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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VIBD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00727

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245493**

2.STATE VENDOR OR MEDICAID NO.
(L2) **470843100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA CHAPEL VIEW CARE CENTER**
(L4) **615 MINNETONKA MILLS ROAD**
(L5) **HOPKINS, MN** (L6) **55343**

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 **03/15/2013** (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 **118** (L18)

13.Total Certified Beds **118** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(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 :
Gayle Lantto, Unit Supervisor 03/18/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/08/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/23/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/14/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5493

At the time of the standard survey completed February 1, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On March 15, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on February 1, 2013, effective March 13, 2013. Therefore, the remedies outlined in our letter dated February 19, 2013, will not be imposed.
See the attached CMS-2567B form for the results of the March 15, 2013 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5493 April 8, 2013

Ms. Mary Roy, Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, Minnesota 55343

Dear Ms. Roy:

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 March 13, 2013 the above facility is certified for:

118 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 118 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,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 18, 2013

Ms. Mary Roy, Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, Minnesota 55343

RE: Project Number S5493023

Dear Ms. Roy:

On February 19, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 1, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On March 15, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 1, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 1, 2013, effective March 13, 2013 and therefore remedies outlined in our letter to you dated February 19, 2013, will not be imposed.

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

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

Feel free to contact me if you have questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5493r113.rtf

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245493	A. Building B. Wing	3/15/2013

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0278** Reg. # **483.20(g) - (j)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/13/2013**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **03/13/2013**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/13/2013**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0327** Reg. # **483.25(j)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/13/2013**
ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/13/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/13/2013**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GL/sd	03/18/13	15507	03/15/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245493	A. Building B. Wing	3/15/2013

Name of Facility	Street Address, City, State, Zip Code
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/13/2013**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GL/sd	03/18/13	15507	03/15/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 2/1/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VIBD

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00727

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245493**

2.STATE VENDOR OR MEDICAID NO.
(L2) **470843100**

3. NAME AND ADDRESS OF FACILITY
(L3) **AUGUSTANA CHAPEL VIEW CARE CENTER**
(L4) **615 MINNETONKA MILLS ROAD**
(L5) **HOPKINS, MN** (L6) **55343**

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 **02/01/2013** (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 **118** (L18)

13.Total Certified Beds **118** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	118			
(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 :
Jonathan Hill, HFE NE II 03/04/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/06/2013 (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
08/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/14/2013 CO. VIBD

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5493

At the time of the standard survey completed February 1, 2013, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 6089

February 19, 2013

Ms. Mary Roy, Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, Minnesota 55343

RE: Project Number S5493023

Dear Ms. Roy:

On February 1, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 13, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 1, 2013 (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 August 1, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

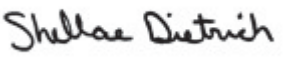
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5493s13.rtf

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	02/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000	POC 2013 Augustana Chapel View strives to provide quality care to the patients and residents we serve. The following response and plan of correction does not imply agreement with the areas identified but rather our commitment to improving quality of care quality of life for those we serve.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual	F 278	RECEIVED MAR 01 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION Accepted 3-9-13 Lynn Dent	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary A. Roy — TITLE: Administrator — (X6) DATE: 02/28/13

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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	245493	A. BUILDING _____ B. WING _____	02/01/2013

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F 278	Continued From page 1 to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document, the facility failed to ensure pressure ulcer status was accurately coded in the minimum data set (MDS) for 1 of 2 residents (R87) in the sample who were reviewed with pressure ulcers and the facility failed to ensure psychotropic medication was accurately coded for 1 of 3 residents (R189) who received psychotropic medication in the sample. Findings include: R87 was admitted to the facility from an acute care hospital on 8/9/12, with diagnoses which included back pain, hypertension, osteoporosis, aortic stenosis and history of compression fractures. The interagency transfer form the hospital dated 9/4/12, indicated R87's main complaint was back pain due to degenerative disk disease, with past medical history of vertebral compression fracture, thoracic kyphosis and osteoporosis. Per the form, R87 lived alone independently prior hospitalization and ambulated with assistance of a walker while in the hospital. R87's hospital physical examination indicated "no jaundice or cyanosis or rash", intact skin. The physician's note dated 8/7/12, also indicated there were "no areas of skin breakdown". The	F 278	R87 expired on 8-24 in the facility. To prevent recurrence, process has been reviewed with MDS Coordinators and they will review temporary care plans with each MDS completion as well as review of progress notes and care path to ensure inclusion of all information. Wounds will be audited by Nurse Manager Team to ensure interventions are in place and MDS information accurate.	3-13-13

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F 278	Continued From page 2 physician's hospital discharge summary dated 8/9/12, indicated R87 was discharged with instructions for: occupational and physical therapy, long term nursing home placement and palliative care management. The nursing admission and temporary care plan completed upon admission dated 8/9/12, skin assessment body diagram identified past surgical incision sites, and bruising. No skin breakdown was identified on R87's back. The summary dated 8/13/12, (4 days after admission) written with a different colored pen indicated "noted mid back o/a [open area] stage 2 (pressure ulcer) - curved area of the spine". The admission assessment and the note from 8/13/12 were not signed by staff that completed the assessments. Per the physical functioning assessment R87 needed one staff assistance with bed mobility, transfers, walking, toileting, bathing and grooming. The Admission Minimum Data Set (MDS) dated 8/22/12, identified R87 with severely impaired cognitive skills per the Brief Interview Mental Status, with hallucinations and delusion present. The MDS also indicated R87 needed one staff's extensive assistance with bed mobility and transfers, used wheel chair for locomotion. Per the MDS, R87 was at risk for pressure ulcer and had an identified one Stage 2 pressure ulcer present on admission, with date unknown. The Care Area Assessment (CAA) dated 8/22/12, indicated R87 had "stage two pressure ulcer to mid back on spinal curvature", and identified R87 at risk for further skin breakdown. The CAA also indicated R87 was working with therapies, and	F 278		

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F 278	Continued From page 3 improvement was expected with mobility. According to the nurses notes dated 8/13/12, R87 was noted to have a "stage 2 pressure ulcer mid back curvature area measuring 0.5 cm [centimeter] x 0.3 cm, Allevyn dressing applied & [and] will change Q [every] 3 days & as needed." The note also indicated air mattress and every one hour repositioning was initiated. During interview on 1/31/12, at 10:59 a.m. the transitional care unit clinical coordinator (TCU CC) stated he was notified first on 8/13/12, regarding R87's pressure ulcer. The TCU CC verified the pressure ulcer was not present at the time of the admission. The TCU CC explained they talked about the pressure ulcer in staff meeting if it was present or not upon admission, nobody confirmed it, so as far as he could tell the pressure ulcer was acquired in the facility. During interview on 1/31/12, at 10:41 a.m. the MDS coordinator verified the inaccuracy of admission MDS (pressure ulcer coded as present upon admission) and explained that when she took the information from the admission assessment, she have not noticed that the entry regarding the Stage 2 pressure ulcer dated 8/13/12. The admission MDS was inaccurate as the pressure ulcer was acquired after the resident entered the facility. R189's significant change MDS failed to identify the use of Haldol (an antipsychotic medication). The significant change MDS dated 1/9/13, indicated R189 had moderate cognitive impairment, had no mood or behavior problems,	F 278		

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F 278	Continued From page 4 and was given an antidepressant medication. The CAA for Psychotropic Medication Use V05 dated 1/16/13, checklist identified R189 used an antipsychotic medication, but failed to identify the use of an antidepressant medication as indicated by the MDS. The Analysis of Findings section of the form indicated, "Resident has depression, takes trazodone[an antidepressant]. Measures are in place for adverse side effects to be monitored and reported to MD [medical doctor], pharmacist to review medication regimen." The section "Document reasons care plan will/will not be developed:" indicated, "Already in care path." The MDS assessment failed to identify the use of an antipsychotic medication, the CAA failed to identify the complete psychoactive medication regimen, such as the use of Haldol and as needed (PRN) Haldol, the indications for the use of the Haldol, the use of Trazodone for sleep. The Physician Orders dated 12/3/12, indicated R189 received the following medications: - Trazodone HCl 50 milligrams (mg) oral (PO) tablet every hour of sleep (HS) for the diagnosis insomnia; - haloperidol lactate (Haldol) 0.5 mg tablet PO daily for "anxiety" and 0.5 mg concentrate PO every six hours PRN repeating for "delirium agitation." - On 12/31/12, R189 was discharged from the Hospice program for "no longer meeting hospice criteria." The Medication Administration Records (MARs) for January 2013, December 2012, and November 2012, indicated the above scheduled medications were administered as ordered. The November 2012 MAR indicated PRN Haldol was	F 278	R189 has had Haldol discontinued. Care Plan and CAA note and were updated to include use of Trazadone. Plan to correct includes review of all medication regimes during MDS assessment period to ensure care plan includes all classes of medications and monitoring for risks and side effects. MDS Coordinators educated on this process. Audit sample of 5 charts per month for 90 days will be done to ensure compliance. MDS Coordinators and DON responsible.	3-13-13

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F 278	Continued From page 5 administered 16 times; the December 2012 MAR indicated the PRN Haldol was administered five times, the last PRN dose given was on 12/9/12. On 2/1/13, at 10:15 a.m. the nurse manager (RN) -A verified the findings.	F 278		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to ensure a care plan was developed to address the use of medications for 6 of 10 residents (R73, R67, R194, R189, R41, R184) reviewed for un-necessary	F 279		

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F 279	Continued From page 6 medications; failed to develop a care plan to address pain for 1 of 1 resident (R194) initiated for pain management; failed to develop a care plan for 1 of 3 residents (R98) to reflect incontinence care. Findings include: R73's care plan was not developed to address the use of Lithium Carbonate (an antimanic medication used to stabilize mood), Remeron (an antidepressant) and Celexa (an antidepressant). R73 had diagnoses to include diabetes mellitus, bipolar disorder and Parkinson's. The admission Minimum Data Set (MDS) dated 1/7/13, indicated R73 had severe cognitive impairment and was identified to receive the following classes of medications: antianxiety, antidepressant and a diuretic. The Care Area Assessment (CAA) for Psychotropic Medication Use VO5 dated 1/11/13, consisted of a checklist which identified R73 used an "antianxiety" and "antidepressant" medication. Although the rest of the checklist was blank, the Analysis of Findings section of the CAA indicated, "Resident uses psychotropic medications daily. There are measures in place for nursing to monitor for adverse side effects and update MD [medical doctor], social services to monitor for behaviors and the pharmacist to review medication regimen." The section, "Document reasons care plan will/will not be developed:" indicated, "Monitoring of adverse side effects daily." The CAA lacked identification of the specific medications associated with antianxiety and antidepressant, lacked identification of the target behaviors being monitored for the use of these medications and was incomplete.	F 279	R73's care plan has been updated to address use of Lithium Carbonate , Remeron and Celexa including indications for use, efficacy, target behavior monitoring, non-pharmacologic interventions and side effect monitoring.	3-13-13

