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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UILV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00390

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245367**
2.STATE VENDOR OR MEDICAID NO.
(L2) **346314100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOW MANOR**
(L4) **210 EAST GRAND AVENUE, PO BOX 365**
(L5) **GRAND MEADOW, MN** (L6) **55936**

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 **05/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (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
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 05/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/19/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/19/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/11/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245367

June 19, 2015

Mr. Thomas Stevens, Administrator
Meadow Manor
210 East Grand Avenue, Po Box 365
Grand Meadow, Minnesota 55936

Dear Mr. Stevens:

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 April 30, 2015 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 29, 2015

Mr. Thomas Stevens, Administrator
Meadow Manor
210 East Grand Avenue, PO Box 365
Grand Meadow, Minnesota 55936

RE: Project Number S5367025

Dear Mr. Stevens:

On April 21, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 2, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On May 27, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 11, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 30, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 2, 2015, effective April 30, 2015 and therefore remedies outlined in our letter to you dated April 21, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245367	A. Building B. Wing	5/27/2015

Name of Facility	Street Address, City, State, Zip Code
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **04/30/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0278** Reg. # **483.20(g) - (i)** LSC	Correction Completed **04/30/2015**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/30/2015**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **04/30/2015**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/30/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/30/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/30/2015**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GPN/kfd	05/29/2015	31221	5/27/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245367	A. Building B. Wing	5/27/2015

Name of Facility	Street Address, City, State, Zip Code
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **04/30/2015**				

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	05/29/2015	31221	5/27/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/2/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245367	01 - MAIN BUILDING 01	5/11/2015

Name of Facility	Street Address, City, State, Zip Code
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	04/30/2015	ID Prefix Reg. # NFPA 101 LSC K0062	04/30/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	05/29/2015	25822	05/11/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/2/2015

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: UILV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00390

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245367**

2.STATE VENDOR OR MEDICAID NO. (L2) **346314100**

3. NAME AND ADDRESS OF FACILITY
(L3) **MEADOW MANOR**
(L4) **210 EAST GRAND AVENUE, PO BOX 365**
(L5) **GRAND MEADOW, MN** (L6) **55936**

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 **04/02/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kyla Einertson, HFE NE II 05/04/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/11/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 21, 2015

Mr.. Thomas Stevens, Administrator
Meadow Manor
210 East Grand Avenue, PO Box 365
Grand Meadow, Minnesota 55936

RE: Project Number S5367025

Dear Mr. Stevens:

On April 2, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 12, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 12, 2015 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 2, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		4/30/15

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

Electronically Signed | 04/30/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING _____ B. WING _____	04/02/2015

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide proper liability and appeal rights notice on a timely manner prior to termination of Medicare skilled services for 2 of 3 residents (R41, R15) reviewed for liability notice and beneficiary appeal rights. Findings Include: R41 was admitted to the facility on 1/5/15 on Medicare part-A services and discharged from the facility on 2/18/15. The Length Stay Report showed R41 used 44 Medicare part-A days during his stay in the facility. A Notice of Medicare Provider Non-Coverage indicated R41's skilled services would end effective 2/17/15, the notice was provided and signed on 2/16/15 which was less than forty eight hours before Medicare	F 156	F 156 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R41 resident was discharged from the facility on 2-18-15. b. With respect to R15 resident was discharged form the facility on 3-16-2015	

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F 156	Continued From page 3 skilled services would be terminated. R15 was admitted to the facility on 11/10/14 and was discharged off of Medicare part-A services and remained in the facility and started paying privately for her stay on 1/31/15. The perspective payer source (PPS) log showed R15 used 82 Medicare part-A days during her stay in the facility. A Notice of Medicare Provider Non-Coverage indicated R15's skilled services would end effective 1/30/15 and was signed 3/3/15, The Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) was reviewed via telephone with the power of attorney on 1/29/15, which was less than forty eight hours before Medicare skilled services would be terminated. On 3/30/2015 7:05 p.m. the licensed social worker verified R41 and R15 were not provided forty- eight hours ' notice their Medicare skilled services would be terminated. The LSW stated she took over the denial notices after a team member left their position and did not receive training. The LSW stated she thought she was only required to give a one or two day notice of Medicare non-coverage. A policy was requested, but not provided by the facility.	F 156	c. All residents entitled to Medicare benefits will be provided proper liability and appeal rights notice in a timely manner prior to termination of Medicare skilled services. d. The LSW received re-training on the procedure for providing Medicare denial in timely manner on 4-02-2015 e. LSW/ Designee will audit 3 resident records per month for 8 weeks to ensure timeliness of denial. The data will be shared at the next quality assurance meeting by the LSW/designee for input and further direction. f. LSW is responsible.	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		4/30/15

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F 241	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide cares in a dignified manor for 1 of 1 resident (R33) who asked for assistance to use bathroom and nursing assistant (NA) responded with an undignified response to R33's request. Findings Include: R33 was interviewed on 3/30/15 at 6:04 p.m. and R33 stated within the last month a nursing assistant answered her call light, R33 requested assistance to go to the bathroom and the nursing assistant told R33 she had just been in her room and helped her to the bathroom about twenty minutes ago. R33 stated the nursing assistant shut off her call light and left the room without assisting her to the bathroom. During the interview R33 was unable to recall the name of the staff member involved in the concern. R33 stated she reported the concern to the facility, but could not recall who she told. On 3/30/15 at 6:37 p.m. R33 approached surveyor in the common area of the facility and identified nursing assistant (NA)-F involved in the incident. R33's admission Minimum Data Set (MDS) dated 1/5/15, identified diagnoses of Parkinson's disease, anxiety disorder and depression. R33 had intact cognition with a brief interview for mental status score (BIMS) of thirteen and required extensive assist from staff for activities of daily living, which included transfers and toileting.	F 241	F 241 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R33, upon notification by MDH surveyor of the incident the facility initiated an investigation... b. NA-F was provided re-education regarding providing cares with dignity and respect on 4-1-2015. c. All staff received re-education on treating residents with dignity and respect on 4-22-15. d. DNS/designee will audit 3 residents for dignity and respect for 4 weeks and then 2 residents for 8 weeks. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. e. DNS responsible	

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F 241	Continued From page 5 On 4/01/2015 at 7:39 a.m. the licensed social worker (LSW)-A stated to her knowledge there had been no concerns or grievances regarding R33 filed and stated she would follow-up with her regarding this concern. Social Services Documentation Interview with R33 dated 4/1/15 at 9:00 a.m. read, " Massage therapist was here and had to go to the bathroom. Call light turned on and waited 20 minutes. Aide came in and turned off call light and stated "You just went 20 minutes ago!" R33 then turned on call light again and someone else came in and took me to the bathroom. R33 could not name the aide. Stated the aide usually works nights. Is very neat and very efficient. Did not report to anyone as "The girls [NAs] do get busy and I might have misunderstood her as I had my hearing aids out and can't hear very well without them." Then R33 stated, "I shouldn't have told my tablemates about this it was not a big deal and has only happened once." On 4/01/2015 at 10:54 a.m. LSW-A stated the facility followed up with NA-F and NA-F confirmed this incident happened last week with R33. LSW-A stated facility planned to re-educate NA-F regarding treating residents with dignity and respect, and taking residents to the bathroom per their request. LSW-A stated she expected residents to be taken to the bathroom upon their request and it did not matter if they were just taken fifteen minutes or an hour ago. LSW-A verified R33 was not treated with dignity or respect when NA-F answered R33's call light, told R33 they had just went to the bathroom twenty minutes ago, shut the call light off and left the room without assisting R33 to the bathroom.	F 241		

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F 241	Continued From page 6 The employee handbook with a revised date of May 2014 read, "We expect all employees to: 1. Work hard, in a caring, compassionate, respectful manner, to the best of their abilities and skills, always in a safe and correct manner. 2. Provide the best customer care as possible. Always meeting or exceeding our customer care standards as well as those of government agencies ... "	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a	F 278		4/30/15

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F 278	Continued From page 7 material and false statement. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to accurately assess behaviors for the Minimum Data Set (MDS) (an assessment tool) for 1 of 3 residents (R30) reviewed for behaviors. Findings included: R30's quarterly Minimum Data Set (MDS) dated 2/27/2015 indicated verbal behaviors directed toward others were displayed one to three days during the look back period and R30 had displayed other behavioral symptoms not directed towards others one to three days during the look back period. R30's mood and behavior evaluation completed on 2/27/2015 read, "Resident does have paranoia which often results in aggressive behavior, throwing things, grabbing items, refusing medication or cares, over the last few months the resident has had no mood or behavior problems." The mood and behavior evaluation also read, " Behaviors were not exhibited during the last seven days. " R30's nursing progress notes from 2/21/15 through 2/27/15 were reviewed; notes did not indicate behaviors that were coded on the MDS had been displayed. A progress note dated 2/27/15 summarized the mood and behavior evaluation that included the statement " No behaviors exhibited in the last seven days." R30's behavior monitoring documentation from 2/21/15 through 2/27/15 was reviewed and did not reflect verbal or " other behavioral symptoms " that had been coded on the quarterly MDS.	F 278	F 278 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R30 a medical record review was completed, Care Plan was updated to reflect behavioral symptoms. b. All residents with identified behavioral symptoms are comprehensively assessed upon admission, quarterly or with a significant change with Care Plan revisions as needed. c. All staff has received re-education regarding the documentation of behavioral symptoms on 4-22-15. d. DNS/Designee will audit 2 medical records for behavioral symptoms and individualized care plans for 4 weeks and then 1 medical record for 8 weeks. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. e. DNS responsible	

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F 278	Continued From page 8 During an interview on 4/2/15, at approximately 3:15 p.m., licensed social worker (LSW) verified lack of documentation to substantiate coding of behaviors on the MDS as being present during assessment period.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to include assessed fall interventions for 1 of 3 residents (R26) reviewed for falls and failed to revise the care plan to include monitoring and newly assessed care interventions for	F 280	F 280 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on	4/30/15

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F 280	Continued From page 9 non-pressure related skin wounds and after-care of an arm fracture for 1 of 3 residents (R16) reviewed for falls and failed to include assessed interventions for assistance with ambulation and repositioning needs for 1 of 1 resident (R8) who was dependent on staff for mobility and repositioning needs. Findings Include: R26's incidents reports revealed R26 had two falls occur between 2/4/15 and 3/8/15 and R26's comprehensive care plan and nursing assistant care plan had not been revised to reflect the new preventative measures to be implemented for fall prevention. R26's quarterly Minimum Data Set (MDS) dated 3-7-15, identified diagnoses of Alzheimer's disease and depression. R26 had severe cognitive impairment and required extensive assist from one staff for activities of daily living, which included mobility and transfers. The MDS identified R26 had two or more fall since admission or prior assessment with no injuries. R26's fall investigation dated 2/4/15, indicated intervention to prevent further falls was, "...needs to be monitored [after] super." However this preventative measure had not been care planned. R26's fall investigation dated 3/8/15, indicated intervention to prevent further falls was, "...monitor resident more closely while in RM [room] alone." However this preventative measure had not been care planned. R26's care plan dated 3/18/15; identified R26 was at risk for falls related to dementia, chronic ataxia,	F 280	conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R26 Care plan has been revised to reflect current interventions. b. With respect to R16 Care plan has been revised to reflect current care regarding cast care and toileting needs. c. With respect to R8 Care plan has been revised to reflect current cares regarding repositioning and ambulation. d. All falls/ incidents are reviewed by the IDT for adequate interventions, Care plans will be updated immediately. e. All staff has received re-education regarding revising and updating of the Care plan 4-22-15. f. DNS/Designee will audit all falls/ incidents to ensure interventions are updated. This data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. g. DNS/Designee will audit 3 Care plans for current interventions for 4 weeks and then 2 Care plans/ NAR care sheets for 8 weeks. The data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction h. DNS / Designee responsible.	

