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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: UXQR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00313

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245410**

2.STATE VENDOR OR MEDICAID NO.
(L2) **585219600**

3. NAME AND ADDRESS OF FACILITY
(L3) **RICE CARE CENTER**
(L4) **1801 SOUTHWEST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

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 **05/28/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (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
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 06/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 06/04/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/19/2014
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number:
Item 16 Continuation for CMS-1539

Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective 05/09/2014, the facility is certified for 78 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245410

May 30, 2014

Mr. Tony Ogdahl, Administrator Administrator
Rice Care Center
1801 Southwest Willmar Avenue
Willmar, MN 56201

Dear Mr. Ogdahl:

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

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

Effective May 9, 2014, the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 78 skilled nursing facility beds.

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

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

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,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 4, 2014

Mr. Tony Ogdahl, Administrator
Rice Care Center
1801 Southwest Willmar Avenue
Willmar, Minnesota 56201

RE: Project Number S5410023

Dear Mr. Ogdahl:

On April 22, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 3, 2014. 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 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 15, 2014 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 3, 2014, effective May 9, 2014 and therefore remedies outlined in our letter to you dated April 22, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 4, 2014

Mr. Tony Ogdahl, Administrator
Rice Care Center
1801 Southwest Willmar Avenue
Willmar, MN 56201

Re: Enclosed Reinspection Results - Project Number S5410023

Dear Mr. Ogdahl:

On May 28, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on April 3, 2014, with orders received by you on April 24, 2014. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245410	A. Building B. Wing	5/28/2014

Name of Facility	Street Address, City, State, Zip Code
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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(b)(1)** LSC	Correction Completed **04/23/2014**	ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **05/08/2014**	ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **05/08/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **05/08/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **05/08/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **05/08/2014**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **05/08/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **05/02/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	05/30/2014	19691	5/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
4/3/2014	

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00313	A. Building B. Wing	5/28/2014

Name of Facility	Street Address, City, State, Zip Code
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **05/08/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **05/08/2014**	ID Prefix **20855** Reg. # **MN Rule 4658.0520 Subp. 2 E.** LSC	Correction Completed **05/08/2014**
ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **05/08/2014**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	Correction Completed **05/08/2014**	ID Prefix **21800** Reg. # **MN St. Statute144.651 Subd. 4** LSC	Correction Completed **04/23/2014**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	05/30/2014	19691	05/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/3/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245410	A. Building B. Wing **01 - MAIN BUILDING 01**	5/15/2014

Name of Facility	Street Address, City, State, Zip Code
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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	Correction Completed **04/07/2014**	ID Prefix	Correction Completed **04/02/2014**	ID Prefix	Correction Completed **04/03/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0011		LSC K0017		LSC K0029	
ID Prefix	Correction Completed **04/02/2014**	ID Prefix	Correction Completed **04/11/2014**	ID Prefix	Correction Completed **05/09/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0051		LSC K0052		LSC K0056	
ID Prefix	Correction Completed **04/30/2014**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0069		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	06/04/2014	27200	05/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
4/1/2014	

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245410	A. Building B. Wing 02 - 2011 ADDITION	5/15/2014

Name of Facility	Street Address, City, State, Zip Code
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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 K0017	04/02/2014	ID Prefix Reg. # NFPA 101 LSC K0027	04/07/2014	ID Prefix Reg. # NFPA 101 LSC K0052	04/11/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	06/04/2014	27200	05/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/1/2014

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: UXQR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00313

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245410**

2.STATE VENDOR OR MEDICAID NO.
(L2) **585219600**

3. NAME AND ADDRESS OF FACILITY
(L3) **RICE CARE CENTER**
(L4) **1801 SOUTHWEST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

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 **04/03/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **78** (L18)

13.Total Certified Beds **78** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Karen Aldinger, HFE NE II — 05/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 05/15/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

At the time of the standard survey completed 4/3/2014, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5120

April 22, 2014

Mr. Tony Ogdahl, Interim Administrator
Rice Care Center
1801 Southwest Willmar Avenue
Willmar, Minnesota 56201

RE: Project Number S5410023

Dear Mr. Ogdahl:

On April 3, 2014, 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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320)223-7338
Fax: (320)223-7348

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 13, 2014, 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 13, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 3, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC 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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

(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. 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 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 and for which the resident may be charged, and the amount of charges for those services; and	F 156	Refer to attachment for PoC and date of completion 5/12/14 KK	

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

Anthony J. Ogdahl | acting Administrator | April 30, 2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 1 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 agency concerning resident abuse, neglect, and misappropriation of resident property in the	F 156		

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F 156	Continued From page 2 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 the notice of provider noncoverage, or generic notice, upon discontinuation of Medicare part A services for 1 of 3 residents (R23) reviewed for liability notices. Findings include: R23's Resident Admission Record indicated he had been admitted to the facility on 1/13/14, on Medicare part A services. The Physical Therapist Progress and Discharge Summary dated 2/27/14, indicated R23 had met the therapy goals and skilled services would be ending on 2/27/14. There was no indication R23 had received a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization.	F 156		

F 156 Notice of Rights, Rules, Services, Charges

Corrective Action:

R 23 discharged from facility

Corrective Action – identify other residents

Effective 4/7/2014 all patients being discharged from facility will be given a 48 hour notice of denial.

Corrective action to Prevent Reoccurrence:

Medicare Denial Completion has been added to the check list to alert Nursing or Social Services to complete Medicare Denial 48 hours before discharge.

Business office personal has developed an internal check list for completion for discharged patients

Monitoring for Compliance

Random Audits will be completed weekly by the DON or Designee to assure Medicare denials were given. This audit will continue for 90 days and the results brought to the QA committee for recommendations on the need for further audits.

Date of Completion

April 23, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 156	Continued From page 3 When interviewed on 4/2/14, at 12:00 p.m. business office manager stated R23 was discharged to home on 2/28/14, utilizing only 43 Medicare part A days, and should have been given the Notice of Provider Noncoverage, but had not. A policy was requested, but not provided by the facility.	F 156		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	Refer to attachment for PoC and date of completion	

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F 157	Continued From page 4 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician/practitioner when 1 of 3 residents (R36) developed pressure ulcers. Findings include: R36's admission Minimum Data Set (MDS) dated 2/14/14, included she was cognitively intact, was at risk for pressure ulcers, but did not have any current pressure ulcers. R36 was observed on 4/1/14, at 2:15 p.m. with registered nurse (RN)-G. A pressure ulcer was noted on R36's right inner buttocks, that was a shallow crater, with redness surrounding the area. R36 stated, "I have had that sore for quite a while." RN-G was unsure if the physician or nurse practitioner had been notified of R36's pressure ulcer. Review of R36's Progress notes identified on 2/19/14, "Patient noted to have small area of shearing to middle of left buttocks measuring 2 cm [centimeters] x [by] 0.5 cm. Appears to be	F 157		

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F 157	Continued From page 5	F 157		

wear lift sheet sits during transfers. Will apply calmo [protective barrier cream] to area and continue to monitor." R36's Wound Progress Sheet dated 2/19/14, included a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcer, with a pink wound bed, scant amount of drainage, surrounding tissue pink, and wound edges normal. The wound was listed as being from, "Shearing." The form indicated the practitioner and family had not been notified of the development of the pressure ulcer.

Review of the nurse practitioner (NP) note dated 2/21/14, did not indicate the NP had been informed of the pressure ulcer which had developed on 2/19/14.

The progress note on 3/11/14, indicated, "Weekly skin assessment for high risk patient completed with the following results." Under "skin issues," number "1) Banmchable [sic] right buttock 1 cm x .75 cm."

Review of the physician note dated 3/19/14, did not indicate the physician had been informed of the pressure ulcer even though it developed on 2/19/14.

R36's Progress Notes dated 4/1/14, indicated, "Observed wound to coccyx/buttock crease this evening. 1.75 inches x 3 inches, reddened areas surrounding multiple small areas of stage 2 or skin shearing."

When interviewed on 4/1/14, at 2:43 p.m. RN-C stated she thought the NP had been notified of the pressure ulcer, but was not sure.

F 157 Notification of Physician

Corrective Action:

Res 36 physician notified of pressure ulcer on April 9, 2014

Corrective Action – Identify other residents:

All residents/patients that have pressure areas have been reviewed to ensure physician notification per policy

Corrective action to Prevent Reoccurrence:

Education will be completed on May 8, 2014 regarding the current policy of Notification of changes in resident conditions.

Monitoring for Compliance:

Audits will be completed by RN Care Manager &/or DON weekly at wound meeting to assure the physician has been notified for all pressure ulcers or changes of ulcer.

Results will be brought to QA committee for recommendation on the need to further audit

Date of completion

May 8, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 157	Continued From page 6 Although R36 developed a pressure ulcer on 2/19/14, which continued to become larger, the physician or NP were never notified of the ulcer, to determine if a change to the plan of care was needed to heal the pressure ulcer. A facility policy entitled Skin Care, dated 3/2010, included, "RCC [Rice Care Center] will immediately inform the resident; consult with the resident's physician...Any significant change such as change of Pressure ulcer from stage 1 to stage 2..."	F 157		
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	F 278	Refer to attachment for PoC and date of completion	

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F 278	Continued From page 7 assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the resident assessment accurately reflected the resident's care provided, for 1 of 3 residents (R36) reviewed for assessment accuracy. Findings include: The CMS (Center for Medicare/Medicaid Services) RAI (Resident Assessment Instrument) coding instructions for a toileting program, included, "Review the medical record for evidence of a trial of an individualized, resident-centered toileting program. A toileting trial should include observation of at least 3 days of toileting patterns with prompting to toilet and of recording results in a bladder record or voiding diary." "Review records of voiding patterns (such as frequency, volume, duration, nighttime or daytime, quality of stream) over several days for those who are experiencing incontinence." "Simply tracking continence status using a bladder record or voiding diary should not be considered a trial of an individualized, resident-centered toileting program." For a current toileting program or trial the following criteria must be met, "implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern; evidence that	F 278		

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F 278	Continued From page 8	F 278		

the individualized program was communicated to staff and the resident verbally and through a care plan, flow records , and written report; notations of the resident's response to the toileting program and subsequent evaluations, as needed."

R36's admission Minimum Data Set (MDS) dated 2/14/14, included she was cognitively intact, was frequently incontinent of bowel and bladder, a toileting program had been trialed with no improvement, and was on a current toileting program. The MDS also included a diagnosis of heart failure and received a diuretic (water pill) daily.

R36's Bladder Assessment dated 2/13/14, included risk factors for urinary incontinence, including impaired mobility with dependent transfers, urine leakage on way to bathroom, urgency-unable to suppress, congestive heart failure, and use of a diuretic. The assessment also did not include any voiding patterns as directed by the RAI Manuel.

R36's Urinary Incontinence Care Area Assessment (CAA) dated 2/19/14, included risk factors for urinary incontinence including: extensive assistance required to toilet, urinary incontinence, moisture associated skin damage, pain, restricted mobility, urinary urgency, and use of a diuretic. The type of urinary incontinence was listed as, "Functional (can't get to the toilet in time due to physical disability, external obstacles, or problems thinking or communicating." An analysis of findings included, "[R36] is frequently

F278 Assessment Accuracy/Coordination/Certified

Corrective Action:

Res 36 Bowel & Bladder assessment was reassessed on 4/14/04 – 4/16/2014. Assessment accurately reflected the residents care plan that staff are providing

Corrective Actions – identify other residents:

- The RAI process was reviewed and is current
- All residents with urinary incontinence assessments and care plans reviewed to ensure interventions are in place to improve or maintain urinary incontinence.

Corrective Action to Prevent Reoccurrence:

Education to all nursing staff will be completed on May 8, 2014. Education included the need for accurate assessment by RN and the importance of MDS matches the care plan. Nursing staff are to alert Clinical Coordinator if changes, significant change will be evaluated at that time.

Monitoring for Compliance:

DON or Designee will audit bladder assessment to ensure resident assessment accurately reflects the care plan. Audits will be done weekly for 4 weeks then 2 times a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audit.

Completion Date:

May 8, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 278	Continued From page 9 incontinent of bladder, compounded by loss of mobility. She is on diuretics. Incontinence is chronic, per AL [assisted living]." The form indicated care planning would occur, "Proceed to care plan to assist with toileting and attempt to decrease incontinence as able." There was no indication an assessment has been completed that included a three day voiding diary to determine if R36 had a voiding pattern or not as directed by the CMS RAI Manuel. R36's care plan dated 2/20/14, included, a recent decline in activities of daily living, staff were instructed to, "Assist with toileting, monitor for increased incontinence and/or constipation and notify PCP [primary care physician] if indicated." The care plan failed to address risk factors of immobility, diuretic use, or to direct staff on any program to maintain or improve urinary incontinence. When interviewed on 4/1/14, at 2:43 p.m. RN-C stated staff take R36 to the toilet when they get her up for meals or therapy. There is no schedule, and R36's voiding patterns had never been evaluated for a pattern, frequency, volume, duration, or quality of stream. RN-C had not done this type of an assessment, as the assisted living R36 had come from stated R36 had been frequently incontinent of urine. An actual toileting program had never been trialed and she was not currently on a toileting program, as indicated by the 2/14/14, MDS.	F 278		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	Refer to attachment for PoC and date of completion	

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F 309	Continued From page 10 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 coordinate care with an outside dialysis unit to include fluid intake restrictions, care of dialysis access site, and emergency procedures for 1 of 1 resident (R152) who was reviewed for dialysis care. Findings include: R152's admission Minimum Data Set (MDS) dated 1/27/14, included she was cognitively intact, had diagnoses of cirrhosis, end stage renal disease (ESRD), and a hip fracture. R152 received a therapeutic diet. Entry and discharge tracking MDS's indicated R152 had been hospitalized 2/8/14 to 2/14/14, 2/27/14 to 3/11/14, and 3/18/14 to 3/21/14. R152's care plan dated 1/29/14, included a problem statement of, "Hemodialysis r/t [related to] ESRD; hepatic encephalopathy [brain dysfunction caused by the liver being unable to remove toxic substances from the blood], Dialyzing [sic] 3 days/week at RMH [Rice Memorial Hospital] while at Therapy Suites;	F 309		

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usually dialyzes [sic] in Litchfield." R152's goal was, "Will tolerate dialysis runs while here AEB [as evidenced by] ability to complete 3.5 hour run, remove needed fluid and maintain VS [vital signs]. Staff instructions included, "Follow physician orders including diet restrictions and 1.5 L [liters] fluid restriction. Send Dialysis Communication Record with to all runs. Weigh daily and record." The nutrition care plan dated 1/27/14, included, to "Provide 2 Gram Sodium, High Protein, Low K+ [potassium], 1,500 cc [cubic centimeters, equal to 1.5 liters] restriction per physician order. Monitor weight and meal intake."

R152's Physician Order Report dated 3/12/14, included, "Diet order: diabetic/dialysis diet, low sodium 1000 ml [milliliters, equal to cubic centimeters] fluid restriction." "Kayexalate suspension [medication used to remove large amounts of potassium from the body, typically used if dialysis runs are missed or critically elevated potassium levels] 15 gm [grams]/60 ml: 120 ml oral. TAKE ONLY IN EMERGENCY. CONTACT DIALYSIS PRIOR TO TAKING." Zofran 4 mg [milligrams] every 8 hours as needed for nausea with vomiting.

R152's Dialysis Communication Record dated 3/11/14, included, "Fluid restriction is less than 1000 cc/day." The care plan had not been updated to reflect this change.

When interviewed on 4/1/14, at 1:00 p.m. R152 stated she was on 1000 cc per day fluid restriction, she had a large water mug at her bedside containing approximately 240 cc of water

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F 309	Continued From page 12 in it. R152 stated she gets the mug filled a couple times per day, but she knows she has to watch her fluid intake, which is hard for her due to extreme thirst. R152 stated she only gets 1000 cc from the facility, so drinks less than that. R152 stated she has complications of her liver and kidney disease including: pain, skin being itchy, and extreme nausea and vomiting. R152's dialysis access site was on her left arm, as an AV fistula [where an artery and vein are surgically joined to create an access site for the needle for dialysis]. R152 stated when she is done with each dialysis run, the dialysis unit will place a tight bandage on this access site. When she is getting ready for bed, she requests the bandage be removed, because it is uncomfortably tight, and the bleeding has stopped. R152 stated some nurses will remove the dressing for her, others will not, it depends on who is working. In addition, R152 stated she use to go to dialysis three days a week, but this has been increased to four days a week as she has too much fluid. The care plan did not direct staff on care of the dialysis access site, nausea, vomiting, itching, or the 1000 cc fluid restriction. When interviewed on 4/1/14, at 1:30 p.m. registered nurse (RN)-G stated R152 is on a 1500 cc fluid restriction and monitors her own fluid intake, nursing provides her with a mug of water in her twice a day, 120 cc of a nutritional supplement twice a day with her medications, and however much water it takes to swallow her medications two more times each day. RN-G did not know how much fluid dietary gives R152 with meals, as this is not coordinated with nursing. The facility does not track fluid intake for R152. RN-G stated staff do not remove the dressing on	F 309		

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F 309	Continued From page 13 R152's dialysis access site, this is left up to the dialysis unit. R152 had been having complications of nausea and vomiting, she had given her a medication for nausea earlier, and R152 had vomited shortly afterwards. RN-G stated when she works, she checks the access site for a pulse to ensure patency, this is not documented any where. R152 was observed on 4/2/14, at 8:00 a.m. consuming breakfast, R152 had 90 cc of milk, 120 cc water, 120 cc coffee, and 120 cc lemon lime soda. When R152 was finished with breakfast, she had consumed 360 cc total of the 450 cc's offered at breakfast. On R152's bedside table was 240 cc of water. When interviewed on 4/2/14, at 8:15 a.m. dietary aide (DA)-A stated R152 was on a 1500 cc per day fluid restriction, and provided a card utilized by dietary. The card indicated R152 should be provided with 120 cc of each milk, juice and decaf coffee at breakfast, 120 cc of each juice and water at lunch and supper. This was a total of 840 cc provided by dietary each day. DA-A stated, "There are so many people in and out of the dining room, we don't have control if other people give her fluids too," noting soda had been provided by a visitor. R152 was observed at the noon meal on 4/2/14, at 12:15 p.m. she had been provided with 180 cc water, 120 cc of red juice, and 90 cc of brown juice. In addition, at 12:30 p.m. a visitor had provided R152 with a can of Shasta cola. When finished R152 had drank at total of 390 cc. of the	F 309		

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F 309	Continued From page 14 570 cc offered at the meal. In addition, approximately 100 cc of water was now missing from the mug at her bedside. When interviewed, via telephone, on 4/2/14, at 12:30 p.m. the dialysis manager, RN-I, for Rice Memorial Hospital, stated R152 had orders to decrease her fluids to 1000 cc a day, on 2/14/14. RN-I stated the facility nurses should be checking R152's dialysis access site upon return from dialysis to ensure area is not bleeding, and should check the site for a pulse (bruit) and signs of infection at least daily. The facility should have a book at the nursing home about how to care for the dialysis patient. Only one book is kept in the facility, they are not provided for each resident. These instructions should be followed. When interviewed, via telephone, on 4/2/14, at 12:45 p.m. the dietician for the dialysis unit, as well as consulting dietician for the facility, stated a communication sheet should have gone from dialysis to the facility when R152's fluid restriction changed from 1500 cc to 1000 cc per day. This change occurred due to a nephrologist [kidney doctor] order on 3/12/14. The dietician stated R152 could not keep track of fluid restrictions herself, as she had intermittent extreme confusion related to elevated ammonia levels, and extreme thirst. The dietician stated R152 had trouble managing her thirst, and liked to drink soda pop. The facility should have been tracking R152's fluids and managing the fluid restriction for her. Generally when a resident is on a fluid restriction dietary would divide fluids throughout the day to include meals, med pass, and any fluids the resident could have in	F 309		

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F 309	Continued From page 15	F 309		

between. This would normally be care planned and documented. The dietary card and care plan should have been updated when R152's fluid restriction changed, as well as a determination how much fluid R152 could have with med passes. This had been missed. Dialysis goal is to remove less than 3 kg [kilograms] of fluid with each run, but R152 had been often requiring well over that amount, therefore she was increased from 3 times a week to 4 times a week on 3/27/14. R152 had also been hospitalized for fluid over load and required abdominal parathenteses (removal of fluid in the abdominal cavity). R152 had a care planning conference with the dialysis interdisciplinary team on 3/22/14. R152's care plan should have been updated at that time.