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F 279	Continued From page 7 The Physician Orders dated 1/7/13, indicated R73 received the following medications: - Lithium Carbonate 450 milligrams (mg) oral (PO) tablet controlled release daily for diagnosis of bipolar disorder; - Remeron 7.5 mg PO at HS (hour of sleep) for the diagnosis of bipolar disorder; - Celexa 40 mg PO daily for diagnosis (Dx) of bipolar disorder. Review of R73's care plan dated as effective from 1/11/13 to 4/18/13, indicated R73's ordered psychoactive medications of Lithium, Remeron and Celexa were not identified on the care plan. The care plan and clinical record lacked evidence of indications for the use of the medications, target behavior monitoring associated with the use of the medications. The care plan did not identify side effect monitoring and lacked direction for non-pharmacological interventions to address potential target behaviors. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R73's medication regimen. The consultant pharmacist verified the medications were not addressed on the care plan and stated she "hadn't gotten to them yet." On 2/1/14 at 3:04 p.m. the registered nurse (RN) -A confirmed the care plan did not include specifics, including risks, target behaviors, non-pharmacological interventions and the indications for the use of the psychoactive medications.	F 279		

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F 279	Continued From page 8 R67's care plan did not address the medications Effexor XR (antidepressant), Trazodone HCl (an antidepressant medication used for sleep), as needed (PRN) Xanax (a short acting benzodiazepine), Actos and Glucotrol XL (both medications used to treat diabetes) and Tegretol (anti-seizure medication). R67's diagnoses included diabetes mellitus, depressive disorder, anxiety state, and insomnia. The annual MDS dated 8/29/12, indicated R67 had moderate cognitive impairment and identified R67 received the following medications: an antipsychotic, an antianxiety and an antidepressant. The CAA for Psychotropic Medication Use V05 dated 9/5/12, consisted of a checklist which identified R67 received an antipsychotic, antianxiety and antidepressant medication. The checklist indicated R67 was at increased risk for falls, depression (from use of antipsychotic) and anxiolytics (antianxiety). The Analysis of Findings section indicated, "Potential for alteration due to side effects related to use of psychotropic medication daily. Resident admitted to CV with Dx of Depression & Sleep Disturbance. As well as Rx [prescription] treatment of Effexor XR, Tegretol & Trazodone HS. No noted adverse side effects related to use of antidepressant. Measures in place for nursing to monitor side effects and update the NP [nurse practitioner]/ MD." The Physician Orders dated 1/28/13, indicated R67 had the following medications ordered: - Effexor XR 150 mg PO extended release 24 hour capsule twice daily (BID). The orders directed, "Take with food may sprinkle on	F 279	R67's care plan has been updated to address use of Effexor, Trazadone, Xanax, Actos and Glucotrol including indications for use, efficacy, and target behavior monitoring , non-pharmacologic interventions, sleep monitoring, and side effect monitoring for psychotropics.	3-13-13

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F 279	Continued From page 9 applesauce. Do not cut/crush/chew For Depression New order 9/9/11 OBTAIN CONSENT PRIOR TO ADMINISTRATION." - Tegretol 200 mg tablet PO daily (given at 8:00 a.m.) and 100 mg tablet PO Daily (given at 4:00 p.m.) for diagnosis of convulsions; - Trazodone HCl 50 mg tablet PO at HS and 25 mg PRN one time "q [every] night if 50 mg scheduled dose is not effective" for the diagnosis of insomnia. - Actos 30 mg tablet PO daily for diagnosis of type two diabetes mellitus; - Glucotrol XL (a drug to treat type two diabetes) 10 mg extended release tablet PO daily; - Xanax 0.25 mg table PO three times daily (TID) PRN for "Anxiety." The orders lacked parameters for when to administer the PRN medication. R67's care plan hand dated as effective 9/12/12 through 12/11/12, identified the above diagnoses as risk factors. Although the care plan identified "MOOD - Diagnosis of Depression with Anxiety State receives Antidepressant," the care plan lacked development to address risks associated with the use of Effexor XR, Trazodone and Xanax. In addition, the care plan lacked resident specific target behavior monitoring for the efficacy of the medication, indications for the ongoing use of the medications and non-pharmacological interventions to address the target behaviors. In addition, the care plan did not address R67's use of diabetic medications or the use of anti-seizure medications, including but not limited to the risks associated with the medications, potential side effects, types and frequency of seizures, monitoring to hyper/hypoglycemia and monitoring for efficacy of the medications. The care plan did not address R67's sleeping patterns, use of	F 279		

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F 279	Continued From page 10 Trazodone for sleep, monitoring for sleep, as well as resident specific non-pharmacological interventions to promote sleep for R67. On 1/31/13, at 2:43 p.m. the RN-B and licensed practical nurse (LPN)-D both stated they did not update or change the care plan. RN-B stated a behavior note was written in the progress notes for R67. Both nurses confirmed the care plans did not address medications and verified the lack of parameters for the use of the PRN Xanax. On 2/1/13, at 3:12 p.m. the RN-A confirmed R67's medications were not addressed on the care plan. R194 care plan did not address the use of Paxil (an antidepressant), Neurontin (a drug used for treatment of neuropathic pain), Tylenol (a drug used to treat mild to moderate pain), oxycodone (a narcotic medication), Voltaren (a transdermal gel used to treat pain) and Lasix (a diuretic medication). In addition, the care plan was not developed to address R194's pain, including interventions identified in the assessments. R194's diagnoses included depressive disorder, generalized pain, and idiopathic peripheral neuropathy. The admission MDS dated 9/20/12, indicated R194 had severe cognitive impairment and received an antidepressant and diuretic medication. The CAA for Psychotropic Medication Use V05 dated 9/26/12, consisted of a checklist which indicated R194 used an "antidepressant." The Analysis of Findings section of the form indicated, "Resident takes paxil [sic] for depression, there measures in place for nursing	F 279	R194's care plan has been updated to address pain and use of Paxil, Neurontin, Tylenol, Oxycodone, Voltaren and Lasix including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring for psychotropics.	3.13.13

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F 279	Continued From page 11 to monitor side effects and update the MD, social services to monitor behaviors and pharmacist to review medication regimen use." The Physician Orders dated 12/26/12, directed to give R194 the following medications: - Paxil 10 mg PO tablet daily for diagnosis of depressive disorder; - Lasix 30 mg tablet PO daily; - Voltaren 2 gtts (drops) transdermal gel (jelly) one time PRN; -On 1/30/13, the Physician Orders directed: - Neurontin 200 mg PO TID for pain; - Tylenol 1000 mg PO TID for pain; - Oxycodone 2.5 mg PO q six hours PRN for pain. The orders lacked parameters for the use of the PRN medication. Such as when to administer Voltaren two drops transdermal Gel (jelly) and when to administer the PRN Oxycodone. Pain Identification/Review checklist form dated 1/30/13, indicated R194 had non-verbal sounds of pain, vocal complaints of pain, facial expressions, protective body movements/postures, and restlessness. The checklist identified R194 had a condition or diagnosis "that usually causes pain," R194 received treatments or procedures from which pain can be anticipated, and R194 received medications or non-medication interventions for pain. The checklist indicated R194 was asked if she had pain in the last five days and stated "no." A hand written note under the question asking R194 to rate her pain on a 0-10 scale (zero = no pain, 10= the worst pain you can imagine) indicated, "I don't have pain resident answered." Although the form identified pertinent pain	F 279		

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AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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F 279	Continued From page 12 information, the assessment lacked evidence R194's pain was assessed with movement. R194's care plan dated 10/12/12, and 1/25/13, did not address the use of Paxil, did not identify the use of a Lasix, and did not identify the use of Neurontin, Tylenol, Oxycodone, or Voltaren for pain. In addition, the clinical record lacked evidence of monitoring for the efficacy of the Paxil, did not address the potential side effects of the medications, did not address the risks associated with the use of the medications, such as the risks of dehydration with the use of Lasix, the risk of falls with the use of Paxil and Oxycodone. In addition, the care plan did not identify the assessed indicators of pain, such as pain with movement; did not direct non-pharmacological interventions to address pain, such as the use of heat or cold and did not address the parameters for use of the PRN pain medications. On 2/1/13, at 3:09 p.m. the RN-B reviewed the care plan and confirmed Paxil and the above medications were not addressed in the care plan. On 2/1/13, at approximately 2:22 p.m. the consultant pharmacist was contacted via telephone and stated the Paxil was for inappropriate sexual behaviors and stated she thought the Paxil was discontinued and changed to Zoloft. At 3:09 p.m. the RN-A confirmed the care plan did not address the above medications. R189 did not address the ongoing use of Haldol	F 279		

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F 279	Continued From page 13 (an antipsychotic), including target behavior monitoring and parameters for the PRN use of Haldol. In addition, the care plan did not address the use of Trazodone. The significant change MDS dated 1/9/13, indicated R189 had moderate cognitive impairment, had no mood or behavior problems, and was given an antidepressant medication. The CAA for Psychotropic Medication Use V05 dated 1/16/13, checklist identified R189 used an antipsychotic medication, but failed to identify the use of an antidepressant medication as indicated by the MDS. The Analysis of Findings section of the form indicated, "Resident has depression, takes Trazodone. Measures are in place for adverse side effects to be monitored and reported to MD, pharmacist to review medication regimen." The section "Document reasons care plan will/will not be developed:" indicated, "Already in care path." The MDS assessment failed to identify the use of an antipsychotic medication, the CAA failed to identify the complete psychoactive medication regimen, such as the use of Haldol and PRN Haldol, the indications for the use of the Haldol, the use of Trazodone for sleep. The Physician Orders dated 12/3/12, indicated R189 received the following medications: - Trazodone HCl 50 mg PO one tablet every HS for the diagnosis insomnia; - haloperidol lactate (Haldol) 0.5 mg tablet PO daily for "anxiety" and 0.5 mg concentrate PO every six hours PRN repeating for "delirium agitation." The Medication Administration Records (MARs)	F 279	R189's Haldol was discontinued. Care plan has been updated to address the use of Trazadone including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring .	3-13-13

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F 279	Continued From page 14 for January 2013, December 2012, and November 2012 indicated the above scheduled medications were administered as ordered. The November 2012 MAR indicated PRN Haldol was administered 16 times; the December 2012 MAR indicated the PRN Haldol was administered five times; the last PRN dose given was on 12/9/12. R189's checklist care plan for activities of daily living (ADL) Function/Rehabilitation dated 10/16/12, checked that R189 received "Psychoactive Medication that impairs ability." Further review of the 10/16/13, checklist care plan and the care plans dated 1/23/13, indicated the care plans did not identify the use of Haldol or Trazodone, lacked indications for the use of the medications, the risks associated with the use of the psychotropic medications, monitoring for efficacy of the medications. In addition, the care plan and clinical record lacked evidence a target behavior, such as the resident specific symptoms of R189's delirium were identified and monitored. The care plan lacked development of non-pharmacological interventions to address the target behaviors, such as interventions to promote sleep or to address anxiety and delirium. On 2/1/13, the RN-A confirmed the findings and verified the care plan did not address the use of the medications. R80 had the diagnosis of diabetes mellitus, received the medications Lantus (a long-acting insulin), Actos and Glipizide (drugs used to treat diabetes mellitus) and lacked development of a care plan to address R80's treatment of diabetes mellitus. In addition, R80's care plan lacked	F 279	R80 has discharged.	