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chronic pedal edema, chronic lower back pain, osteoarthritis, bilateral knee pain and had a history of falls with injuries. Interventions in place included are being sure call light was within reach and encourage using it for assistance as needed. Respond promptly to all requests for assistance. Coordinate with appropriate staff to ensure a safe environment with: floors even and free from spills or clutter, adequate, glare-free light, call light, personal items within reach. Educate R26/family/caregivers about safety reminders and what to do if a fall occurs. Encourage activities that promote exercise, physical activity for strengthening and improved mobility. Ensure that R26 was wearing appropriate footwear (tennis shoes) when ambulating. Evaluate for, supply adaptive equipment or devices as needed. Reevaluate as needed for continued appropriateness and to ensure least restrictive or restraint. Remind/encourage R26 to participate in group exercise activities. Sign placed on seat of 4WW (four wheeled walker) to discourage use as a seating device. Sign also placed in highly visible area in room as a reminder. Replace as needed. R26's Nursing Assistant Care Plan: dated 3/30/15 read, "...Fall Prevention: none RM [room] change ... on 10/15/14, sign on walker do not sit, call light within reach, sign to call for assist, offer gripper socks when shoe r [are] not on."

On 4/01/2015 at 11:27 a.m. nursing assistant (NA)-A stated communication of new fall interventions from the IDT (interdisciplinary) team to the nursing assistants was, "pretty poor honestly." NA-A stated the nursing assistant care plan sheets were not always updated right away. NA-A stated the nursing assistants should be alerted to look for changes to the nursing assistant care plans when changes are made for

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residents. NA-A verified the nursing assistant care plan for R26 was not updated to reflect the following fall interventions implemented on 2/415, "Needs to be monitored after supper" or 3/8/15, "Monitor resident more closely while in room alone." NA-A stated she was unaware of these fall interventions for R26.

On 4/01/2015 at 11:55 a.m. licensed practical nurse (LPN)-A stated when a resident had a fall and the nurse was completing the incident report, when they add a fall intervention it needed to be added to the care plan and the nursing assistant care plan. LPN-A verified fall interventions following R26's falls on 2/4/15 and 3/8/15 were not added to the R26's care plan or the nursing assistant care plan. LPN-A stated all of the nursing staff was responsible to update the care plans for R26.

On 4/01/2015 1:00 p.m. the director of nursing (DON) stated her expectation was if there was a new fall intervention implemented the nurse needed to update the care in the residents ' chart and update the nursing assistant care plan and are to write on them and make new copies. The DON verified R26's care plan and nursing assistant care plan had not been updated to reflect the new fall interventions following R26's falls on 2/4/15 or 3/8/15.

A policy was requested for revision of the care plan and was not provided.

R16's care plan had not been updated to reflect care goals and directions of the injuries sustained from the fall on 3/25/15, not updated to reflect increased need for assistance in activities of daily living related to limited mobility of the right arm, risk for increased incontinence, or any sleep hygiene associated with cast and/or pain, and lacked identification of a pain management plan

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	245367	A. BUILDING _____ B. WING _____	04/02/2015

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MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

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related to injuries that would include goals of controlling pain and non-pharmacological interventions to control pain even though R16 was on a pain regimen.

R16's admission record indicated the resident was admitted to the facility on 2/22/14 and the annual Minimum Data Set (MDS) dated 2/20/15 included diagnoses but not limited to depression, history of transient ischemic attack (TIA), and osteoporosis. The MDS indicated R16 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 1 and R16 required extensive assistance from one staff to complete personal hygiene tasks.
R8's Incident note summary of occurrence dated 3/25/2015 where R16 had a fall and sustained a facial tear, hematoma to head, bleeding form mouth and bit her tongue, complain of left are pain. R8 received a cast to her arm then returned to the home from the emergency room.
R16's current nurse care plan was provided by the facility on 4/1/15 and read, "Observe skin daily with cares and report any changes to nurse and to perform weekly skin inspections. "
R16's nursing assistant (NA) care plan last updated on 3/31/15 indicated R16 was assist of one staff for grooming and bathing, and two staff assist for transfers, bed mobility, and walking. The NA care plan did not include direction for toileting and did not outline what R16 could do for herself and did not include any special care instructions for the cast. The NA care plan did indicate the arm was to be elevated on a pillow.
R16 ' s treatment administration record (TAR) read, "CWMS [color, warmth, movement, sensation] to right hand every shift." The TAR indicated this task was performed and completed by the initials of the nurse that checked the

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F 280	Continued From page 13 CWMS. The TAR does not indicate what the results were of the evaluation of the CWMS, and results were not documented consistently in the nurse ' s progress notes. The care plan and TAR lacked direction on parameters on when to contact the physician for abnormal results of abnormal of CWMS. The care plan and TAR did not give a baseline description of R16's "normal" or "acceptable" findings with the cast on. The TAR also did not reflect the abrasion, hematoma, or bruising were being monitored or treated. During an interview on 3/31/15, at 3:01 p.m. director of nursing (DON) explained the care plan was not revised to reflect injuries or cast because the injuries were acute in nature. Facility policy care plan completion last reviewed August 2013 read, "All care plans should include individual and/or combined focus problems that address the following areas ... all current acute and chronic clinical conditions for which they are receiving medication, treatment and/or care." "Mobility/balance problems/functional limitation in range of motion." and "Skin breakdown/pressure ulcers and/or risk" and "Pain-actual or for potential for, include resident response to interview, monitoring." "fall risk factors," type of assistance required for activities of daily living... independent/limited/extensive/dependent, assist of 1 or 2 and should include resident specific details..." R8 lacked revision of his plan of care to include assessed repositioning time and assistance with ambulation services: The facility's Functional and Safe Handling Review dated 2/11/15 and 3/20/15 indicated R8 required assistance of two to transfer and to ambulate. The care plan provided 4/1/15 did not provide interventions related to transfer and ambulation. The Care Resident Sheets (nursing	F 280		

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assistant work sheets) provided 3/30/15 that the director of nursing stated was the most current indicated walk with assistance of one staff.
During observations on 4/1/15 at 8:47 a.m. and 4/2/15 at 3:40 p.m. R8 required extensive assistance of two staff to come to a stand and to walk in the hallway. The Care Resident Sheets (nursing assistant work sheets had not been revised to agree with the assessments dated 2/11/15 and 3/20/15.
Repositioning: The facility's Turning and Repositioning Guidance: Interventions dated 2/12/15, and 3/20/15 listed interventions that included off-load (remove all pressure to skin especially where bony prominences are located) in chair every hour. The care plan provided 4/1/15 did not list interventions related to transfer and ambulation. The Care Resident Sheets (nursing assistant work sheets) provided 3/30/15 that the director of nursing stated was the most current indicated R8 was to be repositioned every 2 hours and as needed. During observations on 3-31-2015 from 1:46 p.m. until 4:03 p.m. R8 was not repositioned for greater than 2 hours and 15 minutes. And on 4-1-2015 from 7:16 a.m. until 9:16 a.m. R8 was not repositioned for 2 hours. Nursing assistant (NA-A) was interviewed on 4-2-2015 at 1:41 p.m. NA-A stated R-8 was to be repositioned every three hours or so. NA-A stated the repositioning schedule was on our Care Resident Sheets that they carry. The DON was interviewed on 4-2-2015 at 1:23 p.m. and stated interventions included that repositioning should be every hour. The Care Resident Sheets (nursing assistant work sheets had not been revised to agree with the assessments dated 2/11/15 and 3/20/15.
The procedure entitled Guidelines for Pressure Ulcer Prevention Guidelines dated 9/10 directed:

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F 280	Continued From page 15 " Revisions to the prevention plan occur when assessments are scheduled, when there is a change of condition, when a new risk factor becomes known or when an intervention is determined ineffective. The individualized care plan addresses these prevention or treatment strategies ..."	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care for 3 of 3 residents (R16, R30, and R8) reviewed for activities of daily living and for 1 of 3 residents (R9) reviewed for skin conditions non-pressure related. Findings included: R16's admission record indicated the resident was admitted to the facility on 2/22/14. R16's annual Minimum Data Set (MDS) dated 2/20/15 included diagnoses but not limited to depression, history of transient ischemic attack (TIA), and osteoporosis. The MDS indicated R16 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 1 and R16 required extensive assistance from staff to complete personal hygiene tasks. R16's current care plan provided by the facility on 4/1/15 read, "Check nails length and trim and	F 282	F 282 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R16 fingernails have been cleaned and trimmed. b. With respect to R 30 fingernails have been cleaned and trimmed. c. All residents have been audited for nail care and will receive nail care on bath days and as needed.	4/30/15

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F 282	Continued From page 16 clean on bath day and as necessary. Report any changes to the nurse." The care plan designated nail care tasks to be completed by nursing assistance's (NAs) and "provide grooming and personal hygiene daily and PRN [as needed]." R16's bath days were scheduled for day shift on Mondays according to the facility's bathing/shower schedule. An observation on 3/30/15, at 4:05 p.m. revealed R16 had soiled fingernails with brown debris. Fingernail polish also had been flaking off. An observation on 3/31/15, at 8:26 a.m. revealed R16 continued to have soiled fingernails with brown debris. An observation on 4/1/15, at 6:45 a.m. revealed R16 continued to have soiled fingernails with brown debris. During an interview on 4/1/15, at 7:08 a.m. Licensed practical nurse (LPN)-C verified R16's fingernails were soiled and stated nails needed to be cleaned. R30's admission record indicated the resident was admitted to the facility on 12/18/2012 and had diagnoses that included but was not limited to Huntington's disease. R30's quarterly MDS dated 2/27/15 indicated severe cognitive impairment and R30 required extensive assistance from staff to complete personal hygiene tasks. R30's current care plan provided by the facility on 4/1/15 read, "Check nails length and trim and clean on bath day and as necessary and keep fingernails short." The care plan designated nail care tasks to be completed by NAs to complete nail care task and directed staff to re-approach and/or to enlist another staff member to offer cares if the resident became agitated or refused personal hygiene cares. R30's bath days were scheduled for Monday	F 282	d. With respect to R8 care plan has been revised to reflect current cares. Ambulation has been added to Point of Care for documentation. e. All residents will receive assistance with ambulation as per plan of care. f. With respect to R9 upon notification from MDH surveyor of bruising the facility initiated an immediate investigation. g. All falls/ incidents are reviewed by the IDT for adequate interventions, Care plans will be updated immediately. h. All staff have been re-educated on nail care, ambulation and revision of the Care plan on 4-22-2015. i. DNS/ Designee will audit nail care for 3 residents per week for 4 weeks then 2 residents per week for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. j. DNS/ Designee will audit ambulation for 3 residents per week for 4 weeks and then 2 residents for 8 weeks. The data will be shared with the next Quality Assurance meeting for input and further direction. k. DNS is responsible.	