When interviewed on 4/2/14, at 1:00 p.m. the director of nursing (DON) was unable to find any book or instructions from the dialysis unit on caring for the dialysis patient. The DON stated care of the dialysis access site should have been care planned, and added to R152's treatment sheets for monitoring by the nurses. Emergency plans such as if R152 was unable to make it to dialysis, had bleeding from the dialysis site, or critical lab values should have been care planned also.

When interviewed on 4/2/14, at 1:45 p.m. the dietary mentor (DM)-E stated she had noted today that R152's fluid restriction had decreased from 1500 cc to 1000 cc on 3/12/14. This was missed. The facility's routine would be to set up how much fluids could be provided at each meal, med pass, and at other times. This information

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F 309	Continued From page 16 would be in the care plan. It had been missed for R152. R152 was discharged from the facility on 4/2/14, at 2:00 p.m. having consumed 850 cc of the 1200 cc being provided by the facility, prior to the evening meal, supplement, refill of the water mug in her room, or fluids with medications remaining for the day. When interviewed on 4/2/14, at 2:00 p.m. the DON had found the book on caring for the dialysis patient. The book had been located in the nursing home portion of the building, not in the Therapy Suites where R152 had resided. The booklet dated 11/12, included Guidelines for Dialysis Nursing Home Patients, and instructions such as: not to take blood pressures or draw blood from the access arm. Need to check the access site daily for a pulse, if no pulse to call the dialysis unit, to remove dressing in 2 hours after dialysis, if the site was bleeding to apply pressure for 15-30 minutes. To send a communication form each day with pertinent information. Information was also included on potential medical complication such as excess fluid gains, itching, and elevated potassium levels. The DON stated care of the access site and fluid restrictions should have care planned, monitored and documented by the facility, but had not. The Rice Memorial Hospital Dialysis Protocol Agreement dated January 2007, included, "A comprehensive care plan will be developed by the interdisciplinary teams from both RMH and facility."	F 309		

F 309 Provide Care/Services For Highest Well Being

Corrective Action:

Res 152 was discharged from the facility

Corrective Action – identify other residents:

All residents receiving dialysis services have been identified. Dialysis Educational manual is in each neighborhood for reference of emergency procedures for staff to refer to.

New Dietary form will be used for documentation of fluids after each meal. Information will be given to med nurse at the end of the shift for fluid intake totals. Dietary will have, on patient dietary card, fluid amounts for each meal

E-mar dialysis section has been added to include orders for dialysis patients to individualize care. This will include: care of access site, emergency procedures

Corrective action to Prevent Reoccurrence:

Education will be completed on May 8, 2014 regarding residents receiving dialysis fluid restriction documentation, dialysis educational manual location, & adding nursing orders in the Treatment section of E-mar.

Monitoring for Compliance:

Audits will be completed by DON &/or Designee weekly for one month then twice a month for one month then monthly till stable. Results will be reported to QA committee for recommendations on the need for further audits.

Date of Completion:

May 8, 2014

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F 309	Continued From page 17 Even though the dialysis unit had communicated a change in fluid restrictions on 3/11/14, the facility failed to communicate the new restriction to staff. In addition, the facility did not have any care planning in place to ensure the fluid restriction was followed, and did not track fluid intake. The facility did not have any care planning in place on how to manage potential complications of dialysis or how to manage the dialysis access site. The facility did have a book on caring for the dialysis unit, however, this was not available on the unit where R152 resided and nurses were not knowledgeable on how to find this information.	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 oral hygiene was provided daily for 1 of 3 residents (R 29) who needed staff assistance with oral care. Findings include: R29's quarterly MDS (Minimum data set) dated 8-14-13 identified R29 was cognitively intact, had good mental capacity and needed extensive	F 312	Refer to attachment for PoC and date of completion	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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assistance of two persons for oral hygiene. The 2/19/14 activities of daily living care area assessment identified R29 needed extensive assistance with grooming and personal hygiene due to self performance problems.

The care plan dated 2/21/14 indicated a problem with activities of daily living related to weakness and impaired mobility due to Parkinsons. The care plan directed staff to provide extensive assistance for one for dressing and grooming due to the resident becoming weak.

During an interview on 4/1/14 at 1:20 p.m. R29 stated, "They never brush my teeth, I would like to brush my teeth myself but I can't." She stated the last time her teeth were brushed was when she was staying on the therapy unit R29 stated she has her own teeth, and is unable to wear dentures due to the roof of her mouth. She can only eat chopped food because she only has a few teeth on her upper mouth, and wants staff to brush her teeth.

An interview on 4/1/14 1:28 p.m. nursing assistant (NA)-K said R29 sits on side of the bed to get dressed and if she (R39) wants her teeth brushed she will ask.

During an interview on 4/1/14 on 1:48 p.m. with NA-I stated R29 sits on the side of the bed and partially washes herself a little but we help her with the rest. NA-I stated R29 can only get into the bathroom with her wheelchair and staff assistance.

During continuous observation on 4/2/14 6:50 a.m. to 9:00 a.m. R29 was not assisted by staff for oral hygiene. At 6:50 a.m. R29 was in her

F 312 Oral Hygiene

Corrective Action:

Res 29 oral hygiene is offered to resident every AM/PM . Staff is allowing R29 to continue to be independent with brushing of teeth; electric toothbrush has been provided to help with oral hygiene. Staff will assist if resident is unable. .

Corrective Action – Identify other residents

Oral Hygiene Policy has been reviewed & updated. Refusal of oral care planned and risk/benefit explained to resident regarding lack of oral hygiene. Oral exam is completed by license staff at least quarterly and PRN.

All residents have been identified if they have dentures, partials or own teeth and pink care card updated with this information for staff.

Corrective action to Prevent Reoccurrence:

Education with all nursing staff will be completed May 8, 2014 reviewing the updated policy of oral hygiene. Pink Care cards reviewed with staff and providing oral hygiene every AM & PM with cares. Staff is to assist with oral hygiene if assistance is necessary. If resident refuses oral care, this will be care planned and risk/benefit explained to resident regarding lack of oral hygiene.

Monitoring for Compliance

Random Audits will be completed by DON or RN/LPN 2 times a week for one month then 1 time a week for one month then monthly till stable. Results will be reported to QA committee for recommendations on the need for further audits

Date of Completion

May 8, 2014

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F 312	Continued From page 19 recliner and stated she did not get assistance with brushing her teeth this morning. The tooth brush in R29's bathroom drawer was dry. The tooth brush remained dry, and R29 confirmed at 9:00 a.m. she still had not been assisted to brush her teeth. During an interview on 4/2/14 at 9:00 a.m. NA-I and NA-J both stated they did not assist R29 to brush her teeth this morning, they were not aware she needed assistance. Neither NA-I or NA-J knew if R29 had dentures or natural teeth, since they have never assisted her with oral hygiene. During interview on 4/2/14 at 9:10 a.m. registered nurse (RN-A) stated she was not aware R29 has not been getting her teeth brushed, "She never complains."	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 ensure 3 of 4 residents (R79, R36 and R150) with pressure ulcers, were assessed, monitored and/or provided care to	F 314	Refer to attachment for PoC and date of completion	

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F 314	Continued From page 20 ensure current pressure ulcers were healing and to prevent the development of new pressure ulcers, which caused actual harm for R79. Findings include: R79's Minimum Data Set (MDS) dated 2/19/14 indicated R79 was cognitively intact, but required extensive assistance with transferring and repositioning in bed and was at risk for pressure ulcer (PU) development. The MDS also identified R79 had diagnoses of peripheral vascular disease, neuropathy and hypertension. The 2/19/14 Pressure Ulcer Care Area Assessment (CAA) identified R79 was at risk for developing pressure ulcers, and needed extensive assistance for bed mobility, and had an unstageable PU due to coverage of wound by slough/eschar. The CAA also identified risk factors of immobility, incontinence, poor nutrition, and recent decline in activities of daily living (ADL). The Skin Risk Assessment (with Braden Scale) scale dated 3/21/14 identified R79 scored an 18, meaning he was at risk for the development of PU. He currently had PU "bilateral to feet, with no new sores." The assessment also indicated he had slight limited mobility, with potential problems of friction and shearing due to "skin probably slide to some extent against sheets, chair... Maintains relatively good position in chair or bed most of time but occasionally slides down." The interventions included pressure relieving devices for bed, ulcer care, application of dressing/ointments and other preventative or	F 314		

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F 314	Continued From page 21 protective skin care and "prevalon boots." There was no indication a turning and repositioning scheduled was implemented even though R79 was at risk for PU, had limited mobility, and was at risk for having friction and shearing of his skin. R79's care plan dated 2/24/14 identified a problem with fragile skin, recurrent skin breakdown, circulatory disease and chronic wounds to lower extremities and skin tears easily. The care plan directed staff to "Dressing changes to open areas as per CNP [certified nurse practitioner]..." The plan also identified he had a decline in mobility and weakness, with the interventions of "Nursing will provide assistance with ADL's and mobility per therapy directives." Physical therapy (PT) and occupational therapy (OT) five times a week for improved mobility, endurance and strength. There was no mention of a turning and repositioning scheduled even though R79 needed staff assistance with mobility, was at risk for pressure ulcer development and had three current pressure ulcers which were not identified on the care plan. During an interview on 4/1/14 at 2:10 p.m. nursing assistant (NA)-L stated she gave R79 a bath this morning and noticed R79, "Had an open spot on the bottom so we put Calizone lotion it is on left cheek". The area was smaller than an eraser on a pencil. During an interview on 4/1/14 at 2:25 p.m. with registered nurse (RN)-C unit clinical coordinator stated R79 has some open areas on his legs, due to poor circulation. RN-C did not mention R79 had any pressure ulcers on his buttocks. R79 was observation on 4/1/14 from 12:58 p.m.	F 314		

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F 314	Continued From page 22 until 4:41 p.m.. At 12:58 p.m. R79 was sitting in a regular high back chair with a cushion asleep with his feet firmly on the floor. R79 continued to sleep in this same position until 2:04 p.m. when an unknown NA entered the room and placed his feet onto a chair. The unknown NA did not repositioned R79, and only placed his feet onto a chair. R79 continued in the same positioned until 3:58 p.m. when an unknown physical therapy staff came into the room and did exercises with R79 legs. R79 remained in the same chair during this time and when the exercises were completed the unknown therapy staff, replaced R79's feet on top of the chair as before. The unknown therapy staff did not offer to assist R79 off the chair into a different position. At 4:41 p.m. R79 continued to sit in the same chair for 3 hours and 43 minutes without being repositioned during this time. An interview on 4/1/14 at 4:50 p.m. R79 said he had not moved from the chair since lunch. R79's family member (F)-A who was present during the interview stated R79 has a new open area and a scabbed area on his buttock. During an interview on 4/1/14 at 4:50 p.m. with licensed practical nurse (LPN)-A said R79's feet were sore so he doesn't move much any more but just sits there. On 4/1/14 at 4:52 p.m. NA-DD stated she was unsure when R79 was last repositioned and NA-DD and NA-S assisted R79 to a standing position. Near R79 scrotal area there was an open area approximately 0.3 cm X 0.3 cm. There was a scabbed area approximately 0.8 cm x 0.3 cm on R79's right tuberosity and an open area 0.8 cm x 0.3 cm on his left tuberosity. NA-DD and NA-S confirmed the open areas. NA-DD and NA-S verified R79 did not have a specific turning or repositioning schedule, even though he had	F 314		

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F 314	Continued From page 23 three pressure ulcers in the same location. During continuous observation on 4/2/14 at 7:50 a.m. R79 was in his room again sitting in room on a regular chair with his feet up on a folding chair. He remained in this positioned until 9:55 a.m. when F-A came to visit. He continued to remain in this chair until 11:00 a.m. when he was assisted by NA-Y to ambulate to the dining room for the noon meal, a total of 3 hours and 10 minutes without being repositioned. During an interview on 4/2/14 at 1:45 p.m. RN-E measured the pressure ulcers on R79 buttocks. There was an open area that measured 0.9 x 0.5 on the right ischeal tuberosity and 0.7 cm x 0.4 cm on the left. The scrotal area measured 0.6 cm X 0.3 cm. RN-E stated R79 had an open area on the scrotum from "shearing" as well as two other open areas on his ischeal tuberosity. R79 skin was poor and agreed the shearing were considered pressure ulcers. She stated the RN clinical manager decides if a resident needs to be placed on a turning and repositioning schedule, which R79 did not have in place. Review of the facility Progress Notes and Wound Progress Sheets from 2/20 through 4/1/14 did not identify any pressure ulcers for R79's scrotum and bilateral ischeal tuberosity until 3/27/14, when the 3/27/14 progress note indicated, "Small open area on scrotum with a small amount of bloody drainage. Possibly from shearing." There was no mention of the bilateral pressure ulcers on the ischeal tuberosity, even though the right ischeal tuberosity was observed to be scabbed over on 4/2/14. These pressure ulcers had not been reassessed or monitored and measured on a weekly basis to determine location, staging, size,	F 314		

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F 314	Continued From page 24 exudate, pain, wound bed and description of surrounding wound edges even though they were a stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough). Although R76 was at risk for pressure ulcers development and developed three separate stage 2 pressure ulcers, one on his scrotum on 3/27/14, and one on each ischeal tuberosity, unknown date of development. The facility did not reassessed these pressure ulcer, to determine what interventions should be implemented to help decrease the risk of R79 from developing further pressure ulcers. Also there was no indication the pressure ulcers were consistently monitored and provided interventions to promote the healing of these pressure ulcers which caused actual harm for R79. R36's admission Minimum Data Set (MDS) dated 2/14/14, included, she was cognitively intact, required extensive to total assistance with bed mobility, transfers and toileting and was frequently incontinent of bladder. R36 had diagnoses of heart failure and arthritis, was at risk for pressure ulcers, and had moisture associated skin damage but did not have current pressure ulcer. R36's Pressure Ulcer Care Area Assessment (CAA) dated 2/14/14, listed R36 had risk factors for development of pressure ulcers including, requiring extensive assistance with bed mobility, frequent urinary and bowel incontinence, poor	F 314		

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F 314	Continued From page 25 nutrition, slides down in bed, requires regular schedule of turning related to pressure, and moisture associated skin damage. The analysis of findings included, "[R36] needs extensive help to make position changes and do any offloading activity, she is a ceiling lift at present. Has a brace to her R [right] leg r/t [related to] knee fx [fracture]." The care planning decision was marked as yes, and "Proceed to care plan to assist with offloading and repositioning, provide thorough cleansing." R36 was observed in bed, on her back with the head of bed up approximately 45 degrees, on 4/1/14, from 1:00 p.m. until 2:15 p.m. At 2:15 p.m. R36's pressure ulcer with registered nurse (RN)-G was observed, on R36's buttock which was a shallow crater with redness surrounding the area. R36 stated, "I have had that sore for quite a while," and commented that she always sleeps on her back due to having problems breathing and this position was the most comfortable for her. RN-G stated the nurse aides would reposition R36 when ever they get her up for meals or therapy but R36 was not on a timed repositioning schedule. RN-G stated the pressure ulcer was from shearing from the use of the ceiling lift sling, which she was no longer using. However, R36 does slides down in bed, placing her at risk for further shearing, RN-G confirmed they had not implemented any interventions to prevent the potential shearing of R36, from sliding down in bed. R36 was observed in bed, on her back with the head of bed elevated approximately 45 degrees, on 4/2/14, from 6:45 a.m. until 7:53 a.m. and on 4/3/14, from 8:00 a.m. until 9:00 a.m.	F 314		