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F 279	Continued From page 15 development to include the medication Paxil. The annual MDS dated 12/26/12, indicated R80 had moderate cognitive impairment, had an active diagnosis of diabetes mellitus and received insulin injections. The CAA for pressure ulcers dated 1/2/13, identified R80 had the diagnosis of diabetes. The Augustana Chapel View Care Center MDS Notes for VCAA12 dated 2/14/12, identified R80 had an alteration in nutritional status, required a therapeutic diet due to diabetes mellitus and identified R80 was at risk for hypo/hyperglycemia as well as weight loss due to the diagnosis. The Physician Orders dated 2/1/13, indicated R80 received the following medications for diabetes: - Lantus 14 units (U) subcutaneous (SQ) solution at the hour of sleep (HS); - Glipizide 10 mg PO tablet daily; - Actos 30 mg PO tablet daily; - Paxil 20 mg tablet PO daily for diagnoses of depression, dementia, "in appropriate external behaviors." The Physician Orders further directed interventions to address diabetes of: - Blood Glucose monitoring four times daily (QID); - File nails every two weeks on Wednesday. R80's care plan, hand dated as effective 7/26/12, through 10/1212, failed to identify a diabetes focus including but not limited to, use of diabetic medications, risks associated with the medications, monitoring for blood glucose, diabetic nail care, monitoring for signs and symptoms of hypo/hyperglycemia. In addition, the care plan did not address the use of Paxil,	F 279		

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F 279	Continued From page 16 including the indications for the use of Paxil, the risks associated with psychoactive medication use and monitoring for side effects. On 2/1/13, the RN-A confirmed the findings and verified the care plan did not address the use of the medications. R41 was admitted to the facility on 1/11/11, with diagnoses which included dementia, anxiety, malaise and fatigue. R41's care plan did not include interventions related to the neuropathic condition. Daily observations from 1/29/13 through 2/1/13, noted the resident to appear calm, pleasant, social, and exhibited no agitation or anxiety. Observation of R41's skin on 2/1/13, at 2:10 p.m. revealed small skin abrasion on R41's right outer below the knee area. The Annual Minimum Data Set (MDS) dated 11/14/12, noted R41 had no mood indicators,or behaviors. The Care Area Assessment (CAA) dated 11/14/12, indicated R41 used psychotropic medications. There were measures in place for nursing to monitor for adverse side effects, social services was to monitor behaviors and the pharmacist was to review medications. Per the CAA, "No adverse effects exhibited during this time." The care planning report last revised on 12/14/12, did not include use of psychotropic medication use, side effect monitoring, and skin condition monitoring related to behaviors of neuropathic condition.	F 279		

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F 279	Continued From page 17 The physician progress note dated 11/6/12, noted R41 had a history of "neurotic excoriation" and was on Risperdal for it. The physician's orders sheet dated 1/7/13, noted an order for Risperdal 0.5 mg to be given daily at bedtime for condition. The Risperdal start date was 3/21/12. R41 also took Celexa 40 mg daily for depression and Lorazepam (antianxiety medication) 0.5 mg every six hours as needed (PRN) for anxiety. The Mood and behavioral record for December 2012 and January 2013, indicated target behaviors which included "repeated requests to go to the bathroom with very short periods of time", and did not include monitoring of the excoriations. When interviewed on 2/1/13, at 11:29 a.m. the licensed practical nurse (LPN)-B stated she did not know what target behaviors were monitored for R41's neuropathic condition, and Risperdal use. The registered nurse (RN)-B was interviewed on 2/1/13, at 2:05 p.m. The RN-B stated R41 used to scratch self, and remembered that just few weeks before R41 had a scratch on her hand, and three staff observed R41 scratching herself. Per the RN-B, R41 scratched mainly her arms and hand. The registered nurse (RN-A) who was the Lower Unit Clinical Coordinator, was interviewed on 2/1/13, at 2:35 p.m. and verified the care plan did not include behavior monitoring for the Risperdal use, skin condition related to neuropathic, excoriation, and scratching oneself.	F 279	R41's care plan has been updated to address neuropathic condition and use of Risperdal, Celexa and Lorazepam including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring .	3.13.13

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F 279	Continued From page 18 R184 was admitted to the facility on 12/14/12, with diagnoses which included anxiety, rib fractures, depression and congestive heart failure. R184 used Xanax for anxiety, however, the facility did not monitor R184's anxiety status. During daily observations from 1/29/13 through 2/1/13, R184 appeared calm, pleasant, social, and exhibited no agitation or anxiety. The physician's order sheet dated 1/10/13, noted an order for Xanax (antianxiety medication) 0.5 mg twice daily PRN. Review of the Medication Administration record for January 2013, indicated R184 took Xanax five times. There was inadequate documentation in the medical record of mood and behavior monitoring to indicate the need for the anti-anxiety medication. The Admission MDS dated 12/27/12, noted R184 had no mood indicators and had no behaviors. The care plan dated 1/2/13, did not indicate use of the Xanax, and did not identify non pharmacological interventions implemented when R184 exhibited signs and symptoms of anxiety, distress. During interview on 2/1/13, at 11:32 a.m. the LPN-B stated R184 requested to take Xanax when R148 felt anxious or when R148 had shortness of breath. During interview on on 2/1/13, at 10:15 a.m. the RN-A verified there was no target behavior	F 279	R184's care plan has been updated to address use of Xanax including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring .	3-13-13

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F 279	Continued From page 19 monitoring in place for the Xanax use, and acknowledged lack of comprehensive care plan for anxiety. The Psychotropic Medication Monitoring policy with revision date 1/2013, indicated "A care plan should be developed with the resident/family/ interdisciplinary team that maximizes patient function and well-being". R98 was admitted with multiple diagnoses which included Alzheimer's dementia. R98 had been listed as continent of bladder. R98 also had a decline in urinary continence indicated on the 90 day Minimum Data Set (MDS) assessment as occasionally incontinent. The care plan for R98 was not developed to reflect individualized needs related to incontinence issues. On 1/30/12, at 7:15 am R98 was observed sitting on her bed getting herself dressed for the day. She stated that she was able to take herself to the bathroom and so far had not had any accidents. She said she did not use incontinent products and would get herself up at night if she had to use the toilet. There were no odors or signs of incontinence. The Care Area Assessment (CAA) for bowel and bladder dated 10/17/12, indicated R98 was continent of bowel and bladder although she had risk factors present for a possible decline. The CAA indicated R98 was unable to express needs and concerns at all times due to cognitive deficits. The quarterly review of bowel and bladder dated 1/2/13, indicated the R98 was able to request assistance with toileting and was mostly continent of bowel and bladder. No revisions to the care	F 279		

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F 279	Continued From page 20 plan were indicated. The plan of care related to elimination indicated that R98 required physical staff assist due to depression, dementia, hypertension, Alzheimer's dementia, degenerative joint disease and gout, and she was unable to initiate or complete toileting on her own. The goal was for R98 to remain continent when assisted to the toilet every two hours while awake and as needed. The interventions listed were to document bowel movements each shift, provide extensive assistance and one person physical assist. The plan of care was not revised to reflect R98's incontinence. On 1/30/12, at 8:15 a.m. RN-A was interviewed and explained R98 had some incontinence episodes, and at times R98 would take herself or ask to go to the bathroom, but not always. He explained further that the incontinence episodes would usually happen at night and she sometimes refused to get up. He stated the plan was to offer toileting every couple hours. On 1/30/12, at 8:40 a.m. LPN-A was interviewed and explained that R98 could get to the toilet and even get her cloths down but did not do a good job with perineal care and was incontinent at times. On 1/31/13, at 9:00 a.m. nursing assistant (NA)-A explained R98 did not wear an incontinence pad, but the staff would put one on her if she was having episodes of increased confusion. At 12:30 p.m. NA-B stated that R98 wore an incontinence pad only at night and was usually dry in the morning.	F 279	R98's care plan has been updated to reflect current status of continence and behavioral factors affecting this have been added. To correct this issue, the policy has been revised to reflect inclusion of medications in the care plan for indications for use, efficacy, target behavior monitoring, non-pharmacologic interventions and side effects. All remaining residents will be reviewed at the next MDS assessment scheduled. RAI staff in-serviced on these issues. Audits sample of 5 charts per month for 90 days will be done to ensure compliance. Social Services, Clinical Managers and DON responsible.	3-13-13

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F 279	Continued From page 21 On 2/1/13 at 2:00 p.m. R98 was observed sleeping in her bed. There was an odor of urine in the room. At 10:30 RN-A explained that R98 sometimes needed a pad sometimes not depending on her cognitive status. He explained that at night a pad was to be offered. After reviewing the care plan for R98, RN agreed that the interventions had not been individualized for R98 relating to her toileting needs.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE-PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 280		

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F 280	Continued From page 22 review, the facility failed to ensure the care plan for 1 of 2 sampled residents (R125) was revised to address the use of bed and chair alarms. Findings include: R125 was admitted on 11/7/12, with diagnoses which included dementia (loss of memory) and left sided cerebrovascular accident (a condition that affects brain function due to the disturbance in the blood supply to the brain) to the transitional care unit (TCU). On 11/30/12, R125 was transferred to the long term care unit. R125's care plan dated 1/13/12, did not indicate the use of bed and chair alarms interventions as identified on Physical Device Assessment dated 11/30/12. On 1/31/13, at 9:30 a.m. R125 was observed in his wheelchair during the breakfast meal in the lower level south dining room without the chair alarm in place. On 1/31/13, at 10:37 a.m. R125 was observed lying on his bed without a bed alarm in place. R125 was continuously observed on 1/31/13, from 9:30 a.m. to 11:00 a.m. and on 2/1/13, from 8:30 a.m. to 9:30 a.m. R125 did not have bed and chair alarms in place. Review of the Physical Device Assessment dated 11/30/12, revealed bed and chair alarms were to be used for R125 to prevent falls due to generalized weakness and dementia. The undated long term care unit nursing assistant	F 280	F280 The care plan and care card for R125 have been updated to include use of mobility alarms in both bed and chair. All other residents with alarms have been reviewed to ensure this intervention is included in the care plan and the care card. All Nursing Department staff in-serviced on use and operation of mobility alarms. Random sample audits of 2 alarms per week for 90 days will be done to ensure ongoing compliance. Clinical Managers and DON responsible.	3-13-13

