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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VEBN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00583

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245277**

2.STATE VENDOR OR MEDICAID NO.
(L2) **175197200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST RAPHAELS HEALTH & REHAB CENTER**
(L4) **601 GRANT AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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 **12/13/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **76** (L18)
13.Total Certified Beds **76** (L17)

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 :
Kathie Siemsen, HFE NE II 12/20/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 02/26/2018 (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
04/01/1985
(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
12/15/2017
(L33)

DETERMINATION APPROVAL

CCN: 24-5277

On October 24, 2017 an extended survey was completed at this facility. The most serious deficiency (F323) was cited at a S/S level of K (IJ/SQC). In addition, a "G" level deficiency was cited at F314. Conditions in the facility at the time of the extended survey constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to residents health and safety. The IJ began on October 21, 2017. The Admin and DON were notified of the IJ on October 23, 2017 at 6:42pm. The IJ was abated on October 24, 2017 at 4:40pm. However non-compliance remained at a lower a S/S level of G, which indicated actual harm that was not immediate jeopardy.

As a result of the survey findings, this Department imposed the Category 1 remedy of State monitoring, beginning November 14, 2017.

In addition, we recommended to the CMS RO, and CMS concurred the following enforcement remedies for imposition:

- CMP for deficiency cited at F314 (S/S=G)
- CMP for deficiency cited at F323 (S/S=K)

On December 13, 2017 MDH surveyors completed an on-site PCR and determined that all of the health deficiencies had been corrected. On December 14, all life safety deficiencies were found to be corrected as well.

As a result, MDH discontinued State Monitoring effective December 9, 2017.

However, MDH continue to recommend to the facility enforcement of the following remedies:

- CMP for deficiency cited at F314 (S/S=G)
- CMP for deficiency cited at F323 (S/S=K).

Also, because substandard quality of care was found at the facility, the facility is prohibited from conducting NATCEP for 2 years.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245277 December 20, 2017

Mr. Michael Schultz, Administrator
St. Raphael's Health & Rehabilitation Center
601 Grant Avenue
Eveleth, MN 55734

Dear Mr. Schultz:

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 December 9, 2017 the above facility is recommended for:

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds. You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

Please contact me if you have any questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

Electronically delivered

December 20, 2017

Mr. Michael Schultz, Administrator
St. Raphael's Health & Rehabilitation Center
601 Grant Avenue
Eveleth, MN 55734

RE: Project Number S5277027

Dear Mr. Schultz:

On November 9, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 14, 2017. (42 CFR 488.422)

On November 9, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on October 24, 2017. The most serious deficiency was found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On December 13, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 14, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on October 24, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 9, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on October 24, 2017, as of December 9, 2017.

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

However, as we notified you in our letter of November 9, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 24, 2017.

In addition, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

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

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

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: VEBN

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00583

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245277**
2.STATE VENDOR OR MEDICAID NO.
(L2) **175197200**

3. NAME AND ADDRESS OF FACILITY
(L3) **ST RAPHAELS HEALTH & REHAB CENTER**
(L4) **601 GRANT AVENUE**
(L5) **EVELETH, MN** (L6) **55734**

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 **10/24/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **76** (L18)
13.Total Certified Beds **76** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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 :
Kimberly Settergren, HFE-NE II 11/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Peterson, Enforcement Specialist 12/14/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(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

A standard survey was completed by the Minnesota Department of Health on October 16, 2017, through October 24, 2017. The survey resulted in an Immediate Jeopardy (IJ) at federal tag F-323 when the facility failed to correctly apply a ceiling-lift canvas, resulting in serious injury to a resident. The practice was used on other residents, placing them at immediate risk for falls and serious injury. The IJ began October 21, 2017, and was removed on October 24, 2017, at 4:40 p.m. There has been no previous substandard quality care of G-or-above level tags for the past 2 calendar years.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 9, 2017

Mr. Michael Schultz, Administrator
St Raphaels Health & Rehabilitation Center
601 Grant Avenue
Eveleth, MN 55734

RE: Project Number S5277027

Dear Mr. Schultz:

On October 24, 2017, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

> Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;
>
> No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);
>
> Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified on October 24, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Teresa Ament, Unit Supervisor
Duluth Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Duluth Technology Village
11 East Superior Street, Suite 290
Duluth, Minnesota 55802-2007
Email: teresa.ament@state.mn.us
Phone: (218) 302-6151 Fax: (218) 723-2359

NO OPPORTUNITY TO CORRECT - REMEDIES

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

- State Monitoring effective November 14, 2017. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

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

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, St Raphaels Health & Rehabilitation Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 24, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board.

Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by January 24, 2018 (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 April 24, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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
	245277	A. BUILDING _____ B. WING _____	10/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(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 A standard survey was completed by the Minnesota Department of Health on October 16, 2017, through October 24, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F323 when the facility failed to correctly apply a ceiling lift canvas (a sling used to hold the resident during a transfer using the ceiling or Hoyer lifts) according to the manufacturer guidelines for 4 of 11 residents (R5, R3, R16, R59) who were identified as using the ceiling lift with the canvas applied incorrectly. This practice resulted in a serious injury for R5 who sustained a humerus fracture, head abrasions, and pain related to a fall from the ceiling lift canvas during a transfer. This practice was also used for R59, R3, and R16, placing them at immediate risk for falls and serious injury. The IJ began October 21, 2017, and was removed on October 24, 2017, at 4:40 p.m. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on October 23,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/16/2017

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

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F 000	Continued From page 1 2017, and October 24, 2017.	F 000		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized	F 279		12/8/17

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F 279	Continued From page 2 rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop a care plan that included nutritional interventions and preferences for 1 of 1 residents (R55) reviewed for dialysis. Findings include: R55's undated Face Sheet indicated R55's diagnoses included diabetes with diabetic neuropathy, protein-calorie malnutrition, end stage kidney disease, and dialysis. R55's quarterly Minimum Data Set (MDS) dated	F 279	F 279 Res. 55 has had a nutritional assessment completed on 10-30-17 and care plan updated on 11-14-17 and included dietary preferences. All residents have been reviewed for the presence of dietary care plans by the dietician on 11-19-17. LN is reviewing all dietary care plans for the presence of dietary preferences and updates will be completed by 12-8-17. The Care Plan Process and Review Policy has been reviewed and updated and will be implemented after training on 11/22/17. Care Plan Change Flowsheet has been	

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F 279	Continued From page 3 7/31/17, indicated R55 was cognitively intact. The MDS further indicated R55 required supervision of one staff with eating, did not have a swallowing disorder but did have weight loss, and received dialysis R55's Nutrition Assessment dated 8/1/17, indicated R55's status was reviewed for the quarterly review and high risk monitoring due to dialysis. R55's weight was 117.5 pounds on 7/31/17, was down a bit from 123.9 pounds on 7/3/17, which was up a bit from 120.5 pounds on 6/6/17. R55's nutritional goal was to remain stable around 120 pounds, or have a slow weight gain as his body mass index (BMI) was under 20. R55 was on a regular renal diet diet that was liberalized due to poor intake, and he was non-compliance with all recommendations for diet changes. The assessment also indicated R55's intake varied depending on his mood, his refusals of some foods, and he liked to order out food. R55 would occasionally eat several helpings at one meal. R55 ate in his room per his choice, and fed himself after staff told him the placement of foods due to poor eyesight. The assessment indicated R55 utilized adaptive equipment, and drank soda in his room. R55 did not have chewing or swallowing issues. The nutrition assessment further indicated R55 did not have a fluid restriction. The nutrition assessment's intervention/recommendation plan included R55 had refused all kinds of supplements provided at that time, and his meal intake varied depending on his mood. R55 often ate rice crispies cereal, as well as chicken noodle soup and toast with jelly and peanut butter. The facility would try to encourage R55 to limit regular soda and other high carbohydrate foods and snacks unless his blood sugar was low. No changes would be made	F 279	created and will be implemented after training on 11/22/17. The dietary manager will audit 5 residents a week for 6 weeks to assure that a dietary care plan is in place. The audits will continue at this frequency for 6 weeks and reviewed by IDT to determine the need for continued audits or frequency of ongoing audits. In order to assure continued compliance with the presence of dietary care plans, the Dietitian or designee will audit dietary care plans for completion quarterly with nutrition assessments and report concerns including noncompliance issues to the DON. In order to assure continued compliance with dietary preferences, the Dietary Manager, in coordination with the RAI schedule will determine food preferences and assure they are on the appropriate communication tool. Newly Admitted residents will be audited weekly by the dietary manager to assure a dietary care plan is in place and preferences are included on the appropriate tool. Audits of new admits will continue for 6 weeks until compliance is achieved and then at a level to maintain compliance as determined by the IDT. Education on above plan of correction will be completed by 11-22-17. The dietary manager is responsible and compliance will be achieved by 12-8-17.	

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F 279	Continued From page 4	F 279		

at that time.

R55's Physician Order Report dated 10/1/17, through 10/31/17, indicated R55's diet was a low concentrated carbohydrate (LCC) diet.

The undated Kardex indicated R55 was on a LCC diet and was non-compliant. The Kardex directed staff to set up and explain where food was using the clock system. The Kardex lacked nutritional interventions and preferences.

On 10/18/17, at 12:30 p.m. R55's lunch meal was observed. R55 drank a glass of chocolate milk. R55 stated he did not like what they were having and did not want or like the alternatives or anything else they had to offer. R55 stated he was going to have some toast. R55 stated he did not have a fluid restriction and usually did not eat breakfast because he liked to sleep in but had eaten breakfast that day. The meal ticket directed staff to inform R55 of food location using the clock positions and use a divided plate. At 1:00 p.m. R55 had eaten two slices of toast with peanut butter and jelly and a glass of orange juice. R55 stated he was not full, but was not hungry either, and not want anything else to eat. R55 stated he liked pizza, spaghetti and hamburgers, but not the hamburgers the facility served. R55 stated he asked for extra pizza when they served pizza, and he would eat a lot of it. R55 had told the facility he liked pizza.

On 10/20/17, at 9:33 a.m. registered nurse (RN)-A was unable to find R55's nutrition care plan. RN-A stated R55 was on a LCC diet, and chose what he wanted to eat.

On 10/20/17, at 2:20 p.m. RN-A provided a

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F 279	Continued From page 5 nutrition care plan dated 10/20/17. RN-A verified the care plan was written that day, RN-A stated she did not usually write the nutrition care plan, the dietitian did the initial care plan. RN-A stated she would have expect the dietitian to write the nutritional care plan. The facility's Care Plan Process and Review policy dated 5/4/17, directed the purpose of the care plan was to provide individualized care based on the resident's needs and preferences.	F 279		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care.	F 280		12/8/17

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F 280	Continued From page 6 (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	F 280		

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F 280	Continued From page 7 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan to include fall interventions for 1 of 4 residents (R74) reviewed for accidents. R74's Face Sheet printed 10/19/17, indicated R74 had diagnoses that included cerebral infarction (stroke), repeated falls, and abnormalities of gait and mobility. R74's quarterly Minimum Data Set (MDS) dated 8/22/17, indicated R74 had significantly impaired cognition and moderately impaired vision (can see objects, but not read newsprint). The MDS also indicated R74 required supervision with bed mobility, toileting, and ambulation, and required limited assistance with transfer and extensive assistance with dressing. The MDS further indicated R74 was continent of bladder and bowel, and had two or more falls since the last assessment, and two or more falls with minor injury.	F 280	F 280 Resident 74 has had a fall risk assessment completed on 10/21/17 and the care plan was reviewed and updated to include fall interventions. All residents have had a Fall Risk Observation completed by 11/14/17 to determine what other residents are at risk for falls. The RN will review and update the care plans by 12-8-17 for all residents to assure fall interventions are in place. The 'Guidelines for IDT after Fall' and 'Care Plan Process and Review' Policies have been reviewed and updated. The Care Plan Change Form Policy/Process has been revised to better track interventions previously implemented for a resident. The Clinical Managers are to assure the Care Plan Change Form is completed and filed under the Care Plan Section in the hard chart and that the Care Plan Change process and tools are updated according to policy.	

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F 280	Continued From page 8 R74's Falls Care Area Assessment (CAA) dated 2/22/17, identified R74 had been admitted to the facility due to severe cognitive impairment, inability to care for self, and frequent falls in his assisted living facility (some with injuries). The CAA indicated R74 appeared to understand others at times, and staff needed to anticipate R74's needs. The CAA also indicated R74 required cues, prompting and daily supervision. The CAA further identified R74 was not always steady with transfers and walking, but was able to maintain balance without staff assistance, and he readily accepted help for cares. R74's medical record lacked any further comprehensive fall assessments. R74's care plan dated 9/11/17, identified a goal that R74 would not be seriously injured due to a fall. The care plan identified the following interventions: call light within reach when resident is in room, anticipate needs, provide toileting assistance as soon as possible at resident's request, speak directly to R74 and allow ample time for him to respond, and refer to Kardex for resident's specific plan of care. R74's Kardex dated 10/17/17, indicated R74 was independent with wheelchair, recliner and bed repositioning, used a front wheeled walker, and was independent with ambulation. The Kardex directed R74 required an assist of one with dressing, was independent to an assist of one with undressing, and was independent to lay down after meals. The Kardex further directed staff to keep the bed close to the bathroom, have a sign posted to call for help, and a sign in the bathroom to pull up pants when done. Review of R74's progress notes, fall event reports	F 280	Audits to assure care plans are updated with effective interventions and the process for care plan revision is followed. Audits will be completed on 5 residents weekly by the nurse and results turned in to the Director of Nursing until compliance is achieved and then at a level to maintain compliance as determined by the IDT. Education on all above corrective measures will be completed by 11-22-17. The DON is responsible. Compliance will be achieved by 12-8-17.	

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and Interdisciplinary Team (IDT) notes indicated 12 falls in 2017 prior to survey: two falls occurred at 5 a.m., one fall occurred at 8 a.m., and nine falls occurred in the afternoon or early evening. The location of each fall was one in the shower, three in the dayroom, and eight in the bedroom/bathroom.

During the survey the following fall occurred:
On 10/22/17, at 6:43 p.m. R74 was found on the floor in his room next to his bed. R74 was sent to the hospital for a contusion. The IDT intervention was to refer R74 to therapy for an evaluation and treatment of transfers and strengthening.

On 10/19/17, at 9:05 a.m. nursing assistant (NA)-B stated fall interventions for R74 include to keep his room free from clutter, check on him, and stated there were signs in his bathroom. NA-B also stated they make sure the table was out of R74's way when he stood up after meals. NA-B stated there were care plan change sheets that get read at report, but NA-B did not think there had been any care plan changes for R74.

On 10/19/17, at 9:09 a.m. licensed practical nurse (LPN)-C stated the care plan update sheets were shredded after a week.

On 10/19/17, at 9:12 a.m. NA-D stated they made sure R74's door was open, his shoes were on, his pants were up, and that he had his walker.

On 10/19/17, at 9:19 a.m. NA-C stated they try to supervise R74 when walking to the dining room; keep grippy socks on him; make sure he had his walker, and his floor was clear of clutter (he liked to pick things up off of the ground).

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On 10/19/17, at 9:22 a.m. LPN-A stated they have rearranged R74's room so his bed was closer to the bathroom, and they made sure he had his walker with him, and his shoes were on. LPN-A stated he had grip strips on his bathroom floor, and regular white athletic socks available. LPN-A stated she didn't know if family had been asked to not provide white socks or not.

On 10/19/17, at 10:27 a.m. the DON stated they were not going to prevent R74's falls, they just wanted to make him safe. The DON stated they have moved items out of R74's way, moved the bed closer to the bathroom, and applied non-slip strips to the bathroom floor. The DON stated they cannot use a low bed, as R74 was tall, a low bed would be a restraint, and fall mats would be at tripping hazard. The DON stated R74 had not worked with therapy. The DON verified current interventions should be on the Kardex.

On 10/19/17, at 11:31 a.m. the DON reviewed R74's Kardex and confirmed it did not include all interventions that should be in place to prevent R74's falls. The DON stated they were working on updating all Kardex's as they were behind in getting them updated. The DON verified R74's Kardex lacked guidance on:
-wearing shoes or grippy socks.
-assisting back to bedroom after meals
-assisting in undressing prior to laying down after meals.
-assisting in dressing.
-assistance with sitting/standing from dining room chair.

The facility's Care Plan Process and Review policy dated 11/10/15, directed care plans were to be updated as changes occurred by the

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F 280	Continued From page 11 department identifying the change, and the IDT member would update the care plan electronically, and the Care Plan Reference Sheet (Kardex) as needed.	F 280		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the care plan was followed for repositioning for 1 of 4 residents (R3) reviewed for pressure ulcers. Findings include: R3's Face Sheet printed 10/23/17, identified diagnoses that included multiple sclerosis (MS), palliative care, and a history of Stage 3 and Stage 4 pressure ulcers to the buttock area. R3's annual Minimum Data Set (MDS) dated 5/1/17, indicated R3 was at risk for pressure ulcers, and had a Stage 4 pressure ulcer present that had not been present at a lesser stage on the prior assessment. R3's 7/31/17, quarterly MDS dated 7/31/17, indicated R3 had one Stage 2 pressure ulcer that	F 282	F 282 R3 is now deceased. All residents have had a Skin Risk Assessment completed by 11-30-17 by the RN's in order to determine other residents who could be affected and the repositioning schedules are being reviewed and will be updated by 12-8-17. The NAR resident group lists have been reviewed and will be updated before 12-8-17 by the RN and NAR mentor to include more detailed guide for repositioning plans and documentation of the repositioning times. Personal Equipment, Emotion/Comfort, Elimination, and Positioning (PEEP) protocol has been developed by RN and will be implemented before 12-8-17. This protocol is to assure that staff encourages	12/8/17

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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 282	Continued From page 12 was not present upon admission or re-entry. The pressure ulcer was first observed on 6/14/17. The MDS also identified one Stage 4 pressure ulcer that had been previously noted. R3's significant change MDS dated 8/8/17, indicated R3 had a Stage 4 pressure ulcer. The MDS further indicated R3 had no rejection of cares, required extensive assistance with bed mobility, dressing, and personal hygiene, and was totally dependent upon staff for transfer and toileting. The MDS further indicated R3 had pressure ulcers on the prior assessment of 7/31/17, but one Stage 2 and one Stage 4 pressure ulcer were now present, and they were not present at a lesser stage on the prior assessment. R3's Care Area Assessment (CAA) dated 8/8/17, indicated R3 had one Stage 2 pressure ulcer and one Stage 4 pressure ulcer, and he was at risk of developing pressure ulcers. The CAA indicated R3 was to be turned and repositioned or offloaded according to his care plan and Kardex. The CAA further indicated R3 had a pressure reduction mattress on his bed and a cushion in his wheelchair to aid in healing and prevention of future pressure ulcers. R3's care plan for skin started 8/2/11, and discontinued on 9/25/17, indicated R3 had pressure ulcers on his right heel, left inner ankle and left gluteal crease. The goal was for the pressure ulcers to heal without complication. Staff approaches were listed as: turn and reposition every one hour and as needed while in bed, have resident lay on his side or stomach, and noted that R3 had a history of noncompliance with turning and repositioning.	F 282	repositioning as part of each resident encounter. Repositioning audits have been initiated to assure that care planned repositioning schedules are followed. These are to be completed on 3 residents a day for 6 weeks by the nurses. Immediate re-education will be delivered for any non-compliance with the care planned repositioning schedule. Results turned in to the Director of Nursing until compliance is achieved and then at a level to maintain compliance as determined by the IDT. Audits of the all NAR group lists will be done daily each shift by the supervising nurse to assure that the repositioning is documented and done according to the plan of care and immediate re-education to be delivered as indicated. Audits will continue for 6 weeks and until compliance is achieved and then at a level to maintain compliance as determined by IDT. The CM is responsible to assure completion of audits and then turn them in to the DON. The DON is responsible for compliance. Education on the above corrective measures, skin care and ulcer prevention, and care planned interventions will be completed by 11-22-17. Compliance will be achieved by 12-8-17	

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R3's care plan for skin updated 9/25/17, indicated R3 had an alteration in skin integrity related to a diagnosis of MS, and had a pressure ulcer to his buttock. R3's goals were the wound would remain free from infection, and would not impair his lifestyle or activities. Interventions included to refer to the Kardex for resident specific plan of care.