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F 314	Continued From page 26 When interviewed on 4/1/14, at 2:15 p.m. nursing assistant (NA)-AA stated R36 was not on any repositioning schedule, she lays on her back when in bed, she will change positions when ever she gets up for therapy or meals. NA-AA stated R36 had been ill recently, and didn't always get up. During interview on 4/2/14, at 7:53 a.m. NA-A stated R36 was not on a repositioning schedule, she will mostly lay on her back in bed, with head of bed elevated a little. However, sometimes R36 will get up into her wheel chair. R36's progress note dated 2/12/14, included, "Crack in coccyx area, no drainage noted. Calazime applied." This area was not identified as to if it was a pressure ulcer, or any further description including size, wound bed, drainage, wound edges, tissue surrounding wound, or if any pain was associated with it. The progress note on 2/19/14, indicated "Patient noted to have small area of shearing to middle of left buttocks measuring 2 cm [centimeters] x [by] 0.5 cm." R36's Wound Progress Sheet dated 2/19/14, included a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcer, with a pink wound bed, scant amount of drainage, surrounding tissue pink, and wound edges normal. The progress note on 3/11/14, indicated, "Weekly skin assessment for high risk patient completed with the following results." Under "skin issues," number "1) Banmchable [sic] right buttock 1 cm x .75 cm." There was no way to determine if the 2/19/14, pressure ulcer on the left buttocks had	F 314		

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F 314	Continued From page 27 healed or not, or if this was the same area as identified on 2/12/14. R36's progress notes dated 3/20/14, indicated she had been hospitalized with pneumonia, and on 3/24/14 had returned to the facility. R36's hospital return Skin Risk Assessment dated 3/24/14, indicated she did not have any pressure ulcers or other skin issues on her buttocks or coccyx. A Skin Risk Assessment with Braden Scale assessment (a scale used to predict pressure ulcer risk) was completed on 3/24/14 which included risk factors for development of pressure ulcers that included: Cardiovascular disease, chronic incontinence, abrasions, bruises, cast/brace/splint, steroid use, occasional moist skin, bedfast, very limited ability to change and control body position, as well as a problem with friction and shear. The form indicated a plan of care would be initiated to prevent the development of pressure ulcers. The 4/1/14 progress note, indicated, "Observed wound to coccyx/buttock crease this evening. 1.75 inches x 3 inches, reddened areas surrounding multiple small areas of stage 2 or skin shearing." There was no staging, exudate, pain, wound bed, description of surrounding wound edges or if this was the same open area from the 3/11/14 progress note or if this was a new area. Review of R36's care plan updated 2/20/14, included nursing would provide assistance with ADL's [activities of daily living] and mobility per therapy directives." The care plan did not address the risk factors listed on the CAA and	F 314		

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F 314	Continued From page 28 Skin Risk Assessment to determine appropriate interventions to help prevent the development of pressure ulcers even though R36 was at risk for the development of PU and currently had a stage two pressure ulcer. When interviewed on 4/1/14, at 1:55 p.m. the house supervisor, registered nurse (RN)-E, stated she was not aware R36 had any pressure ulcer at any time. RN-E was unsure if the 2/12/14, 2/19/14, and 3/11/14, pressure ulcers had healed during the hospital stay, or before R36's hospital stay or if they did not heal at all. When interviewed on 4/1/14, at 2:43 p.m. the clinical coordinator, RN-C verified there was no timed repositioning plan for R 36, staff would reposition her when ever she got up for therapy or meals even though R36 spent most of the time in bed on her back due to breathing difficulty. There was no toileting plan, even though R36's pressure ulcer CAA of 2/14/14, indicated urinary incontinence placed R36 at risk for development of pressure ulcers. RN-C stated she had no way to determine when the, "Crack in coccyx area," identified on 2/12/14, had healed, or when or if, the stage 2 pressure ulcer identified on 2/19/14, had healed, or if the area identified on 4/1/14, was the same area as had been identified on 2/12/14, 2/19/14, or 3/11/14. RN-C stated R36 should have been reassessed after R36 had returned from the hospital weaker, and was spending more time in bed. Although R36 was at risk for pressure ulcers and had developed a pressure ulcer on 2/19/14 to present, these ulcers had not been consistently monitored on a weekly basis to determine	F 314		

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F 314	Continued From page 29 location, staging, size, exudate, pain, wound bed and description of surrounding wound edges. Also, a comprehensive assessment had not been completed to determine what interventions should be implemented to help decrease the risk of R36 from developing pressure ulcers. R150's, closed record review for pressure ulcers, indicated R150's admission MDS, dated 1/23/14, indicated R150 had no unhealed pressure ulcers and was at risk for development of pressure ulcers. The MDS also indicated the resident required limit ability for bed mobility and extensive assistance for transfers. In addition, the MDS indicated R150 had multiple diagnoses including pneumonia, depression, arthritis, and hypertension. R150's skin assessment, completed on 1/18/14, indicated the resident had a Braden Scale [scale of pressure ulcer risk factors] score of 16, identifying R150 was at risk for pressure ulcer development. The resident's pressure ulcer Care Area Assessment (CAA), dated 1/27/14, identified R150 was in therapy to improve ability to offload independently. R150's care plan, dated 1/27/2014, indicated "Skin: has rough, tender area to "L" buttock on admit. Needs help to offload from lower surfaces, i.e. recliner." The care plan directed staff to assist with offloading activities and "Cover offending [sic] area with mepilex border and apply calazime PRN [as needed]. A review of R150's, Resident Progress Notes, dated 1/25/14, identified the resident continued to	F 314		

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F 314	Continued From page 30 have complaints of tenderness and discomfort to coccyx and area to left inner buttocks which measured 4 cm [centimeters] by 1.5 cm. The note indicated the area had "Calmo applied and covered with Mepilex." The resident's progress notes, dated 1/26/14, identified that R150 continued to complain of discomfort to coccyx area with "Calmo applied various times throughout shift. Calmo what effective for discomfort." Again, on 1/28/14, progress notes identified R150 had an "Area of raised, firm tissue on (L) [left] buttock noted to be macerated this a.m. Area cleansed, Calazime applied, and covered with a Mepilex Border." The progress notes, dated 1/29/14, indicated the Nurse Practitioner (NP), observed the resident's buttocks, noted this was an area of shearing from sliding forward on seated surfaces. The NP ordered "Calizime to (L) [Left] butt TID [three times a day]; do not cover with Mepilex border; software cushion in any chair surface he sits in." Although the facility had identified, on admission, R150 was at risk for pressure ulcer development and identified R150 developed a pressure ulcer to the left buttock, after admission; the care plan was not updated to reflect the current treatment as prescribed by the nurse practitioner (NP) to promote healing and prevent the development of additional pressure ulcers. Also, the assessment did not identify what interventions could be implemented to prevent R150 from developing pressure ulcers. When interviewed, on 4/3/2014 at 1:26 p.m., the RN-E stated the macerated area on the left buttock was a pressure ulcer. RN-E also stated the care plan was not updated to reflect the pressure ulcer treatment ordered 1/29/14 by the	F 314		

F 314 Treatment/SVCS to Prevent/Heal Pressure Sores

Corrective Action:

Res 36 Revised comprehensive pressure ulcer risk assessment completed on April 14, 2014. Appropriate interventions to prevent further development of additional pressure ulcers have been added to care plan. Wound progress sheet reviewed and updated. R36 discharged from facility on April 23, 2014 with no open areas.

Res 79 expired at hospital

Res 150 closed record review/discharged

Skin Care Policy reviewed and updated

Corrective Action-identify other residents:

All Residents with pressure ulcers have been reviewed for appropriate assessment. Wound monitoring progress sheet reviewed to ensure current pressure ulcers are healing and to prevent the development of new pressure ulcers.

Care plan interventions reviewed for appropriate interventions to prevent the development of new pressure ulcers.

LTC Pink care cards updated with repositioning guidelines, Therapy Suites patient roster updated with heart shape if patient needs assistance with repositioning.

Corrective action to prevent reoccurrence:

Education will be completed on May 8, 2014 regarding the Skin Care Policy to all nursing staff. Review of LTC Pink care cards with repositioning guidelines, Therapy Suites patient roster reviewed with heart shape if patient needs assistance with repositioning.

Monitoring for Compliance:

Audits will be completed by RN Clinical Coordinator &/or DON weekly at Wound meetings in each neighborhood to assure wound monitoring sheets are completed and pressure ulcer is healing and measures in place to prevent the development of new pressure ulcers.

Care plans will be reviewed weekly at wound meeting for appropriate interventions.

High risk residents/patients pink care cards or patient roster will be reviewed for accuracy.

Results will be brought to QA committee for recommendation on the need to further audit.

Completion Date:

May 8, 2014

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F 314	Continued From page 31 nurse practitioner. A policy entitled Skin Care, Rice Care Center, dated 3/10, included, a purpose of, "To maintain skin integrity, prevent skin breakdown, and to promote healing of non-intact skin." The procedure identified upon admission or hospital return, a skin assessment would be completed within 24 hours; a comprehensive risk assessment with Braden scale would e completed along with a tissue tolerance test (a test to see how long skin can withstand pressure) would be completed. If a resident was found to be at risk for skin breakdown, skin would be monitored weekly and documented in the progress notes. Residents with reddened, open areas, or ulcers would be entered on the treatment sheet, and documented on weekly to include: "treatment given, interventions to prevent further breakdown, size, depth, odor, and drainage." The policy further indicated the physician would be consulted with if there was any significant change in the ulcer. The policy contained a definition of an "Avoidable Pressure Ulcer," which included, "an ulcer that has developed because one or more of the following were not done: a residents clinical condition was not evaluated, risk factors were not identified, interventions were not implemented, or effectiveness of interventions not monitored or revised.	F 314		
F 315 SS=D	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	F 315	Refer to attachment for PoC and date of completion	

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F 315	Continued From page 32 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 observation, interview, and document review, the facility failed to comprehensively assess, and place interventions to improve or maintain urinary incontinence for 1 of 2 residents (R36) reviewed for urinary incontinence. Findings include: R36's admission Minimum Data Set (MDS) dated 2/14/14, included she was cognitively intact, required extensive assistance with mobility, toileting and hygiene. R36 was frequently incontinent of bowel and bladder, had a trial toileting program with no improvement, and was on a current toileting program. The MDS also included diagnoses of heart failure and arthritis, and received a diuretic (water pill) daily. R36's Bladder Assessment dated 2/13/14, included risk factors for urinary incontinence, including impaired mobility with dependent transfers, urine leakage on way to bathroom, urgency-unable to suppress, congestive heart failure, and use of a diuretic.	F 315		

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F 315	Continued From page 33 R36's Urinary Incontinence Care Area Assessment (CAA) dated 2/19/14, included risk factors for urinary incontinence including, extensive assistance required to toilet, urinary incontinence, moisture associated skin damage, pain, restricted mobility, urinary urgency, and use of a diuretic. The type of urinary incontinence was listed as, "Functional (can't get to the toilet in time due to physical disability, external obstacles, or problems thinking or communicating." An analysis of findings included, "[R36] is frequently incontinent of bladder, compounded by loss of mobility. She is on diuretics. Incontinence is chronic, per AL [assisted living]." The form indicated care planning would occur, "Proceed to care plan to assist with toileting and attempt to decrease incontinence as able." R36's care plan dated 2/20/14, included, "Recent decline in ADL's r/t [related to] CHF [congestive heart failure], RA [rheumatoid arthritis], weakness, COPD [coronary obstructive pulmonary disease] R [right] patellar [knee] fx [fracture]; Here for short term stay with desire to return to community." The goal for R36 was, "Will regain independence in ADL's [activities of daily living] to allow safe return to community." Staff were instructed to, "Assist with toileting, monitor for increased incontinence and/or constipation and notify PCP [primary care physician] if indicated." The care plan did not address the risk factors of immobility, diuretic use, or to direct staff on any program to maintain or improve urinary incontinence even though the assessment identified these areas of risk for R36. R36 was observed on 4/1/14, at 2:15 p.m. she	F 315		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 34 had been assisted to the toilet by nursing assistant (NA)-L and NA-AA. R36's incontinent product was dry and she voided in the toilet. NA-AA stated R36 was not on any routine toileting schedule, just when they get her up, or R36 calls to get her incontinent product changed. R36 had been ill recently and did not always get up. R36 was observed on 4/2/14, at 7:53 a.m. she had been assisted from bed to her wheel chair by NA-L and NA-A. R36 was not assisted to the toilet at this time, and her incontinent product was saturated with urine. NA-A stated R36 does not use the toilet, she just gets her pad changed whenever she gets up into the wheel chair. When interviewed on 4/1/14, at 2:43 p.m. RN-C verified the assessment had not been developed for R36 regarding toileting needs for staff, the use of a diuretic with the possible need to toileting shortly after taking the diuretic. The assessment did not identify if R36 had urgency, nor were there any indication that her environment was modified to aid with functional incontinence. RN-C had not assessed or evaluated any voiding patterns to determine an appropriate toileting plan. RN-C verified R36 had been ill frequently and often did not get up out of bed. There was no plan to assist R36 with toileting needs at these times, or to maintain or improve her urinary incontinence. When interviewed on 4/3/14, at 2:00 p.m. the director of nursing (DON) stated an assessment with interventions should have been developed for R36 to aid in maintaining or improving urinary	F 315		

F 315 No Catheter, Prevent UTI, Restore Bladder

Corrective Action:

Resident 36 Comprehensive Assessment with analysis and interventions put in place to improve or maintain urinary incontinence completed on April 16, 2014

Corrective Actions-identify other residents:

All residents with urinary incontinence assessments & care plans reviewed to ensure interventions are in place to improve or maintain urinary incontinence.

Corrective Action to Prevent reoccurrence:

Education to all nursing staff will be completed on May 8, 2014. Education included the need for accurate assessment by RN and the importance of the MDS matching the care plan. Nursing staff are to alert the Clinical Coordinator if there changes, significant change will be evaluated at that time.

Monitor for Compliance:

DON or Designee will audit bladder assessment to ensure completion and interventions are indentified on Care Plan to improve or maintain urinary incontinence. Audits will be done weekly for 4 weeks then twice a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audits.

Date of Completion:

May 8, 2014

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F 315	Continued From page 35 continence. A policy was requested, but not provided by the facility.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure resident were assessed for safe transfers with the use of the LIKO brand mechanical standing lift with an EZ brand lift harness which the LIKO manufacture had not recommenced to be used for the LIKO brand lifts. This affected 5 of 5 residents (R36, R70, R40, R51, and R11) who used the LIKO brand mechanical lift. Findings include: R36's admission Minimum Data Set (MDS) dated 2/14/14, included she was cognitively intact, had diagnoses of heart failure and arthritis, and required total staff assistance for transfers.	F 323	Refer to attachment for PoC and date of completion	

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F 323	Continued From page 36 R36's ADL (activities of daily living) Functional Status/Rehabilitation Potential Care Area Assessment (CAA) included, R36 had a fracture knee cap, and was totally dependent upon staff for transfers with a ceiling lift (a full body lift). The form indicated care planning would occur to address this. R36's care plan dated 2/20/14, included, "Nursing will provide assistance with ADL's and mobility per therapy directions." The care plan did not direct staff on which type of mechanical lift, harness/vest, or leg strap should be used. R36's physical therapy and occupational therapy notes were reviewed from 2/7/14 through 3/31/14, and failed to direct nursing staff on any transfer techniques. The notes did indicate R36 varied from total staff assist to two person assist for transfers. R36 was observed on 4/1/14, at 2:15 p.m. being assisted from her bed to her wheel chair by nursing assistant (NA)-L and NA-AA. A transfer belt was placed up under R36's axilla (arm pits). NA-L and NA-AA attempted to lift R36 into a standing position, R36 was unable to bear any weight. Registered nurse, (RN)-C who was the clinical coordinator came into room, and witnessed R36 not bearing any weight. RN-C instructed NA-L and NA-AA to use the mechanical standing lift which was a LIKO brand instead. The LIKO mechanical standing lift was brought into the room, R36's feet were placed on the foot platform, an EZ-way brand lift harness was placed under R36's arms, pulled in front of	F 323		

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F 323	Continued From page 37 her body, and fastened with a belt. There was no belt on the LIKO lift to secure R36's legs. The LIKO lift was turned on and NA-AA started to lift R36 off the bed with it. R36's buttocks hung down, and R36 was in a sitting position, with her knees were bent, and was unable to bear any weight. R36's arms were being pulled up by the lift and she kept saying, "Owe, owe, owe," while being lifted. R36 was transported by the lift into the bathroom, and remained in a sitting position with her knees bend, and her arms were pulled up by the harness lift under her axilla. R36 was placed on the toilet. RN-C came into the bathroom and witnessed R36 in the LIKO mechanical lift with the EZ Way harness being transferred off the toilet. While NA-AA and NA-L attempted to provide pericare with the lift in the stand up position, R36's buttocks continued to hang down in a sitting position, she was unable to bear any weight and was yelling during this time to get placed back onto the toilet twice, which NA-AA completed. R36 stated she wasn't really in pain, but was more, "Stiff," because her legs were too weak and she was unable to stand. When interviewed on 4/1/14, at 2:35 p.m. NA-L stated R36 could sometimes transfer with two assist, but has been weaker since she had returned from the hospital with pneumonia. NA-L stated they sometimes used the leg strap on the LIKO lift to secure the resident's legs, but this one was missing, and was unsure how long it had been missing. NA-L stated the EZ-Way harness was used with the LIKO mechanical because the harness was more comfortable for residents, than the LIKO harness was.	F 323		

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F 323	Continued From page 38 When interviewed on 4/1/14, at 2:40 p.m. RN-C stated R36 use to be a full mechanical lift with a ceiling lift, had been improving and staff were able to transfer her with two assist and a transfer belt, but R36 had recently been hospitalized with pneumonia and had returned to the facility on 3/24/14, much weaker. R36 had not been re-evaluated for transfers, but was working with therapy on getting stronger. If R36 would be unable to stand, she would expect staff to get the standing lift. She did not expect them to use the ceiling lift, even if R36 could not stand up, as the ceiling lift sling had caused skin shearing to R36's buttocks. When interviewed on 4/1/14, at 4:00 p.m. NA-E stated she had worked in the facility for over five years, she remembered being trained many years ago by the director of nursing (DON) on how to use the lifts. When ever a new nursing assistant starts, other nursing assistants train them on how to use the lifts. NA-E verified they were allowed to use the EZ Way harness's with the LIKO lifts. The residents like them better, they are not as stiff as the LIKO harness's and they do not use the leg strap on residents. The LIKO harness's (vests) wrap around the torso and are not as comfortable as the EZ Way harness's which do not wrap around the body. When interviewed on 4/1/14, at 4:05 p.m. NA-DD stated most residents like the EZ Way harness instead of the LIKO harness's, and they are allowed to interchange the harness and mechanical lift. She started working at the facility a year ago and another nursing assistant showed her how to use the standing LIKO lift.	F 323		

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When interviewed on 4/1/14, at 4:10 p.m. the DON stated staff do use the EZ Way harness for the LIKO standing lifts, they are interchangeable. When nursing assistants are hired, another assistant will show them how to use the lifts. The leg strap would be used only if the resident needs it, this should be care planned. The DON stated if R36 could not stand up in the LIKO standing lift, the staff should have consulted with therapy about appropriate transfers.