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F 282	Continued From page 17 evenings provided by the facility and Thursday mornings provided by hospice according to the facility's bathing/shower schedule. During an observation on 3/30/15, at 3:57 p.m. R30's fingernails had blue nail polish on; fingernails were long and caked with dried reddish/brown debris. During an observation on 4/1/15, at 9:01 a.m. R30's fingernails continued to be long and soiled with dried reddish/brown debris. During an interview on 4/1/15, at 9:03 a.m. nursing assistant (NA)-E verified R30's nails were dirty. NA-E explained nail care is provided on bath days. NA-E stated, "If she refuses we re-approach her and if we can't get it done then we let the nurse know." During an interview on 4/1/15, at 7:08 a.m. licensed practical nurse (LPN)-C stated NA's were to provide nail care unless the resident is diabetic and if the resident refused the NA's are supposed to report to the nurse. LPN-C explained the nurses would then document refusals in a nursing note. R30's nursing progress notes from 3/30/15 were reviewed and did not reflect resident refusal of nail care or nail care had been provided. A facility policy pertaining to nail care was requested and not received. R8 lack provision of services for ambulating. R8 was observed during breakfast and lunch on 4/1/15. He was noted to propel his wheelchair in and out of the dining room independently. He was not assisted to walk to and from the meal. He was not observed to be asked if he would like to walk. The Care Resident Sheets (nursing assistant work sheets which is to include current care plan interventions for the resident) provided 3/30/15 that the director of nursing stated was the	F 282		

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F 282	Continued From page 18 most current indicated walk with assistance of one staff to and from all meals. On 4/2/15 at 1:23 p.m. the DON stated R8 would refuse to ambulate daily. Documentation provided entitled A Walk-in Corridor Self-Performance did not indicate R8 refused daily and also did not indicate R8 walked daily or to all meals. R9 was observed on 3/30/2015 4:19 p.m. to have a to have a bruise on the back of her left hand with no documentation of the bruise being found until the staff was informed of the bruise by surveyor on 3/31/15. R9's quarterly Minimum Data Set (MDS) dated 12-26-14, identified diagnoses of heart failure, Alzheimer's disease, anxiety disorder and depression. R9 had severe cognitive impairment with a brief interview for mental status score (BIMS) of two and required extensive assist from two staff for activities of daily living, which included mobility and transfers. R9's plan of care dated 1/26/15 read, "...easily bruisability secondary to anticoagulant therapy." Interventions included: "Observe skin daily with cares and report any changes to the nurse. " R9's Body Audit 10-14 dated 3-31-15 read, "...left hand (back side) bruising L [length] 2 cm [centimeters] x W [width] 2.5 cm [centimeters]...Bruise to top of left hand, dark purple in color, skin thin over top of hand." On 3/31/2015 at 1:50 p.m. the director of nursing verified R9 had a bruise on her left hand and there was no documentation in the medical record regarding this bruise. The DON stated she talked to the nursing assistant that assisted R9 with her cares that morning and the nursing assistant told her she did not notice the bruise on	F 282		

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F 282	Continued From page 19 R9's hand during cares. The DON stated she expected staff to look at residents ' skin for any concerns as a part of their daily cares when they were assisting residents. On 04/02/2015 at 11:23 a.m. the DON verified the facility staff did not follow the plan of care to, " observe skin daily with cares and report any changes to the nurse." A policy was requested for following a care plan and none was provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify and monitor bruising and/or abrasions for 2 of 3 residents (R16, R9) reviewed for non-pressure related skin issues. Findings included: R16 sustained a fall with injury (right wrist fracture) on 3/25/15 according to a facility ' s resident incident report. An observation on 3/30/2015, at 4:47 p.m. revealed extensive dark purple facial bruising. Bruising encompassed both eyes, nose, and followed both cheek bones. R16 also had an abrasion on the bridge of her nose	F 309	F 309 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R16 Care plan has	4/30/15

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F 309	Continued From page 20 covered with a steri-strip and a large hematoma on the left frontal lobe region (forehead) measuring approximately 0.5 inches in diameter. R16 also had a cast on right arm; fingers were noted to be swollen. Documentation and/or evidence of on-going monitoring of the injuries could not be found in the medical record. R16 ' s admission record indicated the resident was admitted to the facility on 2/22/14 and an annual Minimum Data Set (MDS) dated 2/20/15 included diagnoses but not limited to depression, history of transient ischemic attack (TIA), and osteoporosis. The MDS indicated R16 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 1. R16's current care plan was provided by the facility on 4/1/15 read, "Observe skin daily with cares and report any changes to nurse and to perform weekly skin infections." The care plan had not been updated to reflect care goals and directions of the injuries sustained from the fall on 3/25/15. R16 ' s treatment administration record (TAR) indicated the injury and cast to right arm had been monitored. The TAR did not reflect abrasion, hematoma, or bruising was being monitored. R16 ' s nursing progress notes reviewed from 3/25/15 through 4/1/15 did not reflect monitoring of facial injuries. A nursing progress note post fall dated 3/25/15 read, " ...skin tear to nose from glasses, hematoma to left of head above eyebrow, and mouth noted to be bleeding from maybe biting tongue." A progress note dated 3/30/15 read, " ...bruising due to fall over weekend is yellowing, " the note lacked identification of location of bruising, how diffuse bruising was, and if the bruising had caused discomfort. The progress notes reviewed did not	F 309	been reviewed and revised to reflect cast cares and bruising. b. With respect to R9 care plan has been reviewed and revised. c. All staff has received re-education regarding skin care, revision of care plan and condition/follow up documentation on 4-22-15 d. All falls/ incidents are reviewed by the IDT for adequate interventions, Care plans will be updated immediately. e. DNS/Designee will audit all falls/ incidents to ensure interventions are updated. This data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. f. DNS/ Designee will audit 2 resident records for condition/follow up charting per week times 4 weeks and then 2 resident records per week times 8 weeks. The data will be shared with the next Quality Assurance meeting for input and further direction. g. DNS is responsible.	

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F 309	Continued From page 21 indicate ongoing management of the " skin tear " or ongoing monitoring of the head hematoma or bruising. A post fall skin assessment had not been completed following the fall on 3/25/15 that would indicate the original extent of the facial injuries was not found in the medical record. During an interview on 3/31/15, at 7:08 a.m. licensed practical nurse (LPN)-C stated, " there should have been an initial skin assessment or documentation that outlined the extent of her injuries. " LPN-C explained, bruises were charted on weekly unless the bruises were related to fall, then charting was done every shift every day for 3 days. During an interview on 3/31/15, at 3:01 p.m. director of nursing (DON) stated there should have been monitoring documentation done of the sustained injuries. DON explained nurses used a flow sheet that directed them when to chart. The facility condition/follow up charting directed nurses to perform the following for fall with injury: chart type of injury, location, pain, discoloration, and effect on activities of daily living (ADLs). Chart every shift for 24 hours then three times a week until injury resolved. Also to include: bruises/discoloration: chart location, appearance, pain, swelling, signs and symptoms of infection. Chart three times a week until resolved, skin tear/abrasion, chart location, appearance, pain, swelling, signs and symptoms of infection. Chart three times a week until resolved. R9 was observed on 3/30/2015 4:19 p.m. to have a to have a bruise on the back of her left hand with no documentation of the bruise being found until the staff was informed of the bruise by surveyor on 3/31/15. R9's quarterly Minimum Data Set (MDS) dated	F 309		

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12-26-14, identified diagnoses of heart failure, Alzheimer's disease, anxiety disorder and depression. R9 had severe cognitive impairment with a brief interview for mental status score (BIMS) of two and required extensive assist from two staff for activities of daily living, which included mobility and transfers.

R9's plan of care dated 1/26/15 read, "...easily bruisability secondary to anticoagulant therapy." Interventions included: "Observe skin daily with cares and report any changes to the nurse. "

R9's March 2015 progress notes were reviewed and there was no documentation in regards to the bruise on the back her left hand.

R9's Body Audit 10-14 dated 3-31-15 read, "...left hand (back) bruising L [length] 2 cm [centimeters] x W [width] 2.5 cm [centimeters]... Bruise to top of left hand, dark purple in color, skin thin over top of hand."

On 3/31/2015 1:50 p.m. the director of nursing verified R9 had a bruise on her left hand and there was documentation in the medical record regarding this bruise. The DON stated she talked to the nursing assistant that assisted R9 with her cares that morning and the nursing assistant told her she did not notice the bruise on R9 ' s hand during cares. The DON stated she expected staff to look at residents ' skin for any concerns as a part of their daily cares when they were assisting residents.

On 4/01/2015 at 11:39 a.m. nursing assistant (NA)-A stated she monitored resident skin for any skin concerns when providing cares daily and reported any bruises to the nurse right away after

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F 309	Continued From page 23 providing cares. On 04/01/2015 at 11:50 a.m. licensed practical nurse (LPN)-A stated skin monitoring was completed by the nursing assistants daily during cares in the morning and evening. LPN-A stated once weekly the licensed staff complete a thorough skin check before or after their shower and documented the skin inspection in the general progress notes titled bath note. LPN-A stated when a bruise was identified, nursing initiated weekly wound monitoring and completed an incident report. LPN-A stated nursing would monitor the bruise daily for healing until it was resolved. A policy for monitoring of non-pressure related skin conditions was requested and not provided.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents unable to perform personal hygiene were provided services for 2 of 2 residents (R16, R30) reviewed for activities of daily living. Findings included: R16's admission record indicated the resident	F 312	F312 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction	4/30/15

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	245367	A. BUILDING _____ B. WING _____	04/02/2015

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F 312	Continued From page 24 was admitted to the facility on 2/22/14. R16's annual Minimum Data Set (MDS) dated 2/20/15 included diagnoses but not limited to depression, history of transient ischemic attack (TIA), and osteoporosis. The MDS indicated R16 had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 1 and R16 required extensive assistance from staff to complete personal hygiene tasks. R16's current care plan provided by the facility on 4/1/15 read, " Check nails length and trim and clean on bath day and as necessary. Report any changes to the nurse. " The care plan designated nail care tasks to be completed by nursing assistants (NAs) and " provide grooming and personal hygiene daily and PRN [as needed]. " R16's bath days were scheduled for day shift on Mondays according to the facility's bathing/shower schedule. R16's current physician orders provided by the facility on 4/1/15 indicated R16 had started treatment on 3/27/15 for shingles and a urinary tract infection An observation on 3/30/15, at 4:05 p.m. revealed R16 had soiled fingernails with brown debris. Fingernail polish also had been flaking off. An observation on 3/31/15, at 8:26 a.m. revealed R16 continued to have soiled fingernails with brown debris. An observation on 4/1/15, at 6:45 a.m. revealed R16 continued to have soiled fingernails with brown debris. During an interview on 4/1/15, at 7:08 a.m. licensed practical nurse (LPN)-C verified R16's fingernails were soiled and stated nails needed to be cleaned. R30's admission record indicated the resident	F 312	prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R 16 fingernails have been cleaned and trimmed. b. With respect to R30 fingernails have been cleaned and trimmed. c. All residents have been audited for nail care and will receive nail care on bath days and as needed. d. All staff has been re-educated on nail care on 4-22-15. e. DNS/ Designee will audit nail care for 3 residents per week for 4 weeks then 2 residents per week for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. f. DNS is responsible.	