R3's Kardex dated 10/17/17, directed staff to apply lotion, moisturize skin as needed, float heels, use blue boots (to relieve pressure), apply barrier cream as needed, use a Roho/gel cushion in his wheelchair (for pressure relief), and an alternating air pressure mattress in bed. The Kardex further directed staff to reposition R3 every hour when in his wheelchair, recliner and bed, and to use a gel insert under his wheelchair cushion to reduce shearing.

On 10/19/17, after surveyor intervention, a progress note was written directing staff to continue on an hourly repositioning schedule while R3 was in his wheelchair. The note further indicated that tilting in the wheelchair was to be used to offload pressure from R3's bony prominences.

Documentation of R3's refusals to reposition was requested but not received from the facility.

Repositioning sheets for June 2017, immediately after the development of the left ischial/buttock pressure ulcer developed, were requested but not received.

On 10/18/17, at 1:12 p.m. Licensed practical nurse (LPN)-C stated they were shredded after 3

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months. The sheets lacked information in the repositioning times column, but LPN-C stated the toileting times were the times they repositioned residents. LPN-C confirmed that there were many sheets that lacked complete information including the shift worked, not all columns completed, etc.

Review of R3's repositioning sheets from 7/1/17, to 7/12/17, revealed:
-7/1/17 day shift, 10:50 a.m. (up) to 12:35 p.m. (down): 1 hour, 45 minutes
-7/1/17 afternoon shift, 6:30 p.m. to 10:06 p.m.: 3 hours, 36 minutes
-7/2/17 day shift, 8:30 a.m. (down) to 11:30 (up): 3 hours
-7/2/17 afternoon shift, 6:30 p.m. to 10:05 p.m.: 3 hours, 35 minutes
-7/4/17 afternoon shift, 3:40 p.m. (up) to 6:30 p.m.: 2 hours, 50 minutes
-7/5/17 afternoon shift, 4:05 p.m. to 7:00 p.m. to 10:20 p.m.: 2 hours, 55 minutes and 3 hours, 20 minutes
-7/7/17 afternoon shift, 6:30 p.m. to 10:17 p.m.: 3 hours, 47 minutes
-7/8/17 afternoon shift, 3:51 p.m. to 6:15 p.m. to 10:05 p.m.: 2 hours, 24 minutes and 3 hours 50 minutes
-7/10/17 afternoon shift, 6:15 p.m. to 10:00 p.m.: 3 hours, 45 minutes
-7/11/17 afternoon shift, 6:45 p.m. until 10:20 p.m.: 3 hours, 25 minutes
-7/12/17 afternoon shift, 6:20 p.m. until 10:20 p.m.: 4 hours.

Repositioning sheets near to the survey time were also reviewed and provided the following data:
-10/3/17 day shift, 7:00 a.m., 9:00 a.m., 11:00 a.m., 12:30 p.m.: 2 hours, 3 times; 1 hour, 30

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minutes
-10/8/17 afternoon shift, 4:15 p.m. to 6:45 p.m. to 10:04 p.m.: 2 hours, 30 minutes; 3 hours, 19 minutes
-10/9/17 day shift, 6:40 a.m. to 9:20 a.m. to 11:00 a.m. to 1:10 p.m.: 2 hours, 40 minutes; 1 hour, 40 minutes; 2 hours, 10 minutes
-10/9/17 afternoon shift, 6:40 p.m. to 8:49 p.m. to 10:15 p.m.: 2 hours, 10 minutes; 1 hour, 26 minutes
-10/10/17 day shift, 11:05 a.m. to 1:00 p.m.: 1 hour, 55 minutes
-10/10/17 afternoon shift, 3:30 p.m. to 6:30 p.m. to 10:18 p.m.: 3 hours; 3 hours, 48 minutes
-10/11/17 afternoon shift, 6:38 p.m. to 10:07 p.m.: 3 hours, 29 minutes
-10/13/17 afternoon shift, 3:45 p.m. to 6:30 p.m. to 10:00 p.m.: 2 hours, 45 minutes, 3 hours, 30 minutes
-10/17/17 day shift, 8:05 a.m. to 11:05 a.m.: 3 hours
-10/17/17 evening shift, 3:45 p.m. to 6:40 p.m.: 2 hours, 55 minutes

On 10/18/17, R3 had continuous observation from 7:04 a.m. until 9:17 a.m. At 7:04 a.m. R3 was observed up in the wheelchair in his room. At 8:07 a.m. nursing assistant (NA)-D wheeled R3 to the dining room for breakfast. At 8:48 a.m. R3's wheelchair was repositioned so he was at a 45 degree angle, with his back and upper legs angled up. He remained in this position, on his back in his wheelchair until 9:17 a.m. when NA-D wheeled R3 back to his room to lay down. The total time was two hours and thirteen minutes. At 9:17 a.m. NA-D stated he had gotten R3 up right before breakfast. NA-D stated R3 was to be repositioned every hour.

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F 282	Continued From page 16 On 10/18/17, at 9:24 a.m. NA-B stated she did not know how often R3 was to be repositioned but supposed it was every 2 hours. On 10/18/17, at 10:24 a.m. LPN-C stated R3 was to be repositioned every hour when in his wheelchair, and that intervention had probably been in place since June. On 10/18/17, at 1:30 p.m. RN-A stated R3 got up for meals, and then lay back down. RN-A did not know if R3 was to be repositioned hourly or every two hours. RN-A verified 2 hours and 15 minutes was too long for R3 to be sitting in his wheelchair. On 10/19/17, at 9:56 a.m. the director of nursing (DON) was interviewed and stated she expected the care plan would be followed. The DON stated R3 was to be repositioned every hour when in his wheelchair. The facility's Care Plan Process and Review policy dated 11/10/15, directed the Kardex was utilized for care-planned interventions, and it was appropriate to refer to these as interventions in the care plan.	F 282		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's	F 309		12/8/17

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F 309	Continued From page 17 comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to conduct a pain assessment and monitor and provide pain relief for 1 of 1 residents (R71) reviewed for pain. Findings include: R71's Face Sheet dated 10/19/17, identified diagnoses of osteoporosis and osteoarthritis. R71's significant change Minimum Data Set	F 309	F309 Resident 71 was assessed for pain and pain management interventions were reviewed and care plan updated by the RN after review of findings with MD. MD was informed on 10-18-17 and orders for therapy obtained. MD stated he could give a cortisone injection during next visit if needed. MD saw resident 10-27-17 and did not administer injection as R 17 was without pain.	

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F 309	Continued From page 18 (MDS) dated 10/9/17, indicated R71 had moderate cognitive impairment. The MDS also indicated R71 required extensive assistance of two staff for transfers. The MDS indicated R71 had no impairment with her range of motion, received regularly scheduled pain medications, and did not have any pain. R71's care plan revised 9/13/17, indicated R71 was at risk for pain related to osteoarthritis. R71's goal was to have pain at a tolerable level that would not interfere with activities. R71's pain interventions directed staff to monitor for pain every shift, observe verbal and nonverbal communication of pain, complete a pain assessment per protocol, and referenced the Medication Administration Record (MAR), the Treatment Administration Record (TAR), and the Kardex. R71's Kardex revised 10/16/17, indicated R71 had pain in her knees, and she required assistance of two staff members for transfers. The Kardex lacked indications of pain in R71's shoulder, and direction on how staff was to transfer R71. R71's Physician's Order Report for 10/1/17, thru 10/31/17, identified orders for acetaminophen (Tylenol) 650 milligrams (mg) every six hours for osteoarthritis. On 10/15/17, at 2:31 p.m. a progress note indicated the following: licensed practical nurse (LPN) was alerted that R71 had hollered out in pain when her arm was lifted up to use the sling for transfers. R71 stated her shoulder hurt at that time, and only hurt when it was moved. R71's medical record lacked monitoring for pain every	F 309	In order to identify other residents at risk for pain, monitoring or relief, all residents have had shiftly PAINAD Scale completed by the LN and the data was then reviewed by the RN 11-16-17. Residents with indication of pain have had a comprehensive pain assessment completed by the RN, and the care plan will be reviewed and updated by the RN by 12-8-17. The PAINAD Policy, Pain Assessment and Management Policy, Notification of MD, and Change in Condition Policy have been reviewed. Staff also will receive additional education on documentation requiring follow up by an LN, the Stop and Watch Policy, and reporting and notifications with changes in resident condition, including complaints of pain and functional decline in training on 11/22/17. Stop and Watch Tool will now be a carbon copied form which the IDT will utilize the carbon copy for a twice weekly audits of actions taken, including care plan revision and notifications as needed. These tools have been ordered through BHS. The audits will continue for 6 weeks until compliance is achieved and then at a frequency to be determined by IDT. Audits of pain assessment and management will be completed on one resident daily for 6 weeks until compliance is achieved with recognizing, documenting, follow up and interventions for pain management and then frequency of audits to be determined by IDT. The RN managers are responsible to assure completion of audits and turn	

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F 309	Continued From page 19 shift, and lacked observations of verbal and nonverbal communication of pain directed by the care plan On 10/17/17, at 9:52 a.m. R71 was interviewed and stated she had pain in her left shoulder when she raised her left arm. R71 demonstrated by lifting her left arm up, and was unable to lift it past her shoulder level. R71 demonstrated she was able to raise her right arm up above her head. R71 stated she received a handful of pills, and was not sure if any were pain medications. R71 stated she had no pain if she didn't lift her left arm. R71 stated she had missed the exercise group because of pain, and expressed hope on being able to return to the group exercise program. On 10/18/17, at 8:56 a.m. R71 was observed being manually transferred from her wheelchair to the toilet. R71 was being assisted by nursing assistant (NA)-J and NA-M. NA-J and NA-M placed a transfer belt on R71's upper chest, and then grabbed the transfer belt under R71's arms. R71 cried out, "Ouch, ouch, my arm, my arm!" R71's legs were extended forward, and she bore little to no weight as NA-M and NA-J transferred and pivoted her from the wheelchair to the toilet, pausing to remove R71's garments. NA-M told R71 she knew her arm hurts. During the transfer, NA-J stated R71's arm had been hurting for a couple of weeks. NA-M stated R71 complained of leg pain at times also. On 10/18/17, at 9:06 a.m. NA-M and NA-J both stated R71 usually was transferred manually and she did not stand on her own. NA-J verified R71 did not bear weight during the transfer onto the toilet.	F 309	completed audits in to the DON. The DON is responsible for compliance. Education on all above corrective interventions to be completed by 11-22-17. Compliance will be achieved by 12-8-17.	

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F 309	Continued From page 20 On 10/18/17, at 1:21 p.m. the director of nursing (DON) was interviewed and stated she was unaware of R71's reported pain with the manual transfer. The DON stated she would have expected R71's pain to be assessed, evaluated and monitored, and occupational therapy (OT) be notified for a transfer evaluation. The DON stated she would expect the pain to be reported if needed. The DON stated staff can always use more supportive transfer methods (such as mechanical lifts) for residents if the resident is weak or if a manual transfer is not comfortable for the resident. The DON reviewed the progress note of 10/15/17, and stated she would have expected staff to conduct a three day pain observation for R71, an assessment of her transfers, and an investigation into why R71 had pain. On 10/18/17, following interview with the DON, the facility sent a fax was sent to R71's physician requesting orders for physical and occupational therapy to assess transfers and mobility, noting R71 had had changes in her functional status. R71's care plan was updated to document and assess pain each shift from 10/18/17, through 10/25/17. On 10/18/17, R71's TAR was updated to include an assessment and documentation of left shoulder for changes in pain, range of motion and functional abilities on every shift. On 10/19/17, at 9:29 a.m. NA-P stated on that morning, R71 had no pain with transfers. NA-P stated the transfer did not go well, but she had not reported it, because R71 had always been transferred manually.	F 309		

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On 10/19/17, at 9:34 a.m. NA-N stated R71 did not bear weight that morning during transfers. NA-N stated R71 had been manually transferred for at least eight months. NA-N stated R71 had increased complaints of pain over the last few weeks. NA-N stated she reported R71's pain to the nurse on Saturday or Sunday.

On 10/19/17, at 9:40 a.m. the DON stated R71's physician was contacted regarding her increase in pain yesterday, on 10/18/17. The DON verified pain monitoring was not started for R71 until that morning. The DON stated RN-A had conducted a pain assessment on R71 that morning. The DON verified R71 was unable to lift her arm past her shoulder height.

On 10/19/17, at 9:56 a.m. R71 was interviewed and stated she had some pain in her left shoulder when she had gotten out of bed that morning. R71 stated the pain came out of nowhere, and although she has had pain before, the pain she had experienced that morning of the observation was the worst she had.

On 10/19/17, at 3:51 p.m. R71 was observed to be transferred by physical therapist (PT)-B and the DON. PT-B and DON discussed what size sling to use for a Hoyer lift (mechanical lift) transfer. PT-B told the DON a stand aid lift was not appropriate, as it would hurt R71's shoulder. PT-B stated they were going to transfer R71 manually with two staff to demonstrate the difficulty R71 was having problems with transfers. PT-B placed the gait belt on R71 with a slight lift of her arms. PT-B stated the way staff usually transfer using the gait belt, and staff lifting her from the front with each staff holding onto one

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side of the gait belt often leads to shoulder injuries. PT-B and the DON started to transfer R71 using this method, with the DON and PT-B in front of R71. Each held onto opposite sides of the transfer belt. R71 did not bear weight when transferred from the wheelchair to her easy chair. R71's left leg came out in front of her body, and the gait belt slid up to R71's breast area. R71 was transferred back to the easy chair, with one in front of her and one on her side, lifting her from her back and front. R71 denied pain at this time. R71 demonstrated to the DON that her left arm did not rise above her shoulder, and her right arm rose easily over her head. R71 pointed to the left outer edge of her shoulder to identify her where pain was.

On 10/19/17, at 3:59 p.m. PT-B was interviewed and stated PT would now work with R71 on transfers. PT-B stated R71 would be transferred by a Hoyer lift. PT-B stated an informal screening to R71's shoulder demonstrated moderate internal rotation. PT-B stated therapy cannot assist with shoulder limitations, but can work on transfers. PT-B stated R71's wheelchair arm rests were too high, and R71's limited ability to bend her mid-section affects her balance, making transfers more difficult.

On 10/19/17, at 4:03 p.m. the DON stated she did not know if R71 had a decline in her shoulder range of motion. The DON further stated R71 was able to bear a little bit of weight when transferred, but she would be safer transferred with a Hoyer lift.

On 10/19/17, at 11:28 a.m. R71's physician was interviewed via phone call. The physician stated more documentation would have been expected

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from the initial report of pain noted in the medical chart on 10/15/17. The physician stated the DON had contacted him on 10/18/17, with R71's pain assessment. The physician stated the assessment indicated R71's shoulder pain was new, and had occurred over the weekend, and she had no pain present unless her left arm was moved. The physician stated R71 had a history of osteoarthritis, and a fracture was not suspected as R71 would have constant pain to the site. The physician verified the pain assessment did not include an assessment of R71's shoulder range of motion.

On 10/19/17, at 11:34 a.m. R71's family member (FM)-C stated the facility had not updated her about R71's shoulder pain. FM-C stated R71 has had back pain from osteoarthritis over the years, but had not complained of shoulder pain.

On 10/21/17, at 10:11 a.m. NA-M stated R71 had not been able to bear weight with transfers since the start of the summer, and it had been reported to licensed nurses. NA-M stated R71 complained of pain to her shoulder over the past week, and that had been reported to the nurses as well.

On 10/21/17, at 10:47 a.m. NA-N stated R71 used to be able to bear weight about six months ago, and she could take a few steps. NA-N stated she had reported it to the LPN. NA-N reported R71 has had shoulder pain on and off in the past two weeks, the pain had worsened, and the pain was new for R71. NA-N stated the pain was reported to the DON and RN-A a week ago. NA-N stated R71 was unable to lift her left arm up to put it into her shirt sleeve.

On 10/21/17, at 10:32 a.m. NA-J stated R71 had

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a change in her transfer ability, and a communication form was completed to alert the licensed nursing staff. NA-J stated about a month ago physical therapy (PT) had asked why R71 was not walking or standing well. NA-J stated she thought PT had brought their concerns to licensed nursing staff. NA-J stated R71 continued to be manually transferred after that, the NAs were not alerted to change the way they transferred R71. NA-J stated R71 had some pain in her left upper arm and shoulder area, and she thought R71 had slept on it wrong. NA-J stated she had not noticed any change in R71's shoulder range of motion.

The facility policy Pain Management dated 2/11, directed staff to complete a consistent, accurate and timely comprehensive assessment of a resident's comfort level as related to acute, chronic or suspected pain. The policy further directed for each resident who experienced pain, the facility should implement a prevention and intervention plan. The policy further directed the nurse to initiate a pain assessment and reassessment upon reports of a potential for pain, such as: nonverbal indicators, change in behavior status, grimacing or moaning with cares, and with resistance of body movement indicating pain.

The facility policy Change in Condition Early Warning Tool dated 8/12, directed nursing assistants and other staff to complete a Stop and Watch tool to document any changes, concerns or questions related to the resident, and to give the forms immediately to the licensed nurse or clinical manager. The policy directed licensed nursing staff to follow up with an assessment of any changes noted through direct observation or interview, and note changes to the next shift or on

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F 309	Continued From page 25 the 24 hour report form. In addition, licensed nurses were directed to obtain any other data necessary to complete an assessment, notify the resident's physician and the resident's family of the assessment findings. Licensed nursing staff were directed to update the plan of care with any pertinent information as appropriate.	F 309		
F 314 SS=G	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to assess, identify and implement interventions to prevent the development and/or worsening of pressure ulcers for 2 of 4 residents (R3, R68) reviewed for pressure ulcers. This resulted in actual harm for R3 who developed pressure ulcers that worsened.	F 314	314 Resident 3 is deceased R 68 has had a Skin Risk Assessment completed and the care plan was reviewed and updated with interventions. Weekly skin monitoring and documentation by RN was enforced, and repositioning schedule was reviewed and	12/8/17

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F 314	Continued From page 26 Findings include: Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP): Stage 2 Pressure Ulcer: Partial thickness dermis loss Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptures serum-filled blister. Stage 3 Pressure Ulcer: Full-thickness skin loss Full-thickness loss of skin, in which adipose (fat) is visible in the ulcer and granulation tissue and epibole (rolled wound edges) are often present. Slough and/or eschar may be visible. The depth of tissue damage varies by anatomical location; areas of significant adiposity can develop deep wounds. Undermining and tunneling may occur. Fascia, muscle, tendon, ligament, cartilage and/or bone are not exposed. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Stage 4 Pressure Ulcer: Full-thickness skin and tissue loss Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Ulcer. Unstageable Pressure Ulcer: Obscured full-thickness skin and tissue loss	F 314	updated. In order to identify other residents potentially affected and assure that residents were up to date on the skin risk assessments, all residents have had a Skin Risk Assessment completed and care plans were reviewed by RN and will be updated based on the skin assessments by 12-8-17. All residents with current pressure ulcers have been identified and those who are at high risk for pressure ulcer development have been identified. DON/ADON will perform weekly audits on all residents with current pressure injury for accurate identification and staging of pressure ulcers and appropriate documentation. The audits will continue for 6 weeks until compliance and then to be determined at a frequency as determined by IDT. Audits of the skin risk assessments will be completed on 2 residents a week by the MDS coordinator and immediate re-education will follow on any noncompliance with the assessment guidelines or completion. Audits will continue for 6 weeks until compliance is achieved and then at a frequency to maintain compliance as established by IDT. The MDS coordinator is responsible for the audits and will turn them in to the DON upon completion. Wheelchair cushions have been logged by resident use, need or preference and will be updated on the care plans by 12-8-17. The Skin Risk Assessment Policy has been reviewed and updated.	