R36 was observed on 4/2/14, at 7:53 a.m. being assisted from bed to the wheel chair by NA-L and NA-A. R36 was very shaky while trying to sit on edge of bed, NA-L and NA-A had to hold her up. R36 stated she was out for hours at doctors appointment yesterday, and was feeling very weak. A transfer belt was placed under R36's arms and she was instructed to push off of the bed with her hands. R36 was pulled upwards by NA-L and NA-A and pivoted into her wheel chair, R36 was not able to bare much weight.

When interviewed on 4/2/14, at 8:00 a.m. NA-A stated R36's transfers usually go poorly, she has so much edema in her abdomen, they need to put the transfer belt under her arm pits, this pulls on her arms and shoulders. When R36 can not stand at all, they use the LIKO standing lift on her, but R36 "Does not do well, she hangs, and her shoulders have arthritis." The full lift, the ceiling lift is not used because the sling had caused a sore on her, "bottom."

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F 323	Continued From page 40 When interviewed on 4/2/14, at 9:50 a.m. physical therapy aid (PTA)-H stated she had been working with R36, she had not been asked, nor had she made any recommendations to nursing on how to transfer R36. When interviewed on 4/3/14, at 8:05 a.m. RN-C stated she was not aware how R36 was transferring since returning from the hospital. No one had reported problems to her. She was not aware R36 could not stand in the lift and her buttocks hung down as she hung from her axilla and that R36 needed to be reassessed for her transfer ability so she would remain safe during transfers. R70's diagnoses from the Minimum Data Set dated 9/24/2013, included left- sided hemiplegia, obesity and osteoarthroses. The MDS also identified R70 as cognitively intact, and required extensive assistance, with the physical support of one, for transferring. The Care Area Assessment (CAA) for falls dated 9/27/2013, indicated R70 was unstable, and only able to balance if assisted by staff, and that R70 required assistance for all her mobility. R70's care plan, updated 3/18/2014, directed staff to use LIKO [brand name] stand (a mechanical stand-assist lift), for transfers, to be aware of R70's 'L' (left) side neglect for safety, and also to be watchful of [R70's] position of left ankle/foot so it [sic] does not roll during transfer/weight bearing when in the stand. The care sheet in R70's room, undated, directed staff to transfer R70 with "one assist" and use "EZ Stand".	F 323		

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F 323	Continued From page 41 During observation on 4/2/2014 at 9:24 a.m., nursing assistant (NA)-A assisted R70 to transfer from the wheel chair onto the toilet in the resident's room. NA-A positioned a LIKO brand stand-assist lift in front R70's wheel chair. From R70's bed, NA-A retrieved a large maroon and green-colored harness, with an "EZ" insignia on the label. NA-A placed the harness behind R70's back and underneath of each of R70's arms, and then attached the ends of the harness to the handlebar of the lift. NA-A also fastened the seat buckle, which held the harness around R70's torso in place. NA-A positioned R70's feet on the lift platform, and informed R70 the lift was starting. As the handlebars raised, R70 grasped the handlebar with only her right hand. R70's left hand was near her shoulder, positioned as if clutching a book. During the lift, R70's lower right leg and knee were bumped up to the padded leg guide. Neither R70's left lower leg, nor left knee touched the lift leg pad. The leg strap, which would go behind R70's legs, was not attached, and was hanging on the lift near the foot platform. During the lift and transfer, R70 was not completely upright, but rather hanging in the lift, and the harness supported R70's weight. NA-A moved the lift into the bathroom and lowered R70 onto the toilet. NA-A assisted R70 with toileting, then transferred R70 from the toilet into the recliner. In an interview on 4/2/2014 at 9:29 a.m., NA-A verified R70's legs were not strapped on the lift during the transfer. NA-A said "I don't always put it [the leg strap] on, I guess I should." NA-A also verified the lift stand used for R70's transfer was a "LIKO" brand, and also verified the sling used was an "extra large" maroon and green "EZ" labeled harness. NA-S said "That's what fits	F 323		

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F 323	Continued From page 42 [R70] best." During an interview on 4/2/2014 at 12:34 p.m., NA-Q stated R70 only uses her right hand to hold on the lift during transfers, because [R70] "can't fully grab with her left side." NA-Q said you had to make sure R70's feet were flat on the platform, so they doesn't twist off, as [R70] is "a large person." NA-Q said the foot straps on the stand lift were to always be used "for [R70] ...and any resident." R40's diagnoses from the annual Minimum Data Set, dated 9/24/2013, included osteoarthroses, chronic pain, and anemia. The MDS also identified R40 as mildly, cognitively impaired, and that R40 required extensive assistance for transferring, with the physical assistance of one person. The Care Area Assessment (CAA) for Falls, dated 9/27/2013, identified R40 required assistance from staff to maintain balance during all transitions , and that R40 struggles with pain in her knees. A Rice Care Center Assessment for Restraints/Adaptive Equipment, dated 3/1/2014, indicated R40 occasionally required use of an EZ [brand name] stand (a mechanical stand-assist device) for transfers. The care sheet in R40's room, undated, directed staff to transfer R40 with "Two assist" or use "EZ Stand." During observation on 4/2/2014 at 11:34 a.m., nursing assistants (NA)-S and NA-Q prepared to transfer R40 from the toilet in her room into the wheel chair. A LIKO [brand name] stand (a mechanical stand-assist device) was positioned in front of R40, who had a green and maroon-colored harness under her arms, and around the back of her torso, in a U-shaped	F 323		

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fashion. The harness was secured to R40 with a seatbelt buckle, which was in place. The harness ran parallel to and underneath R40's arms, and each of the ends were fastened to corresponding hooks on the lift's handlebar. NA-S started the lift, and told R40 to "hold on." As the handlebars moved upward, R40 said "it hurts, hurry up." When R40 was upright in the stand, NA-Q adjusted R40's clothing, and NA-S moved the lift out of the bathroom, and in front of R40's wheel chair. R40 was observed standing upright, and had a firm grip on the handle bars. R40 was wearing shoes, and both feet were flat on the lift platform, and her legs were against the leg guides of the lift. The leg strap, which would go behind R40's right and left legs, was not secured, but was dangling at the side of R40's leg. After R40 was lowered into the wheel chair, NA-S unbuckled the safety belt and removed the harness from around R40. NA-Q adjusted the wheel chair and pushed R40 out of the room. Then, NA-S exited the room carrying the harness and placed it atop a portable piano near R40's room. An insignia "EZ" was visible on the green and maroon-colored harness that was used during the transfer for R40.

During an interview on 4/2/2014 at 11:42 a.m., NA-S said R40 occasionally needed the "EZ [brand name] stand" (a mechanical stand-assist device) for transferring. NA-S verified that the lift used for transferring R40 was the "LIKO" brand lift. NA-S said that staff routinely referred to the "Likko" lift as the "EZ stand" lift. [Likko and EZ-Stand are two brand names of similar stand-assist devices.] NA-S said the green and maroon-colored harness with the 'EZ' insignia was the one used for R40's transfers. NA-S confirmed that during R40's lift and transfer from

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the toilet to the wheel chair, the leg strap on the lift was not fastened. NA-S said the leg strap was often "not fastened" while transferring R40, and "other residents," when using the "EZ Stand." NA-S stated the purpose of the strap was to keep a resident's legs from moving or slipping out of position when being transferred. NA-S said that if a resident was known to "kick back", move or curl their feet during a transfer, then "we would put the strap on."

During an interview on 4/2/2014 at 12:02 p.m., licensed practical nurse (LPN)-C stated that use of leg straps when transferring a resident on an "EZ Stand" was "a matter of safety." LPN-C stated she has "heard and seen" that the safety straps were not always used on the "EZ" stands." LPN-C said it was "good practice" for the aides and nurses to put the legs straps "every time" the lift is used for resident transfers. LPN-C was unaware that "EZ" Stand" brand harnesses were used with the "Likko" brand lifts. "We always used those [harnesses], LPN-C stated, "I thought they were interchangeable."

During an interview on 4/3/2014 at 10:41 a.m., registered nurse (RN)-B verified that both R40 and R70 utilized stand lifts for transfers. RN-B said transfer instructions for residents was care planned, and "would expect" nursing assistants to follow the protocol for transfers and apply "safety belts and the legs straps" during transfers. RN-B said safe lift use was part of "an employee's orientation checklist." RN-B acknowledged the facility utilized LIKO brand stand lifts, and also used harnesses from "EZ Stand", a different brand. RN-B was unaware of any difference

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F 323	Continued From page 45 between "EZ Stand" and "LIKO" brand lifts, and the slings or harnesses. RN-B said the harnesses out on the floor have been used "for a long time." R51's significant change minimum data set (MDS) dated 2/5/14 indicated R51 had dementia and was cognitively impaired. R51's care plan dated, 2/13/14 indicated R51 was an extensive assist of two staff with an EZ stand to transfer to the wheelchair and to and from bed. During observation on 4/2/14, at 8:00 a.m. nursing assistant (NA)-L was assisting R51 with the LIKO mechanical standing lift. NA-L used an EZ Way dark green color harness and placed the EZ Way harness behind R51, buckled the abdominal strap, and attached to the LIKO mechanical standing lift. NA-L pushed the control to raise R51 up out of bed and transferred him with the LIKO lift to R51's wheelchair. R51 into lowered into the wheelchair and NA-L removed the EZ Way harness from R51. R11's quarterly minimum data set (MDS) dated 12/31/13 indicated R11's had severe cognitive impairment. The care plan reviewed on 1/10/2014 indicated R11 was an extensive to total assistance for transfers with 1 or 2 staff and the EZ stand (mechanical standing lift). A Balance Assessment dated 3/29/14 indicated R11 used an EZ stand for transfers. During observation on 4/2/14, at 9:11 a.m. of NA-L assisted R11 with the LIKO mechanical standing lift. NA-L placed a maroon color sling, that had an EZ Way tag on the harness behind R11. R11 was buckled into the harness with the abdominal strap, and attached it to the LIKO	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 46	F 323		

mechanical standing lift. NA-L pushed the control to raise R11 out of the wheelchair and transferred him into the bathroom. When R11 had finished using the bathroom, R11 was moved to the wheelchair and lowered into the wheelchair. The EZ Way harness was removed from R11.

On 4/2/14, at 12:19 p.m. an interview with NA-R verified she uses the EZ Way harnesses on residents with the LIKO lift. At 12:28 p.m. NA-L stated the mechanical standing lifts used in the facility were LIKO lifts and verified the harnesses used were EZ Way harness and not the LIKO harnesses. NA-L stated that new harnesses came with the new LIKO lifts but they did not have the abdominal strap on them that buckled around the residents.

During an interview on 4/2/2014 at 12:37 p.m., the physical therapist (PT)-A stated in order to use a mechanical stand lift, a resident would have to demonstrate "ability to bear weight," have sufficient range of motion, have arm and shoulder strength, and do so "without pain." The PT said a resident should not look like they're "sitting in a wheel chair" while using the lift. The PT said the sling or harness should not be bearing the weight of a resident. The PT also stated safety precautions needed to followed when a resident is transferred, and that should include "putting on leg straps" during a transfer.

In an interview on 4/3/2014 at 9:27 a.m., the occupational therapist (OT)-A stated that she provided staff training on proper use of the stand-assist lift. Further, the OT stated, that she instructed staff to "always" lock the seat belt buckle on the harness, and "always fasten the leg

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F 323	Continued From page 47 straps" before transferring a resident using the stand-assist lifts. A Sabina/comfort IN-Service Summary provided by the facility, that included three different type vests/harness's that could be used with the LIKO Sabina standing lift. None of these included harness's from other companies. A passive lifting form a sitting position with Sabina form indicated if the resident couldn't stand or cooperate to use a sling that fits under the residents buttocks for full support. This could be used infrequently, if the resident was unable to bear weight, staff were instructed to use a full body lift with a sling. When interviewed via telephone April 2, at 9:30 a.m. the LIKO Barrier Free Access, director of health care ergonomics (DHCE), stated he had been at the facility a few years ago and trained staff on the use of the LIKO standing lift (named Sabina), the resident must be able to bear weight, have muscle tone and ability to follow commands. DHCE stated the leg strap is an option to use to remind the resident not to step off the platform. DHCE stated the only harness's that should be used on the LIKO lifts, is the LIKO brand, these are vests that wrap around the residents torso, other harness's are not made the same way and are not made for this particular machine, and is not safe. The DHCE provided a LIKO Lift Sign-In Sheet, dated 1/25/2010 with the names of 15 NA's signed in, and provided a LIKO Sabina Lift Training Outcomes Check-Off list. The check off list included, "Patient assessment, Patient criteria	F 323		

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F 323	Continued From page 48 including the ability of the patient to bear about 20% of his weight at least on one leg, have some upper body control and have the ability to follow simple commands. If patients weak, confused or unpredictable the SafetyVest should be used." Under, "Vest application and connection, all types of Sabina Vests must be applied with the patient in a seated position. The vest application is at the patient's low back and/or just below the umbilicus. Connect the vest using the style of connection appropriate for that vest. The vest connection style differs with the SupportVest using a belt clip design and the SafetyVest styles using a criss-cross "D" ring connection."	F 323		

F323 Free of Accident Hazards/Supervision/Devise

Corrective Action:

Resident # 36, 11, 51, 40 & 70 have all been assessed by RN Clinical Coordinator & Barrier Free Access for safe transfers when using the Liko Sabina Standing mechanical lift. Harness size and style have been identified.

Corrective Action – Identify other residents:

RN Clinical Coordinator in each neighborhood & Barrier Free Access has assessed other residents/patients using the Liko Sabina Standing mechanical lift. Harness size and style have been identified.

RN Clinical coordinator will monitor significant changes in resident/patient for the use of Liko Standing Mechanical lift or Hoyer lift. OT/PT Screening will be obtained if RN deemed appropriate.

Corrective Action to Prevent Reoccurrence:

Education was completed on April 25, 2014 to all nursing staff for the appropriate harness size & style for each resident/patient. Pink card in Long Term Care has been reviewed for accuracy of how resident transfers. Therapy Suites roster identifies how patient is to transfer

Monitoring for Compliance:

Random audits will be completed by DON or RN Clinical Coordinator for the proper use of Liko Sabina Standing mechanical lift. This audit will continue for 90 days and the results brought to the QA committee for recommendation on the need for further audits.

Date of Completion:

May 2, 2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Rice Care Center - Building 01, was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 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 444 CEDAR STREET, SUITE 145	K 000	POC ok JS 5-5-14 RECEIVED MAY - 1 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony J Oydahl	Acting Administrator	April 28, 2014

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

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K 000	Continued From page 1 ST. PAUL, MN 55101-5145, or By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was inspected as two separate buildings: Rice Care Center - Building 01, is a 1-story building with no basement that was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1995, an addition was constructed on the south side of the original building and was determined to be of Type II(111) construction. Since the original building and the 1995 addition are both Type II (111) construction they were both inspected as Building 01 under Existing Healthcare requirements. The facility is equipped with a fire alarm system that has smoke detection in the corridors and in spaces that are open to the corridors, and that is monitored for automatic fire department	K 000		

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K 000	Continued From page 2 notification. The facility is fully protected by an automatic fire sprinkler system. At the time of the inspection the facility has a capacity of 78 beds and had a census of 74. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of 1 fire barriers located within the facility did not meet the rated requirements for a two hour fire separation and is not maintained in accordance with NFPA 101 "The Life Safety Code" 2000 edition (LSC) section 19.1.1.4.3,. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 51 of 74 residents, staff and visitors of the facility. Findings include: On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observations revealed, that the 2 hour fire separation wall that is separating the original 1965 building and the 1995, 2011, and	K 011		

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K 011	Continued From page 3 the 2014 additions has the following deficient conditions: 1. A penetration around the fire sprinkler piping that is going through that wall of the Kitchen Dry Storage room and a personnel office located on the other side of the 2 hour fire separation wall, and 2. In the 90 minute fire rated double doors located outside of the Kitchen Dry Storage room in the 2 hour fire separation wall there is a 1/4 inch gap between the two doors. This deficient condition was confirmed by the Interim Administrator (TO).	K 011	Mechanical contractor was recalled and fire caulked around noted pipe. Rick Wandersee, Maintenance, will be responsible to monitoring for and fill wall penetrations as needed. Smoke barrier brushes have been installed on the noted door. Rick Wandersee, Maintenance, will be responsible for monitoring future smoke barrier issues on doors and for installing brushes where needed.	4-7-14 4-7-14
K 017 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5	K 017		

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K 017	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility several penetrations located throughout the facility that are not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 51 of 74 residents, staff and visitors. Findings include: On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observations revealed, that the facility had numerous penetrations in ceiling tiles that are located throughout the facility. Such locations include: 1. A 1 inch diameter hole located in the ceiling tile by the med room storage by the receptionist desk, 2. A 2 inch by 3/4 inch hole in the ceiling tile located in the day room next to the receptionist desk, and 3. A 1/4 inch gap around the multiple sprinkler heads located in the dayroom by the receptionist desk. This deficient condition was confirmed by the Interim Administrator (TO).	K 017	1. Fire caulk was used to fill noted holes. Rick Wandersee, Maintenance, will be responsible to monitor for and fill holes or replace ceiling tiles as needed. 2. Fire caulk was used to fill noted holes. Rick Wandersee, Maintenance, will be responsible to monitor for and fill holes or replace ceiling tiles as needed. 3. Fire caulk was used to fill noted holes. Rick Wandersee, Maintenance, will be responsible to monitor for and fill holes or replace ceiling tiles as needed.	4-2-14 4-2-14 4-2-14

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K 029 K 029 SS=D	Continued From page 5 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 observations and staff interview, it was revealed that the facility has failed to provide proper protection from 2 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 18 of 74 residents, staff and visitors. Findings include: On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observation revealed, that the following deficient conditions were identified:	K 029 K 029		