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F 312	Continued From page 25	F 312		

was admitted to the facility on 12/18/2012 and had diagnoses that included but was not limited to Huntington ' s disease.
R30's quarterly MDS dated 2/27/15 indicated severe cognitive impairment and R30 required extensive assistance from staff to complete personal hygiene tasks.
R30's current care plan provided by the facility on 4/1/15 read, "Check nails length and trim and clean on bath day and as necessary." The care plan designated nail care tasks to be completed by NAs to complete nail care task and directed staff to re-approach and/or to enlist another staff member to offer cares if the resident became agitated or refused personal hygiene cares.
R30's bath days were scheduled for Monday evenings provided by the facility and Thursday mornings provided by hospice according to the facility's bathing/shower schedule.
During an observation on 3/30/15, at 3:57 p.m. R30's fingernails had blue nail polish on; fingernails were long and caked with dried reddish/brown debris.
During an observation on 4/1/15, at 9:01 a.m. R30's fingernails continued to be long and soiled with dried reddish/brown debris.
During an interview on 4/1/15, at 9:03 a.m. nursing assistant (NA)-E verified R30's nails were dirty. NA-E explained nail care is provided on bath days. NA-E stated, "If she refuses we re-approach her and if we can't get it done then we let the nurse know."
During an interview on 4/1/15, at 7:08 a.m. licensed practical nurse (LPN)-C stated NAs were to provide nail care unless the resident is diabetic and if the resident refused the NA's are supposed to report to the nurse. LPN-C explained the nurses would then document refusals in a nursing note. R30's nursing progress notes from 3/30/15

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F 312	Continued From page 26 were reviewed and did not reflect resident refusal of nail care or nail care had been provided. A facility policy pertaining to nail care was requested and not received.	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide skin treatments and services as comprehensively assessed and reassessed to promote current pressure ulcers to heal and prevent new pressur ulcers from developing for 1 of 2 residents (R8) reviewed with current open pressure ulcers. This lack of services resulted in harm to R8. Findings include: R8 was admitted to facility with an open pressure sore and developed an unstageable pressure ulcer in February 2015. During observations R8 was not repositioned while in wheelchair to relieve pressure on current pressure ulcers for over two hours even though the skin reassessment interventions included to attempt to	F 314	F 314 The facility does not agree with various facts and conclusions in the statement of deficiencies and licensing violations and is seeking an appeal at this time. The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R8 was re-admitted to	4/30/15

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F 314	Continued From page 27 position off the affected area and to "Off-load in chair q [every] 1 hour" according to the facility's Turning and Repositioning Guidance: Interventions/Plan of Care dated 2/12/15. The assessed intervention of repositioning/off-load every 1 hour did not get included on R8's personal care plan, nor on the Resident Care Sheet used by nursing assistants when providing care to residents. R8 was identified by the Director of Nursing (DON) on 3/31/15 at 8:45 a.m. as having an unstageable pressure ulcer located on the left hip. The DON also verified the facility staff continued to utilize treatments & interventions they'd used to promote healing for prior ulcers that had been treated and healed in the past few months. R8 was observed on 3/30/15 from 4:15 p.m. to 5:08 p.m. independently propelling the wheelchair with his feet while in the hallway. R8 was observed on 3/31/15 from 8:27 a.m. until 9:13 a.m. independently wheeling his wheelchair. R8 was continually observed on 3/31/15 from 1:46 p.m. until 4:03 p.m. (two hours and 17 minutes), during which time he was sitting in his wheelchair without staff intervention to reposition or encouragement for the resident to do independent repositioning. During the observation, R8 was seated on a three inch pressure relieving wheelchair cushion. R8 was not observed to independently stand or reposition himself during the observation. R8 was continually observed on 4/1/15 from 7:16 a.m. to 8:47 a.m. (1 hour and 31 minutes interval), without assistance for repositioning or	F 314	the facility after a hospitalization from 2-7-15 through 2-10-15. Upon re-admission to facility a body audit was performed and revealed a suspected deep tissue injury on left trochanter not previously noted prior to transfer to hospital. Interventions in place prior to and following hospitalization included pressure redistribution cushion, mattress replacement, dietary recommendations, and repositioning schedule. b. All resident skin is observed daily with cares and comprehensive skin assessment is done upon admission, quarterly and with a change in condition. a. DNS / Designee will audit 2 residents for repositioning per week for 4 weeks then 1 resident record for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. b. DNS is responsible.	

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F 314	Continued From page 28	F 314		

encouragement to independently reposition in order to remove pressure from the resident's buttock. Observations during this time period revealed R8 was independently propelling his wheelchair with his feet and made no attempt to reposition himself or independently stand. At 8:47 a.m. R8 was assisted by the DON and a nursing assistant (NA) to stand. R8 required extensive assistance of 2 staff and a walker to stand and was observed to have stood for approximately 4 minutes. At 9:19 a.m. R8 stated to the surveyor, "It makes me feel better when they stand me up. They can do that often for all I care, it feels good."

A physician's hospital dismissal summary dated 2/12/15, included information concerning admission to hospital from 2/7 -2/10/15, with a chief complaint of mental status change. According to the discharge summary- diagnoses included: Failure to thrive, likely due to progression of severe dementia; dementia progressive, likely vascular in etiology; malnutrition and weight loss; and concern for dysphagia. Under the system review, in the area of "SKIN," the documentation noted that the resident complains of pain with dressing changes but much improved from hospitalization two days ago.

On 3/19/15, wound clinic documentation indicated R8 had an ulcer on his left buttock and an ulcer on his left superior hip. In addition the primary physician's note dated 3/13/15, identified diagnosis of failure to thrive due to severe vascular dementia; history of stroke; hypertension; and stage III pressure ulcer (Full thickness tissue loss with bone not exposed) under left ischial tuberosity.

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Review of R8's quarterly Minimum Data Set (MDS) assessments dated 12/20/14, and 3/23/15, identified R8 had a BIMS (Brief Interview Mental Status) score of 12 out of a possible 15 which indicated the resident had moderate cognitive impairment. The quarterly MDS did not identify any behaviors in relation to refusal of care, extensive assist of 1 for bed mobility,transfers, walking and toileting. The 12/20/14 quarterly MDS indicated R8 was at risk to develop pressure ulcers, had an open lesion but had no unhealed pressure ulcers, and did not have a turning and repositioning schedule. The 3/23/15 quarterly MDS identified R8 was at risk for pressure ulcer development, had one stage 1 or higher pressure ulcer. The 3/23/15 lacked identification of a turning/repositioning program.

The Discharge MDS dated 2/8/15, indicated R8 required more staff assistance with activities of daily living, extensive assist with locomotion and transferring between surfaces including to and from bed, chair and wheelchair, and moving himself in bed.

An Admission Body Audit dated on 9/13/14 at 5:00 p.m., indicated the resident had a left buttock abscess, an open area 4 cm (centimeter) x 1.5 cm. In addition, the nurse comments identified redness/irritation had been observed to the resident's inner bilateral ankles. A Care Area Assessment (CAA) dated 9/25/14 indicated R8 had a pressure ulcer and deep tissue injury upon admission to facility. At that time, risk factors were identified as including weight loss, weakness, and dementia. According to the CAA, the plan was to remind R8 to off-load (remove all pressure to skin located over bony prominences) off bottom frequently. The goal was to encourage

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pressure ulcer to heal and prevent new ulcers from developing.

As indicated above, the facility's Turning and Repositioning Guidance: Interventions/Plan of Care (a computerized assessment form) dated 2/12/15, had identified an unstageable (pressure ulcer) present on seating surface/upper torso and the interventions were to include: Pressure redistribution cushion, mattress replacement system, turn & reposition every two hours in bed and "Off-load" (to remove pressure to skin over bony prominences) in chair every one hour, encourage rest periods, attempt to position off the affected area, in chair for meals and activity of choice, minimize incontinence, alternate seating surfaces. Although a subsequent Turning and Repositioning Guidance form dated 3/20/15, identified the same details under Interventions/Plan of Care, R8's individual care plan was still not updated to reflect the repositioning schedule to be followed when in bed and/or when in the chair. In addition, the "Care Resident Sheet" (not dated) used by the nursing assistants to provide individual care for the residents, was inconsistent with the Turning and Repositioning Guidance and included under the heading, "Transfer/Reposition" that R8 required turning/repositioning "every 2 hours and as needed per his request" rather than the 1 hour determined to be required while R8 was seated in the wheelchair.

During interview with the DON on 4/2/15 at 1:23 p.m., the DON stated interventions for R8 included every one hour repositioning. When questioned how they keep track of the repositioning, the DON stated the facility did not record actual repositioning times, frequency, or

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F 314	Continued From page 31 whether a resident refused to be repositioned. During interview with nursing assistant (NA)-A on 4/2/15 at 1:41 p.m., NA-A stated R-8 was supposed to be repositioned every three hours or so. NA-A also stated R8 "likes to stand up and stretch his legs for a bit, whenever he can stand." NA-A stated the repositioning schedule is on our "Resident Care Sheet." At that time, NA-A and the surveyor checked the Resident Care Sheet and it included: "Reposition every 2 hours and as needed per his request." All Weekly Wound Documentation was requested and provided for current pressure ulcers. Measurements were noted as follows: Pressure Ulcer A -located on the Left trochanter: 2/16/15 left (L) trochanter (hip) 0.5 cm x 0.2 cm stage- suspected deep tissue injury (DTI) first noted 3/3/15 L trochanter pressure 1 cm x 0.4 cm stage- suspected DTI 3/8/15 L trochanter pressure 1.2 cm x 1.2 cm stage- unstageable 3/14/15 L trochanter (hip) pressure 1 cm x 1 cm stage- stage II 3/30/15 L trochanter (hip) pressure 1 cm x 0.5 cm unstageable 4/2/15 L trochanter (hip) pressure 0.9 cm x 1 cm with surrounding red tissue Pressure Ulcer B is located on the L trochanter near Pressure Ulcer A. 2/16/15 Date of onset, L trochanter (hip) reddened area 1.8 cm x 1.7 cm stage I 2/23/15 L trochanter (hip) reddened area 0.5 cm x 0.2 cm stage I (Suspected DTI) 4/2/15 Resolution date unknown but currently not open.	F 314		

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F 314	Continued From page 32 Pressure Ulcer C is located on the left buttock. 9/14/14 Admitted with pressure ulcer stage II. (Had abscess surgically removed) 2/28/15 Other, L buttock ulcer 1.5 cm x 1.5 cm depth 3.5 cm stage III 3/14/15 Other, L buttock pressure 1.5 cm x 1.5 cm depth 3 cm stage III R8's wound care was observed to be completed by registered nurse (RN)-B on 4/2/15 at 1:55 p.m. Pressure ulcer A was measured as 0.9 cm x 1 cm, and the surrounding red tissue measured 3 cm x 2 cm. The open area had defined edges with white solid substance in the center. RN-B was unable to obtain a measurement of the wound depth. Pressure ulcer-C was not observed at this time. R8's primary physician note dated 3/12/15 indicated, "[R8] has had a left hip pressure ulcer [A] about 6 mm [millimeters] [or 0.6 cm] x 8 mm [or 0.8 cm], probably stage II. It has moist, creamy colored exudate covering. Looks like it is probably superficial but not really stageable at this point. His other longstanding wound [pressure ulcer-C] is 1.5 cm x 1.5 cm at its opening and 2.5 cm deep." Interview with RN-B on 4/2/15 at 1:55 p.m. stated, "Has [referring to ulcer wounds] gotten worse since coming back from the hospital [readmitted on 2/10/15 from hospital]." The facility's Guidelines for Pressure Ulcer Prevention dated September 2010, were provided by the corporate nurse consultant. The guidelines included: "Reassess for the pressure ulcer risk factors as required..." and	F 314		

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F 314	Continued From page 33 "...Comprehensive Risk Assessment in addition to other pertinent assessments including bowel and bladder function, nutrition status, tissue tolerance based on clinical status, pain and consideration of the resident's psychosocial status are required to determine the individual's risk of pressure ulcer development." The facility guidelines also included: "Monitor the effects of the interventions and modify the interventions when indicated... Their effectiveness [regarding interventions] in prevention is monitored by the interdisciplinary team...and measure and records the pressure ulcers, and notes the largest ulcer and deepest anatomical stage of any pressure ulcer identified in the inspection, identify any known or likely unstageable pressure ulcers, determine the greatest tissue type severity."	F 314		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure comprehensive bladder assessments that included an assessment of risks for developing urinary tract infections (UTI)	F 315	F 315 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted	4/30/15