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F 280	Continued From page 23 care sheet did not indicate the use of bed and chair alarms interventions identified on 11/30/12. Review of the Treatment/Procedures Administration Record dated 2/1/13, revealed staff nurses had signed off every shift from 1/1/13 to 1/31/13 R125 had bed and chair alarms. On 2/1/13, at 9:33 a.m. interview with registered nurse (RN)-B revealed the staff ensured R125 had bed and chair alarms every shift. RN-B went to R125's room to observe bed and chair alarms. RN-B verified R125 did not have bed and chair alarms. On 2/1/13, at 10:37 a.m. RN-A went to R125's room to observe the bed and wheelchair alarms. RN-A verified R125 did not have the bed and chair alarms in place. RN-A also verified the care plan did not include the use of bed and chair alarms identified on Physical Device Assessment dated 11/30/12. On 2/1/13, at 10:55 a.m. RN-A was observed in the hallway with bed and chair alarms headed to R125's room. On 2/1/13, at 10:58 a.m. NA-B was not aware of the use of bed and chair alarms for R125 as NA-B had cared for R125 at least five times in the past month. In addition, NA-B verified the nursing assistant care sheet for the long term care unit did not direct staff to ensure R125 had bed and chair alarms. Review of the Fall and Injury Reduction policy dated 12/00, indicated fall reduction measures included bed and wheelchair sensor alarms. The policy specified, "All interventions for fall and injury reduction were noted on the resident's plan	F 280		

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F 280	Continued From page 24 of care and resident care card." R125's care plan dated 1/13/12, did not indicate the use of bed and chair alarms interventions.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop care planning sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and care plan for 1 of 2 residents (R87) identified with pressure areas. Findings include: R87 was admitted to the facility from an acute care hospital on 8/9/12, with diagnoses which included back pain, hypertension, osteoporosis, aortic stenosis and history of compression fractures. The interagency transfer form the hospital dated 8/4/12, indicated R87's main complaint was back pain due to degenerative disk disease, with past medical history of vertebral compression fracture, thoracic kyphosis and osteoporosis. Per the form, R87 lived alone independently prior hospitalization and ambulated with assistance of a walker while in the hospital. R87's hospital physical examination indicated "no jaundice or cyanosis or rash", intact skin. The physician's note dated 8/7/12, also indicated there were "no areas of skin breakdown".	F 281		

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	245493	A. BUILDING _____ B. WING _____	02/01/2013

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F 281	Continued From page 25 The nursing admission and temporary care plan completed upon admission dated 8/9/12, skin assessment body diagram identified past surgical incision sites, and bruising. No skin breakdown was identified on R87's back. The summary dated 8/13/12, written with a different colored pen indicated "noted mid back o/a [open area] stage 2 (pressure ulcer) - curved area of the spine". The admission assessment and the note from 8/13/12, were not signed by staff that completed the assessments. Per the physical functioning assessment, R87 needed one staff assistance with bed mobility, transfers, walking, toileting, bathing and grooming. Although staff identified R87's need for assistance with bed mobility and transfers, the temporary care plan for skin integrity was left blank, and did not identify a repositioning time interval. The Transitional Care Unit (TCU) care card used by staff to provide cares to dated 8/9/12, for turning and repositioning was left blank. The TCU care card was updated on 8/13/12, with interventions including: air mattress, blue boots and Allevyn dressing (used to treat wounds) to mid back Stage 2 pressure ulcer. The care card update of 8/13/12, still lacked evidence of how often R87 was to be turned and repositioned. The Tissue Tolerance Evaluation Sitting form (tool used to determine ability of the skin to endure the effects of pressure) dated 8/10/12, indicated no redness was noted after client has been sitting for two hours. The record lacked evidence of a tissue perfusion test was completed while R87 laid in bed.	F 281	F281 As stated above, R87 expired in the facility. Other identified residents at risk have been reviewed to ensure proper interventions are in place in care plan and care card. To prevent recurrence, all residents will be reviewed during 90 day MDS assessment period. All Nursing Staff in-serviced on comprehensive skin assessment and appropriate interventions. Random sample audit of 4 admission comprehensive skin assessments per month will be done for 90 days to ensure ongoing compliance. Clinical Managers and DON responsible.	3-13-13

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F 281	Continued From page 26 The Braden scale/Comprehensive Skin Risk Evaluation assessment completed upon admission, dated 8/9/12, noted a score of 18, 16 or lower indicated risk for developing pressure ulcer. The summary noted R87 was blind who exhibited anxiety, restlessness, and needed assist of one staff with all activities of daily living. According to the nurses notes dated 8/13/12, R87 complained of pain while in physical therapy, but denied when nurse assessed. Per the note R87 was noted to "stage 2 pressure ulcer mid back curvature area measuring 0.5 cm [centimeter] x 0.3 cm, Allevyn dressing applied & [and] will change Q [every] 3 days & as needed." The note also indicated air mattress and every one hour repositioning was initiated. The card card for the TCU unit was not revised with the new repositioning times. During interview on 1/31/12, at 10:59 a.m. the registered nurse (RN)-C, who was the TCU's clinical coordinator, stated he was notified first on 8/13/12, regarding R87's pressure ulcer. The RN-C verified the pressure ulcer was not present at the time of the admission. Per the RN-C R87 was repositioned as per standard of practice every two hours during the first four days of the admission. The RN-C also verified the temporary care plan and the TCU care card lacked evidence of interventions listed to prevent potential skin breakdown. During interview on 1/31/12, at 2:49 p.m. the director of the nursing stated staff were expected to assess residents upon admission, and implement interventions based on those assessments to prevent residents from skin	F 281		

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F 281	Continued From page 27 breakdown. The Care Plans policy with a revision date of 3/12, indicated, "a paper copy of the Nursing Admission/Temporary Care Plan is completed by the admitting nurse." The policy also indicated the nursing staff on the TCU "will utilize this form as their Care Card and make any necessary corresponding written notes on their assignment to ensure proper care delivery."	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed for 3 of 8 residents (R189, R194, R178). Findings include: R189 was not provided oral cares or both hearing aids as directed by the care plan. R189's diagnoses included hearing loss, mixed hearing loss and debility. R189's care plan for Sensory Perception/Expression dated 10/9/12, identified R189 had a hearing aid for both the right and left ear, directed to encourage R189 to wear the hearing aid, assist to insert/remove/change the batteries. The activities	F 282		

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F 282	Continued From page 28 of daily living (ADL) Functional/Rehabilitation care plan dated 10/16/12, identified R189 required assistance with bathing, dressing and grooming due to "end stage debility" psychoactive medications and weakness. The goal identified, "Res. will have all ADL functions complete w/ [with] staff assistance for the next 90 days." The care plan directed, "Set up all supplies and encourage Res to participate as far able." The care plan identified R189 required one staff assistance, including "Brush teeth/dentures." The care plan for Communication directed to "Observe for hearing deficit/changes." The care plan had a check in "Hearing aid(s)" and the right and left. On 1/30/13, the following was noted: - At 7:23 a.m. R189's was observed to be in bed with the door open and the room dark. - At 7:31 a.m. the licensed practical nurse (LPN) -B entered the room and gave "Synthroid [thyroid replacement] " to R189 and left the room. - From 7:31 a.m. to 8:14 a.m. not staff entered the room. - At 8:14 a.m. a nursing assistant (NA)-C entered the room, spoke with the roommate and asked if she was "ready for breakfast." NA-C greeted R189; NA-E entered the room, spoke with NA-C and left the room closing the door. NA-C remained in the room. - At 8:21 a.m. the door opened and the roommate ambulated out of the room with NA-C. R189 was observed to still be in bed. NA-C closed the door to the room and remained in the room to assist R189. - At 8:25 a.m. NA-C was observed to assist R189 with morning cares. The left hearing aid was observed to be in and NA-C was assisting R189.	F 282	R189 has had hearing aide added to care plan and care card for staff to assist on in am and remove at hs. All other at risk residents requiring assistance have had hearing aides added to care card and care plan for on in am and off at hs. Oral care is included in the care plan and the care card for staff to assist. Staff involved was re-educated on this.	3-13-13

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F 282	Continued From page 29 NA-C was observed to assist R189 with changing of her incontinence product and dressing. NA-C stated R189 "does more for herself." At the time, the surveyor asked NA-C were R189's right hearing aid was. NA-C confirmed the right hearing aid was not in the ear and asked R189 very loudly "Where is your hearing aid?!" R189 stated, "I didn't quite get that." NA-C asked the question again even louder. R189 pointed to her right ear and stated, "It's missing, I don't know where it is." R189 pointed to her left ear and the NA stated loudly, "Your hearing aid is in!" NA-C checked the hearing aid and continued to dress R189, assisted R189 to transfer to the wheelchair, then proceeded to dispose of the incontinence product and make the bed. NA-C stated, "She brushes her teeth after breakfast." NA-C left the room. R189 was transported to the dining area shortly after. - At 12:03 p.m. the surveyor used the white board to ask R189 if she had received assistance with denture/oral cares after breakfast. R189 stated no one helped her brush her teeth. Confirmed NA-C was the staff "who was taking care of me" in the morning. R189 denied brushing her dentures/teeth herself. - At 12:21 p.m. NA-D denied assisting R189 with oral cares and stated she was assigned to "[NA-C's name]." - At 1:29 p.m. R189 was observed to be brushing her teeth, with a visitor providing assistance. The visitor stated they were a nursing assistant from a "home care" company that was hired privately to provide "companionship" to R189. The visitor stated R189 "told me she hasn't brushed her teeth since she's been here." The visitor stated she assisted R189 with her oral care.	F 282		

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F 282	Continued From page 30 At approximately 1:40 p.m. NA-C was interviewed and stated he thought R189 was able to "do it [denture/oral cavity cleaning] herself." NA-C stated the supplies were in the bedside table and confirmed he did not use the white board to communicate with the resident. NA-C confirmed he did not report the missing hearing aide. On 1/30/13, at 3:30 p.m. the nurse manager (RN) -A and social worker (SW)-A both were interviewed and stated R189 did not require the use of the white board and stated they had "tested" her hearing and stated R189 was able to hear. Both denied any concerns being communicated regarding communication or hearing problems. RN-A stated R189 should have been set up for oral cares and NA-C should have assisted R189. SW-A stated he was not aware R189 was missing a hearing aide. On 2/1/13, at 10:40 a.m. SW-A was interviewed and stated "one hearing aid" was in the nursing cart and "one in her ear." SW-A confirmed R189 arrived with both hearing aids. SW-A confirmed the therapeutic recreation staff did the hearing assessment and documented R189 had two hearing aids when she first arrived. SW-A stated R189 kept "removing the left hearing aid" because it was "squeaking." SW-A stated staff did not check the hearing aid for function, was unclear if the family was notified of a hearing aid problem and unclear how long it had been since R189 had the hearing aide removed and placed in the medication cart. R194 did not have fluids encouraged between meals as directed by the care plan.	F 282		