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K 029	Continued From page 6 1. There was a penetration found around the sprinkler piping above the entry door to the boiler room in the wall that is separating the boiler room from the corridor. 2. There are penetrations that were found around the fire sprinkler piping that passes through two wall and into three rooms. The penetrations start where the piping passes through that northwest corner of the wall that separates the boiler room from the laundry room, across the laundry room and through the northwest corner of the opposite wall that is separating the laundry room from a staff office. This deficient condition was confirmed by the Interim Administrator (TO).	K 029	Holes were filled with fire brick and sealed with fire caulk. Rick Wandersee, Maintenance, will be responsible to monitor for and fill holes as needed. Penetrations were covered with sheetrock and sealed with fire caulk. Rick Wandersee, Maintenance, will be responsible to monitor for and fill holes/ penetrations as needed.	4-2-14 4-3-14
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6	K 051		

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K 051	Continued From page 7 This STANDARD is not met as evidenced by: Based on observation and staff interview it was revealed that the facility failed to maintain the unobstructed access to 1 of several manually actuated alarm-initiating devices located throughout the facility in accordance with NFPA 101 Life Safety Code (00), Sections 19.3.4.2 and 9.6.2.6 as well as NFPA 72 National Fire Alarm Code (99), Sections 2-8.2.1. This deficient condition could adversely affect the ability to initiate the fire alarm system and delay emergency actions, and emergency forces notification in the event of an emergency, thus negatively affecting 51 of 74 residents, staff, and visitors of the facility. Findings include: On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observation revealed, that the manual fire alarm pull station located in the original 1965 building's north dining room's east exit had carts, boxes, and other equipment that were obstructing access to that manual fire alarm pull station in the event of an emergency. The requirements of both the NFPA 101 (00) and the NFPA 72 (99) require that manual fire alarm boxes shall be unobstructed and accessible at all times.	K 051	This room was temporarily being used for storage. It is now cleaned out and the noted fire pull station is clear of obstructions. Rick Wandersee, Maintenance, will be responsible to monitor for and remedy pull station obstructions.	4-2-14

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K 051	Continued From page 8 This deficient condition was confirmed by the Interim Administrator (TO).	K 051		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system, and could delay the timely notification and emergency actions for the facility thus negatively affecting 74 of 74 residents, staff, and visitors of the facility. Findings include: On facility tour between 11:00 AM to 3:00 PM on	K 052	Original inspection date was rescheduled and conducted on April 11, 2014 by Simplex. The inspection report is located in the Fire Safety Documentation Book. Future inspections, 12 months from the most recent inspection, will be scheduled in advance by Rick Wandersee, Maintenance, and noted on the Maintenance schedule/calendar.	4-11-14

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K 052	Continued From page 9 04/01/2014, observation revealed from a review of all available fire alarm documentation for the last 12 months, and by a interview with the Administrator (TO), that at the time of the inspection the facility had failed to conduct the required annual test and inspection of the facility's fire alarm system. This deficient condition was confirmed by the Interim Administrator (TO).	K 052		
K 056 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility's automatic fire sprinkler system was not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow system being place	K 056		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 10 out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 18 of 74 residents, visitors and staff of the facility. Findings include: On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observation revealed that the sprinkler heads located throughout the kitchen area were heavily corroded and had a hard green colored scale like material that was covering, and possible sealing the sprinkler head's actuator and plug assemble in place, that would cause the affected fire sprinkler heads to fail in the event of a fire. This deficient condition was confirmed by the Interim Administrator (TO).	K 056	per t/c w/ Admin 5-9-14 KB The noted sprinkler heads will be scheduled for replacement. Rick Wandersee, Maintenance, will be responsible to monitor for and remedy sprinkler head cleanliness and functionality.	~~6-1-14~~
K 069 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was determined that the facility has failed to ensure the accessibility to the manual activation pull station for the hood suppression system is in compliance with the requirements of NFPA 96 Fire Extinguishing systems (98) section 7-5.1. This deficient condition would delay the activation of the kitchen's hood suppression system in the event of a fire above the cooking area of the kitchen; and could negatively affecting 18 of 74 residents, staff, and visitors of the facility.	K 069		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICE CARE CENTER	1801 SOUTHWEST WILLMAR AVENUE WILLMAR, MN 56201

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K 069	Continued From page 11 Findings Include: On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observation revealed that the manual pull station for the kitchen's hood fire suppression system was blocked by a large floor stand mixer, shelving and a storage counter. these obstructions prevent the accessibility to the manual pull station in the event of a fire emergency in the facility's kitchen. This deficient condition was confirmed by the Interim Administrator (TO).	K 069	The mixer noted in this deficiency has been relocated. The shelf noted in this deficiency will be cut down to a size that will allow for visibility and accessibility of the fire pull station. Rick Wandersee, Maintenance, will be responsible to monitor for and remedy pull station obstructions.	4-30-14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING 02 - 2011 ADDITION B. WING _____	04/01/2014

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the Rice Care Center - Building 03, additions were 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 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	POC K 5-5-14 RECEIVED MAY - 1 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-13-14

EXIT: 4-3-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anthony J. Osdahl	Acting Administrator	April 28, 2014

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245410	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**04/01/2014**

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was inspected as two separate buildings: The Rice Care Center - Building 03 consists of five separate additions that were constructed at four different times. The first addition was built in 2011, and is a 1-story addition without a basement that is located on the south side of Building - 01 and was determined to be of Type V(111) construction. The second addition was built in 2012, and is a 1-story addition without a basement that is located on the south side of the northeast wing of Building - 01 and was determined to be of Type V(111) construction. The third addition was built in 2013, and is a 1-story addition without a basement that is located on the south side of the northwest wing of Building - 01 and was determined to be of Type V(111) construction. The fourth addition to the facility consisted of two	K 000		

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	245410	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**04/01/2014**

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 building that were both built in 2014, both additions are 1-story additions without basements that are located on the west side of Building - 01 and on the west side of the 2011 addition. It was determined that both 2014 additions are of Type V(111) construction. Since the five additions are all constructed of Type V(111) construction, they were inspected as one building labeled as Building - 03 and to New Health Care facility standards. The facility is equipped with a fire alarm system that has smoke detection in the corridors and in spaces that are open to the corridors. The facility's fire a;arm system is also monitored for automatic fire department notification. The facility is fully protected by an automatic fire sprinkler system. At the time of the inspection the facility has a capacity of 78 beds and had a census of 74 The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		
K 017 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Corridor walls form a barrier to limit the transfer of smoke. Such walls are permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.5 This STANDARD is not met as evidenced by:	K 017		

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	245410	A. BUILDING 02 - 2011 ADDITION B. WING	04/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 017	Continued From page 3 Based on observations and staff interview, it was revealed that the facility had a penetration in the corridor that was not in compliance with NFPA Life Safety Code 101 (00) Sections 19.3.6.2 and 8.2.4.4.1 in resisting the passage of smoke. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for 6 of 74 residents, staff and visitors. Findings include: On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observations revealed, that there was a ceiling tile hanging from the grid system located directly across from the Physical Therapy entrance in the corridor ceiling that is creating a vertical penetration that measured approximately 6 inches by 24 inches. This deficient condition was confirmed by the Interim Administrator (TO).	K 017	The ceiling tile noted in this deficiency was damaged. Rick Wandersee, Maintenance, will be responsible for the replacement of the damaged tile and in monitoring for future damaged tile replacement.	4-2-14
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors are arranged so that each door swings in an opposite direction. Doors are self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	K 027		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245410	A. BUILDING 02 - 2011 ADDITION B. WING	04/01/2014

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K 027	Continued From page 4 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility had failed to provide the proper protection for 1 of 3 corridor smoke barrier doors located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.6.3.1., and NFPA 80 Fire Doors and Fire Windows (99). This deficient condition could negatively affect 23 of 74 residents, staff, and visitors, by allowing the products of combustion to migrate between smoke compartments making the corridor untenable in the event of a fire. Findings include: On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observations revealed, that the corridor smoke barrier doors located in the 2011 addition next to resident room 201 had a gap between the smoke barrier doors measuring 1/4 of an inch in width, which is greater than the maximum allowable gap of 1/8 of an inch.	K 027	Smoke barrier brushes have been installed on the noted door. Rick Wandersee, Maintenance, will be responsible for monitoring future smoke barrier issues on doors and for installing brushes where needed.	4-7-14

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	245410	A. BUILDING 02 - 2011 ADDITION B. WING	04/01/2014

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K 027	Continued From page 5 This deficient condition was confirmed by the Interim Administrator (TO).	K 027		
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, it was revealed that the facility had failed to install and maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1999 NFPA 72, Sections 7.1. This deficient condition could adversely affect the functioning of the fire alarm system operability and could delay the timely notification and emergency actions for the facility thus negatively affecting 74 of 74 residents, staff, and visitors of the facility. Findings include: On facility tour between 11:00 AM to 3:00 PM on 04/01/2014, observation revealed during a review of all available fire alarm documentation for the last 12 months, and an interview with the Administrator (TO), that at the time of the inspection the facility had failed to conduct the required annual test and inspection of the facility's	K 052	Original inspection date was rescheduled and conducted on April 11, 2014 by Simplex. The inspection report is located in the Fire Safety Documentation Book. Future inspections, 12 months from the most recent inspection, will be scheduled in advance by Rick Wandersee, Maintenance, and noted on the Maintenance schedule/calendar.	4-11-14

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K 052	Continued From page 6 fire alarm system. This deficient condition was confirmed by the Interim Administrator (TO).	K 052		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5147 5120

April 21, 2014

Mr. Tony Ogdahl, Interim Administrator
Rice Care Center
1801 Southwest Willmar Avenue
Willmar, Minnesota 56201

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5410023

Dear Mr. Ogdahl:

The above facility was surveyed on March 31, 2014 through April 3, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to Brenda Fischer at Minnesota Department of Health, 3333 W Division, #212 St Cloud Mn 56301. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00313	A. BUILDING: _____ B. WING _____	04/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On March 31, 2014 through April 3, 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program, 3333 West Division St, Suite 212, St Cloud, MN 56301.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths.	2 265	Refer to attachment for PoC and date of completion	

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2 265	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify the physician/practitioner when 1 of 3 residents (R36) developed pressure ulcers. Findings include: R36's admission Minimum Data Set (MDS) dated 2/14/14, included she was cognitively intact, was at risk for pressure ulcers, but did not have any current pressure ulcers. R36 was observed on 4/1/14, at 2:15 p.m. with registered nurse (RN)-G. A pressure ulcer was noted on R36's right inner buttocks, that was a shallow crater, with redness surrounding the area. R36 stated, "I have had that sore for quite a while." RN-G was unsure if the physician or nurse practitioner had been notified of R36's pressure ulcer. Review of R36's Progress notes identified on 2/19/14, "Patient noted to have small area of shearing to middle of left buttocks measuring 2 cm [centimeters] x [by] 0.5 cm. Appears to be wear lift sheet sits during transfers. Will apply calmo [protective barrier cream] to area and continue to monitor." R36's Wound Progress Sheet dated 2/19/14, included a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcer, with a pink wound bed, scant amount of drainage, surrounding tissue	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 265	Continued From page 3 pink, and wound edges normal. The wound was listed as being from, "Shearing." The form indicated the practitioner and family had not been notified of the development of the pressure ulcer. Review of the nurse practitioner (NP) note dated 2/21/14, did not indicate the NP had been informed of the pressure ulcer which had developed on 2/19/14. The progress note on 3/11/14, indicated, "Weekly skin assessment for high risk patient completed with the following results." Under "skin issues," number "1) Banmchable [sic] right buttock 1 cm x .75 cm." Review of the physician note dated 3/19/14, did not indicate the physician had been informed of the pressure ulcer even though it developed on 2/19/14. R36's Progress Notes dated 4/1/14, indicated, "Observed wound to coccyx/buttock crease this evening. 1.75 inches x 3 inches, reddened areas surrounding multiple small areas of stage 2 or skin shearing." When interviewed on 4/1/14, at 2:43 p.m. RN-C stated she thought the NP had been notified of the pressure ulcer, but was not sure. Although R36 developed a pressure ulcer on 2/19/14, which continued to become larger, the physician or NP were never notified of the ulcer, to determine if a change to the plan of care was needed to heal the pressure ulcer. A facility policy entitled Skin Care, dated 3/2010, included, "RCC [Rice Care Center] will immediately inform the resident; consult with the	2 265		

2265 Notification of Physician

Corrective Action:

Res 36 physician notified of pressure ulcer on April 9, 2014

Corrective Action – Identify other residents:

All residents/patients that have pressure areas have been reviewed to ensure physician notification per policy

Corrective action to Prevent Reoccurrence:

Education will be completed on May 8, 2014 regarding the current policy of Notification of changes in resident conditions.

Monitoring for Compliance:

Audits will be completed by RN Care Manager &/or DON weekly at wound meeting to assure the physician has been notified for all pressure ulcers or changes of ulcer.

Results will be brought to QA committee for recommendation on the need to further audit

Date of completion

May 8, 2014

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	00313	A. BUILDING: _____ B. WING _____	04/03/2014

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2 265	Continued From page 4 resident's physician...Any significant change such as change of Pressure ulcer from stage 1 to stage 2..." Suggested Method of Correction: The director of nursing (DON) or desigee could work with the medical director to update policies and procedures for when to notify the physician of changes in the resident, and then could educate staff. The DON or designee could also perform audits of resident records to determine if the physician had been notified as appropriate. Time Period for Correction: twenty-one (21) days.	2 265		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	2 830	Refer to attachment for PoC and date of completion	

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2 830	Continued From page 5 review, the facility failed to coordinate care with an outside dialysis unit to include fluid intake restrictions, care of dialysis access site, and emergency procedures for 1 of 1 resident (R152) who was reviewed for dialysis care. Findings include: R152's admission Minimum Data Set (MDS) dated 1/27/14, included she was cognitively intact, had diagnoses of cirrhosis, end stage renal disease (ESRD), and a hip fracture. R152 received a therapeutic diet. Entry and discharge tracking MDS's indicated R152 had been hospitalized 2/8/14 to 2/14/14, 2/27/14 to 3/11/14, and 3/18/14 to 3/21/14. R152's care plan dated 1/29/14, included a problem statement of, "Hemodialysis r/t [related to] ESRD; hepatic encephalopathy [brain dysfunction caused by the liver being unable to remove toxic substances from the blood], Dialyzing [sic] 3 days/week at RMH [Rice Memorial Hospital] while at Therapy Suites; usually dialyzes [sic] in Litchfield." R152's goal was, "Will tolerate dialysis runs while here AEB [as evidenced by] ability to complete 3.5 hour run, remove needed fluid and maintain VS [vital signs]. Staff instructions included, "Follow physician orders including diet restrictions and 1.5 L [liters] fluid restriction. Send Dialysis Communication Record with to all runs. Weigh daily and record." The nutrition care plan dated 1/27/14, included, to "Provide 2 Gram Sodium, High Protein, Low K+ [potassium], 1,500 cc [cubic centimeters, equal to 1.5 liters] restriction per physician order. Monitor weight and meal intake."	2 830		

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2 830	Continued From page 6 R152's Physician Order Report dated 3/12/14, included, "Diet order: diabetic/dialysis diet, low sodium 1000 ml [milliliters, equal to cubic centimeters] fluid restriction." "Kayexalate suspension [medication used to remove large amounts of potassium from the body, typically used if dialysis runs are missed or critically elevated potassium levels] 15 gm [grams]/60 ml: 120 ml oral. TAKE ONLY IN EMERGENCY. CONTACT DIALYSIS PRIOR TO TAKING." Zofran 4 mg [milligrams] every 8 hours as needed for nausea with vomiting. R152's Dialysis Communication Record dated 3/11/14, included, "Fluid restriction is less than 1000 cc/day." The care plan had not been updated to reflect this change. When interviewed on 4/1/14, at 1:00 p.m. R152 stated she was on 1000 cc per day fluid restriction, she had a large water mug at her bedside containing approximately 240 cc of water in it. R152 stated she gets the mug filled a couple times per day, but she knows she has to watch her fluid intake, which is hard for her due to extreme thirst. R152 stated she only gets 1000 cc from the facility, so drinks less than that. R152 stated she has complications of her liver and kidney disease including: pain, skin being itchy, and extreme nausea and vomiting. R152's dialysis access site was on her left arm, as an AV fistula [where an artery and vein are surgically joined to create an access site for the needle for dialysis]. R152 stated when she is done with each dialysis run, the dialysis unit will place a tight bandage on this access site. When she is getting	2 830		

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2 830	Continued From page 7 ready for bed, she requests the bandage be removed, because it is uncomfortably tight, and the bleeding has stopped. R152 stated some nurses will remove the dressing for her, others will not, it depends on who is working. In addition, R152 stated she use to go to dialysis three days a week, but this has been increased to four days a week as she has too much fluid. The care plan did not direct staff on care of the dialysis access site, nausea, vomiting, itching, or the 1000 cc fluid restriction. When interviewed on 4/1/14, at 1:30 p.m. registered nurse (RN)-G stated R152 is on a 1500 cc fluid restriction and monitors her own fluid intake, nursing provides her with a mug of water in her twice a day, 120 cc of a nutritional supplement twice a day with her medications, and however much water it takes to swallow her medications two more times each day. RN-G did not know how much fluid dietary gives R152 with meals, as this is not coordinated with nursing. The facility does not track fluid intake for R152. RN-G stated staff do not remove the dressing on R152's dialysis access site, this is left up to the dialysis unit. R152 had been having complications of nausea and vomiting, she had given her a medication for nausea earlier, and R152 had vomited shortly afterwards. RN-G stated when she works, she checks the access site for a pulse to ensure patency, this is not documented any where. R152 was observed on 4/2/14, at 8:00 a.m. consuming breakfast, R152 had 90 cc of milk, 120 cc water, 120 cc coffee, and 120 cc lemon lime soda. When R152 was finished with breakfast, she had consumed 360 cc total of the	2 830		