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F 315	Continued From page 34 and failed to monitor symptoms for urinary tract infections for 4 of 4 residents (R17, R16, R22, R24) reviewed with recurrent urinary tract infections Findings include: The monthly Infection Control Data Collection for October 2014 through March 2015 was reviewed. R17, R16, R22 & R24 had multiple/recurrent urinary tract infections during this period. R17 had four urinary tract infections identified between October 2014 and March 2015, but lacked a comprehensive assessment of his risks to develop UTIs and lacked documentation that identified symptoms/signs of a UTI or nursing interventions used to assist the resident to manage the UTIs. R17 had a care plan that identified a problem of intermittent catheterizations and history of UTI. The care plan directed staff to observe for signs and symptoms of discomfort on urination and frequency. The care plan did not identify nursing interventions for management of potential UTIs. R17 had a quarterly Minimum Data Set (MDS) dated 2/1/15 that indicated an indwelling catheter and frequent urinary and bowel incontinence; and indicated R17 required extensive assistance of 2 for toilet use. The MDS did not identify R17 had experienced a urinary tract infection during the previous 30 days. The monthly Infection Control Data Collection reports indicated R17 had a UTI 10/6/14. No organisms were listed, but R17 received Levofloxacin. A note indicated the infection was recurrent. The Data Collection noted that R17 had developed a UTI on 11/19/14 and that E-coli were the organism responsible. R17 received Cipro (antibiotic) for the infection. R17 was identified having a UTI on 11/27/14 of E-Coli. On	F 315	as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: c. With respect to R17, R16 and R24 a comprehensive bladder assessment has been completed. d. With respect to R22 identifying number was misstated in statement of deficiencies. With respect to R32 a comprehensive bladder assessment was completed. e. All residents receive a comprehensive bladder assessment upon admission, quarterly and with a significant change in condition. f. All staff has been re-educated on symptoms and monitoring for Urinary tract infections on 4-22-15. g. DNS/ Designee will audit 2 resident records for changes in condition per week for 4 weeks then 1 resident record for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. h. DNS is responsible.	

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F 315	Continued From page 35 1/3/15 R17 was identified as having a UTI with the organism of E-Coli. Nitrofurantoin (antibiotic) was given. Nursing progress notes were reviewed for 10/1/14 to 10/6/14. On 10/3/14 the progress notes identified clouding odorous urine and encouragement of fluids to drink as a nursing intervention. On 10/5/14 the nursing notes indicated R17 had been sent to the emergency department and was being admitted for a UTI. Nursing progress notes for 11/13/14 through 11/27/14 were reviewed. On 11/16/14 the nursing notes indicated R17 had a low grade temp and changes in the urine characteristics. A urine specimen was submitted on 11/17/14 and antibiotic therapy was started by the physician prior to the culture results. Nursing progress notes of 11/23/14 noted the resident was receiving cefazolin for a UTI. The progress notes of 11/27/14 noted R17 had been admitted to the hospital for a UTI. R16 had four urinary tract infections identified between October 2014 and March 2015, but lacked a comprehensive assessment of her risks to develop UTIs and lacked documentation that identified symptoms/signs of a UTI or nursing interventions used to assist the resident to manage the UTIs. R16 lacked a bladder assessment that identified the risk factors for developing urinary tract infections. R16 had a care plan that did not identify a problem of recurrent UTI ' s, but did list signs and symptoms to report if R16 developed a urinary tract infection. R16 had an annual MDS on 2/20/15 that indicated R16 required extensive assistance of one staff, was frequently incontinent of urine and had not experienced a UTI during the previous 30 days.	F 315		

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R16 had infections listed on the Data Collection as 10/17/14 with E-coli as the organism and received Cipro as an antibiotic. R16 had a UTI listed as starting 11/1/14 with E-coli as the organism and Ceftin as the antibiotic Treatment. R16 had a UTI noted for 2/27/15 with the bacteria as Proteus Mirabilis and received Amoxicillin (antibiotic). Again on 3/27/15 R16 had a UTI identified with E-coli as the organism and Keflex as the antibiotic used.

Nursing notes of 10/12/14 through 10/17/14 were reviewed. On 10/15/14 documentation indicated a low grade temperature, complaints of burning with urination, and back pain. However, these symptoms were not noted during the previous shift and no complaints of burning, pain or frequency with urination.

Nursing progress notes were reviewed for R16. Notes from 10/27/14 through 11/1/14 did not identify symptoms/signs that would indicate a possible UTI, but did identify that on 10/30/14 a urine specimen was obtained and on 11/1/14 an order for Ceftin was received. The nursing notes did not include the use of any nursing interventions.

Nursing notes of 2/24/15 noted a urine specimen was obtained for symptoms that included a low grade temperature, increased toileting frequency, change in color/odor of the urine and increased incontinence. The nursing notes did not include the use of any nursing interventions. The nursing notes of 2/27/15 indicated Amoxicillin had been ordered.

Nursing notes of 3/25/15 through 3/30/15 were reviewed. No documentation of signs/symptoms of a UTI was noted. On 3/27/15 the nursing progress notes indicated the physician ordered Keflex (antibiotic) for a UTI.

R22 had three urinary tract infections identified

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between October 2014 and March 2015, but lacked a comprehensive assessment of her risks to develop UTIs and lacked documentation that identified symptoms/signs of a UTI or nursing interventions used to assist the resident to manage the UTIs.
R22 lacked a bladder assessment that identified the risk factors for developing urinary tract infections. R22 had a care plan problem dated 8/8/14 that identified a problem of bladder incontinence. The care plan directed staff to observe for signs and symptoms of changes of urine characteristics, altered mental status, fever/chills. The care plan did not identify nursing interventions for management of potential UTIs.
The quarterly MDS dated 2/7/15 indicated R22 required extensive assistance of one with toilet use, was occasionally incontinent of bladder and bowel and had not experienced a UTI in the past 30 days.
The monthly Infection Control Data Collection was reviewed. R22 had a UTI caused by E-coli 10/10/14 and received Cipro for treatment. R22 had a UTI on 1/6/15 that cultured polymicrobial and she received Macrobid. R22 had a UTI in March that had bacteria identified and received Bactrim which was later discontinued without notation as to why
The nursing progress notes provided were reviewed. The notes of 10/7/14 to 10/9/14 were reviewed. On 10/7/14 R22 complained of lower back pain and increase urgency/frequency. A urine specimen was obtained. The note of 10/9/14 stated the facility was waiting for a culture report. No further nursing notes were provided for this incident.
Nursing notes of 1/4/15 to 1/6/15 were provided and reviewed. Nursing notes of 1/6/15 noted a change in behavior that resulted in emergency

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room visit. The emergency room diagnoses included UTI and provided an order for Bactrim. No culture reports were noted. The nursing notes provided did not include March notes. The notes did not include nursing interventions offered to assist the resident to manage her UTIs.
R24 had three urinary tract infections identified between October 2014 and March 2015, had an indwelling catheter, but lacked a comprehensive assessment of his risks to develop UTIs and lacked documentation that identified symptoms/signs of a UTI or nursing interventions used to assist the resident to manage the UTIs.
R24 lacked a bladder assessment that identified the risk factors for developing urinary tract infections.
R24 had a care plan problem dated 1/3/14 that indicated R24 had a supra pubic catheter and a history of recurrent UTIs. The care plan directed staff to observe for signs and symptoms of a urinary tract infection, but the care plan did not identify nursing interventions for management of potential UTIs. The care plan had a problem dated 1/13/14 of infections related to a history of UTI, neurogenic bladder, and suprapubic catheter placement that provided directions to change the suprapubic catheter following the completion of the antibiotic therapy for UTI, to irrigate the suprapubic catheter daily. The interventions did not include physical care of the catheter and catheter bag to prevent or minimize the risk of UTIs.
R24 had a quarterly MDS dated 2/1/15 that noted an indwelling catheter, frequent urine and bowel incontinence and no urinary tract infections in the past 30 days.
The monthly Infection Control Data Collection noted R24 had a UTI 11/4/14 for which he received rocephin. No organisms were identified.

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F 315	Continued From page 39 R24 was identified as having a UTI on 1/5/15 caused by Proteus mirabilis and Klebsiella oxytoca for which he received the antibiotics Cipro and Augmentin. On 1/23/15 the data collection form noted R24 had a urinary tract infection and an upper respiratory infection with sepsis. He received Zithromax (antibiotic). Enterococcus and methicillin resistant staphylococcus aureus (MRSA) were identified as the organisms. Nursing progress notes were reviewed for R24. Notes for 10/30/14 through 11/2/14 were provided and reviewed. On 10/31/14 the notes indicated R24 was not responding to staff and had no urine output. R24 was admitted to the hospital with a diagnosis of UTI. No further progress notes were provided. The director of nursing (DON) was interviewed. On 4/1/15 at 1:30 p.m. the DON stated signs and symptoms of the infections were to be documented in the nursing notes. DON said that for a UTI, the resident should have three symptoms and that would not include a mental status change. On 4/2/15 at 2:00 p.m. the DON stated the facility did not complete a urinary tract infection risk assessment. A urinary tract infection management policy/procedure was requested and none provided however, the facility did provide a Condition/Follow-up Charting form. The form directed with urinary tract infection: " increase fluid intake, monitor I & O [intake and output] frequency of urination, pain with urination, antibiotic use ... "	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a	F 318		4/30/15

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F 318	Continued From page 40 resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide exercise programs as recommended by therapy for 1 of 2 residents (R8) reviewed for restorative programs. Findings include: The physical therapy Discharge Summary dated 12/12/14 recommended: patient to perform repeated sit to stand using railing in a hallway 5-10 times. Every two hours the patient is to independently continue with supine and seated leg exercises. The patient may work on the leg restorator daily for 5 to 15 minutes as tolerated. Nursing staff should ambulate patient at least three times a day with front wheel walker. The occupational therapy Discharge Summary dated 12/12/14 recommended: Education provided patient on a home exercise program using red resistance band and sit to stand at railing. Continue with home exercise program. Assist of one for standing task during activities of daily living (ADLs) and ambulation. The Therapy/Nursing Communication of 12/12/14 directed a therapy carry-over program that included: 1) Please encourage patient to complete his upper and lower body exercises, complete walking three times a day, attend	F 318	F 318 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R8 all recommended exercises have been initiated into Plan of Care for documentation by NAR. Care plan has been reviewed and revised to reflect current needs. b. All residents with a limited range of motion Care plan has been reviewed and revised. c. All staff has received re-education on completion and documentation of exercise programs on 4-22-15. d. DNS/ Designee will audit 2 resident records for exercise programs per week for 4 weeks then 2 resident records for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/	

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F 318	Continued From page 41 activities well-fit classes. 2) Patient is okay to self-transfer using bed rail to/from bed and wheelchair. 3) Patient continues to require assist of one during standing ADLs and ambulation. R8 was observed on 3/30/15 from 4:15 p.m. to 5:08 p.m. independently propelling the wheelchair with his feet while in the hallway. R8 was observed on 3/31/15 from 8:27 a.m. until 9:13 a.m. independently wheeling his wheelchair. R8 was continually observed on 3/31/15 from 1:46 p.m. until 4:03 p.m.; during which time R8 was sitting in his wheelchair independently wheeling himself. During these observations R8 was not observed attempting to stand independently at the bed rail or being assisted by staff to stand, walk, or do exercises. R8 was observed on 4/1/2015 at 8:47 a.m. R8 was assisted by the Director of Nursing (DON) and a Nursing Assistant (NA) to stand. He required extensive assist from both staff to come to a stand from the wheelchair. R8 had not attempted to stand independently at the bed rail and required more than one staff to assist him with the standing. The physician notes dated 2/12/15 listed diagnoses that included: failure to thrive, progressive dementia, malnutrition, significant weight loss, history of stroke, hypertension, rheumatoid arthritis, stage III pressure ulcer left ischial tuberosity (hip) and low back pain. The quarterly Minimum Data Set (MDS) dated 12/20/14 indicated R8 did not refuse cares, required extensive assist of 1 to transfer and walk, had no functional limitations of extremities, and did not receive range of motion services. The	F 318	Designee for input and further direction. e. DNS is responsible.	