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F 314	Continued From page 27 Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure ulcer will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed. Deep Tissue Pressure Injury: Persistent non-blanchable deep red, maroon or purple discoloration Intact or non-intact skin with localized area of persistent non-blanchable deep red, maroon, purple discoloration or epidermal separation revealing a dark wound bed or blood filled blister. Pain and temperature change often precede skin color changes. Discoloration may appear differently in darkly pigmented skin. This injury results from intense and/or prolonged pressure and shear forces at the bone-muscle interface. The wound may evolve rapidly to reveal the actual extent of tissue injury, or may resolve without tissue loss. If necrotic tissue, subcutaneous tissue, granulation tissue, fascia, muscle or other underlying structures are visible, this indicates a full thickness pressure injury (Unstageable, Stage 3 or Stage 4). Do not use DTPI to describe vascular, traumatic, neuropathic, or dermatologic conditions. R3's medical record lacked a comprehensive skin assessment, weekly skin monitoring, and R3 was not repositioned in a timely manner. R3's Face Sheet printed 10/23/17, identified diagnoses that included multiple sclerosis (MS), palliative care, and a history of Stage 3 and Stage 4 pressure ulcers to the buttock area, and	F 314	The NAR resident group lists have been reviewed and will be updated before 12-8-17 by the RN and NAR mentor to include more detailed guide for repositioning plans and documentation of the repositioning times. Personal Equipment, Emotion/Comfort, Elimination, and Positioning (PEEP) protocol has been developed by RN and will be implemented before 12-8-17. This protocol is to assure that staff encourages repositioning as part of each resident encounter. Repositioning audits have been initiated to assure that care planned repositioning schedules are followed. These are to be completed on 3 residents a day for 6 weeks by the nurses. Immediate re-education will be delivered for any non-compliance with the care planned repositioning schedule. Results turned in to the Director of Nursing until compliance is achieved and then at a level to maintain compliance as determined by the IDT. Audits of the all NAR group lists will be done daily each shift by the supervising nurse to assure that the repositioning is documented and done according to the plan of care and immediate re-education to be delivered as indicated. Audits will continue for 6 weeks and until compliance is achieved and then at a level to maintain compliance as determined by IDT. The CM is responsible to assure completion of audits and then turn them in to the DON. The policy for impaired skin and tissue management has been reviewed and updated. Skin and nutrition	

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F 314	Continued From page 28 diabetes. R3's annual Minimum Data Set (MDS) dated 5/1/17, indicated R3 was at risk for pressure ulcers, and had a Stage 4 pressure ulcer present that had not been present at a lesser stage on the prior assessment. R3's 7/31/17, quarterly MDS dated 7/31/17, indicated R3 had one Stage 2 pressure ulcer that was not present upon admission or re-entry. The pressure ulcer was first observed on 6/14/17. The MDS also identified one Stage 4 pressure ulcer that had been previously noted. R3's significant change MDS dated 8/8/17, indicated R3 had a Stage 4 pressure ulcer. The MDS further indicated R3 had no rejection of cares, required extensive assistance with bed mobility, dressing, and personal hygiene, and was totally dependent upon staff for transfer and toileting. The MDS further indicated R3 had pressure ulcers on the prior assessment of 7/31/17, but one Stage 2 and one Stage 4 pressure ulcer were now present, and they were not present at a lesser stage on the prior assessment. R3's Care Area Assessment (CAA) dated 8/8/17, indicated R3 had one Stage 2 pressure ulcer and one Stage 4 pressure ulcer, and he was at risk of developing pressure ulcers. The CAA indicated R3 was to be turned and repositioned or offloaded (a process in which pressure to an area of the body is relieved)according to his care plan and Kardex. The CAA further indicated R3 had a pressure reduction mattress on his bed, and a cushion in his wheelchair to aid in healing and prevention of future pressure ulcers.	F 314	documentation guidelines have been established and will be implemented after training on 11-22-17. Audits on wound condition and documentation will be done by the DON/ADON weekly on all residents who are followed in 'skin and nutrition at risk.' The audits will continue for 6 weeks until compliance and then to be determined at a frequency as determined by IDT. The use of the bath body tool and LN/RN follow up has been reviewed and remains appropriate and staff will be re-educated on the expectations of the process by 11-22-17. Audits of completion and documentation will be done weekly on each residents bath day by the RN manager with immediate re-education on the process with any deficiencies noted. Audits will be turned in to the DON and continue for 6 weeks, until compliance is achieved and then at a frequency to be determined by IDT. The facility has established a protocol for double checking of all physician orders. HI will audit for second check on orders and report concerns to DON weekly until compliance achieved and then at a level to maintain compliance by IDT. The DON is responsible for compliance with all above measures. Education on the above corrective measures will be completed by 11-22-17. Date of compliance is 12-8-17.	

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R3's care plan for skin started 8/2/11, and discontinued on 9/25/17, indicated R3 had pressure ulcers on his right heel, left inner ankle and left gluteal crease. The goal was for the pressure ulcers to heal without complication. Staff approaches were listed as: turn and reposition every one hour and as needed while in bed, have resident lay on his side or stomach, and noted that R3 had a history of noncompliance with turning and repositioning.

R3's care plan for skin updated 9/25/17, indicated R3 had an alteration in skin integrity related to a diagnosis of MS, and had a pressure ulcer to his buttock. R3's goals were the wound would remain free from infection, and would not impair his lifestyle or activities. Interventions included to refer to the Kardex for resident specific plan of care.

R3's Kardex dated 10/17/17, directed staff to apply lotion, moisturize skin as needed, float heels (keep the heels off of any surface), use blue boots (to relieve pressure), apply barrier cream as needed, use a Roho/gel cushion in his wheelchair (for pressure relief), and an alternating air pressure mattress in bed. The Kardex further directed staff to reposition R3 every hour when in his wheelchair, recliner and bed, and to use a gel insert under his wheelchair cushion to reduce shearing.

On 10/18/17, at 9:17 a.m. R3's pressure ulcer was observed with NA-D and NA-B. The pressure ulcer was observed to be an uncovered open area on the left buttock/ischial tuberosity, approximately 1.5 cm by 2.5 cm by 1.0 cm in depth with surrounding blanchable redness and

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irregular edges. R3 had an alternating air pressure mattress on his bed, per his care plan. In addition, a think foam cushion (approximately 3-4 inches) and below that, a thick gel cushion were on R3's wheelchair.

R3's medical record indicated the following on information documented on his pressure ulcers:

On 6/9/17, a progress note referred to R3 returning from the wound clinic with new orders for a left ischial (sitting bone) ulcer.

On 6/14/17, a progress note indicated R3 had a black area on his bottom that was identified as a deep tissue injury on the left buttocks. This was not the same pressure ulcer as noted in the 6/9/17, note. The note directed staff to reposition R3 hourly. The physician and family were updated.

On 6/14/17, a facility Skin Integrity Event Report indicated R3 had a 2 centimeter (cm) by 1 cm deep tissue injury on his left buttock. The report indicated a treatment to apply foam dressing to this deep tissue injury on the left buttock, change every seven days and as needed.

On 6/15/17, a progress note indicated the nurse practitioner (NP) assessed the open area on R3's left buttock, and ordered a foam dressing to the deep tissue injury on the left buttock to be changed every seven days and as needed, to continue using an air mattress on R3's bed, to provide frequent repositioning (every 2 hours) and use a wheelchair cushion.

On 6/15/17, a progress note indicated nursing had changed the dressing to R3's buttocks

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pressure ulcer, and had noted redness to the area, but no drainage or odor.

On 6/20/17, a progress note indicated R3's air flow mattress was not holding air pressure, a regular mattress was placed on R3's bed, and the manufacturer contacted. This note was a late entry for 6/15/17. The note further indicated a second mattress did not hold air and had to again be replaced. There was no documentation as to how long prior to 6/14/17, or after 6/15/17, R3 was without a pressure relieving mattress.

A 6/27/17, a Body Observation sheet indicated "sores" on R3's coccyx area. The sheet lacked any further description or measurements of the area.

On 6/27/17, a Weekly Skin note indicated R3 had two sores on the right side of his buttocks. The note indicated a dressing change had been done. The note also indicted R3 also had an open sore on his right heel. The note further indicated there were no other skin issues at that time. The sheet lacked any further description or measurements of the areas.

On 6/29/17, a nurse practitioner (NP) progress note indicated R3 had a wound on his left buttock and right heel, and indicated R3 had poor wound healing. The note directed staff to apply a foam dressing every seven days and as needed, and to provide pressure relief. The note lacked any further description or measurements of the area.

A 7/4/17, Body Observation sheet indicated "open" and 3 "X"s: one on R3's left buttock, one on R3's left ischial area, and one on R3's right buttock. The sheet lacked any further description

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or measurements of the areas.

On 7/4/17, a Weekly Skin note indicated R3 had an open area on his right heel, and two small open areas on the left side of his groin. The note lacked any documentation of the pressure ulcers on R3's ischial area. The note also lacked any further description or measurements of the areas.

A 7/11/17, Body Observation sheet had no areas indicated on R3's buttocks area.

A 7/18/17, Body Observation sheet indicated R3 had an open area indicated on the outer, upper left buttock area.

On 7/18/17, a Weekly Skin note indicated R3 had an open area on his left buttocks that was still present but small.

On 7/27/17, a NP progress note indicated R3 had a pressure ulcer on his left buttock: 1.0 cm by 1.0 cm by 0.9 cm, with a small amount of bloody drainage, pink granulation tissue in the wound bed, no odor, and the surrounding skin was intact. The NP directed staff to continue current wound care: saline moist to dry twice daily (BID) with follow up at the wound clinic. Staff were reminded to be mindful to minimize pressure.

On 7/31/17, a quarterly Skin Assessment indicated R3 scored a 14 on the Braden scale, which indicated he was at risk for skin breakdown. The assessment indicated R3 had a Stage 2 pressure ulcer on his left buttock/sacral area measuring 3.0 cm by 1.8 cm, another area described as 1.0 cm by 1.0 cm area on his coccyx, and a 3.0 cm by 1.3 cm area on his right heel; the last 3 areas did not have staging

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indicated. The assessment indicated R3 was a maximum to total assist with mobility and the plan of care had been reviewed and remained appropriate.

Review of physician orders revealed a treatment to a left buttock deep tissue pressure injury that ended on 7/27/17, and continuing orders for a left ischial Stage 4 pressure ulcer continuing throughout.

An 8/1/17, Body Observation sheet lacked documentation of any of R3's pressure ulcers.

On 8/1/17, a progress note indicated R3 was admitted to the hospital with pneumonia and a urinary tract infection. Another 8/1/17, progress note indicated R3 would return to the facility on hospice cares.

On 8/8/17, a Significant Change skin assessment note indicated R2 scored a 12 on the Braden scale which put him at risk for skin breakdown. The note further indicated R3 had a Stage 2 pressure ulcer on his left buttock/sacral area measuring 3.0 cm x 1.8 cm; an area on his coccyx measuring 1.0 cm by 1.0 cm and an area on his right heel measuring 3.0 cm by 1.3 cm. The coccyx and right heel pressure ulcers were not staged. Potential risk factors for impaired skin integrity included severely impaired mobility, and use of wheelchair for primary means of locomotion due to diagnoses of MS. The plan of care was reviewed and remained appropriate.

An 8/8/17, Body Observation sheet indicated R3 had a pressure ulcer on his right inner buttock. No other details were provided on the pressure ulcer.

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On 8/8/17, a Weekly Skin note indicated R3 had a red perineal area, the pressure ulcer on his buttocks was still present, and R3 had two red areas noted on right upper abdomen. No other details were provided on the pressure ulcers.

An 8/15/17, Body Observation sheet indicated R3 had an ulcer on his left lower, inner buttock. No further details were documented R3's medical record lacked a comprehensive assessment following the development of the pressure ulcer to R3's left buttock.

On 8/15/17, a Weekly Skin note indicated R3 continued to have pressure areas on his right heel and left ischial. No other details were provided on these pressure ulcers.

On 8/22/17, a Weekly Skin note indicated R3 continued to have a pressure ulcer on his left ischial. No other details were provided on this pressure ulcer.

An 8/29/17, Body Observation sheet lacked indication of pressure ulcers on R3's buttocks.

On 8/31/17, a progress note indicated a fax was received from the hospital with new orders for R3's ischial pressure ulcer. The new order was to cleanse the ischial pressure ulcer with normal saline and apply ADB pad (a sterile, highly absorbent dressing with a moisture resistant barrier), and to change the dressing daily and as needed.

A 9/5/17, Body Observation sheet indicated R3 had a pressure ulcer on his left buttock. No other details were provided on this pressure ulcer.

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On 9/5/17, a progress note indicated R3 had a Stage 3 pressure ulcer on his left buttocks measuring 1.0 cm by 0.7 cm with a depth of 0.2 cm, no drainage or odor were noted. The note indicated the wound bed had 100% granulation (healing) tissue, and the skin surrounding the wound was pink and intact, there was no undermining or tunneling; the wound was noted to be improving. R3's medical record lacked further documentation of the pressure ulcers on R3's right buttocks or right heel.

On 9/11/17, a Weekly Skin note indicated R3 still had a pressure ulcer on his left buttock. No other details were provided on this pressure ulcer.

A 9/12/17, Body Observation sheet indicated R3 had a pressure ulcer on his left buttock. No other details were provided on this pressure ulcer.

On 9/12/17, a progress note indicated R3 had a Stage 3 pressure ulcer on his left buttock measuring 0.9 cm by 0.5 cm and a depth of 0.1 cm, with no odor or drainage noted. The wound bed was described as having 100% granulation tissue with intact wound edges, and the surrounding tissue was pink and intact with no undermining or tunneling noted. The pressure ulcer was described as improving.

A 9/18/17, Body Observation sheet lacked documentation of the pressure ulcers on R3's buttocks.

On 9/19/17, a progress note indicated R3 had a Stage 3 pressure ulcer on his left buttocks, measuring 1.0 cm by 1.5 cm with no odor or drainage. The wound bed was described as

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having 100% granulation tissues, with edged macerated (softened, often from prolonged exposure to moisture), with a 2.4 cm by 0.3 cm laceration noted at the bottom of the pressure ulcer; no undermining or tunneling was noted.

On 9/26/17, a progress note indicated R3 had a Stage 3 pressure ulcer to his left gluteal area, measuring 1.0 cm by 0.9 cm and a depth of 0.3 cm, with no odor or drainage noted. The wound bed was described at 100% granulation tissue, with macerated edges and irregular, surrounding tissue was pink and intact with no undermining or tunneling noted.

On 10/3/17, a Weekly Wound Assessment indicated R3 had a Stage 3 pressure ulcer to his left gluteal area, measuring 1.0 cm by 0.5 cm and a depth of 0.3 cm with no odor or drainage noted. The wound bed was described as 100% granulation tissue with wound edges macerated and irregular, surrounding tissue intact and no undermining or tunneling noted.

A 10/9/17, Body Observation sheet lacked documentation of the pressure ulcers on R3's buttocks.

On 10/10/17, a Weekly Wound Assessment indicated R3 had a Stage 3 pressure ulcer on his left gluteal area, measuring 1.0 cm by 0.5 cm with no odor or drainage noted. The wound bed was described as 100% granulation tissue, the wound edged were macerated and irregular and the surrounding tissue pink and intact with no undermining or tunneling noted.

On 10/17/17, a Weekly Wound Assessment indicated R3 had a Stage 3 pressure ulcer to his

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left gluteal area, measuring 1.0 cm by 0.5 cm and a depth of 0.3 cm with no odor present, but a light amount of serosanguineous drainage was noted. The wound bed was described as having 100% granulation tissue with the surrounding tissue pink and intact with no undermining or tunneling noted.

On 10/19/17, after surveyor intervention, a progress note was written directing staff to continue on an hourly repositioning schedule while R3 was in his wheelchair. The note further indicated that tilting R3 in his wheelchair was to be used to offload pressure from R3's bony prominences.

Documentation of R3's refusals to reposition was requested but not received from the facility.

Repositioning sheets for June 2017, immediately after the development of the left ischial/buttock pressure ulcer developed, were requested but not received. Licensed practical nurse (LPN)-C stated they are shredded after 3 months. The sheets lack information in the repositioning times column, but LPN-C stated the toileting times are the times they repositioned residents. LPN-C confirmed that there were many sheets that lacked complete information including the shift worked, and not all columns were completed. Review of R3's repositioning sheets from 7/1/17, to 7/12/17, revealed:

-7/1/17 day shift, 10:50 a.m. (up) to 12:35 p.m. (down): 1 hour, 45 minutes
-7/1/17 afternoon shift, 6:30 p.m. to 10:06 p.m.: 3 hours, 36 minutes
-7/2/17 day shift, 8:30 a.m. (down) to 11:30 (up): 3 hours

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-7/2/17 afternoon shift, 6:30 p.m. to 10:05 p.m.: 3 hours, 35 minutes
-7/4/17 afternoon shift, 3:40 p.m. (up) to 6:30 p.m.: 2 hours, 50 minutes
-7/5/17 afternoon shift, 4:05 p.m. to 7:00 p.m. to 10:20 p.m.: 2 hours, 55 minutes and 3 hours, 20 minutes
-7/7/17 afternoon shift, 6:30 p.m. to 10:17 p.m.: 3 hours, 47 minutes
-7/8/17 afternoon shift, 3:51 p.m. to 6:15 p.m. to 10:05 p.m.: 2 hours, 24 minutes and 3 hours 50 minutes
-7/10/17 afternoon shift, 6:15 p.m. to 10:00 p.m.: 3 hours, 45 minutes
-7/11/17 afternoon shift, 6:45 p.m. until 10:20 p.m.: 3 hours, 25 minutes
-7/12/17 afternoon shift, 6:20 p.m. until 10:20 p.m.: 4 hours.

Repositioning sheets near to the survey time were also reviewed and provided the following data:
-10/3/17 day shift, 7:00 a.m., 9:00 a.m., 11:00 a.m., 12:30 p.m.: 2 hours, 3 times; 1 hour, 30 minutes
-10/8/17 afternoon shift, 4:15 p.m. to 6:45 p.m. to 10:04 p.m.: 2 hours, 30 minutes; 3 hours, 19 minutes
-10/9/17 day shift, 6:40 a.m. to 9:20 a.m. to 11:00 a.m. to 1:10 p.m.: 2 hours, 40 minutes; 1 hour, 40 minutes; 2 hours, 10 minutes
-10/9/17 afternoon shift, 6:40 p.m. to 8:49 p.m. to 10:15 p.m.: 2 hours, 10 minutes; 1 hour, 26 minutes
-10/10/17 day shift, 11:05 a.m. to 1:00 p.m.: 1 hour, 55 minutes
-10/10/17 afternoon shift, 3:30 p.m. to 6:30 p.m. to 10:18 p.m.: 3 hours; 3 hours, 48 minutes
-10/11/17 afternoon shift, 6:38 p.m. to 10:07 p.m.:

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3 hours, 29 minutes
-10/13/17 afternoon shift, 3:45 p.m. to 6:30 p.m. to 10:00 p.m.: 2 hours, 45 minutes, 3 hours, 30 minutes
-10/17/17 day shift, 8:05 a.m. to 11:05 a.m.: 3 hours
-10/17/17 evening shift, 3:45 p.m. to 6:40 p.m.: 2 hours, 55 minutes

On 10/18/17, R3 was continuously observed from 7:04 a.m. until 9:17 a.m. At 7:04 a.m. R3 was observed up in the wheelchair in his room. At 8:07 a.m. nursing assistant (NA)-D wheeled R3 to the dining room for breakfast. At 8:48 a.m. R3's wheelchair was repositioned so he was seated at a 45 degree angle, with his back and upper legs angled up. R3 remained in that position, on his back in his wheelchair until 9:17 a.m. when NA-D wheeled R3 back to his room to lay down. The total time was two hours and thirteen minutes. NA-D was interviewed at this time and stated he had gotten R3 up right before breakfast. NA-D stated R3 was to be repositioned every hour.