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2 830	Continued From page 8 450 cc's offered at breakfast. On R152's bedside table was 240 cc of water. When interviewed on 4/2/14, at 8:15 a.m. dietary aide (DA)-A stated R152 was on a 1500 cc per day fluid restriction, and provided a card utilized by dietary. The card indicated R152 should be provided with 120 cc of each milk, juice and decaf coffee at breakfast, 120 cc of each juice and water at lunch and supper. This was a total of 840 cc provided by dietary each day. DA-A stated, "There are so many people in and out of the dining room, we don't have control if other people give her fluids too," noting soda had been provided by a visitor. R152 was observed at the noon meal on 4/2/14, at 12:15 p.m. she had been provided with 180 cc water, 120 cc of red juice, and 90 cc of brown juice. In addition, at 12:30 p.m. a visitor had provided R152 with a can of Shasta cola. When finished R152 had drank at total of 390 cc. of the 570 cc offered at the meal. In addition, approximately 100 cc of water was now missing from the mug at her bedside. When interviewed, via telephone, on 4/2/14, at 12:30 p.m. the dialysis manager, RN-I, for Rice Memorial Hospital, stated R152 had orders to decrease her fluids to 1000 cc a day, on 2/14/14. RN-I stated the facility nurses should be checking R152's dialysis access site upon return from dialysis to ensure area is not bleeding, and should check the site for a pulse (bruit) and signs of infection at least daily. The facility should have a book at the nursing home about how to care for the dialysis patient. Only one book is kept in the	2 830		

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2 830	Continued From page 9 facility, they are not provided for each resident. These instructions should be followed. When interviewed, via telephone, on 4/2/14, at 12:45 p.m. the dietician for the dialysis unit, as well as consulting dietician for the facility, stated a communication sheet should have gone from dialysis to the facility when R152's fluid restriction changed from 1500 cc to 1000 cc per day. This change occurred due to a nephrologist [kidney doctor] order on 3/12/14. The dietician stated R152 could not keep track of fluid restrictions herself, as she had intermittent extreme confusion related to elevated ammonia levels, and extreme thirst. The dietician stated R152 had trouble managing her thirst, and liked to drink soda pop. The facility should have been tracking R152's fluids and managing the fluid restriction for her. Generally when a resident is on a fluid restriction dietary would divide fluids throughout the day to include meals, med pass, and any fluids the resident could have in between. This would normally be care planned and documented. The dietary card and care plan should have been updated when R152's fluid restriction changed, as well as a determination how much fluid R152 could have with med passes. This had been missed. Dialysis goal is to remove less than 3 kg [kilograms] of fluid with each run, but R152 had been often requiring well over that amount, therefore she was increased from 3 times a week to 4 times a week on 3/27/14. R152 had also been hospitalized for fluid over load and required abdominal parathenteses (removal of fluid in the abdominal cavity). R152 had a care planning conference with the dialysis interdisciplinary team on 3/22/14. R152's care plan should have been updated at that time.	2 830		

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2 830	Continued From page 10 When interviewed on 4/2/14, at 1:00 p.m. the director of nursing (DON) was unable to find any book or instructions from the dialysis unit on caring for the dialysis patient. The DON stated care of the dialysis access site should have been care planned, and added to R152's treatment sheets for monitoring by the nurses. Emergency plans such as if R152 was unable to make it to dialysis, had bleeding from the dialysis site, or critical lab values should have been care planned also. When interviewed on 4/2/14, at 1:45 p.m. the dietary mentor (DM)-E stated she had noted today that R152's fluid restriction had decreased from 1500 cc to 1000 cc on 3/12/14. This was missed. The facility's routine would be to set up how much fluids could be provided at each meal, med pass, and at other times. This information would be in the care plan. It had been missed for R152. R152 was discharged from the facility on 4/2/14, at 2:00 p.m. having consumed 850 cc of the 1200 cc being provided by the facility, prior to the evening meal, supplement, refill of the water mug in her room, or fluids with medications remaining for the day. When interviewed on 4/2/14, at 2:00 p.m. the DON had found the book on caring for the dialysis patient. The book had been located in the nursing home portion of the building, not in the Therapy Suites where R152 had resided. The booklet dated 11/12, included Guidelines for	2 830		

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2 830	Continued From page 11 Dialysis Nursing Home Patients, and instructions such as: not to take blood pressures or draw blood from the access arm. Need to check the access site daily for a pulse, if no pulse to call the dialysis unit, to remove dressing in 2 hours after dialysis, if the site was bleeding to apply pressure for 15-30 minutes. To send a communication form each day with pertinent information. Information was also included on potential medical complication such as excess fluid gains, itching, and elevated potassium levels. The DON stated care of the access site and fluid restrictions should have care planned, monitored and documented by the facility, but had not. The Rice Memorial Hospital Dialysis Protocol Agreement dated January 2007, included, "A comprehensive care plan will be developed by the interdisciplinary teams from both RMH and facility." Even though the dialysis unit had communicated a change in fluid restrictions on 3/11/14, the facility failed to communicate the new restriction to staff. In addition, the facility did not have any care planning in place to ensure the fluid restriction was followed, and did not track fluid intake. The facility did not have any care planning in place on how to manage potential complications of dialysis or how to manage the dialysis access site. The facility did have a book on caring for the dialysis unit, however, this was not available on the unit where R152 resided and nurses were not knowledgeable on how to find this information. Based on observation, interview, and document review the facility failed to ensure resident were	2 830		

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2 830	Continued From page 12 assessed for safe transfers with the use of the LIKO brand mechanical standing lift with an EZ brand lift harness which the LIKO manufacture had not recommenced to be used for the LIKO brand lifts. This affected 5 of 5 residents (R36, R70, R40, R51, and R11) who used the LIKO brand mechanical lift. Findings include: R36's admission Minimum Data Set (MDS) dated 2/14/14, included she was cognitively intact, had diagnoses of heart failure and arthritis, and required total staff assistance for transfers. R36's ADL (activities of daily living) Functional Status/Rehabilitation Potential Care Area Assessment (CAA) included, R36 had a fracture knee cap, and was totally dependent upon staff for transfers with a ceiling lift (a full body lift). The form indicated care planning would occur to address this. R36's care plan dated 2/20/14, included, "Nursing will provide assistance with ADL's and mobility per therapy directions." The care plan did not direct staff on which type of mechanical lift, harness/vest, or leg strap should be used. R36's physical therapy and occupational therapy notes were reviewed from 2/7/14 through 3/31/14, and failed to direct nursing staff on any transfer techniques. The notes did indicate R36 varied from total staff assist to two person assist for transfers.	2 830		

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2 830	Continued From page 13 R36 was observed on 4/1/14, at 2:15 p.m. being assisted from her bed to her wheel chair by nursing assistant (NA)-L and NA-AA. A transfer belt was placed up under R36's axilla (arm pits). NA-L and NA-AA attempted to lift R36 into a standing position, R36 was unable to bear any weight. Registered nurse, (RN)-C who was the clinical coordinator came into room, and witnessed R36 not bearing any weight. RN-C instructed NA-L and NA-AA to use the mechanical standing lift which was a LIKO brand instead. The LIKO mechanical standing lift was brought into the room, R36's feet were placed on the foot platform, an EZ-way brand lift harness was placed under R36's arms, pulled in front of her body, and fastened with a belt. There was no belt on the LIKO lift to secure R36's legs. The LIKO lift was turned on and NA-AA started to lift R36 off the bed with it. R36's buttocks hung down, and R36 was in a sitting position, with her knees were bent, and was unable to bear any weight. R36's arms were being pulled up by the lift and she kept saying, "Owe, owe, owe," while being lifted. R36 was transported by the lift into the bathroom, and remained in a sitting position with her knees bend, and her arms were pulled up by the harness lift under her axilla. R36 was placed on the toilet. RN-C came into the bathroom and witnessed R36 in the LIKO mechanical lift with the EZ Way harness being transferred off the toilet. While NA-AA and NA-L attempted to provide pericare with the lift in the stand up position, R36's buttocks continued to hang down in a sitting position, she was unable to bear any weight and was yelling during this time to get placed back onto the toilet twice, which NA-AA completed. R36 stated she wasn't really in pain, but was more, "Stiff," because her legs were too weak and she was unable to stand.	2 830		

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2 830	Continued From page 14 When interviewed on 4/1/14, at 2:35 p.m. NA-L stated R36 could sometimes transfer with two assist, but has been weaker since she had returned from the hospital with pneumonia. NA-L stated they sometimes used the leg strap on the LIKO lift to secure the resident's legs, but this one was missing, and was unsure how long it had been missing. NA-L stated the EZ-Way harness was used with the LIKO mechanical because the harness was more comfortable for residents, than the LIKO harness was. When interviewed on 4/1/14, at 2:40 p.m. RN-C stated R36 use to be a full mechanical lift with a ceiling lift, had been improving and staff were able to transfer her with two assist and a transfer belt, but R36 had recently been hospitalized with pneumonia and had returned to the facility on 3/24/14, much weaker. R36 had not been re-evaluated for transfers, but was working with therapy on getting stronger. If R36 would be unable to stand, she would expect staff to get the standing lift. She did not expect them to use the ceiling lift, even if R36 could not stand up, as the ceiling lift sling had caused skin shearing to R36's buttocks. When interviewed on 4/1/14, at 4:00 p.m. NA-E stated she had worked in the facility for over five years, she remembered being trained many years ago by the director of nursing (DON) on how to use the lifts. When ever a new nursing assistant starts, other nursing assistants train them on how to use the lifts. NA-E verified they were allowed to use the EZ Way harness's with the LIKO lifts. The residents like them better, they are not as	2 830		

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2 830	Continued From page 15 stiff as the LIKO harness's and they do not use the leg strap on residents. The LIKO harness's (vests) wrap around the torso and are not as comfortable as the EZ Way harness's which do not wrap around the body. When interviewed on 4/1/14, at 4:05 p.m. NA-DD stated most residents like the EZ Way harness instead of the LIKO harness's, and they are allowed to interchange the harness and mechanical lift. She started working at the facility a year ago and another nursing assistant showed her how to use the standing LIKO lift. When interviewed on 4/1/14, at 4:10 p.m. the DON stated staff do use the EZ Way harness for the LIKO standing lifts, they are interchangeable. When nursing assistants are hired, another assistant will show them how to use the lifts. The leg strap would be used only if the resident needs it, this should be care planned. The DON stated if R36 could not stand up in the LIKO standing lift, the staff should have consulted with therapy about appropriate transfers. R36 was observed on 4/2/14, at 7:53 a.m. being assisted from bed to the wheel chair by NA-L and NA-A. R36 was very shaky while trying to sit on edge of bed, NA-L and NA-A had to hold her up. R36 stated she was out for hours at doctors appointment yesterday, and was feeling very weak. A transfer belt was placed under R36's arms and she was instructed to push off of the bed with her hands. R36 was pulled upwards by NA-L and NA-A and pivoted into her wheel chair, R36 was not able to bare much weight.	2 830		

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2 830	Continued From page 16 When interviewed on 4/2/14, at 8:00 a.m. NA-A stated R36's transfers usually go poorly, she has so much edema in her abdomen, they need to put the transfer belt under her arm pits, this pulls on her arms and shoulders. When R36 can not stand at all, they use the LIKO standing lift on her, but R36 "Does not do well, she hangs, and her shoulders have arthritis." The full lift, the ceiling lift is not used because the sling had caused a sore on her, "bottom." When interviewed on 4/2/14, at 9:50 a.m. physical therapy aid (PTA)-H stated she had been working with R36, she had not been asked, nor had she made any recommendations to nursing on how to transfer R36. When interviewed on 4/3/14, at 8:05 a.m. RN-C stated she was not aware how R36 was transferring since returning from the hospital. No one had reported problems to her. She was not aware R36 could not stand in the lift and her buttocks hung down as she hung from her axilla and that R36 needed to be reassessed for her transfer ability so she would remain safe during transfers. R70's diagnoses from the Minimum Data Set dated 9/24/2013, included left- sided hemiplegia, obesity and osteoarthroses. The MDS also identified R70 as cognitively intact, and required extensive assistance, with the physical support of one, for transferring. The Care Area Assessment (CAA) for falls dated 9/27/2013, indicated R70 was unstable, and only able to balance if assisted by staff, and that R70 required assistance for all	2 830		

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2 830	Continued From page 17 her mobility. R70's care plan, updated 3/18/2014, directed staff to use LIKO [brand name] stand (a mechanical stand-assist lift), for transfers, to be aware of R70's 'L' (left) side neglect for safety, and also to be watchful of [R70's] position of left ankle/foot so it [sic] does not roll during transfer/weight bearing when in the stand. The care sheet in R70's room, undated, directed staff to transfer R70 with "one assist" and use "EZ Stand". During observation on 4/2/2014 at 9:24 a.m., nursing assistant (NA)-A assisted R70 to transfer from the wheel chair onto the toilet in the resident's room. NA-A positioned a LIKO brand stand-assist lift in front R70's wheel chair. From R70's bed, NA-A retrieved a large maroon and green-colored harness, with an "EZ" insignia on the label. NA-A placed the harness behind R70's back and underneath of each of R70's arms, and then attached the ends of the harness to the handlebar of the lift. NA-A also fastened the seat buckle, which held the harness around R70's torso in place. NA-A positioned R70's feet on the lift platform, and informed R70 the lift was starting. As the handlebars raised, R70 grasped the handlebar with only her right hand. R70's left hand was near her shoulder, positioned as if clutching a book. During the lift, R70's lower right leg and knee were bumped up to the padded leg guide. Neither R70's left lower leg, nor left knee touched the lift leg pad. The leg strap, which would go behind R70's legs, was not attached, and was hanging on the lift near the foot platform. During the lift and transfer, R70 was not completely upright, but rather hanging in the lift, and the harness supported R70's weight. NA-A moved the lift into the bathroom and lowered R70 onto the toilet. NA-A assisted R70 with toileting, then transferred R70 from the toilet into the	2 830		

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2 830	Continued From page 18 recliner. In an interview on 4/2/2014 at 9:29 a.m., NA-A verified R70's legs were not strapped on the lift during the transfer. NA-A said "I don't always put it [the leg strap] on, I guess I should." NA-A also verified the lift stand used for R70's transfer was a "LIKO" brand, and also verified the sling used was an "extra large" maroon and green "EZ" labeled harness. NA-S said "That's what fits [R70] best." During an interview on 4/2/2014 at 12:34 p.m., NA-Q stated R70 only uses her right hand to hold on the lift during transfers, because [R70] "can't fully grab with her left side." NA-Q said you had to make sure R70's feet were flat on the platform, so they doesn't twist off, as [R70] is "a large person." NA-Q said the foot straps on the stand lift were to always be used "for [R70] ...and any resident." R40's diagnoses from the annual Minimum Data Set, dated 9/24/2013, included osteoarthroses, chronic pain, and anemia. The MDS also identified R40 as mildly, cognitively impaired, and that R40 required extensive assistance for transferring, with the physical assistance of one person. The Care Area Assessment (CAA) for Falls, dated 9/27/2013, identified R40 required assistance from staff to maintain balance during all transitions , and that R40 struggles with pain in her knees. A Rice Care Center Assessment for Restraints/Adaptive Equipment, dated 3/1/2014, indicated R40 occasionally required use of an EZ [brand name] stand (a mechanical stand-assist device) for transfers. The care sheet in R40's room, undated, directed staff to transfer R40 with "Two assist" or use "EZ Stand."	2 830		

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2 830	Continued From page 19 During observation on 4/2/2014 at 11:34 a.m., nursing assistants (NA)-S and NA-Q prepared to transfer R40 from the toilet in her room into the wheel chair. A LIKO [brand name] stand (a mechanical stand-assist device) was positioned in front of R40, who had a green and maroon-colored harness under her arms, and around the back of her torso, in a U-shaped fashion. The harness was secured to R40 with a seatbelt buckle, which was in place. The harness ran parallel to and underneath R40's arms, and each of the ends were fastened to corresponding hooks on the lift's handlebar. NA-S started the lift, and told R40 to "hold on." As the handlebars moved upward, R40 said "it hurts, hurry up." When R40 was upright in the stand, NA-Q adjusted R40's clothing, and NA-S moved the lift out of the bathroom, and in front of R40's wheel chair. R40 was observed standing upright, and had a firm grip on the handle bars. R40 was wearing shoes, and both feet were flat on the lift platform, and her legs were against the leg guides of the lift. The leg strap, which would go behind R40's right and left legs, was not secured, but was dangling at the side of R40's leg. After R40 was lowered into the wheel chair, NA-S unbuckled the safety belt and removed the harness from around R40. NA-Q adjusted the wheel chair and pushed R40 out of the room. Then, NA-S exited the room carrying the harness and placed it atop a portable piano near R40's room. An insignia "EZ" was visible on the green and maroon-colored harness that was used during the transfer for R40. During an interview on 4/2/2014 at 11:42 a.m., NA-S said R40 occasionally needed the "EZ [brand name] stand" (a mechanical stand-assist device) for transferring. NA-S verified that the lift	2 830		

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2 830	Continued From page 20 used for transferring R40 was the "LIKO" brand lift. NA-S said that staff routinely referred to the "Likko" lift as the "EZ stand" lift. [Likko and EZ-Stand are two brand names of similar stand-assist devices.] NA-S said the green and maroon-colored harness with the 'EZ' insignia was the one used for R40's transfers. NA-S confirmed that during R40's lift and transfer from the toilet to the wheel chair, the leg strap on the lift was not fastened. NA-S said the leg strap was often "not fastened" while transferring R40, and "other residents," when using the "EZ Stand." NA-S stated the purpose of the strap was to keep a resident's legs from moving or slipping out of position when being transferred. NA-S said that if a resident was known to "kick back", move or curl their feet during a transfer, then "we would put the strap on." During an interview on 4/2/2014 at 12:02 p.m., licensed practical nurse (LPN)-C stated that use of leg straps when transferring a resident on an "EZ Stand" was "a matter of safety." LPN-C stated she has "heard and seen" that the safety straps were not always used on the "EZ" stands." LPN-C said it was "good practice" for the aides and nurses to put the legs straps "every time" the lift is used for resident transfers. LPN-C was unaware that "EZ" Stand" brand harnesses were used with the "Likko" brand lifts. "We always used those [harnesses], LPN-C stated, "I thought they were interchangeable." During an interview on 4/3/2014 at 10:41 a.m., registered nurse (RN)-B verified that both R40 and R70 utilized stand lifts for transfers. RN-B said transfer instructions for residents was care planned, and "would expect" nursing assistants to	2 830		