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3/23/15 quarterly MDS indicated R8 needed extensive assistance with mobility, transferring, locomotion and one staff to assist with walking.

The care plan provided 4/1/15 did not have an identified problem related to need for exercises and the care plan did not have interventions that directed staff to encourage or assist R8 in the participation of the exercise program recommended by therapy.

The Resident Care Sheet provided on 3/30/15 noted R8 was to be repositioned every two hours and was to walk to and from meals. The care sheet noted " restorative program: none. "

The facility ' s Functional and Safe Handling Review for 12/17/14 (after therapy discharge) was compared to the Review completed 3/20/15. On 12/17/14 R8 was able to transfer with assist of 1 staff, and ambulate with assist of one staff. The Review completed 3/20/15 indicated R8 required 2 staff assist to transfer and walk.

On 3/31/15 at 1:55 p.m. R8 was interviewed and stated that he would generally have staff help him to transfer because he had a fear of falling. R8 stated that at times nursing would take him down to the larger bathroom, put a belt around help and help him stand and do exercises. " When they have time. " During an interview on 4/1/15 at 8:28 a.m. R8 stated he could not walk anymore and that nursing needed to help him stand from the wheelchair.

The occupational therapist (OT)-A was interviewed on 4/1/15 at 11:35 a.m. She indicated R8 had reached his maximum level of independence and safety and that OT had

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F 318	Continued From page 43 established a home exercise program for him. OT-A stated therapy had recommended to nursing an exercise program using a therapy band, ambulation, dressing tasks, and attending the well-fit classes. On 04/01/2015 at 11:55 a.m. the director of nursing stated the facility did not have a restorative nursing program for R8 however, each nursing assistant is responsible for services assigned to them for the shift.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to adequately determine individualized mobility and safety needs and interventions for 1 of 3 residents (R30) reviewed for accidents that were at high risk for falls. Findings included: R30 sustained four falls between 1/1/15 and 3/15/15 and care plan interventions were not developed based on comprehensive reassessments. R30's physician visit dated 2/19/2015 included diagnoses of Huntington's disease with advanced behavioral dyscontrol, dementia, and history of	F 323	F 323 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R30 Care plan was	4/30/15

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F 323	Continued From page 44 right hip, foot, and left buttock pain. R30's quarterly Minimum Data Set (MDS) dated 2/27/15 indicated severe cognitive impairment and required supervision with one staff physical assist for transfers and walking, and required limited assistant of one staff person for toilet use. Assessment for balance during transitions and walking indicated R30 was not steady, but able to stabilize without staff assistance when moving from a seated to standing position, when walking, turning around, moving on and off the toilet, and surface to surface transfers. This MDS assessment also indicated R30 used a cane/crutch and R30 had sustained one fall with no injury and one fall with injury since the last scheduled assessment three months prior to this one. R30's current care plan provided by the facility on 4/1/15 referenced conditions that would increase risk for falls as Huntington ' s disease, dementia, hypertension, unsteady gait, impaired balance, impulsivity, poor insight into safety issues, confusion and agitation. The care plan failed to identify psychotropic and diuretic medications as an increased risk for falls. The care plan included but was not limited directions for staff to: "...is wearing appropriate footwear (slippers) when ambulating" hospice was to "monitor risk for falls and implement appropriate interventions as needed, and provide physical assist to maintain balance." The care plan indicated R30 required assist of one staff for ambulation with use of gait belt and a cane to maintain balance, required standby assist for transfers" per request due to increased unsteadiness and fear of falling" and had choreiform movements affecting gait and upper extremities. The care plan directed staff to "keep routine consistent and to provide consistent care givers as much as possible in order to	F 323	reviewed in conjunction with hospice services and revised to reflect current care needs. b. All falls/ incidents are reviewed by the IDT for adequate interventions, Care plans will be updated immediately. c. All staff has received re-education regarding revising and updating of the Care plan on 4-22-15. d. DNS/Designee will audit all falls/ incidents to ensure interventions are updated. This data will be shared at the next quality assurance meeting by the DNS/designee for input and further direction. e. DNS is responsible.	

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decrease confusion " and the care plan also directed hospice staff to " continue to follow facilities plan of care to assist for transfers and ambulating. " R30 ' s care plan included direction to " be sure call light is within reach and encourage using it for assistance as needed."
R30's current signed physician orders signed on 2/19/15 included Lasix (diuretic medication) 10 milligrams (mg) by mouth one time daily, Lorazepam (anti-anxiety medication) 0.5 milliliters (ml) by mouth two times per day, Risperdal (anti-psychotic medication) 0.5 mg by mouth one time a day and 1 mg by mouth two times per day.
The facility nursing assistant assignment sheet indicated R30 required one assist with ambulation and transfers and one assist with locomotion on and off the unit. The assignment sheet instructed nursing assistants to monitor for position changes and offer assist as needed and to walk R30 out of room at least daily and to document refusals.
R30 had a fall on 1/10/15 at 5:40 a.m. in the west hallway according to the fall investigation report. The report indicated the fall was witnessed by staff, the resident lost balance while ambulating and turning around, was independent with a cane (the amount of assist conflicted both with the care plan and with the MDS), identified use of at risk medication and stated root cause of the fall was increased gait disturbance related to increased dose of Risperdal. The intervention was to taper back Risperdal to original dose.
The corresponding fall risk assessment (Morse fall scale) dated 1/10/15 indicated a high risk for falls with a score of 90. The assessment indicated R30 had impaired gait defined as "difficulty rising from chair, keeps head down when walking, and grasps furniture ...cannot walk unassisted." Also it states R30 overestimates or forgets limits own limits and abilities to ambulate

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F 323	Continued From page 46 safely. No new fall interventions or plans to decrease risk for falls were added to this assessment. R30 had a fall on 1/25/15, at 5:00 p.m. in the lobby area according to the fall investigation report. The report indicated the fall was witnessed, was the result of environmental clutter, R30 was ambulating independently with no assist "but was being observed at the time," was not using an assistive device, and included the statement, "has had a few fall recently. " Balance unsteady at times and is encouraged to use cane for assist with balance. Again no new fall preventative interventions were put into place. R30 had a second fall on 1/25/15, at 7:00 p.m. in the day room according to the fall investigation report. The report indicated the incident was witnessed, R30 was ambulating unassisted in lobby area but had been observed, and R30 was not using cane at the time. The report read, "Resident walking in hall not watching where she was going." Also stated there was indicated environmental clutter was present at the time of the fall. Another statement on the report read, "Has had falls recently, balance is unsteady at times, at times will not use cane ... " No new falls interventions were put into place nor were current interventions such as cane assessed to be affective to reduce chance of falls. The corresponding fall risk assessment (Morse Fall scale) dated 1/25/15 indicated a high risk for falls with a score of 55. The assessment indicated R30 used an assistive device for ambulation, and gait was "NORMAL" defined as, walks with head erect, arms swing freely at the side, strides without hesitation. The assessment further indicated R30 "knows own limits of their abilities to ambulate safely." However, this fall risk assessment conflicts with both fall investigation	F 323		

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reports from 1/25/15.
R30 had a fall on 2/22/15, at 4:10 p.m. in her room according to the fall investigation report. The report indicated the incident was not witnessed; R30 had lost balance and had been attempting to transfer self with socks on and no shoes. The report further indicated a medication change had occurred within past 30 days. The fall investigation indicated cause of the fall was "self-ambulating without proper device or foot wear." An intervention to prevent future falls outlined as "shoes on, cane." Again the current interventions such as the cane were not assessed to be an affective device to prevent further falls.
The corresponding fall risk assessment (Morse Fall scale) dated 2/22/15 indicated a high risk for falls with a score of 90. The assessment indicated R30 used an assistive device, had impaired gait and over estimates or forgets own limits and abilities to ambulate safely.
R30 had a fall on 3/13/15 at 1:15 a.m. in another resident's room according to the fall investigation report. The report indicated the following information: the fall was unwitnessed, R30 had been ambulating prior to the fall, R30 had been wearing shoes, and no root cause analysis was identified. The report indicated the intervention put into place to prevent future falls was listed as "observe gait." However, this was not based on a root cause analysis which would have directed an intervention that was affective to reduce falls and determine if current interventions were appropriate.
The corresponding fall risk assessment (Morse Fall scale) dated 3/13/15 indicated a high risk for falls with a score of 65. The assessment indicated R30 did not use an ambulatory aide and had weak gait (defined as; stooped but able to lift heads without losing balance, steps are short,

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resident may shuffle), and over estimates or forgets own limits and abilities to ambulate safely.
A nursing progress note dated 3/16/15 read, "...recent falls noted, potential for increased gait disturbance secondary to TD [tardive dyskinesia] side effects of antipsychotic use. Will plan to discuss with PCP [primary care provider] this week for further direction. Evidence of this discussion or follow-up was not found in the medical record nor provided when requested.
R30 had been treated for lack of coordination by physical therapy (PT) and occupational therapy (OT) and R30 was discharged on 2/28/14.
Discharge instructions to nursing staff dated 2/25/14 read, "Please continue to ask if she would like to go for walks in hallways daily up to 3 times per day. " Also it read, " For transfers requires minimum assist, contact guard assist utilizing single point cane." The summary indicted there was ongoing balance concerns and was high risk for falls.
The PT discharge summary signed on 2/28/14 included discharge instructions read, "Patient to continue with ambulation program with nursing staff. Patient to remain at contact guard assists for all transfers due to high fall risk." "Nursing staff to ambulate patient in hallway daily to prevent further decline."
During an observation on 3/30/2015, at 3:45 p.m. in the R30's room, one multi-colored cane was wedged between a chair cushion with a blanket and pillow on top of it. The cane was only about 25% visible. Another wood cane was sitting on the opposite side of the chair partially covered by a pillow.
During an observation on 4/1/15, at 7:52 a.m. R30 was laying on her bed, the call light was on the floor on the right side of the bed behind the divider curtain; the call light was not visible.