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F 282	Continued From page 31 R194's diagnoses included dementia and glaucoma. R194's care plan for Nutrition/Hydration dated 12/19/12, identified R194 was at risk for nutrition/hydration problems because R194 required assistance with meals and "multiple medical diagnoses" which included "Dementia." The care plan identified R194 had a significant weight loss over 30 days on 12/12/12. The care plan goal for R194 was to be free from signs and symptoms of dehydration. The interventions section directed: "amount eaten a.c. [after meals], bed time snack at hour of sleep, provide a regular diet" and "Encourage intake of fluids." During continuous observations on 1/30/13, beginning at 7:23 a.m. and ending at 11:50 a.m. R194 covered blue mug at the bedside was observed to be out of the resident's reach, full, room temperature warm and to still have the paper on the drinking end of the straw while R194 was in bed. R194 was not offered fluids until the breakfast and lunch meals and was not provided opportunities for fluid intake, such as after care or while sitting in the lounge area. On 1/30/13, at approximately 3:35 p.m. the RN-A verified fluids should have been offered to R194 throughout the day. On 2/1/13, at 7:44 a.m. R194 was observed to be lying in bed flat on his/her back, the blue covered water mug was out of reach and appeared full. At 7:47 a.m. when LPN-C was interviewed and asked if R194 could drink fluids if placed in reach, LPN-C stated R194 "will sometimes try to drink,"	F 282	R194 has had intake monitoring and scheduled fluids added to care plan and care card to promote offering and encouraging fluids between meals. Additional documentation for fluids offered between meals has been added to intake monitoring. All other at risk residents have had this added as well. Ongoing review of all other residents to occur at 90 day MDS assessment. Random sample audit of 5 charts per week will be done for 90 days to ensure ongoing compliance.	3-13-13

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F 282	Continued From page 32 and stated R194 was "sometimes" able to drink fluids without staff assistance. LPN-C stated R194 needed cuing to consistently drink. LPN-C confirmed the mug of water was out of reach of R194. At 7:58 a.m. RN-A was interviewed and confirmed R194's water glass was full and stated it should have been offered to R194 by the night shift staff. RN-A initially stated the water was "just filled," but then confirmed the cup was warm and the water lacked ice. The blue mug was observed to have paper from the straw missing, RN-A opened the mug and stated it was "nearly full." R178 was not provided every one hour repositioning and did not have the indwelling Foley catheter tubing secured as directed by the care plan. R178's diagnoses included stage IV pressure ulcer and dehydration. R178's care plan for Elimination dated 8/11/12, directed pertinent interventions to address the resident's Foley catheter including, "Catheter Positioning: - Secure indwelling cath [catheter] to leg (SP [suprapubic] cath to hip) w/ [with] cath strap or tape to avoid pulling on/dislodging cath AM & PM." The Skin care plan dated 12/17/12, identified the resident had a stage IV pressure ulcer located on the sacrum. The care plan interventions section had an undated hand written note which directed, "Turn, reposition, OFF-load Q 1 Hr." The care plan further directed to use the draw sheet for repositioning. During continuous observations on 1/30/13,	F 282		

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F 282	Continued From page 33 beginning at 7:23 a.m. and ending at 9:52 p.m. R178 was observed to not be offloaded (repositioned) for three hours and seven minutes. At 9:52 a.m. NA-D and NA-E were observed to enter R178's room after the LPN-B directed both NA staff to "boost" the resident in bed. While R178 was laid flat in the bed and prepared to be turned to the right side, the Foley catheter tubing was observed to be loosely moving against R178's thighs. Although the catheter tubing was connected to the drainage bag, the catheter tubing was not secured and anchored to prevent the potential pulling on the tubing inserted to the urethra. NA-D stated the strap to secure the catheter tubing was in the "drawer" of the night stand and stated, "I haven't dressed her yet." NA-D pointed to the top drawer of the night stand. At 10:13 a.m. the RN-A was notified of R178 going for three hours and seven minutes without offloading and the catheter tubing not secured. RN-A confirmed R178 should have been offloaded for one full minute every one hour and the catheter tubing should have been secured. The Augustana Chapel View Care Center Skin Care Program policy and procedure dated 1/13, identified, "...A resident who has pressure sores will receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing..." The policy directed to complete the facility's various assessment forms, to identify risk factors and to note the risk factors on the care plan and nursing assistant care sheet. The procedure directed, "a. Turning and repositioning every 2 hours or more frequently as needed by resident skin status. Utilize pillows and positioning devices to	F 282	R178 has had hourly repositioning added to the care card. A catheter strap has been added to secure Foley and included in care card and care plan. Staff involved educated on this. All other at risk residents have been reviewed to ensure repositioning needs are included on care path and care card. All other residents with catheters have been reviewed to ensure inclusion of catheter strap to secure tubing. To prevent recurrence, all Nursing Department staff in-serviced on above information. Random sample audits of 5 residents per week for 90 days will be done for timely repositioning. Random sample of 2 catheters per week for 90 days will be done for properly secured. Clinical Managers and DON responsible.	3-13-13

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F 282	Continued From page 34 decrease pressure over bony prominences."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R194) initiated for pain and observed to have lower extremity pain which manifested with movement, was assessed for pain with movement; In addition, the facility failed to ensure staff reported an observed episode of pain with movement to the licensed practical nurse (LPN) to have it treated in a timely manner, which included the use of as needed (PRN) topical Voltaren (used to treat pain or inflammation caused by arthritis). Findings include: R194's diagnoses included dementia, idiopathic peripheral neuropathy, osteoarthrosis, pain in limb, and generalized pain. The admission Minimum Data Set (MDS) dated 9/20/12, indicated R194 had severe cognitive impairment, required extensive physical assistance from staff activities of daily living (ADLs), was on a scheduled pain regimen, did not receive as	F 309		

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F 309	Continued From page 35 needed pain medications and had no pain when interviewed. The Care Area Assessments (CAA's) for pain did not trigger. On 1/30/13, R194 was observed: - At 7:23 a.m. through 8:10 a.m. R194 was observed to be in her room in bed until 7:40 a.m. A nursing assistant (NA)-C entered the room at that time for morning cares. The door was closed. R194 appeared calm and relaxed while lying in bed. - At 8:10 a.m. R194 was wheeled out of the room by NA-C and to the dining area for the breakfast meal. From 8:10 a.m. until 9:28 a.m. R194 remained at the breakfast meal in the wheelchair. R194 did not appear to be in pain. - At 9:28 a.m. NA-D was observed to enter information into a computer kiosk on the wall directly behind R194. R194's legs were observed to be extended straight out in the wheelchair with the left foot rotated inward and the heels of both feet resting on the front edge of the foot pedal. R194 had light blue padded booties on both feet. - At 9:31 a.m. the nursing assistant (NA)-D noted the positioning of R194's left leg and adjusted it. R194 stated loudly, "Careful! That hurts so bad! It hurts so bad!" when NA-D moved the left leg. R194's left leg was observed to be rotated inward, the knee bent slightly in and the lower leg extended laterally from midpoint. The right leg was observed to be extended straight out, the right heel resting on the edge of the foot pedal. NA-D moved R194 from the breakfast table and faced the wheelchair towards the center aisle of the dining area, then returned to entering information into the computer kiosk on the wall. R194 sat in the wheelchair and made rapid anxious moaning noises which gradually reduced	F 309	Pain Assessment was done for R194. Oxycodone PRN was added for pain. Pain rating scheduled to be done every am prior to getting out of bed with interventions offered as appropriate. Nursing Department in-serviced on pain assessment and rating scale and reporting expectations. Clinical Manager and DON responsible.	3-13-13

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ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	02/01/2013

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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F 309	Continued From page 36	F 309		

to a repeated humming. R194 was observed to be gripped the armrests tightly while the left leg was adjusted. NA-D asked NA-C if R194's wheelchair was a "new chair," NA-C stated it was the "same chair." NA-D and NA-C discussed R194's positioning. NA-C moved R194's left leg. R194 loudly yelled, "Ow, ow, ow! Help me!" NA-D pointed to the foot pedals and stated to NA-C, "They're far apart." NA-D then approached the licensed practical nurse (LPN)-B at the medication cart directly outside the dining area and in the hallway. NA-D explained to LPN-B immediately after R194 had called out in pain, that another resident had "a shower," read a piece of paper from the medication cart, obtained a blood pressure (BP) machine and took another resident's (R73's) BP. NA-D asked LPN-B if she was "through with him" and wheeled R73 down the hallway with the BP machine. NA-C returned to the dining area and began bagging linens after wheeling R194 to the lounge area directly across from the nursing station.
- From 10:00 a.m. to 11:50 a.m. R194 remained in the lounge area, was not administered any medications. R194 did not move either lower extremity and hummed to herself. At 11:50 a.m. R194 remained in the wheelchair unmoved until R194 was wheeled to the Celebration of Life activity off the unit.

The Comprehensive Pain Data Collection and Assessment dated 9/16/12, identified R194 had "bilateral leg pain," was disoriented to place and time, that R194 "denied pain" but was able to report pain and be understood. The assessment indicated the pain was the "Reason she was admitted to hospital and now brought here," and rest/repositioning/medication made the pain

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F 309	Continued From page 37 "better." The assessment identified "movement" made the pain worse and goals for pain management were for R194 to sleep comfortably, have comfort with movement, comfort at rest, stay alert and perform activities. R194's care plan for Pain Management dated 10/4/12, identified R194 had generalized pain, osteoarthritis and received scheduled medications for pain management. The care plan directed to offer repositioning, scheduled pain medications. The care plan identified scheduled Tylenol (a mild analgesic). Although the physician's orders directed to administer scheduled Neurontin (used to nerve pain) and PRN Voltaren (nonsteroidal anti-inflammatory drug) topical medications for pain, the care plan did not identify the use of Neurontin for pain and lacked direction for when to administer the as needed (PRN) Voltaren. The care plan lacked pertinent assessed information regarding R194's pain, such as the location and intensity of the pain, that R194's pain manifested with movement, or non-verbal indicators of pain such as grimace, furrowed eye brows or calling out. The ADL - Pain Interventions form dated 10/5/12, indicated to "offer repositioning" and "Scheduled pain medication" of Tylenol. The Pain identification/Review dated 12/6/12, consisted of a check list which identified non-verbal sounds such as crying, whining, gasping, moaning or groaning; R194 would express vocal complaints of pain such as "that hurts, ouch, stop;" R194 had facial expressions of pain such as grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw;	F 309		

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F 309	Continued From page 38 protective body movements and restlessness. The review identified R194 received "treatments or procedures from which pain can be anticipated;" the review indicated R194 had occasional pain in the last five days, but R194 was unable to rate their pain. The quarterly MDS dated 12/12/12, indicated no changes in R194's pain status. Physician Orders for R194 dated 12/26/12, indicated R194 received the following medications for pain control beginning on 9/14/12: - Tylenol 1000 milligrams (mg) by mouth (PO) four times daily (QID) for generalized pain; - Neurontin 100 mg capsule PO three times daily (TID) for idiopathic peripheral neuropathy; - Voltaren (a topical medication used to treat pain) two drops transdermal gel (jelly) as needed [PRN] topically to medial and inner left knee. The Monitoring Assessments Report (MRS) dated 11/1/12 to 2/1/13, for "Pain" indicated: - November 2012 R194 had "moderate pain" once and "slight pain" once "during dressing change to (L) [left];" - December 2012 R194 had pain five times, "slight pain" three times and "moderate" pain two times; - January 2013 R194 had two episodes of "slight pain." The MRS dated 11/1/12 to 2/1/13, for "Pain Scale 1-10" indicated: November 2012 R194 had: - 30 times in that timeframe rated the pain as "1-Mild Pain,"	F 309		