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2 830	Continued From page 21 follow the protocol for transfers and apply "safety belts and the legs straps" during transfers. RN-B said safe lift use was part of "an employee's orientation checklist." RN-B acknowledged the facility utilized LIKO brand stand lifts, and also used harnesses from "EZ Stand", a different brand. RN-B was unaware of any difference between "EZ Stand" and "LIKO" brand lifts, and the slings or harnesses. RN-B said the harnesses out on the floor have been used "for a long time." R51's significant change minimum data set (MDS) dated 2/5/14 indicated R51 had dementia and was cognitively impaired. R51's care plan dated, 2/13/14 indicated R51 was an extensive assist of two staff with an EZ stand to transfer to the wheelchair and to and from bed. During observation on 4/2/14, at 8:00 a.m. nursing assistant (NA)-L was assisting R51 with the LIKO mechanical standing lift. NA-L used an EZ Way dark green color harness and placed the EZ Way harness behind R51, buckled the abdominal strap, and attached to the LIKO mechanical standing lift. NA-L pushed the control to raise R51 up out of bed and transferred him with the LIKO lift to R51's wheelchair. R51 into lowered into the wheelchair and NA-L removed the EZ Way harness from R51. R11's quarterly minimum data set (MDS) dated 12/31/13 indicated R11's had severe cognitive impairment. The care plan reviewed on 1/10/2014 indicated R11 was an extensive to total assistance for transfers with 1 or 2 staff and the EZ stand (mechanical standing lift). A Balance Assessment dated 3/29/14 indicated R11 used an EZ stand for transfers. During observation on 4/2/14, at 9:11 a.m. of	2 830		

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2 830	Continued From page 22 NA-L assisted R11 with the LIKO mechanical standing lift. NA-L placed a maroon color sling, that had an EZ Way tag on the harness behind R11. R11 was buckled into the harness with the abdominal strap, and attached it to the LIKO mechanical standing lift. NA-L pushed the control to raise R11 out of the wheelchair and transferred him into the bathroom. When R11 had finished using the bathroom, R11 was moved to the wheelchair and lowered into the wheelchair. The EZ Way harness was removed from R11. On 4/2/14, at 12:19 p.m. an interview with NA-R verified she uses the EZ Way harnesses on residents with the LIKO lift. At 12:28 p.m. NA-L stated the mechanical standing lifts used in the facility were LIKO lifts and verified the harnesses used were EZ Way harness and not the LIKO harnesses. NA-L stated that new harnesses came with the new LIKO lifts but they did not have the abdominal strap on them that buckled around the residents. During an interview on 4/2/2014 at 12:37 p.m., the physical therapist (PT)-A stated in order to use a mechanical stand lift, a resident would have to demonstrate "ability to bear weight," have sufficient range of motion, have arm and shoulder strength, and do so "without pain." The PT said a resident should not look like they're "sitting in a wheel chair" while using the lift. The PT said the sling or harness should not be bearing the weight of a resident. The PT also stated safety precautions needed to followed when a resident is transferred, and that should include "putting on leg straps" during a transfer. In an interview on 4/3/2014 at 9:27 a.m., the occupational therapist (OT)-A stated that she	2 830		

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2 830	Continued From page 23 provided staff training on proper use of the stand-assist lift. Further, the OT stated, that she instructed staff to "always" lock the seat belt buckle on the harness, and "always fasten the leg straps" before transferring a resident using the stand-assist lifts. A Sabina/comfort IN-Service Summary provided by the facility, that included three different type vests/harness's that could be used with the LIKO Sabina standing lift. None of these included harness's from other companies. A passive lifting form a sitting position with Sabina form indicated if the resident couldn't stand or cooperate to use a sling that fits under the residents buttocks for full support. This could be used infrequently, if the resident was unable to bear weight, staff were instructed to use a full body lift with a sling. When interviewed via telephone April 2, at 9:30 a.m. the LIKO Barrier Free Access, director of health care ergonomics (DHCE), stated he had been at the facility a few years ago and trained staff on the use of the LIKO standing lift (named Sabina), the resident must be able to bear weight, have muscle tone and ability to follow commands. DHCE stated the leg strap is an option to use to remind the resident not to step off the platform. DHCE stated the only harness's that should be used on the LIKO lifts, is the LIKO brand, these are vests that wrap around the residents torso, other harness's are not made the same way and are not made for this particular machine, and is not safe. The DHCE provided a LIKO Lift Sign-In Sheet, dated 1/25/2010 with the names of 15 NA's	2 830		

2830 Provide Care/Services For Highest Well Being

Corrective Action:

Res 152 was discharged from the facility

Corrective Action – identify other residents:

All residents receiving dialysis services have been identified. Dialysis Educational manual is in each neighborhood for reference of emergency procedures for staff to refer to.

New Dietary form will be used for documentation of fluids after each meal. Information will be given to med nurse at the end of the shift for fluid intake totals. Dietary will have, on patient dietary card, fluid amounts for each meal

E-mar dialysis section has been added to include orders for dialysis patients to individualize care. This will include: care of access site, emergency procedures

Corrective action to Prevent Reoccurrence:

Education will be completed on May 8, 2014 regarding residents receiving dialysis fluid restriction documentation, dialysis educational manual location, & adding nursing orders in the Treatment section of E-mar.

Monitoring for Compliance:

Audits will be completed by DON &/or Designee weekly for one month then twice a month for one month then monthly till stable. Results will be reported to QA committee for recommendations on the need for further audits.

Date of Completion:

May 8, 2014

2830 Free of Accident Hazards/Supervision/Devise

Corrective Action:

Resident # 36, 11, 51, 40 & 70 have all been assessed by RN Clinical Coordinator & Barrier Free Access for safe transfers when using the Liko Sabina Standing mechanical lift. Harness size and style have been identified.

Corrective Action – Identify other residents:

RN Clinical Coordinator in each neighborhood & Barrier Free Access has assessed other residents/patients using the Liko Sabina Standing mechanical lift. Harness size and style have been identified.

RN Clinical coordinator will monitor significant changes in resident/patient for the use of Liko Standing Mechanical lift or Hoyer lift. OT/PT Screening will be obtained if RN deemed appropriate.

Corrective Action to Prevent Reoccurrence:

Education was completed on April 25, 2014 to all nursing staff for the appropriate harness size & style for each resident/patient. Pink card in Long Term Care has been reviewed for accuracy of how resident transfers. Therapy Suites roster identifies how patient is to transfer

Monitoring for Compliance:

Random audits will be completed by DON or RN Clinical Coordinator for the proper use of Liko Sabina Standing mechanical lift. This audit will continue for 90 days and the results brought to the QA committee for recommendation on the need for further audits.

Date of Completion:

May 2, 2014

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2 830	Continued From page 24 signed in, and provided a LIKO Sabina Lift Training Outcomes Check-Off list. The check off list included, "Patient assessment, Patient criteria including the ability of the patient to bear about 20% of his weight at least on one leg, have some upper body control and have the ability to follow simple commands. If patients weak, confused or unpredictable the SafetyVest should be used." Under, "Vest application and connection, all types of Sabina Vests must be applied with the patient in a seated position. The vest application is at the patient's low back and/or just below the umbilicus. Connect the vest using the style of connection appropriate for that vest. The vest connection style differs with the SupportVest using a belt clip design and the SafetyVest styles using a criss-cross "D" ring connection." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies regarding the care of dialysis patients, and the proper use of a mechanical lift for transfers. They could educate staff, and then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked	2 855	Refer to attachment for PoC and date of completion	

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2 855	Continued From page 25 lips This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure oral hygiene was provided daily for 1 of 3 residents (R 29) who needed staff assistance with oral care. Findings include: R29's quarterly MDS (Minimum data set) dated 8-14-13 identified R29 was cognitively intact, had good mental capacity and needed extensive assistance of two persons for oral hygiene. The 2/19/14 activities of daily living care area assessment identified R29 needed extensive assistance with grooming and personal hygiene due to self performance problems. The care plan dated 2/21/14 indicated a problem with activities of daily living related to weakness and impaired mobility due to Parkinsons. The care plan directed staff to provide extensive assistance for one for dressing and grooming due to the resident becoming weak. During an interview on 4/1/14 at 1:20 p.m. R29 stated, "They never brush my teeth, I would like to brush my teeth myself but I can't." She stated the last time her teeth were brushed was when she was staying on the therapy unit R29 stated she has her own teeth, and is unable to wear dentures due to the roof of her mouth. She can only eat chopped food because she only has a few teeth on her upper mouth, and wants staff to brush her teeth. An interview on 4/1/14 1:28 p.m. nursing assistant (NA)-K said R29 sits on side of the bed	2 855		

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2 855	Continued From page 26 to get dressed and if she (R39) wants her teeth brushed she will ask. During an interview on 4/1/14 on 1:48 p.m. with NA-I stated R29 sits on the side of the bed and partially washes herself a little but we help her with the rest. NA-I stated R29 can only get into the bathroom with her wheelchair and staff assistance. During continuous observation on 4/2/14 6:50 a.m. to 9:00 a.m. R29 was not assisted by staff for oral hygiene. At 6:50 a.m. R29 was in her recliner and stated she did not get assistance with brushing her teeth this morning. The tooth brush in R29's bathroom drawer was dry. The tooth brush remained dry, and R29 confirmed at 9:00 a.m. she still had not been assisted to brush her teeth. During an interview on 4/2/14 at 9:00 a.m. NA-I and NA-J both stated they did not assist R29 to brush her teeth this morning, they were not aware she needed assistance. Neither NA-I or NA-J knew if R29 had dentures or natural teeth, since they have never assisted her with oral hygiene. During interview on 4/2/14 at 9:10 a.m. registered nurse (RN-A) stated she was not aware R29 has not been getting her teeth brushed, "She never complains." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies regarding providing oral hygiene daily for residents, educate staff, then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One	2 855		

2855 Oral Hygiene

Corrective Action:

Res 29 oral hygiene is offered to resident every AM/PM . Staff is allowing R29 to continue to be independent with brushing of teeth; electric toothbrush has been provided to help with oral hygiene. Staff will assist if resident is unable. .

Corrective Action – Identify other residents

Oral Hygiene Policy has been reviewed & updated. Refusal of oral care planned and risk/benefit explained to resident regarding lack of oral hygiene. Oral exam is completed by license staff at least quarterly and PRN.

All residents have been identified if they have dentures, partials or own teeth and pink care card updated with this information for staff.

Corrective action to Prevent Reoccurrence:

Education with all nursing staff will be completed May 8, 2014 reviewing the updated policy of oral hygiene. Pink Care cards reviewed with staff and providing oral hygiene every AM & PM with cares. Staff is to assist with oral hygiene if assistance is necessary. If resident refuses oral care, this will be care planned and risk/benefit explained to resident regarding lack of oral hygiene.

Monitoring for Compliance

Random Audits will be completed by DON or RN/LPN 2 times a week for one month then 1 time a week for one month then monthly till stable. Results will be reported to QA committee for recommendations on the need for further audits

Date of Completion

May 8, 2014

Minnesota Department of Health

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 855	Continued From page 27 (21) days.	2 855		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 4 residents (R79, R36 and R150) with pressure ulcers, were assessed, monitored and/or provided care to ensure current pressure ulcers were healing and to prevent the development of new pressure ulcers, which caused actual harm for R79. Findings include: R79's Minimum Data Set (MDS) dated 2/19/14 indicated R79 was cognitively intact, but required extensive assistance with transferring and	2 900	Refer to attachment for PoC and date of completion	

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	00313	A. BUILDING: _____ B. WING _____	04/03/2014

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2 900	Continued From page 28 repositioning in bed and was at risk for pressure ulcer (PU) development. The MDS also identified R79 had diagnoses of peripheral vascular disease, neuropathy and hypertension. The 2/19/14 Pressure Ulcer Care Area Assessment (CAA) identified R79 was at risk for developing pressure ulcers, and needed extensive assistance for bed mobility, and had an unstageable PU due to coverage of wound by slough/eschar. The CAA also identified risk factors of immobility, incontinence, poor nutrition, and recent decline in activities of daily living (ADL). The Skin Risk Assessment (with Braden Scale) scale dated 3/21/14 identified R79 scored an 18, meaning he was at risk for the development of PU. He currently had PU "bilateral to feet, with no new sores." The assessment also indicated he had slight limited mobility, with potential problems of friction and shearing due to "skin probably slide to some extent against sheets, chair... Maintains relatively good position in chair or bed most of time but occasionally slides down." The interventions included pressure relieving devices for bed, ulcer care, application of dressing/ointments and other preventative or protective skin care and "prevalon boots." There was no indication a turning and repositioning scheduled was implemented even though R79 was at risk for PU, had limited mobility, and was at risk for having friction and shearing of his skin. R79's care plan dated 2/24/14 identified a problem with fragile skin, recurrent skin breakdown, circulatory disease and chronic wounds to lower extremities and skin tears easily. The care plan directed staff to "Dressing changes	2 900		

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2 900	Continued From page 29 to open areas as per CNP [certified nurse practitioner]..." The plan also identified he had a decline in mobility and weakness, with the interventions of "Nursing will provide assistance with ADL's and mobility per therapy directives." Physical therapy (PT) and occupational therapy (OT) five times a week for improved mobility, endurance and strength. There was no mention of a turning and repositioning scheduled even though R79 needed staff assistance with mobility, was at risk for pressure ulcer development and had three current pressure ulcers which were not identified on the care plan. During an interview on 4/1/14 at 2:10 p.m. nursing assistant (NA)-L stated she gave R79 a bath this morning and noticed R79, "Had an open spot on the bottom so we put Calizone lotion it is on left cheek". The area was smaller than an eraser on a pencil. During an interview on 4/1/14 at 2:25 p.m. with registered nurse (RN)-C unit clinical coordinator stated R79 has some open areas on his legs, due to poor circulation. RN-C did not mention R79 had any pressure ulcers on his buttocks. R79 was observation on 4/1/14 from 12:58 p.m. until 4:41 p.m.. At 12:58 p.m. R79 was sitting in a regular high back chair with a cushion asleep with his feet firmly on the floor. R79 continued to sleep in this same position until 2:04 p.m. when an unknown NA entered the room and placed his feet onto a chair. The unknown NA did not repositioned R79, and only placed his feet onto a chair. R79 continued in the same positioned until 3:58 p.m. when an unknown physical therapy staff came into the room and did exercises with R79 legs. R79 remained in the same chair during this time and when the exercises were completed	2 900		

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2 900	Continued From page 30 the unknown therapy staff, replaced R79's feet on top of the chair as before. The unknown therapy staff did not offer to assist R79 off the chair into a different position. At 4:41 p.m. R79 continued to sit in the same chair for 3 hours and 43 minutes without being repositioned during this time. An interview on 4/1/14 at 4:50 p.m. R79 said he had not moved from the chair since lunch. R79's family member (F)-A who was present during the interview stated R79 has a new open area and a scabbed area on his buttock. During an interview on 4/1/14 at 4:50 p.m. with licensed practical nurse (LPN)-A said R79's feet were sore so he doesn't move much any more but just sits there. On 4/1/14 at 4:52 p.m. NA-DD stated she was unsure when R79 was last repositioned and NA-DD and NA-S assisted R79 to a standing position. Near R79 scrotal area there was an open area approximately 0.3 cm X 0.3 cm. There was a scabbed area approximately 0.8 cm x 0.3 cm on R79's right tuberosity and an open area 0.8 cm x 0.3 cm on his left tuberosity. NA-DD and NA-S confirmed the open areas. NA-DD and NA-S verified R79 did not have a specific turning or repositioning schedule, even though he had three pressure ulcers in the same location. During continuous observation on 4/2/14 at 7:50 a.m. R79 was in his room again sitting in room on a regular chair with his feet up on a folding chair. He remained in this positioned until 9:55 a.m. when F-A came to visit. He continued to remain in this chair until 11:00 a.m. when he was assisted by NA-Y to ambulate to the dining room for the noon meal, a total of 3 hours and 10 minutes without being repositioned. During an interview on 4/2/14 at 1:45 p.m. RN-E	2 900		

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2 900	Continued From page 31 measured the pressure ulcers on R79 buttocks. There was an open area that measured 0.9 x 0.5 on the right ischeal tuberosity and 0.7 cm x 0.4 cm on the left. The scrotal area measured 0.6 cm X 0.3 cm. RN-E stated R79 had an open area on the scrotum from "shearing" as well as two other open areas on his ischeal tuberosity. R79 skin was poor and agreed the shearing were considered pressure ulcers. She stated the RN clinical manager decides if a resident needs to be placed on a turning and repositioning schedule, which R79 did not have in place. Review of the facility Progress Notes and Wound Progress Sheets from 2/20 through 4/1/14 did not identify any pressure ulcers for R79's scrotum and bilateral ischeal tuberosity until 3/27/14, when the 3/27/14 progress note indicated, "Small open area on scrotum with a small amount of bloody drainage. Possibly from shearing." There was no mention of the bilateral pressure ulcers on the ischeal tuberosity, even though the right ischeal tuberosity was observed to be scabbed over on 4/2/14. These pressure ulcers had not been reassessed or monitored and measured on a weekly basis to determine location, staging, size, exudate, pain, wound bed and description of surrounding wound edges even though they were a stage 2 pressure ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough). R79 Although ~~R76~~ was at risk for pressure ulcers development and developed three separate stage 2 pressure ulcers, one on his scrotum on 3/27/14, and one on each ischeal tuberosity, unknown date of development. The facility did not reassessed these pressure ulcer, to determine what interventions should be implemented to help	2 900		

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2 900	Continued From page 32 decrease the risk of R79 from developing further pressure ulcers. Also there was no indication the pressure ulcers were consistently monitored and provided interventions to promote the healing of these pressure ulcers which caused actual harm for R79. R36's admission Minimum Data Set (MDS) dated 2/14/14, included, she was cognitively intact, required extensive to total assistance with bed mobility, transfers and toileting and was frequently incontinent of bladder. R36 had diagnoses of heart failure and arthritis, was at risk for pressure ulcers, and had moisture associated skin damage but did not have current pressure ulcer. R36's Pressure Ulcer Care Area Assessment (CAA) dated 2/14/14, listed R36 had risk factors for development of pressure ulcers including, requiring extensive assistance with bed mobility, frequent urinary and bowel incontinence, poor nutrition, slides down in bed, requires regular schedule of turning related to pressure, and moisture associated skin damage. The analysis of findings included, "[R36] needs extensive help to make position changes and do any offloading activity, she is a ceiling lift at present. Has a brace to her R [right] leg r/t [related to] knee fx [fracture]." The care planning decision was marked as yes, and "Proceed to care plan to assist with offloading and repositioning, provide thorough cleansing." R36 was observed in bed, on her back with the head of bed up approximately 45 degrees, on 4/1/14, from 1:00 p.m. until 2:15 p.m. At 2:15 p.m. R36's pressure ulcer with registered nurse (RN)-G was observed, on R36's buttock which	2 900		