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During an observation on 4/1/15, at 8:52 a.m. The call light continued to be in the same place.
During an observation on 4/1/15, at 9:01 a.m. R30 walked out of her room independently without an assistive device, with tennis shoes on. R30's gait was swaying with short unsteady discontinuous steps. No nursing staff was present in the immediate area as R30 ambulated towards the dining room. At 9:03 a.m. nursing assistant (NA)-E entered the R30's room and verified the call light had been on the floor. NA-E stated the R30 was capable of using the call light and it should have been placed on the bed. NA-E explained R30 would put the call light on the floor. When asked, "How often do you check to make sure the call light is in place?" NA-E stated, "once per shift."
During an observation on 4/1/15, at 10:30 a.m. R30 was walking independently in the lobby area in front of the nurses station without an assistive device (cane), had tennis shoes on. R30's gait was very poor. R30 had a lurching swaying gait pattern, legs are straight with no observable flexion at the knee during steps as R30 turned around in a circle, and balance was lost causing a slight stumble. R30 was able to recuperate balance by holding onto the medication cart. No staff members were within sight of R30 to witness near fall. R30 then attempted to turn around again with her hands clasped behind her back, as the right leg came off the floor it rubbed up against the carpet and caused R30 to loose balance again. R30 was able to catch gain control. At 10:34 a.m. NA-B entered the lobby area and redirected R30 into the opposite direction, NA-B walked with R30 for approximately 10 feet. R30 was most cooperative during this encounter with NA-B. NA-B then turned and walked to the right to assist another

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resident in the lobby area NA-B's back was turned toward R30, while R30 continued to ambulate approximately another 15 feet across the lobby area with no direct visual oversight.
During an observation on 4/1/15, at 10:45 a.m. R30 was walking in the hallway by the dining room with no assistive device (cane). Gait pattern was notably unstable. No nursing staff was present or within visual sight of R30.
During an observation on 4/1/15, at 12:20 p.m. R30 was walking from the dining room to lobby area with no assistive device and no staff members present. R30 had tennis shoes on. R30's gait was wide and swaying with intermittent shuffles. R30 walked approximately 20 feet then sat down in a chair next to the medication cart.
During an observation on 4/2/15, at 9:17 a.m. R30 was in the hallway standing in front of room 14 waving to the resident inside. R30 did not have an assistive device and had tennis shoes on. No staff was visible in the hallway where R30 was. R30 then walked up the hallway toward the dining room. R30 demonstrated a wide swinging lurching gait pattern. Tip of tennis shoes were noted to get caught on the carpet in the hallway during ambulation that would cause R30 to become unbalanced.
During an interview on 4/1/15, at 11:12 a.m. registered nurse (RN)-A stated R30 waxed and waned with the amount of assistance from staff is required and some days were better than others. RN-A stated R30 had been like that since admission.
During an interview on 4/1/15, at 11:34 a.m. director of nursing (DON) stated R30's gait fluctuates routinely and her expectations were staff attempt to use a gait belt and walk with R30 and staff needed to follow the care plan. DON explained R30 did not like to use the gait belt, so

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staff would "just guide her and go by where she wanted to go." DON further explained staff should be supervising her when ambulating.
During an interview on 4/1/15, at 12:20 p.m. occupational therapist (OT)-B stated R30 had been treated and discharged February 2015 and at the time of discharge recommended R30 ambulate with a cane. OT-B indicated she was not aware R30 was not using the cane and stated a referral was probably needed to determine if the cane or other assistive devices would be appropriate.
During an interview on 4/1/15, at 1:34 p.m. hospice RN stated R30 was very non-compliant with assistive devices. RN stated months back a wheelchair and a walker were tried; however R30 would not use them. RN indicated R30 was supervised by staff all of the time and has not used the cane for walking. RN stated R30 chose not to use it. RN stated a referral to OT or PT has not been done to determine alternatives to decrease the risk for falls. Hospice RN further explained it was the family's goal to keep R30 as independent as possible.
During an interview on 4/2/15, at 10:39 a.m. DON stated R30 was not on a walking program with staff because R30 was ambulatory. The DON stated if a mobility assessment had been done it would be in the medical record. The DON was not aware if hospice had evaluated R30 for mobility and safety.
During an interview on 4/2/15, at 10:47 a.m. RN-A stated R30 was supposed to be ambulated with a cane and should have staff always watching her. RN-A further explained staff watch her as much as possible. RN-A verified assessments and care plans were not consistent in regards to ambulation and falls safety interventions.
During an interview on 4/2/15, at 12:16 p.m. the

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F 323	Continued From page 52 question "What kind of assistance does R30 require?" was asked to NA-A. NA-A stated, "Supervision on some days and as far I as I know its general over site, we watch her from a distance if we are in the same room." NA-A then stated staff was supposed to try and walk her with a gait belt. NA-A stated R30 had a cane but generally did not use it. NA-A stated she did not think the cane improved her gait. NA-A indicated staff didn't offer to get R30's cane when she did not have it because R30 could become violent. During an observation on 4/2/15, at 3:00 p.m. R30 was walking with cane and a staff member. R30's gait was stable steps were mainly even with no swaying or lurching gait pattern, did not appear to be off balanced. R30 was being cooperative with staff at this time. Facility policy comprehensive fall risk guidelines and fall prevention guidelines read, "...a comprehensive Fall Risk Assessment consists of: ...the resident plan of care which identifies; the fall history, the resident's risk areas consistent with resident specific conditions, needs, behaviors, and preferences, if the resident refuses or resist intervention, the care plan reflects efforts to seek alternatives to address the needs identified ..." and "List all interventions on the care plan and nursing assistant assignment sheet, consider PT/OT assessment."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of	F 329		4/30/15

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F 329	Continued From page 53 adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor physician identified target behaviors to determine if the antipsychotic medication (Seroquel) was affective for 1 of 5 residents (R4) reviewed for unnecessary medications. Findings include: R4 was observed on 3/30/15, at 1:00 p.m., R4 sat upright in wheelchair in lobby near medication room with oxygen on. No behaviors were noted. Observations on 3/30/15, at 5:26 p.m., revealed family visiting with R4 in the lobby near the medication room. No behaviors noted. Observations on 3/31/15, at 3:50 p.m., revealed R4 in bed, awake, and positioned on right side. No behaviors noted. Observations on 4/1/15, at	F 329	F 329 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R4 a comprehensive Mood and Behavior assessment was completed. Care plan reviewed and revised to reflect target behaviors for	

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F 329	Continued From page 54 9:25 a.m., R4 received morning cares, repositioned side to side, awake, and no behaviors noted. R4 had physician orders signed 3/26/15, for Seroquel 12.5 milligrams via G-tube (gastrostomy tube) at bedtime for " agitation/insomnia/agitation. " The order start date was 2/11/15. Document review of R4 ' s medical record revealed R4 had received Seroquel for several years with successful gradual dose reductions. The facility identified R4 on the significant change Minimum Data Set (MDS) dated 2/10/15, to have short and long term memory problem, severely impaired decision making, no behaviors, moods included feeling down, trouble falling asleep or staying asleep, and tired, and received antipsychotic medication. Document review of facility care area assessment (CAA) dated 2/20/15, revealed R4 received psychotropic medication for agitation and insomnia, no mood/behavior concerns noted, and proceed to care plan for any changes in mood, sleep, or behavior. Document review of R4's Behavior/Mood Evaluation dated 2/10/15, revealed will usually become agitated, may strike out verbally or physically, no mood or behavior symptoms noted. Document review of R4's sleep history questionnaire dated 2/11/5 and 3/22/15, revealed R4 denied trouble going to sleep, denied trouble staying asleep, and naps during the day.	F 329	medications. b. All resident□s receiving psychoactive medications have been reviewed to assure there are appropriate indications for the use of these medications, care plans updated and Behavior monitoring and/or Sleep monitoring will be initiated as indicated. c. All staff has received re-education regarding the requirements for monitoring Target behavior on 4-22-15. d. DNS/ Designee will audit 3 resident records for target behaviors per week for 4 weeks then 2 resident records for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. e. DNS is responsible.	

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Document review of R4's care plan initiated on 2/26/15, revealed staff were directed R4 had a focus of antipsychotic medication Seroquel related to diagnosis of advanced Lewy Body dementia and history of hallucinations. Interventions included give antidepressant medications and observe side effects and effectiveness.

Document review of facility medication administration record (MAR) and treatment administration record (TAR) dated 3/1/15 to 3/31/15, revealed Seroquel 12.5 milligrams via gastrostomy tube at bedtime for agitation/insomnia/agitation, with start date of 2/11/15. Review of the MAR and TAR revealed no evidence of monitoring target behaviors.

Document review of nursing assistant behavior documentation for 3/4/15 to 4/1/15, revealed monitoring of 13 various behaviors and none of these identified behaviors were noted. However, the 13 behaviors had not been specific to what R4 exhibited for " agitation and insomnia. "

During interview on 4/1/15, at 12:10 p.m., nursing assistant (NA)-B stated R4 had no moods and no behaviors.

During interview on 4/2/15, at 10:45 a.m., director of nursing stated she expected individualized target moods and behaviors were identified and monitored on the facility medication administration record (MAR) and treatment administration record (TAR). Director of nursing stated nurse ' s document moods and behaviors on the MAR and TAR and the nursing assistant's document moods and behaviors on the kiosk (nursing assistant documentation program).

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Director of nursing stated she expected the facility psychoactive medication evaluation and consent form identified target moods and behaviors to be monitored. Director of nursing verified the consent form signed by family 3/30/15, with Seroquel dosage changes noted for 1/28/15, 1/29/15, and 3/20/15, and identified target behaviors of restless and agitation. Director of nursing verified the facility had not monitored target behaviors of restless and agitation.

During interview on 4/2/15, at 1:15 p.m., director of nursing verified physician orders and medication administration record (MAR) identified Seroquel for agitation/insomnia. Director of nursing stated R4 did not have a behavior of insomnia and verified there was no monitoring of sleep patterns.

Document review of facility behavior monitoring and psychoactive medication monitoring guidelines policy dated 2013, read, " Daily behavior monitoring is required for those residents on anti-psychotic and anti-anxiety medications. Behaviors monitored need to meet the specific target behavior requirements as detailed in the psychotropic and sedative/hypnotic tapering guidelines. This monitoring should be completed on the MAR or TAR generated from Point Click Care. " Other forms of documentation may be used where computer generated forms are not available. " " Behavior monitoring allows you to evaluate the interventions and effectiveness of medication being used. If a new behavior occurs, it is then added to the behavior monitoring form and a summary written in the nursing progress notes. All new behaviors should be added to the 24 hour

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F 329	Continued From page 57 report for at least 72 hours to make everyone aware of the monitoring that is now in place. " During interview on 4/2/15, at 1:15 p.m., director of nursing verified physician orders and MAR identified use of Seroquel for agitation and insomnia. Director of nursing stated R4 did not have a behavior of insomnia; therefor the facility did not monitor sleep patterns. Director of nursing verified R4 received Seroquel for agitation and restless, according to facility psychoactive evaluation and consent form dated 3/30/15. Director of nursing verified nurses were not monitoring agitation and restless on the MAR and TAR, as she expected. She verified nursing assistants were not monitoring target behaviors of agitation and restless on the computer program, as she expected.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified the lack of facility monitoring of target	F 428	F 428 The preparation of the following plan of correction for this deficiency does not	4/30/15

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F 428	Continued From page 58 behaviors for antipsychotic medication use for 1 of 5 residents (R4) reviewed for unnecessary medications. Findings include: R4's medical record did not include evidence of monitoring of identified target behaviors and sleep patterns with the use of Seroquel. The consultant pharmacist had not identified the irregularity of facility lack of monitoring in monthly pharmacy reviews. R4 had physician orders signed 3/26/15, for Seroquel 12.5 milligrams via G-tube (gastrostomy tube) at bedtime for "agitation/insomnia/agitation." The order start date was 2/11/15. Document review of R4's medical record revealed R4 had received Seroquel for several years with successful gradual dose reductions. The facility identified R4 on the significant change Minimum Data Set (MDS) dated 2/10/15, to have short and long term memory problem, severely impaired decision making, no behaviors, moods included feeling down, trouble falling asleep or staying asleep, and tired, and received antipsychotic medication. Document review of facility care area assessment (CAA) dated 2/20/15, revealed R4 received psychotropic medication for agitation and insomnia, no mood/behavior concerns noted, and proceed to care plan for any changes in mood, sleep, or behavior. Document review of R4's Behavior/Mood Evaluation dated 2/10/15, revealed will usually	F 428	constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R4 a comprehensive review of the medication record was performed by consulting pharmacist on 4-13-15. b. A comprehensive review of medications was performed for all residents by consulting pharmacist on 4-13-15. c. All staff was re-educated on monitoring of target behaviors on 4-22-15. f. DNS/ Designee will audit 3 resident records per week for target behaviors for 4 weeks then 2 per week for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. d. DNS is responsible.	

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become agitated, may strike out verbally or physically, no mood or behavior symptoms noted.

Document review of R4's sleep history questionnaire dated 3/22/15, revealed R4 denied trouble going to sleep, denied trouble staying asleep, and naps during the day.