On 10/18/17, at 9:24 a.m. NA-B stated she did not know how often R3 was to be repositioned, but she supposed it was every 2 hours.

On 10/18/17, at 10:24 a.m. LPN-C stated R3 had a small, chronic pressure ulcer on his buttock that just wouldn't heal. LPN-C stated R3 was to be repositioned every hour when in his wheelchair, and that repositioning schedule had probably been in place since June.

On 10/18/17, at 10:40 a.m. LPN-C confirmed that R3's wheelchair pad was a thick (approximately 3-4 inches) foam pad, with a gel pad underneath that pad, which she did not know what good that

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would do. LPN-C confirmed the facility had not completed an assessment of R3's tissue perfusion (to determine how long he could put pressure on bony prominences), within the last year, and the last one found in R3's medical record had been completed in 2014.

On 10/18/17, at 1:30 p.m. RN-A stated the references to R3's left buttock and ischial pressure ulcers referred to the same wound, although different terminology was used. RN-A stated R3 got up for meals, and then lay back down. RN-A did not know if R3 was to be repositioned hourly or every two hours. RN-A verified 2 hours and 15 minutes was too long for R3 to be sitting in his wheelchair.

On 10/19/17, at 9:31 a.m. certified occupational therapist assistant (COTA)-A stated R3 had not received occupational therapy (OT) services since March 2016. R3's medical record lacked therapy notes regarding use of a gel cushion or a thick foam pad in his wheelchair. Physical therapist assistant (PTA)-A stated physical therapy (PT) had not seen R3 since 2/17/17, and that was only an evaluation for range of motion.

On 10/19/17, at 9:56 a.m. the director of nursing (DON) was interviewed and stated she expected the care plan would be followed. The DON stated R3 was to be repositioned every hour when in his wheelchair, and an alternating air pressure mattress was to be on his bed. The DON confirmed the facility had identified its pressure ulcer documentation as an area for improvement; indicating there have been different and incomplete ways of documenting pressure ulcer stages and descriptions. The DON further stated since 9/5/17, there had been one RN performing

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all pressure ulcer rounds and documentation; prior to that there were multiple nurses performing this task and the documentation was inconsistent. The DON confirmed there was not consistent references to R3's pressure ulcer locations and staging. The DON would not confirm if R3 had one or several pressure ulcers, nor would she indicate the correct staging of the pressure ulcers, including the pressure ulcer that was currently open. The DON also stated she had talked to the NAs about putting pre-existing pressure ulcers on the skin sheets that are completed with weekly baths; she was aware that this was incomplete documentation. The DON further stated she did not think R3's repositioning refusals had been documented, and she stated she did not look at these daily sheets completed by the NAs. The DON stated the LPNs were responsible to monitor these, and to address any concerns. The DON stated R3 should have had one cushion in his wheelchair, and he was to be repositioned every one hour.

The facility's Skin Risk Observations policy dated 1/31/14, directed a tissue tolerance assessment was to be completed when there was new development of a pressure ulcer. The policy further directed licensed staff to develop an individualized turning and repositioning schedule based on daily skin inspection by NA's, and weekly skin inspections completed by licensed staff, with further direction to complete tissue tolerance tests to determine appropriate interventions that were updated on the care plan.

The facility's Skin Integrity, Pressure Sores policy dated 2/11, directed the pressure ulcer assessment was to be completed weekly to include: location, stage, depth/tunneling,

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measurement (in centimeters), description of exudate/drainage, tissue description, site infection evidence, condition of skin surrounding the ulcer, appropriate care and treatment, resident condition and response to treatment. The policy further directed to specify physician orders. The policy also directed that each pressure ulcer was to be documented separately, with its own skin assessment form.

R68's medical record lacked a comprehensive assessment following the development of a pressure ulcer, and the facility did not complete treatment for a pressure ulcer until 7 days after the treatment had been ordered.

R68's Face Sheet printed 10/18/17, indicated R68 had diagnoses that included cerebral ischemic attack (stroke), and unstageable pressure ulcer of the right heel.

R68's admission MDS dated 8/17/17, indicated R68 had moderately impaired cognition. The MDS also indicated R68 required extensive assistance of two staff for all transfers and bed mobility. The MDS indicated R68 did not have pressure ulcers on admission, and was at risk for pressure ulcer development.

R68's care plan initiated 9/13/17, indicated R68 was at risk for alteration in skin integrity due to general muscle weakness, left side cerebral vascular accident (CVA, commonly known as stroke) with right sided weakness, back pain, chronic pain, osteoarthritis and spinal stenosis.

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The goal was to keep the wound free of infection and not impair R68's lifestyle or activities. Interventions started on 9/13/17, included to treat wound as ordered, staff were directed to reference the medication administration record (MAR), treatment administration record (TAR), and Kardex for R68's specific plan of care instructions. Staff were directed to document wound conditions with dressing changes, to refer to nutrition problem statement and interventions in the care plan, and consult the physician as needed. The facility was unable to provide a care plan prior to 9/13/17.

R68's Kardex dated 10/11/17, directed staff to lotion R68's skin, float heels at all times, apply barrier cream, and reposition R68 every 2 hours and as needed. R68 was to have a pressure reducing mattress on her bed and in her wheelchair, and staff was to reposition R68 in the wheelchair every 2 hours. Staff were directed to use pillows on R68 to protect her bony prominences. The care plan and Kardex lacked directions to staff to use a pressure reducing boot on her right heel.

R68's pressure ulcer CAA dated 8/17/17, indicated R68 showed moderate cognitive impairment and required assistance from staff with all activities of daily living (ADL) due to right side weakness. The CAA indicated R68 was at risk for development of pressure ulcers, and her skin was intact at time of assessment. R68 was provided a pressure redistribution mattress on her bed and a cushion to her wheelchair. Staff were directed to assist R68 with toileting needs, incontinence care, turning, repositioning and off loading per care plan.

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On 10/18/17, at 11:28 a.m. R68's pressure ulcer was observed. Registered nurse (RN)-B and RN-A removed R68's dressing. RN-A verified the dressing she removed was not the dressing that was currently ordered. RN-B measured R68's pressure ulcer as 2.6 cm by 1.9 cm, with 85% of the wound described as slough. R68's wound had 10% eschar and 5% of granulated tissue. At 11:36 a.m. RN-B provided the ordered treatment of a wet to dry dressing.

R68's Seven Day Skin Risk Assessment dated 8/20/17, indicated R68 did not have a pressure ulcer, and she was totally dependent on staff for bed mobility. R68's Braden Scale (done to assess a resident's risk for pressure ulcer development) dated 8/20/17, was 15, which identified R68 as being at risk for pressure ulcer development.

R68's Fourteen Day Skin Risk Assessment dated 8/25/17, indicated R68 did not have a pressure ulcer, and she was totally dependent on staff for bed mobility. R68's Braden Scale Score dated 8/25/17, was 15, which identified R68 as being at risk for pressure ulcer development.

R68's Twenty-One Day Skin Risk Assessment dated 9/3/17, indicated R68 did not have a pressure ulcer, and she was dependent on staff for bed mobility. R68's Braden Scale Score dated 9/317, was 15, which identified R68 at risk for pressure ulcer development.

R68's Physician Orders dated 10/11/17, directed staff to float R68's right heel at all times on every shift. The Physician Orders also directed a wet to dry dressing treatment to the right heel twice a day, hold in place by heel bandage and wrapped in Kerlix ordered on .

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R68's medical record indicated the following pressure ulcer:

On 9/9/17, a progress note indicated R68 had a large open red sore on her inner right ankle. The area was cleansed, dressed and staff was directed to monitor it. The progress note lacked documentation of the size or the staging of the pressure ulcer.

On 9/10/17, a progress note indicated R68 had a Stage 2 pressure ulcer on her right heel that measured 4.8 centimeters (cm) wide and 3.5 cm long. A dressing was applied, a blue boot was placed on R68's right heel (for pressure relief) and the care plan was updated to float her right heel at all times.

On 9/12/17, a progress note indicated R68 had a Stage 3 pressure ulcer to the right heel that measured 4.5 cm by 4.0 cm without depth. Moderate drainage was noted without odor. The wound bed was described to have 90% granulation tissue (new tissue) with 10% slough (dead tissue) on the upper part of wound. Macerated (moist) edges surrounding tissue were pink and intact with no tunneling. R68's Certified Nurse Practitioner (CNP) was updated. A physician fax communication form was sent to CNP with a condition change update that indicated R68 had developed a Stage 3 pressure ulcer to her right heel with 90% granulated with 10% eschar. The CNP was informed that R68's heels would be floated, an air pressure relief mattress was in place, and the facility was requesting orders for a dressing treatment for R68's pressure ulcer.

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On 9/13/17, the CNP assessed R68's pressure ulcer and ordered Mepilex border dressing to the right heel pressure ulcer every three days. The CNP documented R68 was seen on that day and that nursing initially noted a Stage 2 pressure ulcer to the right heel 3 days ago, with this being the first report to the CNP. The CNP indicated staff placed an undetermined dressing R68's right heel and a blue boot to relieve pressure. The CNP indicated the pressure ulcer measured 4.8 cm by 4 cm and a pink base of granulation tissue was noted with a central area of darker tissue. The CNP's assessment and plan for R68's pressure ulcer directed staff to apply Mepiplex dressing to right heel and change every 3 days. Staff were directed to float R68's heels and keep pressure off the heels at all times.

On 9/18/17, the CNP documented a follow up visit for R68, and indicated R68's pressure ulcer was covered with tan slough, and central area remained dark colored. The pressure ulcer had no odor or bogginess, and a small amount of tan colored drainage was on the foam heel dressing. The CNP ordered Mepiplex AG to R68's pressure ulcer to right heel, change every 3 days. Staff were ordered to to cleanse the pressure ulcer with wound cleanser every dressing, and wrap and secure with Kerlix.

On 9/19/17, a progress note indicated R68 had a Stage 3 pressure ulcer to her right heel that measured 4.8 cm by 4.3 cm with depth less than 0.2 cm. The pressure ulcers was described as 100% granulation tissue with a dark center.

On 9/22/17, a physician progress note indicated the CNP had been following R68's pressure ulcer to the right heel with treatment of Mepiplex

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dressing. R68's pressure ulcer was described as slightly improved at that time.

On 9/26/17, a progress note indicated R68's Stage 3 pressure ulcer to the right heel measured 3 cm by 3.2 cm, with a depth less than 0.2 cm. The pressure ulcer had a center area of darker tissue that measured 2.5 cm by 2.5 cm. R68's pressure ulcer had a light amount of yellow brown drainage without odor. The wound bed was 60% granulation tissue and 40% of the ulcer was a darkened area located in the center.

On 9/27/17, the CNP provided a telephone order for a new bandage dressing for R68's pressure ulcer. The CNP ordered Aquacel AG (a dressing that kills wound bacteria held in the dressing. This dressing absorbs high amounts of wound fluid and bacteria and creates a soft, gel that conforms to the wound surface, maintains a moist environment, and aids in the removal of dead tissue from the wound) to R68's right heel, cover with foam dressing and secure with Kerlix, change 3 days.

On 10/3/17, a progress note indicated R68's Stage 3 pressure ulcer measured 3.6 cm by 3.3 cm, with depth less than 0.2 cm, and the center dark tissue measured 2.3 cm by 2.0 cm. R68's pressure ulcer had a light amount of serosanguinous drainage without odor. R68's pressure ulcer wound bed was 10% granulated and 90% of the pressure was a dark area in center.

On 10/4/17, R68's physician note indicated her right heel ulcer measured 4 cm by 3.5 cm with a center of 2.1 cm by 2.2 cm. No color description provided for the center of the wound. The CNP

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ordered an appointment with the physician on next rounds and possible debridement (the medical removal of dead, damaged, or infected tissue to improve the healing potential of the remaining healthy tissue) .

On 10/4/17,the CNP ordered calcium alginate dressing (a wound dressing made from natural alginate fibers derived from brown seaweed, the chemical composition creates a reaction resulting in the formation of a soluble sodium gel. This natural gel helps to speed up the healing of the wound in promoting the wound's autolytic [natural] debridement, while also absorbing excess fluid) to be covered with foam dressing every 3 days to R68's pressure ulcer to right heel.

On 10/10/17, a progress indicated R68's Stage 3 pressure ulcer on the right heel was now an unstageable pressure ulcer (worsening) to the right heel. R68's pressure ulcer measured 3.5 cm by 2.6 cm with undetermined depth. R68's pressure ulcer had eschar (a piece of dead tissue that is cast off from the surface of the skin, hard, dry dead tissue) in the center, and serosanguinous drainage without odor.

On 10/11/17, R68's physician progress note indicated R68 went to the physician for heel pressure ulcer assessment. The exam dictation indicated R68's pressure ulcer to measured 2.5 cm by 2 cm with an unknown depth area due to eschar and slough (dead tissue usually cream or yellow in color). R68 underwent surgical debridement of the pressure ulcer during the office visit. R68's CNP provided an order for wet to dry dressings to the right heel twice a day, and to keep pressure off R68's heel.

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On 10/11/17, at 4:49 p.m. a progress note indicated R68 returned from the appointment with new order for wet to dry dressing to right heel pressure ulcer and to keep pressure of heel.

R68's TAR indicated the order for wet to dry dressing ordered on 10/11/17, was not transcribed or administered until 10/18/17.

On 10/17/17, a progress note indicated R68's Stage 3 pressure ulcer presented itself as an unstageable pressure ulcer to the right heel. The pressure ulcer measured 3.0 cm by 2.5 cm with an undetermined depth. The center was eschar and measured 2.2 cm by 2.0 cm, and was 60% eschar and 40% granulated tissue. There was a light amount of serosanguinous drainage without odor.

On 10/18/17, at 7:08 a.m. R68 was observed seated in her wheelchair in the lobby area watching television. R68 dark blue pressure relieving bootie was on her right foot, and a light blue bootie was on her left foot. R 68's foot pedals were in place and her feet were elevated at 20 degrees. A gray wedge was in between the light blue bootie and the dark blue bootie.

On 10/18/17, at 9:37 a.m. R68 was observed in bed with her heels floated off the mattress.

On 10/18/17, at 9:53 a.m. the director of nursing (DON) verified the order on 10/11/18, had not been transcribed, and the dressing change not completed until 10/18/17. The DON stated she expected orders were to be transcribed and administered as ordered when they were received.

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On 10/21/17, at 10:08 a.m. NA-M stated interventions for R68 were to float her heels in bed, place pressure relieving boots on her when she was up in her chair, and reposition R68 every 2 hours. NA-M stated at times, R68 resisted interventions and cares. NA-M stated she had started using the blue booties on R68 the past month and a half, when the pressure ulcer was discovered. NA-M stated when skin issues were found, it was the expectation to report them to the nurse, and fill out a Stop and Watch form, to alert all staff. NA-M stated they were directed to look at resident's skin on bath days, and check skin during resident cares.

On 10/21/17, at 10:30 a.m. NA-J stated she floated R68's heels when she was admitted, because that is what NA-J does. NA-J stated 68's interventions were to reposition R68 every 2 hours, to float her heels and place the blue booties on R68's feet. NA-J stated the blue booties were initiated when the pressure ulcer to the right heel was discovered.

On 10/21/17, at 10:45 a.m. NA-N stated R68's interventions were to float heels in bed, to use blue boots when in wheelchair, and reposition R68 every 2 hours. NA-N stated R68 started to use the blue boots about a week after R68's pressure ulcer on her right heel was noticed. NA-N stated R68's heels were not floated prior to the right ankle pressure ulcer.

On 10/24/17, at 9:34 a.m. the DON verified the order to float R68's heels at all times was transcribed onto the MAR. The DON verified R68's skin was intact on admission, and on 9/10/17, a Stage 2 pressure ulcer was found to R68's right inner heel that measured 4.8 cm by

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F 314	Continued From page 51 3.5 cm. The DON explained the process for reporting changes to the nurse once again. The facility policy Impaired Skin and Tissue Management Policy dated 3/14/14, directed staff to notify the physician for verification of orders upon new development of any pressure ulcer. The facility policy Physician Orders dated 3/14/14, lacked directions on timely transcription of physician orders and administration of ordered treatments. The facility Physician Standing Orders dated 9/16, directed staff to notify the physician of any pressure ulcers, and to complete an assessment and skin protocol. The standing orders lacked directions on what treatments to provide for any stage of pressure ulcers. The facility policy Skin Integrity - Pressure Ulcers effective February 2011, directed staff to provide physician notification at the time the skin ulceration was identified and to notify physician of implementation of any standing order wound protocol provided.	F 314		
F 323 SS=K	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		12/8/17

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F 323	Continued From page 52 (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure safe transfer techniques when transferring residents utilizing ceiling lift transfers, resulting in actual harm for 1 of 11 residents (R5) who was transferred using a ceiling lift and Guldman brand sling. This resulted in serious injury to R5 who fell from the lift during a transfer, was sent to the emergency room, and sustained pain, abrasions, and a fractured humerus. In addition to R5, the facility failed to ensure safe transfers for 3 additional residents (R3, R16, R59) who were also transferred improperly with ceiling lifts and slings. The facility failed to ensure direct care staff were utilizing manufacturer recommended sling placement technique during transfers, which resulted in an immediate jeopardy (IJ) situation for (R5, R3, R16, and R59). All of these residents were listed as totally dependent upon staff for transfers.	F 323	F323- R 5 was discharged to the hospital due to UTI sepsis and returned on 11/14/17. A Pain Assessment completed on 11/15/17 and no pain expressed by the resident and admission care plan initiated. R 5 has been reviewed for transfer technique and all staff trained on ceiling lift transfer. R3, R5, R16 and R59 were all identified and individually assessed on 10/23 and found to be transferred out of accordance with sling manufacture guidelines. RN Managers observed all residents, including the four identified, who require mechanical lift transfer and provided on the spot education to all direct care nursing staff, with an emphasis on crisscross through the legs sling method, proper body positioning in sling and proper application of sling with	

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F 323	Continued From page 53 The immediate jeopardy began on 10/21/17, when R5 fell from a ceiling lift sling during a transfer from the wheelchair to the bed, was sent to the emergency room and was diagnosed with a fractured humerus (upper arm bone). This incident was identified on 10/23/17. The administrator and director of nursing were notified of the immediate jeopardy on 10/23/17, at 6:42 p.m. The immediate jeopardy was removed on 10/24/17, at 4:40 p.m. but noncompliance remained at the lower scope and severity level of an G, which indicated actual harm that was not immediate jeopardy. In addition, interventions to reduce injuries related to falls were not provided consistently for R74, and a a decline in ability to transfer safely leading to shoulder pain and decreased range of motion was not comprehensively assessed, and interventions were not initiated to prevent further injury for R74. In addition, comprehensive toileting and fall assessments, and root cause analyses of falls was not completed to identify appropriate interventions to prevent falls for R2. This resulted in actual harm for R2 who sustained a cervical (neck) fracture. Findings include: R5 sustained a broken humerus due to a fall from a Guldman sling attached to a ceiling lift in the facility. Staff failed to use the proper sling placement according to manufacturer recommendations for the transfer. In addition to the broken humerus, R5 complained of neck pain, a headache, had several abrasions on her face and red areas on her neck.	F 323	mechanical lift. A Floor Meeting was initiated on 10-23-17 to verbally re-educate all direct care nursing staff as well as requiring them to demonstrate proper sling placement and ceiling lift transfer by the supervising nurse or NAR Mentor Trainer. All staff was required to demonstrate proper sling placement including crisscross method between residents' legs, proper sling placement, Proper body positioning and application of sling to mechanical lift. This was completed prior to staff providing direct cares to resident. In order to identify other residents with a risk to be potentially affected by this, the RN managers observed all residents requiring mechanical lift during transfers and discussed transfer methods and proper sling placement with direct care staff on 10-23-17. Changes to prevent recurrence include utilizing our NAR Mentor Trainer who has demonstrated proper transfer and will provide proper instruction to new hired staff which includes one to one education and return demonstration with proper sling fit, placement, type and safe transfer. NAR Mentor Trainer will also be utilized to provide ongoing education to current staff and will be utilized during annual competency training. NAR Mentor Trainer and RN have reviewed and updated the competency testing for use of mechanical lifts and sling safety on 10-25-17.	