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F 309	Continued From page 39 - Four times the pain was rated as "2- [no description]," - Four times R194's pain was rated at "3- [no description]," - Two times at "4- [no description]," and two times at "5- moderate pain;" December 2012 R194 had: - 37 times the pain was rated as "1- Mild Pain," - Five times the pain was rated at "2-," - Five times the pain was rated at "3-," - Three times the pain was rated at "4-," and - Nine times the pain was rated at "5- Moderate Pain." January 2013 R194 had: - 25 times the pain was rated as "1- Mild Pain," - Six times the pain was rated at "2-," - Eight times the pain was rated at "3-," and - Three times the pain was rated at "4-." Notes indicated the pain occurred during "wound" care and/or treatment. The Medication Administration Records (MARs) for November 2012 through January 2013 indicated no doses of the PRN Voltaren were administered to R194. Further review of the January 2013 MAR indicated R194 was given Oxycodone 2.5 mg on 1/30/13 and 1/31/13. The clinical record lacked evidence PRN Voltaren was offered or attempted to address R194's pain. The nursing Progress Note dated 1/30/13, written at 4:56 p.m. by RN-A indicated, "It was brought to writers attention that resident was experiencing some degree of pain earlier in the day. Pain Review was completed. Did not identify any pain issues. However as writer was reviewing resident's medication regime [sic], noted that resident was receiving [sic] 4000Mg [milligrams]	F 309		

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F 309	Continued From page 40 of tylenol as well as neurontin 300 Mg daily; both medications in ivided [sic] doses. Writer spoke to resident's physician in reference to same. Physician decided to make some changes. See new physician's orders." Although the note indicated R194 did not have pain, the clinical record lacked rational for the addition of a narcotic medication and did not address assessment of R194's pain in the lower extremities with movement. In addition, the clinical record lacked evidence the PRN Voltaren use was reviewed or the use of non-pharmacological pain control interventions, such as cold or heat. On 2/1/13, review of the In-House Attending Physician's Order Form indicated on 1/30/13, R194's pain regimen was changed to Neurontin was increased to 200 mg PO TID for pain; Tylenol was decreased to 1000 mg PO TID and a new order for Oxycodone (a narcotic pain mediation) 2.5 mg PO every six hours PRN for pain was given. The physician's orders lacked parameters when to administer PRN Oxycodone and when to administer PRN Voltaren. Review of R194's undated Group 1 sheet indicated pertinent information directing R194's care to the NA staff such as monitoring the skin, assistance required, diet and safety information. The form lacked information related R194's pain, such as when R194 had pain, or to report to the nurse in charge immediately if R194 had pain. On 1/30/13, at 12:21 p.m. NA-D stated he was not sure where R194 went after breakfast, believed R194 was at therapy and stated he believed they were working with her foot pedals.	F 309		

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F 309	Continued From page 41 NA-D stated he notified LPN-B about R194's pain and LPN-B informed him R194 had "received a pain medication." On 1/30/13, at 12:25 p.m. the director of therapeutic recreation (DTR) confirmed R194 attended the Celebration of Life activity after breakfast and confirmed no fluids or snacks were served to R194. The DTR stated the chaplain brought R194 back to the unit and the "lounge." On 1/30/13, at 12:26 p.m. LPN-B contradicted NA-D's statements and stated she was not informed of R194 having pain after breakfast. LPN-B stated she was not sure if R194 was in therapies or if R194 was at an activity when she left the unit. LPN-B stated she would have offered R194 "PRN [as needed] Tylenol" and confirmed no Tylenol was offered to R194 since breakfast. LPN-B checked the computer and stated R194 was "due for [a scheduled] Tylenol now." LPN-B confirmed she was not aware R194 did not have a PRN Tylenol order. LPN-B confirmed she was not aware R194 had a PRN topical Voltaren order. On 1/30/13, at 12:47 p.m. the chaplain confirmed she transported R194 to the lounge area, stated R194 was not offer fluids or foods and stated she usually parked R194 in the same location "to protect her feet." On 1/30/13, at approximately 3:35 p.m. the nurse manager (RN)-A was notified of the episode when R194 verbalized she had pain and the lack of pain reporting to LPN-B. RN-A stated the pain should have been reported immediately.	F 309		

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F 309	Continued From page 42 On 2/1/13, at 7:47 a.m. while at the medication cart LPN-C was observed to be preparing medications. LPN-C was observed to place a tablet in a medication cup with applesauce. LPN-C stated she was going to give R194 "PRN Oxycodone." LPN-C stated she liked to offer the medication to R194 while the resident was in bed. LPN-C stated R194 "answers better" while she was in bed and confirmed she had not been in R194's room yet to assess her pain. LPN-C reviewed the computer on the medication cart and explained R194's pain medications had changed and explained the medication changes. LPN-C did not mention any changes to R194's PRN Voltaren. When in the room, LPN-C asked R194 if she had pain, R194 denied pain verbally and LPN-C stated the narcotic medication would be held. At no time during the observations did R194 move her lower extremities on her own, LPN-D did not move R194's lower extremities and LPN-C did not ask if R194 had pain with movement. The PRN Voltaren was not offered for pain control. On 1/30/12, at 7:58 a.m. when R194 was lying in bed and before any movement, RN-A asked R194 if she had pain, the resident stated "no." When RN-A asked R194 her name, the resident stated "[R194's first name.]" The surveyor then requested RN-A to assess R194's lower extremities with movement. When RN-A lifted the right leg, R194's eye brows furrowed suddenly, but the resident denied pain. When RN-A bent the right leg slightly, the resident made a moaning sound, grimaced, when RN-A asked if she had pain, R194 stated "yes." When the left leg was lifted by RN-A and RN-A asked the resident if they had pain, R194 did not answer. When RN-A	F 309		

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F 309	Continued From page 43 bent the left leg at the knee, R194 stated she had pain "Be careful!" and made a moaning sound. During the movements of the lower extremities, R194 had moved both hands from either side of the body to the sides of the bed and held onto the edges of the bed and blankets tightly during RN-A's assessment of the lower extremities. RN-A verified R194 had pain with movement in the lower extremities. On 2/1/13, at approximately 8:15 a.m. RN-A stated he had informed LPN-C of R194's pain medication changes. When asked if R194 was pre-medicated for pain before movement of the extremities, such as during morning cares; RN-A stated if R194 were to "call out for cares," he would expect the NA to report the pain to the LPN and a medication administered. When asked if the pain assessments included observations of R194 during cares or movement, RN-A stated observations of cares "were included." RN-A was unclear why the PRN Oxycodone was ordered and stated the scheduled Tylenol was decreased because R194 could not "have anymore Tylenol" and the Neurontin was increased because "the Tylenol was decreased." RN-A stated he directed LPN-C to administer the Oxycodone medication due to the assessed pain with movement. RN-A further stated he assessed R194 prior to notifying the physician of R194 having pain after breakfast and provided a Pain Identification/Review checklist form (printed off from the electronic medical record (EMR) and completed by hand) dated 1/30/13, and completed by RN-A. Pain Identification/Review checklist form dated 1/30/13, indicated R194 had non-verbal sounds of pain, vocal complaints of pain, facial	F 309		

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F 309	Continued From page 44 expressions, protective body movements/postures, and restlessness. The checklist identified R194 had a condition or diagnosis "that usually causes pain," R194 received treatments or procedures from which pain can be anticipated, and R194 received medications or non-medication interventions for pain. The checklist indicated R194 was asked if she had pain in the last five days and stated "no." A hand written note under the question asking R194 to rate her pain on a 0-10 scale (zero = no pain, 10= the worst pain you can imagine) indicated, "I don't have pain resident answered." Although the form identified pertinent pain information, the assessment lacked evidence R194's pain was assessed with movement. On 2/1/13, at 9:11 a.m. R194's physician (MD) was interviewed by telephone. When the MD was asked what his expectations were when R194 was assessed for pain, the MD stated he would expect a "multidimensional approach," and gave examples such as "asking, looking for a grimace, and observing form mood changes." The Pain Management/Assessment policy and procedure dated as reviewed and revised on 11/12, identified the pain assessment on admission including, "3. Pain management will proceed with continual monitoring through the admission process and ongoing throughout stay." The Ongoing Pain Management Procedure section of the procedure directed to "Utilize non-pharmacological interventions for pain management if appropriate," to ensure medication used to treat chronic pain optimally should be administered on a scheduled basis around the clock with medication ordered PRN	F 309		

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F 309	Continued From page 45 for breakthrough pain. The procedure directed, "3. Acute and chronic pain require continual assessment of the pain management regimen. Whenever the results of a pain assessment reveal that a resident's pain is not being managed, the primary physician should be notified immediately." The procedure further directed to update the care plan as needed, update the pain management information on the NA resident care cards and further directed, "6. Staff from all departments should report resident's requests for pain medication or expression of pain to the nurse in charge immediately."	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R189) reviewed for activities of daily living (ADLs) was offered denture and oral cavity cleaning and provided their left hearing aid. Findings include: During the stage one observation and interview on 1/28/13, at 4:49 p.m. R189 requested the surveyor conduct the entire interview by writing questions on a white board with a marker, R189 read the questions and responded verbally. R189 was observed to have a hearing aide in the left	F 311		

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F 311	Continued From page 46 ear and stated she could not hear with her right ear. R189 stated the facility staff "never have" assisted her to brush her dentures. R189 described her dentures as "glued in" and "painted with" a substance. R189 stated several times during the interview staff had not assisted to clean her mouth. At 4:50 p.m. R189 provided the surveyor with a flashlight from her bedside dresser. R189's dentures and oral cavity were observed to have whitish colored debris noted at the front bases of the dentures. At 8:40 p.m. R189 stated she was unclear where her right hearing aid was and stated it was "missing." R189 further stated she had reported the hearing aid missing (was unclear how long ago), that staff "looked for it" but the hearing aid was "still missing." R189 stated the hearing aid used to be stored "at the nursing desk." R189's diagnoses included mixed hearing loss and debility. The significant change Minimum Data Set (MDS) dated 10/9/12, indicated R189 moderate cognitive impairment, required limited physical assistance from staff for dressing and personal hygiene, and identified to have no oral or dental problems. The MDS identified R189 had moderate difficulty hearing (speaker had to increase volume and speak distinctly) and used a hearing aid. The Sensory Expression (hearing, speech, vision) questionnaire dated 10/9/12, identified R189 had a right and left hearing aid and indicated to "Talk into (R) [right] ear." The checklist further indicated, "Encourage to wear hearing aide(s), Assist to insert hearing aide(s), Assist to remove hearing aide(s), Assist to change HA (hearing aide) batteries as needed." An attached Progress	F 311	As previously stated, F189 has had hearing aides added to care cards and care plans to ensure proper application and removal. Oral care is on care plans and care cards and in-servicing on protocol and procedure provided to Nursing Department staff. Clinical Manager and DON responsible.	3-13-13