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2 900	Continued From page 33 was a shallow crater with redness surrounding the area. R36 stated, "I have had that sore for quite a while," and commented that she always sleeps on her back due to having problems breathing and this position was the most comfortable for her. RN-G stated the nurse aides would reposition R36 when ever they get her up for meals or therapy but R36 was not on a timed repositioning schedule. RN-G stated the pressure ulcer was from shearing from the use of the ceiling lift sling, which she was no longer using. However, R36 does slides down in bed, placing her at risk for further shearing, RN-G confirmed they had not implemented any interventions to prevent the potential shearing of R36, from sliding down in bed. R36 was observed in bed, on her back with the head of bed elevated approximately 45 degrees, on 4/2/14, from 6:45 a.m. until 7:53 a.m. and on 4/3/14, from 8:00 a.m. until 9:00 a.m. When interviewed on 4/1/14, at 2:15 p.m. nursing assistant (NA)-AA stated R36 was not on any repositioning schedule, she lays on her back when in bed, she will change positions when ever she gets up for therapy or meals. NA-AA stated R36 had been ill recently, and didn't always get up. During interview on 4/2/14, at 7:53 a.m. NA-A stated R36 was not on a repositioning schedule, she will mostly lay on her back in bed, with head of bed elevated a little. However, sometimes R36 will get up into her wheel chair. R36's progress note dated 2/12/14, included, "Crack in coccyx area, no drainage noted. Calazime applied." This area was not identified as to if it was a pressure ulcer, or any further	2 900		

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2 900	Continued From page 34 description including size, wound bed, drainage, wound edges, tissue surrounding wound, or if any pain was associated with it. The progress note on 2/19/14, indicated "Patient noted to have small area of shearing to middle of left buttocks measuring 2 cm [centimeters] x [by] 0.5 cm." R36's Wound Progress Sheet dated 2/19/14, included a stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) pressure ulcer, with a pink wound bed, scant amount of drainage, surrounding tissue pink, and wound edges normal. The progress note on 3/11/14, indicated, "Weekly skin assessment for high risk patient completed with the following results." Under "skin issues," number "1) Banmchable [sic] right buttock 1 cm x .75 cm." There was no way to determine if the 2/19/14, pressure ulcer on the left buttocks had healed or not, or if this was the same area as identified on 2/12/14. R36's progress notes dated 3/20/14, indicated she had been hospitalized with pneumonia, and on 3/24/14 had returned to the facility. R36's hospital return Skin Risk Assessment dated 3/24/14, indicated she did not have any pressure ulcers or other skin issues on her buttocks or coccyx. A Skin Risk Assessment with Braden Scale assessment (a scale used to predict pressure ulcer risk) was completed on 3/24/14 which included risk factors for development of pressure ulcers that included: Cardiovascular disease, chronic incontinence, abrasions, bruises, cast/brace/splint, steroid use, occasional moist skin, bedfast, very limited ability to change and	2 900		

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2 900	Continued From page 35 control body position, as well as a problem with friction and shear. The form indicated a plan of care would be initiated to prevent the development of pressure ulcers. The 4/1/14 progress note, indicated, "Observed wound to coccyx/buttock crease this evening. 1.75 inches x 3 inches, reddened areas surrounding multiple small areas of stage 2 or skin shearing." There was no staging, exudate, pain, wound bed, description of surrounding wound edges or if this was the same open area from the 3/11/14 progress note or if this was a new area. Review of R36's care plan updated 2/20/14, included nursing would provide assistance with ADL's [activities of daily living] and mobility per therapy directives." The care plan did not address the risk factors listed on the CAA and Skin Risk Assessment to determine appropriate interventions to help prevent the development of pressure ulcers even though R36 was at risk for the development of PU and currently had a stage two pressure ulcer. When interviewed on 4/1/14, at 1:55 p.m. the house supervisor, registered nurse (RN)-E, stated she was not aware R36 had any pressure ulcer at any time. RN-E was unsure if the 2/12/14, 2/19/14, and 3/11/14, pressure ulcers had healed during the hospital stay, or before R36's hospital stay or if they did not heal at all. When interviewed on 4/1/14, at 2:43 p.m. the clinical coordinator, RN-C verified there was no timed repositioning plan for R 36, staff would reposition her when ever she got up for therapy or meals even though R36 spent most of the time in	2 900		

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2 900	Continued From page 36 bed on her back due to breathing difficulty. There was no toileting plan, even though R36's pressure ulcer CAA of 2/14/14, indicated urinary incontinence placed R36 at risk for development of pressure ulcers. RN-C stated she had no way to determine when the, "Crack in coccyx area," identified on 2/12/14, had healed, or when or if, the stage 2 pressure ulcer identified on 2/19/14, had healed, or if the area identified on 4/1/14, was the same area as had been identified on 2/12/14, 2/19/14, or 3/11/14. RN-C stated R36 should have been reassessed after R36 had returned from the hospital weaker, and was spending more time in bed. Although R36 was at risk for pressure ulcers and had developed a pressure ulcer on 2/19/14 to present, these ulcers had not been consistently monitored on a weekly basis to determine location, staging, size, exudate, pain, wound bed and description of surrounding wound edges. Also, a comprehensive assessment had not been completed to determine what interventions should be implemented to help decrease the risk of R36 from developing pressure ulcers. R150's, closed record review for pressure ulcers, indicated R150's admission MDS, dated 1/23/14, indicated R150 had no unhealed pressure ulcers and was at risk for development of pressure ulcers. The MDS also indicated the resident required limit ability for bed mobility and extensive assistance for transfers. In addition, the MDS indicated R150 had multiple diagnoses including pneumonia, depression, arthritis, and hypertension. R150's skin assessment, completed on 1/18/14, indicated the resident had a Braden Scale [scale of pressure ulcer risk factors] score of 16,	2 900		

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2 900	Continued From page 37 identifying R150 was at risk for pressure ulcer development. The resident's pressure ulcer Care Area Assessment (CAA), dated 1/27/14, identified R150 was in therapy to improve ability to offload independently. R150's care plan, dated 1/27/2014, indicated "Skin: has rough, tender area to "L" buttock on admit. Needs help to offload from lower surfaces, i.e. recliner." The care plan directed staff to assist with offloading activities and "Cover offending [sic] area with mepilex border and apply calazime PRN [as needed]. A review of R150's, Resident Progress Notes, dated 1/25/14, identified the resident continued to have complaints of tenderness and discomfort to coccyx and area to left inner buttocks which measured 4 cm [centimeters] by 1.5 cm. The note indicated the area had "Calmo applied and covered with Mepilex." The resident's progress notes, dated 1/26/14, identified that R150 continued to complain of discomfort to coccyx area with "Calmo applied various times throughout shift. Calmo what effective for discomfort." Again, on 1/28/14, progress notes identified R150 had an "Area of raised, firm tissue on (L) [left] buttock noted to be macerated this a.m. Area cleansed, Calazime applied, and covered with a Mepilex Border." The progress notes, dated 1/29/14, indicated the Nurse Practitioner (NP), observed the resident's buttocks, noted this was an area of shearing from sliding forward on seated surfaces. The NP ordered "Calizime to (L) [Left] butt TID [three times a day]; do not cover with Mepilex border; software cushion in any chair surface he sits in." Although the facility had identified, on admission, R150 was at risk for pressure ulcer development	2 900		

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2 900	Continued From page 38 and identified R150 developed a pressure ulcer to the left buttock, after admission; the care plan was not updated to reflect the current treatment as prescribed by the nurse practitioner (NP) to promote healing and prevent the development of additional pressure ulcers. Also, the assessment did not identify what interventions could be implemented to prevent R150 from developing pressure ulcers. When interviewed, on 4/3/2014 at 1:26 p.m., the RN-E stated the macerated area on the left buttock was a pressure ulcer. RN-E also stated the care plan was not updated to reflect the pressure ulcer treatment ordered 1/29/14 by the nurse practitioner. A policy entitled Skin Care, Rice Care Center, dated 3/10, included, a purpose of, "To maintain skin integrity, prevent skin breakdown, and to promote healing of non-intact skin." The procedure identified upon admission or hospital return, a skin assessment would be completed within 24 hours; a comprehensive risk assessment with Braden scale would e completed along with a tissue tolerance test (a test to see how long skin can withstand pressure) would be completed. If a resident was found to be at risk for skin breakdown, skin would be monitored weekly and documented in the progress notes. Residents with reddened, open areas, or ulcers would be entered on the treatment sheet, and documented on weekly to include: "treatment given, interventions to prevent further breakdown, size, depth, odor, and drainage." The policy further indicated the physician would be consulted with if there was any significant change in the ulcer. The policy contained a definition of an "Avoidable Pressure Ulcer," which included, "an ulcer that has	2 900		

2900 Treatment/SVCS to Prevent/Heal Pressure Sores

Corrective Action:

Res 36 Revised comprehensive pressure ulcer risk assessment completed on April 14, 2014. Appropriate interventions to prevent further development of additional pressure ulcers have been added to care plan. Wound progress sheet reviewed and updated. R36 discharged from facility on April 23, 2014 with no open areas.

Res 79 expired at hospital

Res 150 closed record review/discharged

Skin Care Policy reviewed and updated

Corrective Action-identify other residents:

All Residents with pressure ulcers have been reviewed for appropriate assessment. Wound monitoring progress sheet reviewed to ensure current pressure ulcers are healing and to prevent the development of new pressure ulcers.

Care plan interventions reviewed for appropriate interventions to prevent the development of new pressure ulcers.

LTC Pink care cards updated with repositioning guidelines, Therapy Suites patient roster updated with heart shape if patient needs assistance with repositioning.

Corrective action to prevent reoccurrence:

Education will be completed on May 8, 2014 regarding the Skin Care Policy to all nursing staff. Review of LTC Pink care cards with repositioning guidelines, Therapy Suites patient roster reviewed with heart shape if patient needs assistance with repositioning.

Monitoring for Compliance:

Audits will be completed by RN Clinical Coordinator &/or DON weekly at Wound meetings in each neighborhood to assure wound monitoring sheets are completed and pressure ulcer is healing and measures in place to prevent the development of new pressure ulcers.

Care plans will be reviewed weekly at wound meeting for appropriate interventions.

High risk residents/patients pink care cards or patient roster will be reviewed for accuracy.

Results will be brought to QA committee for recommendation on the need to further audit.

Completion Date:

May 8, 2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 900	Continued From page 39 developed because one or more of the following were not done: a residents clinical condition was not evaluated, risk factors were not identified, interventions were not implemented, or effectiveness of interventions not monitored or revised. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies/procedures for pressure ulcer prevention and care, educate staff, and then perform audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced	2 910	Refer to attachment for PoC and date of completion	

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	00313	A. BUILDING: _____ B. WING _____	04/03/2014

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2 910	Continued From page 40 by: Based on observation, interview, and document review, the facility failed to comprehensively assess, and place interventions to improve or maintain urinary incontinence for 1 of 2 residents (R36) reviewed for urinary incontinence. Findings include: R36's admission Minimum Data Set (MDS) dated 2/14/14, included she was cognitively intact, required extensive assistance with mobility, toileting and hygiene. R36 was frequently incontinent of bowel and bladder, had a trial toileting program with no improvement, and was on a current toileting program. The MDS also included diagnoses of heart failure and arthritis, and received a diuretic (water pill) daily. R36's Bladder Assessment dated 2/13/14, included risk factors for urinary incontinence, including impaired mobility with dependent transfers, urine leakage on way to bathroom, urgency-unable to suppress, congestive heart failure, and use of a diuretic. R36's Urinary Incontinence Care Area Assessment (CAA) dated 2/19/14, included risk factors for urinary incontinence including, extensive assistance required to toilet, urinary incontinence, moisture associated skin damage, pain, restricted mobility, urinary urgency, and use of a diuretic. The type of urinary incontinence was listed as, "Functional (can't get to the toilet in time due to physical disability, external obstacles, or problems thinking or communicating." An	2 910		

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2 910	Continued From page 41 analysis of findings included, "[R36] is frequently incontinent of bladder, compounded by loss of mobility. She is on diuretics. Incontinence is chronic, per AL [assisted living]." The form indicated care planning would occur, "Proceed to care plan to assist with toileting and attempt to decrease incontinence as able." R36's care plan dated 2/20/14, included, "Recent decline in ADL's r/t [related to] CHF [congestive heart failure], RA [rheumatoid arthritis], weakness, COPD [coronary obstructive pulmonary disease] R [right] patellar [knee] fx [fracture]; Here for short term stay with desire to return to community." The goal for R36 was, "Will regain independence in ADL's [activities of daily living] to allow safe return to community." Staff were instructed to, "Assist with toileting, monitor for increased incontinence and/or constipation and notify PCP [primary care physician] if indicated." The care plan did not address the risk factors of immobility, diuretic use, or to direct staff on any program to maintain or improve urinary incontinence even though the assessment identified these areas of risk for R36. R36 was observed on 4/1/14, at 2:15 p.m. she had been assisted to the toilet by nursing assistant (NA)-L and NA-AA. R36's incontinent product was dry and she voided in the toilet. NA-AA stated R36 was not on any routine toileting schedule, just when they get her up, or R36 calls to get her incontinent product changed. R36 had been ill recently and did not always get up. R36 was observed on 4/2/14, at 7:53 a.m. she	2 910		

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2 910	Continued From page 42 had been assisted from bed to her wheel chair by NA-L and NA-A. R36 was not assisted to the toilet at this time, and her incontinent product was saturated with urine. NA-A stated R36 does not use the toilet, she just gets her pad changed whenever she gets up into the wheel chair. When interviewed on 4/1/14, at 2:43 p.m. RN-C verified the assessment had not been developed for R36 regarding toileting needs for staff, the use of a diuretic with the possible need to toileting shortly after taking the diuretic. The assessment did not identify if R36 had urgency, nor were there any indication that her environment was modified to aid with functional incontinence. RN-C had not assessed or evaluated any voiding patterns to determine an appropriate toileting plan. RN-C verified R36 had been ill frequently and often did not get up out of bed. There was no plan to assist R36 with toileting needs at these times, or to maintain or improve her urinary incontinence. When interviewed on 4/3/14, at 2:00 p.m. the director of nursing (DON) stated an assessment with interventions should have been developed for R36 to aid in maintaining or improving urinary continence. A policy was requested, but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review/revise policies on bladder assessments, educate staff, and perform audits to ensure each resident has an individualized assessment to	2 910		

2910 Assessment Accuracy/Coordination/Certified

Corrective Action:

Res 36 Bowel & Bladder assessment was reassessed on 4/14/04 – 4/16/2014. Assessment accurately reflected the residents care plan that staff are providing

Corrective Actions – identify other residents:

- The RAI process was reviewed and is current
- All residents with urinary incontinence assessments and care plans reviewed to ensure interventions are in place to improve or maintain urinary incontinence.

Corrective Action to Prevent Reoccurrence:

Education to all nursing staff will be completed on May 8, 2014. Education included the need for accurate assessment by RN and the importance of MDS matches the care plan. Nursing staff are to alert Clinical Coordinator if changes, significant change will be evaluated at that time.

Monitoring for Compliance:

DON or Designee will audit bladder assessment to ensure resident assessment accurately reflects the care plan. Audits will be done weekly for 4 weeks then 2 times a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audit.

Completion Date:

May 8, 2014

2910 No Catheter, Prevent UTI, Restore Bladder

Corrective Action:

Resident 36 Comprehensive Assessment with analysis and interventions put in place to improve or maintain urinary incontinence completed on April 16, 2014

Corrective Actions-identify other residents:

All residents with urinary incontinence assessments & care plans reviewed to ensure interventions are in place to improve or maintain urinary incontinence.

Corrective Action to Prevent reoccurrence:

Education to all nursing staff will be completed on May 8, 2014. Education included the need for accurate assessment by RN and the importance of the MDS matching the care plan. Nursing staff are to alert the Clinical Coordinator if there changes, significant change will be evaluated at that time.

Monitor for Compliance:

DON or Designee will audit bladder assessment to ensure completion and interventions are indentified on Care Plan to improve or maintain urinary incontinence. Audits will be done weekly for 4 weeks then twice a month for 1 month then monthly till stable. Results will be brought to QA committee for recommendation on the need to further audits.

Date of Completion:

May 8, 2014

Minnesota Department of Health

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2 910	Continued From page 43 maintain or improve urinary incontinence. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 910		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800	Refer to attachment for PoC and date of completion	

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21800	Continued From page 44 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the notice of provider noncoverage, or generic notice, upon discontinuation of Medicare part A services for 1 of 3 residents (R23) reviewed for liability notices. Findings include: R23's Resident Admission Record indicated he had been admitted to the facility on 1/13/14, on Medicare part A services. The Physical Therapist Progress and Discharge Summary dated 2/27/14, indicated R23 had met the therapy goals and skilled services would be ending on 2/27/14. There was no indication R23 had received a notice of provider noncoverage (CMS 10123) to notify the resident of the right to an expedited review by the Quality Improvement Organization. When interviewed on 4/2/14, at 12:00 p.m. business office manager stated R23 was discharged to home on 2/28/14, utilizing only 43 Medicare part A days, and should have been given the Notice of Provider Noncoverage, but had not. A policy was requested, but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The administrator or designee could educate staff on the process of providing liability notices and	21800		

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21800	Continued From page 45 resident appeals rights. The administrator or designee could then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21800		

21800 Notice of Rights, Rules, Services, Charges

Corrective Action:

R 23 discharged from facility

Corrective Action – identify other residents

Effective 4/7/2014 all patients being discharged from facility will be given a 48 hour notice of denial.

Corrective action to Prevent Reoccurrence:

Medicare Denial Completion has been added to the check list to alert Nursing or Social Services to complete Medicare Denial 48 hours before discharge.

Business office personal has developed an internal check list for completion for discharged patients

Monitoring for Compliance

Random Audits will be completed weekly by the DON or Designee to assure Medicare denials were given. This audit will continue for 90 days and the results brought to the QA committee for recommendations on the need for further audits.

Date of Completion

April 23, 2014