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F 323	Continued From page 54 R5's Face Sheet printed 10/23/17, identified diagnoses that included quadriplegia (complete paralysis of both arms and legs), and cerebrovascular accident (CVA, commonly known as stroke). R5's quarterly Minimum Data Set (MDS) dated 9/25/17, indicated R5 was cognitively intact, and was totally dependent upon staff for activities of daily living (ADLs), including transfers. The MDS also identified R5 had no falls since the last assessment. R5's Falls Care Area Assessment (CAA) dated 12/26/16, identified R5 was at risk of falls due to being unable to maintain balance without assistance. The CAA indicated R5 was alert and oriented, and able to make her needs known. The CAA also indicated R5 received total assistance with ADLs due to diagnoses of CVA and quadriplegia, she was non-ambulatory, used a lift for transfers, and made no attempts to self transfer. The CAA further indicated R5 was not able to maintain balance without staff assistance due to her diagnoses, and had not had any falls in the assessment look back period and no falls in the last year. R5's care plan dated 9/25/17, indicated R5 was at risk for falls, with the goal to not be seriously injured due to a fall. The care plan also indicated R5 required total assist of staff and ceiling track lift for transfers. The care plan identified the following interventions: keep the call light within reach when in room, anticipate needs, provide toileting assistance as soon as possible at resident's request, redirect if resident observed attempting to stand or walk independently (even	F 323	Education regarding proper sling use was presented to staff during shift to shift report, and in the pay day update, and the daily agenda sheets. All nursing staff will be trained again on sling crisscross method, proper body positioning and sling placement and safe transfer at the mandatory 11/22/17 training. Daily observations will be completed on the 4 identified residents by the RN or designee. The audits will be completed twice weekly on all other residents requiring a mechanical lift for a period of 6 weeks. RN staff and designees will audit lift transfers for proper sling placement, crisscross method, body positioning and safe transfer. DON and Administrator will evaluate upon completion of the 6 week monitoring and determine if bi-weekly monitoring is to continue. If evaluation concludes monitoring has been effective, audits will continue monthly for a period of 6 months. Audits will continue as determined by IDT for frequency. Audits will be submitted monthly to the Quality Council and include any corrective actions taken. Policy for Mechanical Lifts and slings was reviewed and remains appropriate. All staff will be educated on 11-22-17. All Direct Care Staff have been educated on sling use reporting and use of the Stop and Watch on 11/22/17. R 74 has been reviewed for transfer technique and all staff trained on ceiling lift transfer. A fall assessment was completed on R74 and the care plan updated based on the findings. All	

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F 323	Continued From page 55 though the resident was quadriplegic and was unable to attempt to stand or walk independently). The care plan directed to refer to Kardex/behavior tool for resident specific plan of care. R5's Kardex dated 10/17/17, directed staff to use a ceiling track lift with a full sling to transfer R5. R5's care plan and Kardex lacked direction of sling placement. A progress note dated 10/21/17, at 7:53 p.m. indicated R5 fell while being transferred from her wheelchair into bed. The note indicated after the fall, R5 complained of pain to the right side of her forehead and right neck/clavicle area. The note further indicated R5 sustained two pinpoint abrasions above her right eyebrow, and a red area on the right side of her neck. The note also indicated R5 fell to the floor and was laying on her left side/back with her legs slightly bent at the knees and tucked under the bed, with her right arm behind her body, and her head leaning to the left and left arm folded at her side. The note indicated R5 stated she bumped her head and had a headache, nursing assessment indicated R5's pupils were 5+ (high side of normal) and sluggish (abnormal slow response). The note concluded that R5 was sent to the emergency room for further evaluation. A progress note dated 10/21/17, at 9:43 p.m. indicated the emergency room called and informed the facility R5 had sustained a fractured right humerus (upper arm). The note also indicated the hospital was waiting on a few more scans, and would call the facility with further updates. A progress note dated 10/22/17, at 2:16 a.m. indicated R5 returned to the facility.	F 323	residents have had a Fall Risk Observation completed by 11/14/17 to determine what other residents are at risk for falls. The RN will review and update the care plans by 12-8-17 for all residents to assure fall interventions are in place. The 'Guidelines for IDT after Fall' and 'Care Plan Process and Review' Policies have been reviewed and updated. The Care Plan Change Form Policy/Process has been revised to better track interventions previously implemented for a resident. The Clinical Managers are to assure the Care Plan Change Form is completed and filed under the Care Plan Section in the hard chart and that the Care Plan Change process and tools are updated according to policy. Audits to assure care plans are updated with effective interventions and the process for care plan revision is followed. Audits will be completed on 5 residents weekly by the nurse and results turned in to the Director of Nursing until compliance is achieved and then at a level to maintain compliance as determined by the IDT. R2 is deceased. In order to identify others with potential to be affected by bowel and bladder assessments in relation to contributing to falls, an IDT review of the residents bowel and bladder patterns will be conducted for residents who were identified as having falls in the last quarter, and if it is determined to be a contributing factor a 3 day bowel and bladder tracking and focused RN assessment will be completed in order to ensure that the care	

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F 323	Continued From page 56 A progress note dated 10/22/17, at 11:41 a.m. indicated R5 was tired and felt nauseated. Family reported concerns as resident was not finishing sentences with their conversations. According to the note, R5's vital signs were taken and her oxygen saturation was at 85% on room air (normal is 95%). Supplemental oxygen was then used, per standing orders, and R5's oxygen saturation then went up to 90%. Neurological checks were then implemented hourly for 3 hours and then every 4 hours for 24 hours. The facility assured family they would follow up with any changes in condition, and they contacted the nurse practitioner. A progress note dated 10/22/17, at 6:21 p.m. indicated R5 was mumbling and hard to rouse. R5's blood pressure was 53/41 (low), her pupils were dilated, but not symmetrically, and her oxygen saturation was 90% on 1.5 liters per minute of supplemental oxygen. R5 was sent to the emergency room again, and from there transferred to a medical intensive care unit at a larger tertiary hospital with septic shock and a urinary tract infection. On 10/23/17, at 9:56 a.m. the director of nursing (DON) was interviewed and stated R5 fell while one nursing assistant (NA) was transferring R5 from the wheelchair to bed with a Guldman ceiling lift and basic high mesh sling. After the fall, a licensed practical nurse (LPN) completed an initial assessment and assisted R5 back to bed. The DON stated she was called to R5's room and upon arrival, R5 was lucid and able to answer her questions. R5 told the DON she had neck pain and a headache, moderate shoulder pain and the DON noted two small abrasions on her forehead.	F 323	planned interventions are appropriate to better anticipate resident needs, and the care plans will be updated according to the findings. This will be completed by 12-8-17. The DON or designee will audit to ensure that bowel and bladder patterns are discussed in relation to falls after each resident has a fall and that the above stated process is followed if bowel and bladder is a potential contributing factor. The audits will continue for 6 weeks until compliance is achieved and then at a frequency as determined by IDT. A guide for IDT to determine if the implemented interventions after a fall were effective and track the previously tried interventions was created and will be implemented after staff training on 11-22-17. The IDT team which consists of any combination of, but is not limited to, nursing staff, dietary, activities, administration, social services or providers will continue to review for root cause analysis after a resident has a fall and implement an intervention to decrease the chance of another fall or injury related to falls after review of the residents care plan. The above stated guide for IDT will be utilized daily in morning meeting to track progress and compliance with this process. . A fall assessment was completed on R74 and the care plan updated based on the findings. All residents have had a Fall Risk Observation completed by 11/14/17 to determine what other residents are at risk for falls. The RN will review and	

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F 323	Continued From page 57 The DON stated she began some passive range of motion (ROM) on R5's arms, but R5 grimaced when her arm was moved so she stopped. The DON indicated R5's pupils were large and pupil response time was slow. The DON stated she was concerned, and had the LPN call for an ambulance immediately. The DON further stated facility policy allowed staff to transfer residents with only an assist of one staff when using the ceiling lifts. The DON stated that when the LPN entered R5's room on 10/21/17, the sling was still hooked at all four points. The DON stated R5 and the NA performing the transfer recalled the fall differently: R5 told the DON she fell out head first, and the NA told the DON it all happened so fast she doesn't know how R5 fell out of the sling, but thought R5 slipped through the hole created by the straps crossing under R5's bottom and upper legs. The DON confirmed that R5 was sent to the hospital and sustained a humerus fracture. On 10/23/17, at 1:10 p.m. the DON stated the facility hosts an annual safety training day in which all direct care staff are required to demonstrate competency in transferring with a ceiling lift and hoyer lift. The DON stated for the 2017 training day, she was role playing a resident, and staff had to transfer her from bed to wheelchair and back again. The DON stated she trained all staff to position the sling according to manufacturer instructions which included having the sling straps cross up between the legs (not crossed underneath the resident) and up through the strap loops. The DON stated after R5's fall from the lift and sling, she had the LPN review sling use and safety with nursing assistants in report, but she did not implement any house-wide interventions for sling use as they did not yet know the root cause of the fall, and did not know	F 323	update the care plans by 12-8-17 for all residents to assure fall interventions are in place. The 'Guidelines for IDT after Fall' and 'Care Plan Process and Review' Policies have been reviewed and updated. The Care Plan Change Form Policy/Process has been revised to better track interventions previously implemented for a resident. The Clinical Managers are to assure the Care Plan Change Form is completed and filed under the Care Plan Section in the hard chart and that the Care Plan Change process and tools are updated according to policy. Audits to assure care plans are updated with effective interventions and the process for care plan revision is followed. Audits will be completed on 5 residents weekly by the nurse and results turned in to the Director of Nursing until compliance is achieved and then at a level to maintain compliance as determined by the IDT. NAR care sheets have been updated to include a more detailed depiction of required resident cares and toileting/repositioning schedules. The NAR shift duty and accountability lists have been reviewed and updated. The above tools will increase accountability and in turn directly affect compliance with required documentation. Audits of complete documentation will be done each shift by the LN with immediate re-education as indicated, and turned into the DON upon completion. Audits will continue for 6 weeks until compliance is achieved and then at a frequency as	

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F 323	Continued From page 58 which direction to focus interventions. The DON stated she did re-educate the NA who was transferring R5 and ensured a note was read at report that indicated, "Always make sure you are using the right size, right style, and the right set up" when transferring residents with a lift. On 10/23/17, at 1:30 p.m. the DON read from her fall incident investigation notes that the NA indicated she placed the sling on R5 in the "cradle" position (indicating the straps cross under the legs and then remain on the outside of resident's legs, not between the legs and up through the loop, crossing in front of the resident. This "cradle" position was not recommended by the manufacturer and left open the possibility of a resident pitching forward out of the sling without any barrier to falling. The DON further read the incident report, which indicated the full body net sling was placed on R5 so that the top was aligned mid-ear and "cradled" legs and arms inside sling, R5's catheter bag was held in left hand [of NA] and lift remote in the right hand [of NA]. The DON stated the NA believed R5 fell through the hole created by crossing the sling straps under the legs. According to the DON, R5 felt she crashed out, with her upper body hitting the floor first and her bottom after. R5 told the DON that the transfer felt the same as always prior to the fall, with no jerking and her catheter did not pull. Again, the DON stated that R5 felt she slide out of the sling head first, while the NA thought R5 fell through the hole in the sling. On 10/23/17, at 1:46 p.m., the facility report board was reviewed and the note that read, "Always make sure you are using the right size, right style and the right set up," was noted to be there.	F 323	determined by IDT. The fall policy was reviewed and updated. R3 is deceased. RN Managers observed all residents requiring mechanical lift transfer and provided on the spot education to all direct care nursing staff, with an emphasis on crisscross through the legs sling method, proper body positioning in sling and proper application of sling with mechanical lift. This was completed on 10-23-17. A Floor Meeting was initiated on 10-23-17 to verbally re-educate all direct care nursing staff as well as requiring them to demonstrate proper sling placement and ceiling lift transfer by the supervising nurse or NAR Mentor Trainer. All staff was required to demonstrate proper sling placement including crisscross method between residents' legs, proper sling placement, Proper body positioning and application of sling to mechanical lift. This was completed prior to staff providing direct cares to resident. In order to identify other residents with a risk to be potentially affected by this, the RN managers observed all residents requiring mechanical lift during transfers and discussed transfer methods and proper sling placement with direct care staff on 10-23-17. Changes to prevent recurrence include utilizing our NAR Mentor Trainer who has demonstrated proper transfer and will provide proper instruction to new hired staff which includes one to one education and return demonstration with proper sling fit, placement, type and safe transfer.	

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F 323	Continued From page 59 On 10/23/17, at 2:53 p.m. the DON and registered nurse (RN)-A demonstrated the cradle method of sling use to show how R5 was transferred on 10/21/17. The DON stated this was not how she taught staff to apply the sling and straps, nor could she find it in the manufacturer's instructions as a method to use stating, "It's not the typical hook up." On 10/23/17, at 1:35 p.m. RN-A stated there were 11 residents residing in the facilty who were transferred using ceiling lifts and 2 who were transferred with a hoyer lift. On 10/23/17, at 1:48 p.m. NA-O stated she has had training on use of the ceiling lifts and slings, and was told in the last two days (after R5's fall) to ensure that she was using the correct slings. On 10/23/17, at 1:58 p.m. NA- B stated she has had previous training on proper use of ceiling lifts and slings, but has not been reminded recently of proper sling use. On 10/23/17, at 4:06 p.m. the DON stated she did not know that staff were using the cradle method rather than the manufacturer's recommended method to transfer R5. The DON stated she had trained staff on transferring residents, but had not observed staff transferring residents. The DON stated she had not performed audits on ceiling lift transfers nor had she watched actual transfers and how the staff were setting up the sling and straps. On 10/23/17, at 4:07 p.m. RN-A stated she did not know that staff were using the cradle method to transfer R5, she had not observed staff transfer R5.	F 323	NAR Mentor Trainer will also be utilized to provide ongoing education to current staff and will be utilized during annual competency training. NAR Mentor Trainer and RN have reviewed and updated the competency testing for use of mechanical lifts and sling safety on 10-25-17. Education regarding proper sling use was presented to staff during shift to shift report, and in the pay day update, and the daily agenda sheets. All nursing staff will be trained again on sling crisscross method, proper body positioning and sling placement and safe transfer at the mandatory 11/22/17 training. Daily observations will be completed on the 4 identified residents by the RN or designee. The audits will be completed twice weekly on all other residents requiring a mechanical lift for a period of 6 weeks. RN staff and designees will audit lift transfers for proper sling placement, crisscross method, body positioning and safe transfer. DON and Administrator will evaluate upon completion of the 6 week monitoring and determine if bi-weekly monitoring is to continue. If evaluation concludes monitoring has been effective, audits will continue monthly for a period of 6 months. Audits will continue as determined by IDT for frequency. Audits will be submitted monthly to the Quality Council and include any corrective actions taken. Policy for Mechanical Lifts and slings was reviewed and remains appropriate. All staff will be educated on 11-22-17.	

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F 323	Continued From page 60 On 10/23/17, at 5:02 p.m. NA- E stated she had used the cradle method to transfer R5 since June 2017, when someone trained her to set up the sling that way for R5. NA-E also stated she used the cradle method for sling placement when transferring R3, R16, and a couple of other residents whose names she could not think of at the time. On 10/23/17, at 5:10 p.m. NA-P stated R5 was the only resident that she has transferred using the cradle method. NA-P stated she has transferred R5 that way since January 2017, and did not know why that method was used. On 10/23/17, at 5:13 p.m. NA-K stated she has used the cradle method to transfer R5 for over a year. NA-K stated she did not know why that method was used, but indicated she had been trained by other NAs on transfer techniques. On 10/24/17, at 12:48 p.m. the DON stated they had conducted a number of training and provided reminders on correct transfer technique which included: - A NA training on 6/5/17, on selecting the proper sling type and size. - Individual competency and skills demonstrations throughout the summer of 2017, that included demonstration of proper lift sling transfers from bed to wheelchair and wheelchair to bed under the supervision of the DON or assistant director of nursing (ADON). - 7/11/17, staff education that included using the correct sling size and style for the lift and individual resident - Various emails and pay day updates: - 10/20/17 email: "The slings MUST be used	F 323	All Direct Care Staff have been educated on sling use reporting and use of the Stop and Watch on 11/22/17. R 16 has been reviewed for transfer technique and all staff trained on ceiling lift transfer. RN Managers observed all residents requiring mechanical lift transfer and provided on the spot education to all direct care nursing staff, with an emphasis on crisscross through the legs sling method, proper body positioning in sling and proper application of sling with mechanical lift. This was completed on 10-23-17. A Floor Meeting was initiated on 10-23-17 to verbally re-educate all direct care nursing staff as well as requiring them to demonstrate proper sling placement and ceiling lift transfer by the supervising nurse or NAR Mentor Trainer. All staff was required to demonstrate proper sling placement including crisscross method between residents' legs, proper sling placement, Proper body positioning and application of sling to mechanical lift. This was completed prior to staff providing direct cares to resident. In order to identify other residents with a risk to be potentially affected by this, the RN managers observed all residents requiring mechanical lift during transfers and discussed transfer methods and proper sling placement with direct care staff on 10-23-17. Changes to prevent recurrence include utilizing our NAR Mentor Trainer who has demonstrated proper transfer and will provide proper instruction to new hired	

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F 323	Continued From page 61 according to manufacturer's guidelines in order to stay in compliance and increase safety..." - 7/21/17 pay day update: "Safety belts used in slings for transfers to the toilet must be used at all times! No exceptions. The manufacturer's recommendations must be followed." The DON stated they had focused on slings and lifts due to concerns at other area facilities, and the fact that the slings being used in the facility did not always match with the lift available or the correct size for a specific resident. The DON stated they now have correct size and style of sling for each resident being transferred, and had done competency training on correct transfer style. However, neither the DON nor other licensed nursing staff had observed any transfers of actual residents; nor had they audited correct transfer technique. The DON stated no staff had indicated they were using a "cradle" method of sling placement on some residents. The DON stated NAs were getting training on the floor by other NAs and believed this process lead to the unsafe "cradle" method being consistently used on some facility residents. On 10/24/17, at 8:28 a.m. the administrator stated they identified all residents being transferred with the cradle method (R3, R16, R59), and believed the practice originated from a NA who had used it at another facility, and then transferred the practice to this facility and in training other NAs as they were oriented. The administrator stated there are no lifts in the facility in which the cradle method should be used. When staff were using the incorrect cradle method in transfers, they should have been immediately re-educated.	F 323	staff which includes one to one education and return demonstration with proper sling fit, placement, type and safe transfer. NAR Mentor Trainer will also be utilized to provide ongoing education to current staff and will be utilized during annual competency training. NAR Mentor Trainer and RN have reviewed and updated the competency testing for use of mechanical lifts and sling safety on 10-25-17. Education regarding proper sling use was presented to staff during shift to shift report, and in the pay day update, and the daily agenda sheets. All nursing staff will be trained again on sling crisscross method, proper body positioning and sling placement and safe transfer at the mandatory 11/22/17 training. Daily observations will be completed on the 4 identified residents by the RN or designee. The audits will be completed twice weekly on all other residents requiring a mechanical lift for a period of 6 weeks. RN staff and designees will audit lift transfers for proper sling placement, crisscross method, body positioning and safe transfer. DON and Administrator will evaluate upon completion of the 6 week monitoring and determine if bi-weekly monitoring is to continue. If evaluation concludes monitoring has been effective, audits will continue monthly for a period of 6 months. Audits will continue as determined by IDT for frequency. Audits will be submitted monthly to the Quality Council and include any corrective actions taken.	