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F 311	Continued From page 47 Note dated 10/9/12, recapitulated the checklist information and identified R189 had "bilateral hearing aids" and "hearing loss/mixed hearing loss" and the dry erase board was an "additional means of communicating with staff and family." "Res [resident] admits that she is HOH (hard of hearing) and it is better to talk into (R) ear." The significant change MDS dated 1/9/13, indicated R189 required more extensive physical assistance with dressing and grooming, but continued to have moderately impaired cognition, use a hearing aid and have moderate difficulty hearing. The Care Area Assessment (CAA) for ADL Functional Status dated 1/16/13, indicated R189 was off of Hospice, identified R189 required extensive assistance with dressing and personal hygiene. The CAA identified "Contributing factors include: ...impaired functional mobility and hearing loss which makes it hard to communicate. Potential for decline D/T [due to] the same risk factors." Although the CAA identified R189 required extensive assistance with personal hygiene, the CAA did not address R189's denture/oral cavity care needs. The Augustana Chapel View Care Center MDS Notes for VCAA11 dated 1/9/13, indicated, "Due to hearing loss and vision loss, resident finds it difficult to do her favorite activities of reading and listening to music." The note further indicated, "Res [resident] also likes listening to music but d/t severe hearing loss, can no longer hear the music to enjoy it. TR [therapeutic recreation] staff have offered headphones to use with personal radio, but res says they are not loud enough to hear the music." The MDS note for VCAA04 dated 1/9/13, indicated, "Due to severe hearing	F 311		

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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 311	Continued From page 48 loss, res has troubles communicating with others as she may miss part or all of the spoken messages/intent of the message. Res uses a dry erase board and marker to communicate with visitors and staff. This severe hearing loss puts resident at risk for social isolation and depression." The note identified R189 declined "invite and encouragement" to attend activities due to hearing loss. The VCAA04 MDS Note further directed, "Increase voice volume, speak clearly, remove distractions, use dry erase board." The MDS Notes did not address R189's use of hearing aids. The Sensory Expression (hearing, speech, vision) questionnaire dated 1/10/13, identified the same checklist hearing aid information as the previous questionnaire dated 10/9/12. The attached note dated 1/10/13, identified R189 continued to have moderately impaired hearing. The note indicated, "She said she has bilateral hearing aids but never wears them. Res stated to writer that she prefers communicating with the speaker writes on a dry erase board." The note indicated R189 communicated well verbally. The note identified R189's hearing loss as "severe" and indicated R189 declined invites to activities due to the hearing loss. R189's care plan for Sensory Perception/Expression dated 10/9/12, identified R189 had a hearing aid for both the right and left ear, directed to encourage R189 to wear the hearing aid, assist to insert/remove/change the batteries. The ADL Functional/ Rehabilitation care plan dated 10/16/12, identified R189 required assistance with bathing, dressing and grooming due to "end stage debility" psychoactive	F 311		

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	245493	A. BUILDING _____ B. WING _____	02/01/2013

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F 311	Continued From page 49	F 311		

medications and weakness. The goal identified, "Res. will have all ADL functions complete w/ [with] staff assistance for the next 90 days." The care plan directed, "Set up all supplies and encourage Res to participate as far able." The care plan identified R189 required one staff assistance, including "Brush teeth/dentures." The care plan for Communication directed to "Observe for hearing deficit/changes." The care plan had a check in "Hearing aide(s)" and the right and left. Although the care plan identified the use of right and left hearing aids, the care plan did not address storage of the hearing aids.

On 1/30/13, the following was noted:
- At 7:23 a.m. R189's was observed to be in bed with the door open and the room dark.
- At 7:31 a.m. the licensed practical nurse (LPN) -B entered the room and gave "Synthroid [thyroid replacement] " to R189 and left the room.
- From 7:31 a.m. to 8:14 a.m. not staff entered the room.
- At 8:14 a.m. a nursing assistant (NA)-C entered the room, spoke with the roommate and asked if she was "ready for breakfast." NA-C greeted R189; NA-E entered the room, spoke with NA-C and left the room closing the door. NA-C remained in the room.
- At 8:21 a.m. the door opened and the roommate ambulated out of the room with NA-C. R189 was observed to still be in bed. NA-C closed the door to the room and remained in the room to assist R189.
- At 8:25 a.m. NA-C was observed to assist R189 with morning cares. The left hearing aid was observed to be in and NA-C was assisting R189. NA-C was observed to assist R189 with changing of her incontinence product and dressing. NA-C

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F 311	Continued From page 50	F 311		

stated R189 "does more for herself." At the time, the surveyor asked NA-C were R189's right hearing aid was. NA-C confirmed the right hearing aid was not in the ear and asked R189 very loudly "Where is your hearing aid?!" R189 stated, "I didn't quite get that." NA-C asked the question again even louder. R189 pointed to her right ear and stated, "It's missing, I don't know where it is." R189 pointed to her left ear and the NA stated loudly, "Your hearing aid is in!" NA-C checked the hearing aid and continued to dress R189, assisted R189 to transfer to the wheelchair, then proceeded to dispose of the incontinence product and make the bed. NA-C stated, "She brushes her teeth after breakfast." NA-C left the room. R189 was transported to the dining area shortly after.

- At 12:03 p.m. the surveyor used the white board to ask R189 if she had received assistance with denture/oral cares after breakfast. R189 stated no one helped her brush her teeth. Confirmed NA-C was the staff "who was taking care of me" in the morning. R189 denied brushing her dentures/teeth herself.
- At 12:21 p.m. NA-D denied assisting R189 with oral cares and stated she was assigned to "[NA-C's name]."
- At 1:29 p.m. R189 was observed to be brushing her teeth, with a visitor providing assistance. The visitor stated they were a nursing assistant from a "home care" company that was hired privately to provide "companionship" to R189. The visitor stated R189 "told me she hasn't brushed her teeth since she's been here." The visitor stated she assisted R189 with her oral care.

At approximately 1:40 p.m. NA-C stated he thought R189 was able to "do it [denture/oral

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F 311	Continued From page 51 cavity cleaning] herself." NA-C stated the supplies were in the bedside table and confirmed he did not use the white board to communicate with the resident. NA-C confirmed he did not report the missing hearing aide. On 1/30/13, at 3:30 p.m. the nurse manager (RN) -A and social worker (SW)-A were interviewed and both stated R189 did not require the use of the white board and stated they had "tested" her hearing and stated R189 was able to hear. Both denied any concerns being communicated regarding communication or hearing problems. RN-A stated R189 should have been set up for oral cares and NA-C should have assisted R189. SW-A stated he was not aware R189 was missing a hearing aide. On 2/1/13, at 10:40 a.m. SW-A stated "one hearing aid" was in the nursing cart and "one in her ear." SW-A confirmed R189 arrived with both hearing aids. SW-A confirmed the therapeutic recreation staff did the hearing assessment and documented R189 had two hearing aids when she first arrived. SW-A stated R189 kept "removing the left hearing aid" because it was "squeaking." SW-A stated staff did not check the hearing aid for function, was unclear if the family was notified of a hearing aid problem and unclear how long it had been since R189 had the hearing aide removed and placed in the medication cart.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the	F 314		

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F 314	Continued From page 52 individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R178, R87) reviewed for pressure ulcers, were provided the necessary care and services to promote healing, prevent potential development of new pressure ulcers and to prevent further development of current pressure ulcers. Findings include: Although R178 had a Stage 4 (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) sacral/coccyx pressure ulcer and was assessed and care planned to be repositioned every one hour, R178 was not off loaded (repositioned) from 6:45 a.m. to 9:52 a.m. (three hours and seven minutes). During continuous observations on 1/30/13, beginning at 7:23 a.m. and ending at 9:52 p.m. the following was observed: - At 7:23 a.m. R178's room door was observed to be open, the room was dark and the bed was in the low position. R178 was observed to be sleeping on her back and the head of the bed (HOB) was observed to in the up position approximately 20-30 degrees. From 7:23 a.m. to	F 314		

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F 314	Continued From page 53 7:43 a.m. no staff entered the room and R178 made no position changes. - At 7:43 a.m. a licensed practical nurse (LPN)-B entered the room, roused R178 and raised the HOB to 90 degrees. LPN-B assessed R178 for pain and stated she was giving R178 "Synthroid [thyroid replacement]." LPN-B encouraged R178 to drink water after giving the medication, turned off the lights and left the room. R178's HOB was left in the 90 degree position. From 7:43 a.m. to 8:56 a.m. no staff entered R178's room, the lights remained off, R178 made no position change and the HOB remained up in the 90 degree position. - At 8:56 a.m. two nursing assistants (NA-C and NA-D) entered R178's room. NA-C and NA-D lowered the HOB to a flat position, raised the bed up and grasped the lift sheet under R178 from both sides. NA-C and NA-D slid R178 up towards the HOB in one motion, R178's back and bottom slid up the air mattress surface approximately four inches. NA-D then immediately raised the HOB up to a 45 degrees angle. The over bed table was moved into place and a breakfast tray was placed on the table and NA-C left the room. NA-D washed their hands, applied a clothing protector to R178, and prepared the breakfast tray of a hardboiled egg (cut up by NA-D), a bowl of hot cereal; three covered cups containing water, orange juice, milk, and coffee. A pillow was placed under R178's left arm, but her coccyx area was not lifted off the surface of the bed. NA-D stated R178 was "boosted up" in the bed and confirmed she was not offloaded from pressure. NA-D then left R178's room. From 8:56 a.m. to 9:52 a.m. no staff entered the room. R178's bed remained at a 45 degree position while she ate breakfast. - At 9:43 a.m. NA-C stated R178 was last	F 314	As previously stated, repositioning schedule for R178 has been added to the care card. R87 expired within the facility. All other residents at risk have been reviewed to ensure interventions are included in care plan and care card. All other residents will be reviewed during 90 day MDS assessment period. Nursing department staff in-serviced on the comprehensive skin assessment and use of appropriate interventions to maintain skin integrity. Random sample audit of 5 admission comprehensive skin assessments per month will be done for 90 days to ensure ongoing compliance. Clinical Manager and DON responsible.	3-13-13

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F 314	Continued From page 54 offloaded when NA-C started the shift at 6:45 a.m. NA-C stated R178 required repositioning "every two hours." - At 9:49 a.m. LPN-B was asked how frequently R178 was off loaded by the surveyor. LPN-B checked a sheet on top of the medication cart and asked the surveyor, "Offloaded? What does that mean?" LPN-B confirmed she did not know the meaning of "off-loading," and then told NA-D and NA-E to "boost up" R178 and "place a pillow underneath" R178. - At 9:52 a.m. NA-D and NA-E removed the pillow from under R178's left arm, lowered the HOB and prepared to turn R178 on the right side. NA-D stated, "I haven't dressed her yet." R178's skin on the back was observed to be intact and free of redness, the sacral/coccyx area was observed to be covered with a large Tegaderm (A thin, clear sterile dressing that keeps out water, dirt and germs, yet lets skin breathe) dressing extending from the lower back, from the left him and across the left buttock, covering the entire sacral area. A tube connected to a wound vac (a device used to apply negative pressure to a wound to promote healing) on the bedside table was observed to extend from the left hip/buttock area of the dressing. NA-D confirmed the dressing was for a pressure ulcer. NA-D then placed a pillow completely under R178's back and relieved pressure from the coccyx area. NA-D placed the HOB up 45 degrees. R178 was not provided offloading from pressure from 6:45 a.m. until 9:52 a.m. (three hours and seven minutes). The Group 2 NA assignment sheet identified R178 had an air mattress on the bed, wore pressure relief boots in bed, identified R178 was incontinent of bowel and bladder, had fragile skin	F 314		

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F 314	Continued From page 55	F 314		

which "Bruises and tears very easily," and R178 required "A-1 [assistance of one staff] to "Turn/reposition: " The assignment sheet indicated, "Skin risk: Monitor skin for redness, bruises, open areas and report to nurse." Although the assignment sheet identified pertinent skin information, the assignment sheet did not direct the frequency R178 required offloading. In addition, although R178 had extensive dressings to cover a stage IV pressure ulcer, the assignment sheet directed, "Apply lanaseptic to coccyx and peri-area after each incontinence."

