENTER	414 WEST JEFFERSON AVENUE, PO BOX 396 MAHNOMEN, MN 56557

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2 830	Continued From page 50	2 830		

call back. MD did not return phone call prior to survey exit. A phone call was received by MD on 1/10/17, at 4:20 p.m. During the phone interview MD stated he was aware R18 had ongoing pain, especially in his right shoulder. MD stated he was not aware of the overall ineffectiveness of R18's current pain regimen. MD stated he had thought R18's Tylenol and ibuprofen were already given to him on a scheduled basis. MD stated the usual practice was to schedule prn pain medication if they routinely received it. MD stated he had referred R18 to an orthopaedic MD and he had felt an MRI was not necessary. MD stated he had considered adding Tramadol (non-opiate prescription pain medication) to R18's medication regimen but had not at that time. MD stated he was very reluctant to order opioid and/or narcotic pain medications due to the monitoring involved in prescribing those medications. MD stated he would only order opioid and/or narcotic pain medications in cases of acute injury or pain, which he felt R18 did not meet that criteria. MD stated he had also ordered gabapentin for R18's pain in December some time and had hoped that would improve. MD stated R18 could have had heat and cold therapy, but was not sure if the staff had tried them or their effectiveness. .

On 1/6/17, at 1:56 p.m. LPN-B stated R18 had an old fracture to his right collar bone which she felt continued to cause R18 frequent pain. LPN-B stated R18 received Tylenol and ibuprofen for pain, which were overall not effective. LPN-B stated she had reported to the NM, R18 was not receiving relief from pain with the current prn medications, most recently as the previous week.

On 1/6/17, at 2:23 p.m. during a follow up interview the NM stated she was aware R18 was not receiving routine relief with the current prn

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2 830	Continued From page 51 mediations of Tylenol and ibuprofen. The NM stated she had been unable to complete another cognition assessment as requested by the surveyor due to R18 not feeling well with a cough. The NM stated she felt R18 was overall cognitively intact and may have minimal memory loss. The NM stated she felt R18 was a reliable source of information regarding his pain. The NM stated she had reported to R18's primary MD the current pain medication overall was not effective. The NM stated she would routinely struggle with R18's MD regarding R18's pain management due to an unwillingness to try other pain medications. The NM stated R18's MD has started him on gabapentin and only saw minimal improvement. The NM stated she felt R18 continued to experience pain and that his pain was not managed at that time. A facility policy titled, Pain, reviewed 5/2016, revealed it was the facility/s policy to ensure patients were free of pain or would receive pain management that would allow them to maintain the highest degree of functioning and well being, enhance comfort. The policy directed facility licensed staff to complete an initial and ongoing pain assessment of prn medications. The policy directed licensed staff to monitor the effectiveness of medications and to evaluate if a need to schedule prn pain medications. SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) could Inservice staff to ensure that resident's have effective, individualized pain management and safety programs with appropriate assessed interventions and the programs are monitored for efficacy. Audits could be conducted to ensure that pain and safety management programs are	2 830		

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2 830	Continued From page 52 appropriately implemented, revised, and monitored. The results of the audits could be reported to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure residents were dressed in a dignified manner for 1 of 2 residents (R22) reviewed for dignity concerns. Findings include: R22's annual Minimum Data Set (MDS) dated 11/16/16, indicated R22 had Parkinson's disease and Alzheimer's disease. The MDS identified R22 had severely impaired cognition, was incontinent of urine, and required extensive assistance for dressing and ambulation. R22's care plan dated 12/12/16, indicated R22 required the assistance of one to two staff, a gait belt, and walker for ambulation, and assistance of one staff for dressing needs and incontinence cares.	21805	corrected	2/3/17

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21805	Continued From page 53 On 1/3/17, at 5:00 p.m. R22 was observed seated in a recliner in the resident lounge area. R22 was observed wearing a pair of gray sweat pants that had a hole below the left front pocket approximately four inches long in the seam of the pants which exposed R22's left upper, outer thigh. A staff member was observed to assist R22 to stand, then instructed R22 to use the walker and ambulated from the resident lounge, down the hall, and into the dining room. Throughout the observation, staff and other residents were observed to walk near and around R22. On 1/3/17, at 5:49 p.m. R22 was seated in a stationary chair in the dining room outside of the serving door with his left side facing the dining room filled with residents. The hole in R22's pants gaped open and exposed R22's upper, outer left thigh and white incontinence brief. Throughout the dining observation on 1/3/17, from 4:58 p.m. to 5:49 p.m. multiple staff walked past R22 on the way to the serving door, with no attempts or offers to change R22's pants. On 1/5/17, at 7:51 a.m. nursing assistant (NA)-E verified R22 required extensive assistance with dressing, ambulation and incontinence cares. NA-E stated R22 had many pairs of sweat pants, and R22 should have had the sweat pants changed because it was not dignified to walk around with torn sweat pants that showed exposed skin. On 1/5/17, at 12:01 p.m. licensed practical nurse (LPN)-A verified R22's torn sweat pants should have been changed right away, and stated it was not dignified to be seated in the dining room with the leg and incontinent brief exposed.	21805		

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21805	Continued From page 54 On 1/5/17, at 2:12 p.m. the dietary manager (DM)-A confirmed she observed the hole in R22's pants on 1/5/17. DM-A confirmed she could see skin of the left leg, and white material hanging out of the torn area of the sweat pants as R22 was seated in a chair in the dining room. DM-A confirmed staff was aware that R22's clothes were not in the best shape, and stated R22 had a history of picking at his clothing. On 1/5/17, 3:20 p.m. registered nurse (RN)-A found the pair of pants R22 was wearing on 1/3, and confirmed the hole was approximately four inches long and stated R22 should not have been dressed in them. On 1/5/17, at 3:27 p.m. clinical manager (CM)-A confirmed the hole in R22's pants was not dignified, and would have expected staff to change R22's pants. The facility's Quality of Life-Dignity policy dated 3/2016, indicated each resident would be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring residents are dressed in a dignified manner. The DON or designee could develop a system to educate staff and develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21805		