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F 323	Continued From page 62 R3's Face Sheet printed on 10/23/17, identified diagnoses that included multiple sclerosis (MS). R3's significant change MDS dated 8/8/17, indicated R3 was totally dependent upon staff for transfers and had not walked in the assessment period. R3's care plan printed on 10/23/17, indicated R3 had limited functional abilities due to physical deficits and terminal health conditions. R3's care plan referred staff to the Kardex for resident specific plan of care and functional capabilities. R3's Kardex indicated R3 required an assist of one staff with transfers, and was to be transferred with a ceiling track lift and Guldman sling. R5's care plan and Kardex lacked direction of sling placement. R3's 7/30/17, 8/4/17, and 10/20/17, Observation Detail List Reports indicated R3 was unable to stand on his own due to the diagnosis of MS, had a track lift in his room and required two staff assist with transfers. On 10/23/17, at 5:02 p.m. NA- E stated she used the cradle method for sling placement when transferring R3. R3 was at risk of potential harm if he fell while being transferred with the incorrect cradle method, as was facility practice. R16's Face Sheet printed on 10/24/17, identified diagnoses that included spinal stenosis (abnormal narrowing of the spinal canal), amyotranopihic lateral sclerosis (ALS, commonly	F 323	Policy for Mechanical Lifts and slings was reviewed and remains appropriate. All staff will be educated on 11-22-17. All Direct Care Staff have been educated on sling use reporting and use of the Stop and Watch on 11/22/17. R 59 has been reviewed for transfer technique and all staff trained on ceiling lift transfer. RN Managers observed all residents requiring mechanical lift transfer and provided on the spot education to all direct care nursing staff, with an emphasis on crisscross through the legs sling method, proper body positioning in sling and proper application of sling with mechanical lift. This was completed on 10-23-17. A Floor Meeting was initiated on 10-23-17 to verbally re-educate all direct care nursing staff as well as requiring them to demonstrate proper sling placement and ceiling lift transfer by the supervising nurse or NAR Mentor Trainer. All staff was required to demonstrate proper sling placement including crisscross method between residents' legs, proper sling placement, Proper body positioning and application of sling to mechanical lift. This was completed prior to staff providing direct cares to resident. In order to identify other residents with a risk to be potentially affected by this, the RN managers observed all residents requiring mechanical lift during transfers and discussed transfer methods and proper sling placement with direct care staff on 10-23-17. Changes to prevent recurrence include	

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F 323	Continued From page 63 known as Lou Gehrig's disease), and difficulty in walking and unsteadiness on her feet. R16's quarterly MDS dated 9/25/17, indicated R16 was totally dependent upon staff for transfers, and had not walked during the assessment period. R16's care plan dated 9/24/17, identified R16 at risk of falls due to a diagnosis of ALS, generalized muscle weakness, lower back injury and chronic low back pain. R16's care plan did not specify how staff were to transfer R16, but directed staff to the Kardex for the specific plan of care. R16's Kardex indicated she was non-weight bearing and was to be transferred with a ceiling track lift and full body mesh sling. R16's care plan and Kardex lacked direction on sling placement. R16's Fall Risk Assessment dated 10/5/17, indicated R16 required a hoyer lift for transfers and relied on staff assistance for mobility, transfers and daily activities. R16's 10/21/17 Observation Detail List Report indicated she was dependent upon staff for all ADLs including transfers and mobility. On 10/23/17, at 5:02 p.m. NA- E stated she used the cradle method for sling placement when transferring R3. R16 was at risk of potential harm if she fell while being transferred with the incorrect cradle method, as was facility practice. R59's Face Sheet printed on 10/24/17, identified diagnoses that included bilateral below knee	F 323	utilizing our NAR Mentor Trainer who has demonstrated proper transfer and will provide proper instruction to new hired staff which includes one to one education and return demonstration with proper sling fit, placement, type and safe transfer. NAR Mentor Trainer will also be utilized to provide ongoing education to current staff and will be utilized during annual competency training. NAR Mentor Trainer and RN have reviewed and updated the competency testing for use of mechanical lifts and sling safety on 10-25-17. Education regarding proper sling use was presented to staff during shift to shift report, and in the pay day update, and the daily agenda sheets. All nursing staff will be trained again on sling crisscross method, proper body positioning and sling placement and safe transfer at the mandatory 11/22/17 training. Daily observations will be completed on the 4 identified residents by the RN or designee. The audits will be completed twice weekly on all other residents requiring a mechanical lift for a period of 6 weeks. RN staff and designees will audit lift transfers for proper sling placement, crisscross method, body positioning and safe transfer. DON and Administrator will evaluate upon completion of the 6 week monitoring and determine if bi-weekly monitoring is to continue. If evaluation concludes monitoring has been effective, audits will continue monthly for a period of 6 months. Audits will continue as determined by IDT	

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F 323	Continued From page 64 ambulation. R59's annual MDS dated 8/17/17, indicated R59 was totally dependent upon staff for transfers. R59's care plan dated 9/11/17, indicated he had limited functional abilities and ADLs due to physical and sensory deficits. The care plan referred staff to the Kardex for residents specific plan of care and functional abilities. R59's Kardex indicated R59 required a hoyer lift with an assist of one staff, there was a ceiling track lift in R59's room, and to use a large Guldman toileting sling. R5's care plan and Kardex lacked direction of sling placement. R59 was at risk of potential harm if he fell while being transferred with the incorrect cradle method, as was facility practice. On 10/23/17, at 5:02 p.m. NA- E stated she used the cradle method for sling placement when transferring R59. The immediate jeopardy that began on 10/21/17, was removed on 10/24/17, at 4:40 p.m. when the facility updated their policy, trained staff, identified residents who had been transferred incorrectly, and placed measures to ensure staff knew to never use the cradle method for any transfers in the facility. However, the noncompliance remained at the lower scope and severity level of G (isolated scope and severity level), which indicated actual harm that was not immediate jeopardy. R74 sustained multiple falls, some with injury,	F 323	for frequency. Audits will be submitted monthly to the Quality Council and include any corrective actions taken. Policy for Mechanical Lifts and slings was reviewed and remains appropriate. All staff will be educated on 11-22-17. All Direct Care Staff have been educated on sling use reporting and use of the Stop and Watch on 11/22/17. The DON is responsible. Compliance will be achieved by 12-8-17. 441 HAND WASH NA-A has been reeducated on hand washing and glove use on 11-14-17 by the DON. In order to identify others who may be at risk, oncoming nursing and NARS will demonstrate proper hand hygiene technique during shift report to the immediate supervising nurse prior to start of shift until posted nursing staff have passed this demonstration. The supervising nurse is responsible to ensure proper demonstration of hand hygiene knowledge has been completed prior to the start of the shift. The competency verification will be turned into the DON upon completion. The non-nursing staff will be scheduled by their department managers to meet with IP nurse or designee to demonstrate competency on proper hand hygiene technique. This will be completed before 12-8-17. The Handy Hygiene policy has been reviewed and remains appropriate and staff will receive additional training on 11/22/17. Hand Hygiene Audits will be completed	

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F 323	Continued From page 65 and the facility failed to comprehensively assess risk factors related to the continued falls. In addition, interventions to prevent falls were not consistently implemented. R74's Face Sheet printed 10/19/17, indicated R74 had diagnoses that included cerebral infarction (stroke), repeated falls, and abnormalities of gait and mobility. R74's quarterly Minimum Data Set (MDS) dated 8/22/17, indicated R74 had significantly impaired cognition and moderately impaired vision (can see objects, but not read newsprint). The MDS also indicated R74 required supervision with bed mobility, toileting, and ambulation, and required limited assistance with transfer and extensive assistance with dressing. The MDS further indicated R74 was continent of bladder and bowel, and had two or more falls since the last assessment, and two or more falls with minor injury. R74's Falls Care Area Assessment (CAA) dated 2/22/17, identified R74 had been admitted to the facility due to severe cognitive impairment, inability to care for self, and frequent falls in his assisted living facility (some with injuries). The CAA indicated R74 appeared to understand others at times, and staff needed to anticipate R74's needs. The CAA also indicated R74 required cues, prompting and daily supervision. The CAA further identified R74 was not always steady with transfers and walking, but was able to maintain balance without staff assistance, and he readily accepted help for cares. R74's medical record lacked any further comprehensive fall assessments.	F 323	daily for not less than one month and until compliance achieved and then at a level to maintain compliance as determined by IDT. Audits will be submitted monthly to the Quality Council and include any corrective actions taken. The IP nurse is responsible. Compliance will be achieved by 12-8-17	

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F 323	Continued From page 66	F 323		

R74's care plan dated 9/11/17, identified a goal that R74 would not be seriously injured due to a fall. The care plan identified the following interventions: call light within reach when resident is in room, anticipate needs, provide toileting assistance as soon as possible at resident's request, speak directly to R74 and allow ample time for him to respond, and refer to Kardex for resident's specific plan of care.

R74's Kardex dated 10/17/17, indicated R74 was independent with wheelchair, recliner and bed repositioning, used a front wheeled walker, and was independent with ambulation. The Kardex directed R74 required an assist of one with dressing, was independent to an assist of one with undressing, and was independent to lay down after meals. The Kardex further directed staff to keep the bed close to the bathroom, have a sign posted to call for help, and a sign in the bathroom to pull up pants when done.

Review of R74's Falls Event Reports indicated the following:

-3/15/17, at 5:15 a.m. R74 was found on his bottom on the bathroom floor in front of his sink. R74 stated he hit his head and it hurt. The immediate intervention was to remind R74 to use his call light. The interdisciplinary team (IDT) intervention was to keep a urinal accessible at bedside. On 10/19/17, at 10:38 a.m. the DON stated the urinal was not an effective intervention as he did not use it.

-5/8/17, at 3:19 p.m. R74 was standing in his bathroom with blood on his head. R74's pants were lying on the floor of his bedroom and his walker was tipped over. R74 sustained an

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abrasion above his left eye, a small skin tear on his left upper cheek, a small abrasion on his left elbow, and a scratch was noted on left side of rib cage. The immediate intervention was to remind R74 to ask for assistance with cares. The IDT intervention was to have staff follow R74 to his room as he allowed.

-6/24/17, at 5:45 a.m. R74 fell while independently getting into bed. The immediate and IDT intervention was to demonstrate proper hand and foot placement when getting into and out of bed.

-7/7/17, at 1:19 p.m. R74 fell when standing up from his chair in the dayroom. The new intervention was to order and place an adaptive height cushion for R74's dining room table chair.

-7/8/17, at 3:00 p.m. R74 fell in the shower room, with staff present. The immediate intervention was to increase assistance with transfers during that shift. The IDT intervention was to encourage the resident to rise slowly.

-7/18/17, at 6:00 p.m. R74 was found on the floor in his bedroom in front of the dresser. The top dresser drawer was broken and on the floor. R74 sustained a small abrasion on his left mid-shoulder blade and a scratch on his mid-left back, an an abrasion on his left elbow. The IDT intervention was a repeat of the 5/8/17, intervention to watch for R74 as he left the dining area after supper, and to follow him as he allowed and assist him with undressing before he lay down.

-7/28/17, at 4:00 p.m. R74 was found on the floor leaning up against the wall in the day room. Prior

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to the fall he had been having coffee and a snack. R74 hit his head and had a red area on the back left side of his head and a red mark on his mid/left side of his back. The IDT intervention was to anticipate needs after dining and assist with chair as needed.

-8/15/17, at 6:30 p.m. R74 fell in his room. R74 was not wearing socks or shoes and indicated he had mild pain in his buttocks after the fall. The immediate intervention was to put grippy socks on R74's feet, and have staff check more frequently through the night. The IDT intervention was to assess R74's environment and place his bed closer to the bathroom as R74 has a habit of undressing or partially undressing in the bathroom and walking across his room to his bed to lay down. The new arrangement reduced the amount of ambulation needed and allowed for more privacy.

-8/31/17, at 5:00 p.m. R74 slid while attempting to sit down for dinner. R74 did not have his walker with him. R74 hit the back of his head against the wall. The immediate and IDT intervention was to place a sign on the walker reminding R74 to use his walker.

-9/1/17, at 12:47 p.m. R74 was found on the floor in front of his bed with his pants down around his ankles. Resident was walking from bathroom to bed with his pants around his ankles and tripped. The immediate intervention was to remind R74 to pull up his pants before walking. The IDT intervention was to place a sign in the bathroom to remind R74 to pull up his pants before leaving the bathroom.

-9/10/17, at 1:53 p.m. R74 was found on the floor

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by his closet. The immediate and IDT intervention was to encourage R74 to wear shoes.

-10/11/17, at 8:22 a.m. R74 was found on his stomach on the floor next to his bed. The housekeeper had just been in R74's room, and R74 had been lying in bed. The housekeeper had told R74 that it was time for breakfast. R74 sustained a 1 centimeter (cm) skin tear above his left eyebrow, which was cleansed and a steri strip applied. The IDT intervention was to implement orthostatic blood pressure monitoring to determine if that was a contributing factor to his falls as R74's blood pressure was lower than usual.

R74's fall pattern in 2017 prior to survey: 12
2 at 5 a.m.
1 at 8 a.m.
9 in the afternoon/very early evening

Location of R74's falls:
1 in shower
3 in dayroom
8 in bed/bathroom

On 10/19/17, at 10:27 a.m. the above pattern and location of R74's falls was reviewed with the DON. The DON stated she was not surprised by the times, locations or frequency of R74's falls, but she had not done a summary before.

During survey, after surveyor investigation had begun, the following fall occurred:
-10/22/17, at 6:43 p.m. R74 was found on the floor in his room next to his bed. R74 was sent to the hospital for a contusion. The IDT intervention was to refer R74 to therapy for an evaluation and treatment of transfers and strengthening.

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On 10/18/17, at 7:16 a.m. R74 was observed standing with his walker in his bedroom doorway in his underwear and with bare feet. R74 left the doorway and using his walker, returned to his bed and laid down. A housekeeper entered his room at 7:19 a.m.. At 7:21 a.m. LPN-B entered R74's room to take R74's blood pressure and left at 7:25 a.m., at which point R74, still barefoot, returned to the doorway of his bedroom. At 7:30 a.m. LPN-B got R74 some clothes to wear and left, shutting the door as she left. At 7:52 a.m. R74 left his room in a t-shirt, sweatpants and what appeared to be slippers, but were actually black tennis shoes in which R74 had slid his feet into, stepping down the back under his heels. R74 walked independently with his walker to the dining room, ate, stood from the table with assistance from NA-D, and left the dining room independently with his walker; R74 continued to wear his shoes with the backs stepped down.

On 10/19/17, at 8:55 a.m. a height cushion was observed to be in the chair that R74 used for meals, according to care plan and Kardex. A sign was present in R74's bathroom reminding him to pull up his pants or take them off before he left the bathroom. There was no sign on his walker, but there was a sign in R74's bedroom reminding him to take his walker with him.

On 10/19/17, at 8:57 a.m. R74 was observed standing up from his bed independently with white socks on his feet. R74 walked to his bathroom independently with his walker. R74 left his bathroom at 9:10 a.m. with his walker, his sweatpants were pulled up.

On 10/19/17, at 9:05 a.m. NA-B stated fall

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interventions for R74 included to keep his room free from clutter, check on him, and there were signs in his bathroom. NA-B also stated they make sure the table is out of his way when he stands up after meals. NA-B stated there were care plan change sheets that get read at report, but NA-B did not think there had been any care plan changes on R74.

On 10/19/17, at 9:09 a.m. LPN-C stated the care plan update sheets get shredded after a week.

On 10/19/17, at 9:12 a.m. NA-D stated staff make sure R74's door was open, his shoes were on, his pants were up and that he had his walker.

On 10/19/17, at 9:19 a.m. NA-C stated they try to supervise R74 when walking to the dining room; keep grippy socks on him; make sure he has his walker and his floor is clear of clutter (he likes to pick things up).

On 10/19/17, at 9:22 a.m. the LPN-A stated they have rearranged R74's room so his bed is closer to the bathroom and they make sure he has his walker with him and his shoes on. LPN-A stated he has grip strips on his bathroom floor and regular white athletic socks available. LPN-A stated she did not know if family had been asked to not provide white socks or not.

On 10/19/17, at 9:28 a.m. certified occupational therapist assistant (COTA)-A stated R74 used to fall frequently when living in assisted living. COTA-A stated R74 was strong but impulsive and had issues with coordination of movement and safety. Physical therapist assistant (PTA)-A stated R74 had not received physical therapy while a resident of the facility, only an evaluation upon

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F 323	Continued From page 72 admission. On 10/19/17, at 10:27 a.m. the DON stated when a resident falls, the supervising nurse initiates an immediate intervention to keep a resident from falling again. After the immediate intervention, the IDT team meets once to discuss the fall, including contributing factors of the environment, medications, behaviors, and patterns. The DON stated the facility completes a root cause analysis after each fall. The DON stated they have a fall investigation tool, dated 4/17, that they sometimes used in their IDT meetings, but it was not part of the medical record. The DON stated they did not use it each time, only if they need to reference it as a guide. The DON stated R74 liked to take off his clothes and scatter them on the floor. The DON stated R74 will get dressed or undressed before or after meals, and be in and out of his bathroom. The DON stated they try to have staff anticipate R74's needs. R74 was somewhat receptive to interventions, and staff try to follow R74 out of the dining room after meals, but that was not always possible. The DON stated they communicate care plan changes in several ways: verbally in report, sometimes in emails and sometimes on the care plan or Kardex. The DON stated they are not going to prevent R74's falls, they just want to make R74 safe. The DON stated they have moved items out of R74's way, moved the bed closer to the bathroom, and applied non-slip strips to the bathroom floor. The DON stated they cannot use a low bed, as R74 is tall, and a low bed would be a restraint and fall mats would be at tripping hazard. The DON stated R74 has not worked with therapy. The DON stated current interventions should be listed on the Kardex.	F 323		

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On 10/19/17, at 11:24 a.m. the DON stated they were not going to prevent R74 from falling, but wanted to make him safe. The DON reviewed the Kardex and confirmed it did not include all the interventions for fall prevention for R74, as the facility was about to begin a review and updating of all Kardex's.

The facility's Falls policy, dated 8/16, indicated the purpose of the policy was to address contributing factors in regards to the resident's fall, assist with developing the resident's care plan and implement changes to current care plan.

The facility's Care Plan Process and Review Policy, dated 11/10/15, directed that care plans are updated as changes occur.

The facility's Guidelines for Interdisciplinary Team Review of Incident/Accident or fall, dated 6/17, directed the IDT to look at contributing factors that lead to the event; what is going on with the resident medically, emotionally, etc.; what are the current interventions in place; is there a pattern to the events; what was the resident doing prior to the incident; review of lab work; and more. The policy further directed that all changes in resident's care plan will be communicated to all pertinent staff and ensure that documentation of the incident is accurate and complete.