Document review of R4's care plan initiated on 2/26/15, revealed staff were directed a focus of antipsychotic medication Seroquel related to diagnosis of advanced Lewy Body dementia and history of hallucinations. Interventions included give antidepressant medications and observe side effects and effectiveness.

Document review of facility medication administration record (MAR) and treatment administration record(TAR) dated 3/1/15 to 3/31/15, revealed Seroquel 12.5 milligrams via gastrostomy tube at bedtime for agitation/insomnia/agitation, with start date of 2/11/15. Review of the MAR and TAR revealed no evidence of monitoring target behaviors.

Document review of nursing assistant behavior documentation for 3/4/15 to 4/1/15, revealed monitoring of 13 various behaviors. However, the various behaviors were not specific to R4 ' s identified behaviors of agitation and insomnia.

Document review of consultant pharmacist monthly medication regimen review for 4/9/14 to 3/16/15, revealed no identification of the irregularity of facility lack of monitoring target behaviors and sleep patterns.

During interview on 4/2/15, at 1:15 p.m., director of nursing verified physician orders and

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	245367	A. BUILDING _____ B. WING _____	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	210 EAST GRAND AVENUE, PO BOX 365 GRAND MEADOW, MN 55936

(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 428	Continued From page 60 medication administration record (MAR) identified Seroquel for agitation/insomnia. Director of nursing stated R4 did not have a behavior of insomnia and verified there was no monitoring of sleep patterns. During telephone interview on 4/2/15, at 2:30 p.m., pharmacist-C stated he would expect the facility to monitor specific target behaviors for use of Seroquel. Pharmacist-C stated he would expect the facility consultant pharmacist reviewed facility monitoring of Seroquel to identify if medication needed to be changed or eliminated. Document review of facility behavior monitoring and psychoactive medication monitoring guidelines policy dated 2013, read, "Daily behavior monitoring is required for those residents on anti-psychotic and anti-anxiety medications. Behaviors monitored need to meet the specific target behavior requirements as detailed in the psychotropic and sedative/hypnotic tapering guidelines. This monitoring should be completed on the MAR or TAR generated from Point Click Care."	F 428		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be	F 431		4/30/15

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F 431	Continued From page 61 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure accurate medication labels for 1 of 33 resident (R4) medication labels observed during medication pass. Findings include: R4's Sinemet medication label directed to administer medication by mouth, although physician orders directed nothing by mouth. Document review of physician orders signed	F 431	F 431 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to:	

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F 431	Continued From page 62 3/26/15; revealed orders for carbidopa-levodopa (Sinemet) 25-100 milligrams, give 2 tablets via G-Tube (gastrostomy tube) in the evening related to Parkinson's. The order start date was 1/28/15. Document review of physician orders signed 3/26/15, revealed orders for diet of NPO (nothing by mouth). The order start date was 12/8/14. During observation of medication pass on 3/31/15, at 3:35 p.m., licensed practical nurse (LPN)-B placed two tablets of Sinemet into a medication soufflé cup. Observations at that time revealed the medication pharmacy label read, "carbidopa-lev 25-100 (Sinemet), take 1 tablet by mouth twice daily and take two tablets by mouth at bedtime." The pharmacy label identified the medication dispense date of 2/20/15. During interview at that time, LPN-B verified two doses remained on the medication card. LPN-B verified the pharmacy label directed to give by mouth. LPN-B verified the pharmacy dispense date of 2/20/15. LPN-B stated R4 received all medication by gastrostomy tube. LPN-B stated the pharmacy label should have been changed. During observation on 3/31/15, at 3:53 p.m., LPN-B crushed the two tablets of Sinemet, added 30 cubic centimeters (cc) of water into the cup to dissolve medication and administered the medication via gastrostomy tube. During interview on 3/31/15, at 4:25 p.m., director of nursing stated she expected an "order change" sticker placed on the medication card when orders had changed. Although a medication order change policy was requested, none was provided.	F 431	a. With respect to R4 upon notification of medication label discrepancy a change label was implemented. Pharmacy was notified and order was changed in the pharmacy system. b. All medications will be reviewed for accuracy of label to include name, medication, dose route and time of administration. c. All licensed staff was provided re-education on proper verification of medication labels on 4-22-15. g. DNS/ Designee will audit 2 medication labels per week for 4 weeks then 1 medication labels for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. d. DNS is responsible.	

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F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		4/30/15

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F 441	Continued From page 64 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop and implement policy and procedures to direct infection control practices related to urinary tract infections (UTI) identification for 4 of 4 residents (R17, R16, R22, and R24) reviewed with recurrent urinary tract infections. In addition the facility failed to maintain an infection control program that included ongoing surveillance with analysis and trending of data. This had the potential to affect all 34 residents currently living in the facility. Findings include: LACK OF UTI SYMPTOMS IDENTIFIED: R17, R16, R22, R24 were identified by the facility as having facility acquired urinary tract infections (UTI) but lacked identification of symptoms as follows: R17 was noted on the infection control logs to have had four urinary tract infections identified between October 2014 and March 2015, but lacked documentation that identified symptoms/signs of a UTI. R16 was noted on the infection control logs to have had four urinary tract infections identified between October 2014 and March 2015, but lacked documentation that identified symptoms/signs of a UTI. R22 was noted on the infection control logs to have had three urinary tract infections identified between October 2014 and March 2015, but lacked documentation that identified symptoms/signs of a UTI. R24 was noted on the infection control logs to	F 441	F 441 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R17, R16, and R24 a comprehensive bladder assessment was performed to include risk factor for recurrent Urinary Tract Infections. b. With respect to R22 identifying number was misstated in statement of deficiencies. With respect to R32 a comprehensive bladder assessment was performed to include risk factor for recurrent Urinary Tract Infections. c. All residents receive a comprehensive bladder assessment on admission, quarterly and with a significant change in condition. d. All staff has been re-educated on symptoms and monitoring for Urinary tract infections on 4-22-15. e. DNS/ Designee will audit 2 resident records per week for 4 weeks then 1 resident record for 8 weeks. The data will be shared at the next Quality Assurance meeting by the DNS/ Designee for input and further direction. f. DNS is responsible.	

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F 441	Continued From page 65 have had three urinary tract infections identified between October 2014 and March 2015, had an indwelling catheter, but lacked documentation that identified symptoms/signs of a UTI. The director of nursing (DON) was interviewed on 4/1/15 at 1:30 p.m. the DON stated signs and symptoms of the infections (including UTIs) were to be documented in the nursing notes. DON said that for a UTI, the resident should have three symptoms and that would not include a mental status change to warrant the use of an antibiotic. A policy and procedure in regards to UTI assessments and interventions was requested but none was received. The facility did however; provide a Condition/Follow-up Charting form. This form directed with regards to UTIs the following: "Increase fluid intake, monitor I & O [intake and output] frequency of urination, pain with urination, antibiotic use ..." LACK OF ANALYSIS AND SURVEILLANCE OF INFECTIONS TO PREVENT THE SPREAD OF INFECTION: The DON was interviewed on 4/2/15 at 2:30 p.m. and indicated she was responsible for the infection control program and would trend different infections and monitor the infections. She would look at differences between the two resident wings and the different organisms identified. She stated that she would look to see if multiple residents had the same organism and provide training for the staff. The DON stated her analysis of data was "in my head" and that she did not write any information down for the monthly quality committee reports. DON stated that she may at times make a note on a map, but little else. Reproducible documentation in regards to the analysis of resident infections to determine if the analysis was effective to reduce the spread of	F 441		

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F 441	Continued From page 66 infection was requested but none provided. The DON stated all the registered nurses (RN) would write on the infection control logs, rather than complete an infection incident report that would monitor organisms, signs/symptoms of infections etc. DON indicated that as time allowed she would follow-up on the log to obtain the missing information.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident call lights were functioning and in good repair for 1 of 30 residents (R24) whose room were reviewed for call lights. Findings include: R24 was observed on 3/30/15 at 3:30 p.m. R24 was sitting in bed visiting with family (F)-A. The call light did not work when checked. R24 stated he usually did not use it anyway. On 3/30/15 at 5:30 p.m. the maintenance director checked the call light when asked and stated the call light worked. On 03/31/2015 at 9:06 a.m. again the call light did not activate when the surveyor attempted to push the pad with both hands. The wall switch did	F 463	F 463 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: a. With respect to R24 upon notification the call light was replaced. b. All resident call lights were audited to ensure in working order. c. Maintenance Director/ Designee will	4/30/15

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F 463	Continued From page 67 work when the cord was pulled. On 3/31/15 at 11:00 a.m. the maintenance director attempted to activate the call light and observed that it did not work either. The maintenance director stated that he needed to replace the call light. The maintenance director was interviewed on 3/31/15 at 11:24 a.m. He stated that the Aerial system would let him know when the batteries were low by sending a signal from the device to his computer. If a call light was unplugged a signal was also sent to the computer. The maintenance director stated that this was a mechanical failure and that there was no monitoring system for that. The maintenance director stated that in the future when he would do preventative maintenance rounds, he would need to check the call system closer.	F 463	audit full call light system weekly. d. The data will be shared at the next Quality Assurance meeting by the Maintenance Director/ Designee for input and further direction. e. Maintenance Director is responsible.	

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	245367	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Meadow Manor was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/30/2015

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	K 000		

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.

Meadow Manor is a 1-story building . The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(111) construction, with a partial basement. In 1990, an addition was added to the South and was determined to be Type II (111) construction, with a full basement. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building.

The building is fully sprinkled. The facility has a fire alarm system with partial smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 43 beds and had a census of 34 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 5 out 34 residents. Findings include: On facility tour between 8:30 AM and 11:00 AM on 04/02/2015, observation revealed, that the following was found: 1. Basement - File storage room (over 50 sq. ft.) has an open penetration around a cable on north wall;	K 029	K029 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. The open penetrations in both the file storage room and elevator equipment room have been fixed, as to maintain smoke-resistance. Deficient items have	4/30/15

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K 029	Continued From page 3 2. Basement - Elevator equipment room has open penetrations on south wall around / end of 2 inch conduit These deficient practices were confirmed by the Facility Maintenance Director (SB) at the time of discovery.	K 029	been fixed, effective 4/30/2015. 2. The Maintenance Supervisor and/or his designee will visually inspect the facility to ensure no open smoke-resistant penetrations exist in order to meet the requirements of K029. 3. The Maintenance Supervisor is responsible for this area of compliance	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25, sections 2-2.1.2 and 2-4.1.4. This deficient practice could affect all 12 out of 34 residents. Findings include: On facility tour between 8:30 AM and 11:00 AM on 04/02/2015, observation revealed that the following was found: 1. The spare sprinkler head box does not contain 2 of each type of sprinkler head in the facility;	K 062	K062 The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged on conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because it is required by provisions of State and Federal law. Without waiving the foregoing statement, the facility states that with respect to: 1. The spare sprinkler head box has been corrected to include 2 of each type of sprinkler heads. Deficient items have been fixed, effective 4/30/2015. 2. The OT/PT room curtain has been	4/30/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245367	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/02/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEADOW MANOR	**210 EAST GRAND AVENUE, PO BOX 365** **GRAND MEADOW, MN 55936**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 4 2. Basement OT/PT room, has a privacy curtain with no mesh at top of curtain and there is not an 18 inch clearance from fire sprinkler head deflector to top of curtain These deficient practices were confirmed by the Facility Maintenance Director (SB) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 062	replaced to include mesh at the top. Deficient items have been fixed; effective 4/30/2015. 3. The Maintenance Supervisor and/or his designee will visually inspect the facility monthly to ensure compliance with K062. 4. The Maintenance Supervisor is responsible for this area of compliance.	