R2's Diagnoses Report printed on 10/19/17, included diagnoses of muscle weakness, difficulty walking, and vascular dementia without behavioral disturbance.

R2's quarterly MDS dated 7/3/17, indicated R2 had severe cognition deficits. The MDS indicated R2 was occasionally incontinent of bladder and

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always continent of bowels. The MDS indicated R2 had more than two falls with no major injury. The MDS also indicated that a trial of toileting programming such as prompted voiding, scheduled toileting times was not conducted.

R2's quarterly assessment for bowel, bladder, and fall risk were not conducted in July 2017. The MDS indicated R2 required extensive assistance with assistance of two staff for transfers and use of the toilet. R2's balance was not stable without human assistance.

R2's Falls Care Area Assessment (CAA) dated 4/3/17, identified R2 was at risk for falls. The CAA indicated R2 had generalized weakness, was not always steady, and had poor balance which put him at risk for falls. R2 received assistance with mobility, had remained free from falls since the last assessment, but had numerous falls since admission (without any significant injury). R2 received antidepressant medication which increased his risk for falls, his physician was aware of his falls, and his medications were to continue. R2's medical record lacked any further comprehensive fall assessments.

R2's Urinary Incontinence CAA dated 4/3/17, indicated R2 was occasionally incontinent of bladder, he was aware of the need to void, but needed staff assistance to the bathroom. The CAA further indicated R2 had some bladder control, and awareness to void was usually present. R2's medical record lacked any further comprehensive urinary incontinence assessments.

R2's care plan revised on 10/18/17, indicated R2 was at risk for falls related to medication use and

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dementia with confusion. Interventions included: physical and occupational therapy evaluations as needed, clutter free environment, call light within reach, call don't fall signs in room and on bathroom door, and pain monitoring. The care plan also directed staff to assist with transfers and toileting per R2's request, provide R2 encouragement to wear hearing aides and glasses, and to redirect R2 if unsafely transferring or ambulating. The care plan also indicated R2 had obsessive thoughts and actions in regards to toileting, and staff had noted no patterns with his toileting habits.

R2's Kardex care plan dated 10/17/17, included the following interventions: alarm on bathroom door to alert staff of self transfers so staff can assist, R2 should ask for help but won't, he does everything independently, R2 will come out of room at times with pants pulled down to his knees. R2's risk for falls was identified by impulsiveness and refusal of assistance. The Kardex further directed staff to take R2 to the bathroom every 2 hours, indicated R2 was occasionally incontinent of bladder, and he refused to wear an incontinent brief. The Kardex also directed staff to have R2's urinal within reach, to conduct safety checks every hour, have a second call light hooked to tray table at all times, and assist of one for transfers.

R2's Physician Order Report dated 6/27/17, directed the facility to place safety round checks on R2's room, and for staff to document R2's activity on the safety check sheet once a day in the a.m.. A Physician Order Report dated 8/10/17, directed the facility to initiate a fall prevention program for R2 continuously on evening and night shifts.

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Review of R2's Event Reports from 7/7/17, thru 10/13/17, indicated the following falls:

-7/7/17, at 5:38 p.m. R2 was found on floor in his room. R2 stated he was trying to go to the bathroom, and he became faint and fell. Staff assisted R2 to the bathroom and brought him back to bed. R2 did not sustained an injury. New Interventions implemented: staff to clip call light to resident's shirt, and ensure that he has it clipped to him when doing hourly rounding. The IDT met on 7/8/17, with the following: the facility's consultant nurse was contacted to offer further suggestions to reduce falls, awaiting recommendations. R2's noncompliance with transfer assistance and reminders to ask for assistance, risk of noncompliance was discussed and documented as understood by R2. Staff were to continue with frequent checks until the consultant nurse provided more input. IDT review lacked toileting assessment.

-7/19/17, at 12:15 p.m. R2 was found on the bathroom floor. NAs helped R2 back in bed and provided reminders to call for help. R2 did not sustain injury. New interventions implemented: none. The IDT met on 7/20/17, with the following: R2 was noncompliant with transfer assistance and reminders to ask for assistance, R2 had poor fitting shoes and refused to have them replaced, R2 refused to have his pants pulled up to his thigh area, and R2's verbalization that he would rather fall than to wait to ask for help. R2's bowel and bladder tracking was documented as completed, however, there were no patterns established as R2 had obsessive behaviors regarding his bowel patterns. The IDT note further indicated R2's medications were reviewed

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by pharmacy, he had no infections present, his physical and cognitive decline was attributed to the aging process and was the rationale for the increased number of falls. R2's care plan goal to have no injury was met, and aromatherapy was suggested as an intervention from the nurse consultant.

-8/7/17, at 12:45 a.m. R2 was found on the floor next to his bed, and stated he slid out of bed trying to go to the bathroom. R2's feet were bare, his bedding was dry, but his clothing was wet. R2 was assisted into dry clothes, and reoriented on the call light use. R2 did not sustain injury. New interventions implemented: grippy socks on feet. The IDT met on 8/7/17, with the following: care plan was being followed, R2 was assisted to the bathroom a half hour before the fall, and R2 was noncompliant. The IDT note further indicated to continue hourly checks, and in the future screen R2's functional abilities to assess the appropriateness of current interventions. The IDT review lacked a toileting assessment

-8/10/17, at 6:35 p.m. R2 fell from bed, stating he needed to use the bathroom. R2 was incontinent of urine. R2 did not sustain injury. New interventions implemented: bed in low position. The IDT met on 8/10/17, with the following: the care plan was being followed, R2 refused to attend an exercise program, and he had past refusal of attending physical therapy. IDT review lacked a toileting assessment.

-8/14/17, at 11:00 a.m. R2 stood and fell in the bathroom trying to transfer onto the toilet. R2's call light was on. R2 verified putting the light on after the fall, and staff educated him on putting the call light on before transfers. R2 did not

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sustain injury. New interventions implemented: none. The IDT met on 8/15/17, with the following: verification of care plan being followed, R2 was noncompliant, R2 had an obsession with his bowel pattern, noting that R2 does not generally have any actual constipation or diarrhea. Interventions discussed in IDT as immediate included to assist R2 to safety, meet his toileting needs, remind him to use the call light for help before he self transfers, and to obtain a sensor alarm for his bathroom door. IDT review lacked a toileting assessment. Physician progress note of 8/16/17, at 1:58 p.m. stated a review of falls on 8/10/17, and 8/14/17, had been conducted. The note directed staff to consider possibly of more consistent staff assignment or alternative setting that provides more supervision.

-8/17/17, at 10:30 a.m. R2 was found sitting between his wheelchair and recliner, no further details of the fall were documented. R2 did not sustain injury. New intervention implemented: request for OT to evaluate wheelchair positioning and placement. The IDT did not discuss this fall. No root cause analysis was documented.

-9/5/17, at 1:19 a.m. R2 was found lying on the floor next to his bed with his cane in his hand. R2 was dressed and wearing shoes. R2 stated he fell trying to reach for the urinal, which was not within reach. R2 did not sustain injury. New interventions implemented: urinal placed within reach. The IDT met on 9/5/17, with the following: intervention to place personal items close by R2 was reviewed as appropriate, staff was reminded to follow R2's care plan, and they discussed to anticipate R2's needs.

-9/13/17, at 12:07 p.m. R2 was found on the floor

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next to his bed. R2 stated he lost his balance when trying to urinate. R2 did not sustain injury. New intervention implemented: reminded to call for help, which resident responded to with, "That will take a half an hour." The IDT met on 9/13/17, with the following: R2 had limited safety awareness and confusion, he was noncompliant, and staff was following the care plan. R2's transfer ability was also reassessed, and R2 was able to stand up from his bed with no staff assistance. Low bed and mat intervention was discontinued, R2 was noted as unsafe to transfer independently, and staff was to continue to encourage and assist R2 to the bathroom. IDT review lacked a toileting assessment. A progress note dated 9/14/17, at 12:35 p.m. indicated staff had reported R2 was urinating in coffee cups and glasses at 12:35 p.m. and 2:01 p.m.

A progress note dated 9/15/17, at 5:55 a.m. indicated a nurse walked into R2's room as he urinated in a cup. R2 wanted to take pills with the beverage in his cup, and became upset with the nurse, but was convinced to take his pills with water. A progress note dated 9/15/17, at 9:35 a.m. indicated a re-evaluation of the motion sensor on the bathroom was pending as it needed to be positioned to sound when the bathroom door opened, and a post void bladder scan was initiated to assess for bladder retention as most of R2's falls were related to bathroom or urinal use. However, R2's medical record lacked a comprehensive assessment of the post void bladder scan conducted for 9/15/17, through 9/18/17. R2's Treatment Administration Record directed staff to scan bladder for post void residual (the urine left in bladder after emptying it). Staff was also directed to document urine voided prior to scan for each shift. Out of 11 opportunities to document these findings, the

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facility documented 7. The facility lacked a comprehensive assessment of these findings

-9/22/17, at 2:15 p.m. R2 was witnessed falling in his room while standing up from his bed. R2 leaned on the bedside table, and the table tipped over, resulting in his fall. R2 was incontinent of bowel. A progress note dated 9/24/17, at 1:40 p.m. indicated R2 sustained a bruise on his upper posterior left thigh. New intervention implemented: bed lowered to floor.

-9/24/17, at 9:20 a.m. R2 was witnessed to self transfer from his bed to his wheelchair. R2 yelled for help, and a housekeeper saw R2 lower himself to the floor as she placed a pillow behind his head. R2 did not sustain injury. New intervention implemented: none. No root cause analysis of this fall was documented. A progress note dated 9/24/17, at 1:40 p.m. indicated R2's family visited him, reported R2 had a headache, and the family requested medication for R2's headache. R2's pain was rated at a 5 while lying down, and a 10 (most severe pain) when he moved or got up. Pain medication was given at 11:09 a.m. with little to no relief. The progress note indicated R2 would be sent to the emergency room (ER) for evaluation due to his recent falls. A progress note dated 9/24/17, at 2:23 p.m. stated R2 was transferred to the ER for evaluation due to two falls in the last two days.

On 9/24/17, at 3:19 p.m. the facility submitted the fall incident of 9/24/17, to the state agency. The incident was described as a witnessed fall in room, where R2 was attempting to stand up from bed, leaned on his bedside table, and tipped the table. R2 did not hit his head or back. The fall was witnessed by nursing assistant (NA)-J. A

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progress note dated 9/24/17, at 3:30 p.m. indicated a bruise was noticed on R2's left posterior thigh prior to sending him to the ER. The progress note clarified R2's refusals to ask for help, and indicated their would be future IDT meeting to discuss further interventions.
A progress note dated 9/24/17, at 9:45 p.m. indicated R2 returned to facility via ambulance with pain medication orders and cervical collar that needed to be worn for six weeks 24 hours a day, only to be removed for bathing and or to clean area. R2 received a diagnosis of unspecified nondisplaced fracture of the second vertebra. R2 was directed not to move his head much without use of the cervical collar. Follow up appointment details were listed in the progress note. On 9/25/17, at 8:15 a.m. a progress note indicated the IDT reviewed R2's falls, and noted the clinical manager had contacted R2's veteran's nurse and the DON contacted the consultant nurse to brainstorm interventions to decrease R2's falls.

-9/26/17, at 3:06 a.m. R2 was yelling for help with using the bathroom. Staff entered his room, and while staff was assisting him to the edge of his bed to a seated position, R2 began to slid off the edge of the bed and was assisted to the floor by staff. R2 was described as being too close to the edge of the bed, and had slippery sheets on the mattress. R2 did not sustain injury. New interventions implemented: none. The IDT team met on 9/26/17, with the following: summary of meeting with nurse consultant, review of R2's chart, care plan, routines, preferences and environment. R2 was noted to have a history of falls, he was noncompliant with care planned interventions, and valued his independence. R2's care plan goal was to reduce the chance of

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significant injury related to falls. The IDT indicated R2 had a recent fall resulting in a C2 fracture, (fracture of the second vertebrae in the neck), and this injury would not significantly affect R2's sleep or daily activities. Interventions after R2's recent falls were deemed appropriate, R2 remained on hourly safety checks which were not effective in decreasing and or reducing his risk of injury. Hourly checks were discontinued. R2's environment was evaluated, and his bed side table was removed. R2 was re-educated not to raise the height of his bed, and R2 verbalized agreement. The IDT team lacked a root cause analysis of R2's falls, and lacked any toileting assessment. On 9/27/17, a physician progress note indicated most of R2's falls seem to occur around toileting. The note directed staff to toilet him every 2 hours during awake hours and every 3 hours during sleep hours. The note also directed frequent checks.

- 9/30/17, at 2:32 p.m. R2 was found sitting on the floor next to his bed by a housekeeper. R2 stated he stood up and his legs gave out. R2 did not sustain injury. New Interventions were: none. No root cause analysis of the fall was documented.

-9/30/17, at 7:30 p.m. R2 was found on the floor in his bedroom on his back. R2 complained of pain at a 5 out of 10 in his neck area. R2 was reminded to call for help. New interventions implemented: none.
No root cause analysis of the fall was documented. The IDT team met on 9/30/17, at 11:59 p.m. with the following: review of R2's fall history, R2's noncompliance, verification that care plan was followed during fall of 9/30/17, and appropriateness of interventions which were:

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remind resident to use call light, remind R2 that after his emergency visit when he allowed for assistance no injury was sustained and he may become injured if not assisted. The IDT team lacked root cause analysis of the fall and lacked a toileting assessment.

-10/4/17, at 7:48 p.m. R2 was trying to stand from his wheelchair to use the urinal, he fell and was found on the floor by a NA with his head and right side of his body partially under bed. R2 reported some discomfort but did not provide location or intensity of his pain. New interventions implemented: none. The IDT updated the care plan to include clipping the second call light to R2's bedside table.
The IDT team lacked root cause analysis of the fall, and lacked a toileting assessment.

-10/5/17, at 2:15 a.m. R2 fell out of bed while attempting to grab his urinal at bedside. R2 was reported to not be able to see the edge of bed due to cervical collar. R2 complained of mild pain to shoulder due to being picked up from the floor so much. New interventions implemented: none. The IDT met on 10/5/17, at 9:11 a.m. with the following: care plan compliance reviewed, immediate interventions to remind R2 to use call light reviewed as appropriate, new intervention to be implemented due to not being able to turn head will consist of adjustment of bedside table to allow for reach of personal items. IDT review lacked a toileting assessment. A progress note dated 10/5/17, at 1:47 p.m. indicated abnormal vital signs were documented which included elevated pulse of 176, and elevated blood pressure of 136/106. R2 complained of nausea and wanted to be left to die. The clinical manager was updated of R2's condition change. On

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10/5/17, at 2:21 p.m. a progress note indicated R2 had slurred speech, his blood pressure was unstable, he had increased confusion, he had increased body temperature of 100.7, he complained of a terrible headache with bloody discharge from his nose, and urine incontinence. A progress note dated 10/5/17, at 6:13 p.m. indicated R2 was at the hospital for the treatment of a urinary tract infection (UTI) and elevated laboratory value of lactic acid. R2 was expected to return to facility after 7:00 p.m. On 10/6/17, at 4:03 p.m. a progress note indicated the audible motion sensor on bathroom door was reviewed. R2 had very frequent falls, and the majority of the falls were related to self transfers with toileting. The audible motion sensor was described as effective in reducing falls in the bathroom. The progress note did not include details of the number of falls prevented.

-10/10/17, at 8:35 a.m. R2 was found on the floor in front of his bed. R2 sustained an abrasion on his right mid back measuring 2.4 centimeters (cm) by 1.5 cm with a slight amount of clear drainage. R2's blood pressure was elevated at 174/124, and his pulse was elevated at 109 at the time of the fall. New interventions implemented: none. The IDT team met on 10/10/17, at 9:33 a.m. with the following: R2 was trying to get out of bed to use the toilet, and did not use the call light. The care plan was deemed appropriate and followed, R2's noncompliance was mentioned, and R2 was re-educated on safety risks. The note also indicated R2 was recently started on an antidepressant medication due to increased signs and symptoms of depression. The IDT review lacked a toileting assessment. A Physician Progress Report dated 10/11/17, indicated the following regarding R2's falls: R2 did not adhere

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to directions such as to use the call light and wait for assistance before getting up. R2 did have impaired judgement and it was unclear how much R2 understood. It was clear R2 was unhappy with his declining health. Staff was to continue with frequent checks, offer toileting as several falls had been associated with his urinal use, and to monitor his bowel pattern, concurring with constipation.

- 10/13/17, at 1:17 a.m. R2 was found at 12:30 a.m. on his knees, holding onto the side rail, yelling for help. R2 did not sustain an injury. R2 was noted to have open area to his right and left knees that had been reported previous to this fall, but attributed to a prior fall. The IDT team met on 10/13/17, at 11:30 a.m. with the following: R2 had increased confusion, and decreased safety awareness. R2 was re-educated with safety risks. The IDT concluded R2 was trying to get to the bathroom, as he needed to have a bowel movement. Staff was in his room at 11:45 p.m. and assisted R2 to the toilet at that time. R2 was noted to be incontinent of bowel at the time of his fall, his call light was within reach, and R2 did not use the call light. The IDT determined the care plan was followed, and R2 was reported to previously have been capable of standing up unassisted. The IDT determined the red mat would be removed due to an increased risk for falls. Interventions of having a sign on the wall to mark the height of the bed (for consistent placement) and order change of Senna (a medication to relieve constipation) from an as needed basis to scheduled daily. The IDT review lacked a toileting assessment.

R2's toileting time documentation on the NA worksheets lacked documentation on 47 of 90

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documenting opportunities in 8/17, and 16 of 90 documenting opportunities in 9/17.

On 10/18/17, at 7:34 a.m. R2's cervical collar was removed for cares. R2's back and neck were washed, and the cervical collar was placed back on.

On 10/18/17, at 8:23 a.m. R2 was observed seated in his wheelchair in the doorway of his room. His call light was on. An unidentified NA walked by R2, and R2 pointed at the blinking light above his head. R2 wheeled himself out of the doorway, and into the hallway. At 8:27 a.m. RN-A asked R2 if he wanted breakfast, and R2 asked to lay down. RN-A excused herself by stating she needed to get some help, asked R2 to wait a second, and stating she would be right back. R2 was seated in the doorway of his room. At 8:33 a.m. an unidentified NA and RN-A were asking each other if R2 had eaten breakfast. RN-A leaned in to talk to R2, then she stated, "OK" and walked away. At 8:35 a.m. R2 remained in the doorway of his room. At 8:36 a.m. NA-A walked by and R2 reached out and asked NA-A for help. R2's call light was on. NA-A stated for R2 to wait a second, she would get some help. At 8:42 a.m. a housekeeper stopped and asked R2 if he had eaten breakfast, and provided R2 with a stuffed animal to hold. RN-A was observed passing breakfast trays at the end of hall. At 8:46 a.m. NA-A assisted R2 to the bathroom and then bed.

On 10/19/17, at 10:11 a.m. R2 was observed hanging half off his bed, with his feet and legs over the edge of the bed. The head of bed was elevated at 30 degrees, and R2's cervical collar was off. At 10:12 a.m. RN-A and social service designee (SSD)-A entered R2's room, and

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lowered the head of the bed. SSD-A lifted R2's legs back into bed, and RN-A put R2's cervical collar on. R2 cried out in pain with the cervical collar placement, and the cervical collar slipped off again when R2 was boosted up in bed. When RN-A fixed the cervical collar, R2 attempted to take it off once more. RN-A stated R2 was going to be placed on comfort cares, and the order to remove the cervical collar had not come in yet.

On 10/20/17, at 10:25 a.m. RN-A was unable to verify follow up on the physician's recommendations for consistent staff assignment or an alternative facility placement with higher supervision. RN-A stated the majority of staff work on a consistent floor, and they try to keep the same people on a specific assignment.

On 10/20/17, at 10:35 a.m. RN-A verified the Kardex care plan was completed in pencil, and updated by erasing previous interventions. RN-A verified the facility was unable to track interventions they had tried and/or discontinued with the current care plan system.

On 10/20/17, at 10:31 a.m. RN-A stated R2's most recent bowel and bladder assessment was completed on 7/5/17. RN-A stated R2's bowel, bladder and falls assessment should have been done around 10/2/17, with these assessments currently due for R2's quarterly assessment period.

On 10/20/17, at 10:43 a.m. RN-C stated a bladder, bowel and fall assessments should have been conducted for R2 with his last quarterly assessment.

On 10/20/17, at 10:04 a.m. RN-C stated R2 had

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not had a significant change assessment as R2 had no functional decline. RN-C stated R2 did not have enough changes following his cervical fracture to have a significant change completed. RN-C verified R2 was not evaluated for a significant change assessment due to his numerous falls even after the cervical fracture, as the facility had not determined a root cause for his falls.

R2 expired on 10/20/17.

On 10/21/17, at 10:03 a.m. NA-M stated R2 had declined in the past couple of months with transfers, but more so in the past 3 weeks (following the cervical fracture. NA-M stated staff had started using the ceiling track lift for transfers about 2 weeks ago. NA-M continued to state R2 was getting weaker, and had wanted to die since his sister had passed away. R2 was eating until about 5 days ago, and he was just ready to die. NA-M stated, "We checked on him every hour and he was on every two hour checks and repositioning, tried to reassure him, help him transfer, get him in his chair or lay him down as soon as he wanted." R2 was brought him to the shower room to use the ceiling track lift for toileting for the last few weeks. NA-M stated R2 had more difficulty with the use of the urinal, and at time took three staff to help him with that.

On 10/21/17, at 10:26 a.m. NA-J stated R2 had a decline in transfers following the fall with the cervical fracture. NA-J stated R2 was assisted to the bathroom every 2 hours, and staff tried to get in his room frequently. NA-J stated R2 was able to use the urinal, and it was kept at his bedside on the table where he wanted it. NA-J stated R2 had more of a decline after the fall due to losing

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his, "Heart and will to live."

On 10/21/17, at 10:40 a.m. NA-N stated R2 had started to decline with transfers following his fall with the cervical fracture. NA-N stated prior to that fall, staff were to check on R2 every hour, and offer toileting every two hours. NA-N stated after he fell and sustained the fracture, the facility implemented checks every half hour. NA-N stated they would provide assistance as R2 allowed, but he would not allow assistance all of the time. NA-A stated they had started transferring R2 with the ceiling transfer lift at times prior to his passing away, and R2 was still able to use the urinal with staff assistance.

On 10/21/17, at 11:53 a.m. the DON stated R2's interventions were supported by discussion in IDT, and then those were documented on the Kardex. The DON verified there was no supporting documentation to identify what interventions had been found ineffective or changed. The DON stated the facility recognized there was no history on past interventions tried and their effectiveness, and the facilty was working on a system for care planning, and providing the care planned information to the NAs for each resident.

On 10/23/17, at 3:45 p.m. the DON stated it was her expectation that the nursing assistant worksheets be completed every shift with toileting times and verified some were left blank. DON stated the use of this tool was not consistent for accountability of task performance. DON stated she has had to pull the NA worksheets at times, and has found needed information missing. The DON stated the facility was working on a new improved system to improve documentation and

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raise accountability. The DON verified R2 had fallen many times. The DON stated the root cause analysis for the falls had a lot to do with R2's thoughts on his bowel and bladder needs, his weakness and the aging process, but mostly the reason for his falls was due to his obsessive thoughts about toileting. The DON further stated R2 was saying he needed to use the urinal or have a bowel movement on the majority of fall events recorded. The DON added that after OT's assessment of R2's cognitive status completed on 8/11/17, the interventions were appropriate as constant reminders are often needed.

On 10/23/17, at 4:13 p.m. the DON stated a psychiatric evaluation was discussed regarding R2's obsession with bowel and bladder, but the facility failed to provide any documentation regarding discussion or evaluation.

On 10/23/17, at 4:15 p.m. the DON verified the facility lacked an assessment on the post void residual check conducted on 9/15 - 9/18/17, and R2 was only checked for retention for those three days.

An untitled facility document updated on 6/28/17, directed staff to complete the fall risk every quarter. The document directed staff to review the bladder and bowel assessments quarterly from the last annual comprehensive assessment, and make note of any changes on those quarters were there were no changes noted.

The facility's Falls policy updated 3/17/17, directed staff to complete an event, or documentation note after a fall that include the following findings: location of the fall, what the resident was doing prior to the fall, what was said

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	245277	A. BUILDING _____ B. WING _____	10/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST RAPHAELS HEALTH & REHAB CENTER	601 GRANT AVENUE EVELETH, MN 55734

(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 91 at the time of the fall, is there exhibition of pain, rating of pain, and determination if it is a newly developed pain, full body assessment, neurological assent if unwitnessed or hit head, a root cause analysis, interventions put in place, outcome of intervention put in place. If the licensed nurse identifies issues that need to be addressed at the time of the fall, the policy directed the the licensed nurse to implement immediate interventions taken. The policy directed staff to review fall occurrences within 24 hours with the IDT team.	F 323		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections	F 441		12/8/17

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F 441	Continued From page 92	F 441		

before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

(f) Annual review. The facility will conduct an

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F 441	Continued From page 93 annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure hand hygiene was maintained during personal cares for 1 of 2 residents (R53) observed during personal cares. Findings include: R53's undated Face Sheet indicated R53's diagnoses included bladder dysfunction and urinary incontinence. R53's admission Minimum Data Set (MDS) dated 8/10/17, indicated R53 had moderately impaired cognition. The MDS further indicated R53 required extensive assistance of staff with transfers, toilet use, dressing and personal hygiene. The MDS also indicated R53 was frequently incontinent of bowel and bladder and received a diuretic (a water pill). On 10/18/17, at 1:44 p.m. toileting assistance was observed with nursing assistant (NA)-A. NA applied gloves while R53 transferred himself on to the toilet. NA-A removed R53's incontinent brief which was soiled with urine and feces. NA-A removed his soiled gloves, wet paper wash cloths with water from the sink, dried his hands with clean paper towels and donned clean gloves. NA-A cleansed R53's buttocks with the wet paper wash cloths, applied a barrier cream with a paper wash cloth to R53's buttocks and removed his soiled gloves. NA-A removed R53's shoes and soiled pants, and then put clean pants and shoes on R53. NA-A donned clean gloves and then put a clean incontinent brief on R53. NA-A removed	F 441	441 HAND WASH NA-A has been reeducated on hand washing and glove use on 11-14-17 by the DON. In order to identify others who may be at risk, oncoming nursing and NARS will demonstrate proper hand hygiene technique during shift report to the immediate supervising nurse prior to start of shift until posted nursing staff have passed this demonstration. The supervising nurse is responsible to ensure proper demonstration of hand hygiene knowledge has been completed prior to the start of the shift. The competency verification will be turned into the DON upon completion. The non-nursing staff will be scheduled by their department managers to meet with IP nurse or designee to demonstrate competency on proper hand hygiene technique. This will be completed before 12-8-17. The Handy Hygiene policy has been reviewed and remains appropriate and staff will receive additional training on 11/22/17. Hand Hygiene Audits will be completed daily for not less than one month and until compliance achieved and then at a level to maintain compliance as determined by IDT. Audits will be submitted monthly to the Quality Council and include any corrective actions taken. The IP nurse is responsible.	

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F 441	Continued From page 94 his soiled gloves, R53 stood up, NA-A assisted R53 with his pants, flushed the toilet, gathered the trash, and placed R53's soiled pants in the hamper. NA-A then washed his hands in the bathroom. On 10/18/17, at 2:00 p.m. NA-A verified he did not wash or sanitize his hands before, after or between glove changes. On 10/24/17, at 12:38 p.m. the assistant director of nursing (ADON) verified staff need to wash or sanitize their hands before, after and between glove changes. The ADON further stated staff had been trained on this. The facility's Handwashing policy dated 11/16, indicated it was the expectation of the facility that prior to donning and after removing gloves staff would wash their hands.	F 441	Compliance will be achieved by 12-8-17	
F 456 SS=D	ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION CFR(s): 483.90(d)(2)(e) (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a programmable enteral feed pump (a mechanical pump that regulated the rate and volume of the	F 456	F456 The Tube Feeding pump for R 45 was replaced on 10-20-17. The LN also immediately completed a return	12/8/17

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F 456	Continued From page 95 delivery of nutritional feedings and liquids to the gastro-intestinal track through a gastrostomy tube) was functioning properly for 1 of 1 residents (R45) observed with a gastrostomy tube. R45's Face Sheet undated, indicated R45 had diagnoses that included dysphagia (difficulty with swallowing). R45's Physician Order dated 9/26/17, indicated an order for tube feeding Jevity 1.5 Fiber at 50 milliliters (ml) rate per hour to start at 8 p.m. and end at 6 a.m. Findings include: On 10/16/17, at 8:07 p.m. licensed practical nurse (LPN)-E hung a bottle of Jevity tube feeding solution, attached the tubing to the bottle, and placed the tubing through the feeding pump tracks for the delivery of the Jevity, ordered at 50 ml per hour. LPN-E turned on the pump, and the pump's display panel indicated a setting of 85 ml per hour. LPN-E programmed the pump on the menu screen. The pump's display panel failed to display the ml per hour rate, showing only the number 5. LPN-E verified the pump was set at 85 ml when she had turned it on, and the pump would not display the setting of 50 ml in its entirety on the display. LPN-E stated the pump had displayed like that for a while, but since the pump was set with the rate on the programmed menu screen before feeding, LPN-E knew it was running at the right rate. LPN-E stated she did not think there was another pump to replace it with, and had not reported the pump as malfunctioning. LPN-E verified it would not be possible for any other nurse to look at the pump and know what rate was being delivered due to	F 456	demonstration to validate the correct flow rate was being administered as ordered. No other residents receive tube feedings at this time. In order to identify others at risk, all floor nursing staff will complete demonstration of tube feeding pump competency to RN manager. This will be completed by 12-8-17. All Nursing staff has collectively been involved in identifying any equipment that is malfunctioning. An email was sent to all recipients in our current system to inform department managers of any malfunctioning equipment and to follow the tag out process. The Tag out Procedure was reviewed and remains appropriate. Staff will receive additional training on the policy on 11/22/17. Electronic pump will be audited daily by LN utilizing equipment prior to use of equipment and submitted to DON on a weekly basis. The audits will continue each shift for 2 weeks, then daily for 2 weeks until compliance is achieved and then at a frequency as determined by IDT for continued compliance. The RN manager is responsible to assure completion of these audits. Audits will be submitted monthly to the Quality Council and include any corrective actions taken. Staff will receive education on all above corrective measures by 11-22-17. The DON is responsible. Compliance will be achieved by 12-8-17.	

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F 456	Continued From page 96 obscured display. On 10/16/17, at 8:34 p.m. the director of nursing (DON) stated R45 was to receive Jevity at 50 ml per hour. The DON verified the pump's display panel showed a 5, and stated she was not aware the display panel was not displaying correctly. The DON stated it was impossible to verify the rate of feeding set to deliver per hour when the display panel was not working. The DON stated it was expected that the display panel malfunction would have been reported to her and/or the maintenance department when the malfunction occurred. The facility policy Tag Out Procedure dated 4/23/08, directed staff to remove equipment in need of repair from service promptly, malfunctioning equipment was to be brought to the maintenance department and tagged to identify need for service. Staff were directed to report equipment in need of repair to the charge nurse or supervisor immediately.	F 456		
F 497 SS=C	NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE CFR(s): 483.35(d)(7) (d)(7) Regular In-Service Education The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 497	F497	12/8/17

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F 497	Continued From page 97 facility failed to ensure an annual performance review was completed for 3 of 8 staff (NA-J, NA-C, NA-K) reviewed for annual performance review. This had the potential to affect all 52 residents residing in the facility. Findings include: On 10/24/17, a review of personnel records indicated the following: Nursing assistant (NA)-J was hired on 5/17/82. The personnel record indicated NA-J's last annual performance review was done on 6/17/15. NA-C was hired on 6/26/07. The personnel record indicated NA-C's last annual performance review was done on 7/6/15. NA-K was hired on 8/16/16. NA-K's personnel record lacked evidence of an annual performance review. On 10/24/17, at 4:00 p.m. the director of nursing (DON) verified the annual performance review for NA-C, NA-J, and NA-K had not been completed. The DON stated NA-C, NA-J, and NA-K should have had an annual performance review. The facility's Performance Evaluations policy dated 9/1/04, directed each employees job performance would be reviewed at least annually.	F 497	Staff NA-J, NA-C, NA-K, performance reviews were completed on 11/15/17 and will be delivered to the above named staff before 12-8-17. The Performance Review Policy was reviewed and revised. Staff will receive education on the policy on 11/22/17. Process for review now includes utilizing HR or designee to audit for compliance in alignment with annual review dates. The Department Managers may delegate performance reviews for completion. Audits will be submitted monthly to the Quality Council and include any corrective actions taken. In order to identify others who may have been affected, HR and designee will review all staff charts to assure that annual evaluations are in compliance. HR will notify department managers of any evaluations that need to be completed. All evaluations will be completed prior to 12-8-17. In order to maintain compliance, HR or designee will audit 5 employee charts a week for 6 weeks until compliance is achieved and then at a frequency as determined by quality council. Staff will receive education on above corrective measures by 11-22-17. HR is responsible. Compliance with be achieved by 12-8-17.	

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	245277	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/19/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, St. Raphaels Health & Rehabilitation Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/17/2017

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

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K 000	Continued From page 1	K 000		

Or by email to both:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

St. Raphaels Health & Rehabilitation Center is a 2-story building with a full basement. The original building was constructed in 1954 with an addition constructed in 1974. The 1954 building is of type II(000) construction and the 1974 building is type II(000) construction. Therefore, the nursing home was inspected as one building.

The building is fully fire sprinkler protected and has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification.

The facility has a licensed capacity of 76 beds and had a census of 51 at the time of the survey.

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K 000	Continued From page 2 The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a means of egress in accordance with the following requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 7.2.1.1.2 This deficient practice could affect 51 of 51 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 10/19/2017, observation and staff interviews revealed that the 2 East and West exit doors have been painted to look like bookshelves and can be confused as not being an exit. This deficient condition was verified by a Maintenance Supervisor.	K 211	Doors will be resurfaced to match all other exit doors by 12/9/17. Environmental Services Director (ESD) will monitor for compliance.	12/9/17
K 321 SS=F	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure	K 321		12/9/17

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K 321	Continued From page 3 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 3 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the	K 321	Kitchen/food storage area has had a door closer installed as of 11/16/17. Infectious waste room and utility/janitor room D-8 will have access penetrations sealed by 12/9/2017. ESD will monitor for compliance.	

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K 321	Continued From page 4 effected corridors and areas making them untenable, which could negatively affect 51 of 51 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 10/19/2017, observations revealed that the following deficient conditions were found: 1. The infectious waste storage room has a 6 inch square opening in the back wall of the room. 2. The kitchen storage room which is greater than 50 square feet has a door that is not equipped with a self closing device. 3. The janitor room D-8 has a 12 inch square opening directly above the upright sprinkler head that is located in the room. This deficient condition was verified by a Maintenance Supervisor.	K 321		
K 351 SS=D	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for	K 351		11/16/17

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K 351	Continued From page 5 sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition. The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect patients, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 10/19/2017, observations reveled that the fire sprinkler head that is located in the kitchen's dish washing room was found to be corroded. This deficient condition was verified by a Maintenance Supervisor.	K 351	Sprinkler head has been replaced as of 11/16/17. ESD will monitor for compliance.	
K 362 SS=D	Corridors - Construction of Walls CFR(s): NFPA 101	K 362		12/9/17

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K 362	Continued From page 6 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for vertical penetrations in the corridors located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.6.2.3. 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 12 of 51 residents as well as an undetermined number of staff, and visitors. Findings include:	K 362	ALL EAST WING PENETRATIONS WILL BE SEALED BY 12/9/17. ESD WILL MONITOR FOR COMLIANCE.	

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K 362	Continued From page 7 On facility tour between 10:00 a.m. to 3:00 p.m. on 10/19/2017, observations revealed that there were vertical penetration found in the corridor ceiling tile by resident rooms 107, 111, and 115 in the 1 East Wing. This deficient condition was verified by a Maintenance Supervisor.	K 362		
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and interview with the staff the facility had multiple deficient conditions affecting the facility's electrical system that were not in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 9.1.2 and the NFPA 70 "National Electrical Code" 2011 edition. This deficient practice could affect 20 of 51 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 511	AS OF 11/16/2017 ALL MULTI PLUGS HAVE BEEN REPLACED WITH SINGLE RECEPTECALS. ESD WILL MOMITOR FOR COMPLIANCE	11/16/17

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K 511	Continued From page 8 On facility tour between 10:00 a.m. to 3:00 p.m. on 10/19/2017, observations revealed the following deficient conditions: 1. There was a power strip plugged into a fusible 4-plex multi-plug adaptors found in the 1 East Nurse's office. 2. There is an unapproved multi-plug adaptor being used in room 113 in the 1 East Wing. This deficient condition was verified by a Maintenance Supervisor.	K 511		
K 781 SS=F	Portable Space Heaters CFR(s): NFPA 101 Portable Space Heaters Portable space heating devices shall be prohibited in all health care occupancies, except, unless used in nonsleeping staff and employee areas where the heating elements do not exceed 212 degrees Fahrenheit (100 degrees Celsius). 18.7.8, 19.7.8 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility used portable space heaters in non-resident care areas and failed to provide a policy on the use of portable space heaters in the facility that meets the requirements of the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.8. This deficient practice could affect 51 of 51 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 781	SPACE HEATER HAS BEEN REMOVED AS OF 11/16/17. ADMINISTRATOR IS RESPONSIBLE FOR POLICY DEVELOPMENT THAT WILL INSURE SPACE HEATERS ARE NOT ALLOWED. ESD WILL MONITOR FOR COMPLIANCE.	11/16/17

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K 781	Continued From page 9 On facility tour between 10:00 a.m. to 3:00 p.m. on 10/19/2017, observations and staff interview revealed that there was a unapproved space heater being used in the 1 East Director of Nursing office. During the interview regarding the space heaters the maintenance supervisor was asked if the facility had a policy for the use of space heaters he stated that he was not sure. At the time of the inspection the facility could not produce a portable space heating device use policy. This deficient condition was verified by a Maintenance Supervisor.	K 781		
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect 51 of 51 residents, as well as an	K 901	RISK ASSESMENT WILL BE COMPLETED ACCORDING TO NFPA 99 2012 EDITION BY 12/9/2017. ESD WILL MONITOR FOR COMPLIANCE	12/9/17

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K 901	Continued From page 10 undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 10/19/2017, during the documentation review and an interview with the Maintenance Supervisor it was revealed that the facility has a risk assessment document but upon reviewing the document it was found that the assessment was incomplete. The current risk assessment did not account for all of the systems that are identified in chapters 10 and 11 of the NFPA 99 "Health Care Facilities Code" 2012 edition. This deficient condition was verified by a Maintenance Supervisor.	K 901		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per	K 914		12/9/17

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K 914	Continued From page 11 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 51 of 51 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 3:00 p.m. on 10/19/2017, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located throughout the facility. This deficient condition was verified by a Maintenance Supervisor.	K 914	ELECTRICAL TESTING WILL BE COMPLETED BY 12/9/2017. ESD WILL MOITOR FOR COMPLIANCE.	