Review of the To Do List for LPN-B dated 1/30/13, provided directions for R178's pressure ulcer dressing changes and information on R178's wound vac. The To Do List directed, "Off-load Continuous Q [every] 1 hour," "Avoid HOB > [greater than] 30 degrees," "PREVENTATIVE SKIN CARE... Turn and reposition pt [patient] Q 1 hour - dx [diagnosis] pressure ulcer," and "TURN/REPOSITION q [every] shift Continuous and off load Q 1 Hr."

On 1/30/13, at 10:13 a.m. the nurse manager (RN)-A was notified of R178 going for three hours and seven minutes without off loading, RN-A stated since R178 had a pressure ulcer, R178 required "every one hour repositioning."

On 1/30/13, at 10:59 a.m. RN-A provided the Skin Care Program policy and stated an offload from pressure would be for "a complete full minute." RN-A again verified R178 should have been "repositioned every hour." RN-A confirmed R178's HOB needed to be up for meals, but then added the HOB should have been lowered to

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F 314	Continued From page 56 "about 30 degrees" after the medication was administered and after the meal. RN-A confirmed the HOB should not have been left up at 90 degrees and stated, "Lowering it back down would have been the reasonable thing to do." RN-A confirmed LPN-B and the NA staff "should know" what offloading was, including full relief of pressure for "one minute." RN-A reviewed the Skin Care Program policy and stated "the repositioning should be determined by the assessment and care plan" and pointed to the sections of the policy which directed this. RN-A stated R178 did not move and stated R178 should have been propped up off the sacrum. On 1/30/13, at 11:11 a.m. LPN-B and RN-A were observed to change R178's sacral dressing and wound vac tubing. The dressings, foam and tubing were removed, revealing a Stage 4 pressure ulcer located on the upper left aspect of R178's sacral area. The ulcer edges were pink and granulated (pink or red tissue with shiny, moist, granular appearance), a moderate amount of drainage was noted on the dressings. At 11:24 a.m. RN-A flushed the ulcer with normal saline and described the drainage returns as a "moderate amount of serosanguinous [consisting of both blood and serous fluid]" drainage. RN-A inserted a sterile Q-tip into the wound and stated the ulcer had 1.5 centimeter (cm) x 1.4 cm of tunneling at "six to twelve o'clock." RN-A described the wound base as "pink" and covered with granulation tissue. The wound dimensions were 1.8 cm wide x 1.5 cm long, with approximately 2 cm reddish pink area surrounding the wound. RN-A reapplied the Tegaderm dressings, wound vac materials and stated the wound had improved. Review of the	F 314		

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F 314	Continued From page 57 wound monitoring data dated 1/4/13, thru 1/25/13, indicated progressive healing and improvement of the ulcer. R178's diagnoses included stage IV pressure ulcer, cellulitis, and malnutrition. The admission Minimum Data Set (MDS) dated 8/10/12, indicated R178 had severe cognitive impairment, required extensive physical assistance with bed mobility, had an indwelling Foley catheter and R178 was continent of bowel. The MDS indicated R178 was at risk for developing pressure ulcers and had an unstageable pressure ulcer with slough (yellow or white tissue that adheres to the ulcer bed in strings, or thick clumps, or is mucinous). The Care Area Assessment (CAA) for pressure ulcers dated 8/16/12, identified R178 had a "coccyx pressure ulcer wound infection." The CAA description of the wound included the wound bed was covered with "60% slough," had exudate/necrotic tissue and underlying osteomyelitis bone infection which required intravenous (IV) antibiotics. The CAA identified R178 required staff assistance "to move sufficiently to relieve pressure over any one site," was confined to the bed or chair all or most of the time, needed a special mattress or seat cushion to reduce or relieve pressure, and R178 required a regular schedule of turning. The CAA identified, "Patient was admitted with an unstageable pressure ulcer to coccyx area. Remains at risk for decline/further alterations due to bowel incontinence, imp [impaired] functional mobility, potential for friction and shear, cognitive deficits, wound infection, IV abx's [antibiotics], use of O2 [oxygen]." Although the CAA identified the need for a repositioning schedule, the CAA did not address R178's specific assessed repositioning	F 314		

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F 314	Continued From page 58 needs. Although R178 had a pressure area on admission, the Braden Scale/Comprehensive Skin Risk Evaluation dated 9/28/12, identified R178 was at "low risk" of developing pressure ulcers. The summary section of the form directed to "Identify INTERVENTIONS needed, put them in place and schedule them on care path:" The summary indicated, "Resident has an indwelling cath [catheter], but is incontinent of bowel. Resident is able to respond and ask for what she needs. Resident is chairfast. Appetite is fair. Resident does need assistance to move up in bed." The evaluation did not address R178's pressure ulcer or repositioning needs. The Tissue Tolerance Evaluation Laying dated 10/10/12 and 10/19/12, indicated R178 could tolerate a "2 hour interval" of repositioning, identified R178 had a pressure reduction device in the chair and indicated, "Writer checked resident and no new areas of concern noted at this time," after the two hour interval. The evaluation did not identify that R178 had a stage IV pressure ulcer or that R178 may require one hour repositioning due to having a stage IV pressure ulcer. The quarterly MDS dated 10/28/12, indicated R178's cognition had improved to be cognitively intact and continued to require extensive physical assistance for bed mobility. The MDS indicated R178 was frequently incontinent of bowel and the pressure ulcer had progressed from unstageable to a stage IV pressure ulcer measuring 2.5 cm wide x 3.5 cm long with a 3.5 cm depth. The MDS indicated the ulcer had granulation tissue as the	F 314		

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F 314	Continued From page 59 most severe tissue type in the ulcer. The Physician's Orders dated 12/3/12, directed, "Avoid HOB > 30 degrees." beginning on 8/14/12. The orders further directed, "FYI: Limit sitting to only meals." ADL - Skin Integrity Interventions questionnaire dated 12/17/12, consisted of a checklist which identified R178 required a pressure redistribution cushion on her chair and redistribution mattress on the bed. The checklist indicated to apply house lotion to her body after the weekly bath, to bathe R178 with mild soap, to rinse/dry well. The questionnaire identified, "pressure ulcer; treatment/interventions per order." R178's care plan dated 12/17/12, identified the resident had a stage IV pressure ulcer located on the sacrum. The care plan interventions section had an undated hand written note which directed, "Turn, reposition, OFF-load Q 1 Hr." The care plan further directed to use the draw sheet for repositioning. At 11:52 a.m. RN-A stated the redness was from the "Tegaderm" and explained the pressure ulcer was present on admission. RN-A stated within the last month, the last wound clinic consult informed the facility R178 would not need to return "because the wound was healing so well." At 1:40 p.m. NA-C confirmed R178 was not assisted with repositioning or offloading outside the time NA-C assisted NA-D to "boost" R178 at 8:56 a.m. On 1/31/13, at 1:20 p.m. RN-A stated the Tissue	F 314		

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F 314	Continued From page 60 Tolerance "automatically" started at two hours and it was "null and void" due to R178 having a Stage 4 pressure ulcer. The Augustana Chapel View Care Center Skin Care Program policy and procedure dated 1/13, identified, "...A resident who has pressure sores will receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing..." The policy directed to complete the facility's various assessment forms, to identify risk factors and to note the risk factors on the care plan and nursing assistant care sheet. The procedure directed, "a. Turning and repositioning every 2 hours or more frequently as needed by resident skin status. Utilize pillows and positioning devices to decrease pressure over bony prominences." The facility failed to provide services to prevent the development of a pressure ulcer for R87, who developed a stage two pressure ulcer (partial thickness tissue loss) within four days of the admission. A review of R87's the closed medical record revealed lack of comprehensive skin assessment upon admission, and lack of temporary care plan with interventions to prevent potential skin breakdown. R87 was admitted to the facility from an acute care hospital on 8/9/12, with diagnoses which included back pain, hypertension, osteoporosis, aortic stenosis and history of compression fractures. The interagency transfer form from the hospital dated 9/4/12, indicated R87's main complaint was back pain due to degenerative disk disease, with past medical history of vertebral compression fracture, thoracic kyphosis and osteoporosis. Per the form R87 lived alone	F 314		

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F 314	Continued From page 61 independently prior hospitalization and ambulated with assistance of a walker while in the hospital. R87's hospital physical examination indicated "no jaundice or cyanosis or rash", intact skin. The physician's note dated 8/7/12 also indicated there were "no areas of skin breakdown". The physician's hospital discharge summary dated 8/9/12 indicated R87 was discharged with instructions for: occupational and physical therapy, long term nursing home placement and palliative care management. The nursing admission and temporary care plan completed upon admission dated 8/9/12/ skin assessment body diagram identified past surgical incision sites, and bruising. No skin breakdown was identified on R87's back. The summary dated 8/13/12, written with a different colored pen indicated "noted mid back o/a [open area] stage 2 (pressure ulcer) - curved area of the spine". The admission assessment and the note from 8/13/12 were not signed by staff that completed the assessments. Per the physical functioning assessment, R87 needed one staff assist with bed mobility, transfers, walking, toileting, bathing and grooming. Although staff identified R87's need for assistance with bed mobility and transfers, the temporary care plan for skin integrity was left blank, and did not identify a repositioning time interval. The Transitional Care Unit (TCU) care card used by staff to provide cares to dated 8/9/12 for turning and repositioning was left blank. The TCU care card was updated on 8/13/12 with interventions including: air mattress, blue boots and Allevyn dressing (used to treat wounds) to mid back Stage 2 pressure ulcer.	F 314		

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F 314	Continued From page 62 The Braden scale/Comprehensive Skin Risk Evaluation assessment completed upon admission, dated 8/9/12, noted a score of 18 (total score of 19-18 indicated mild risk for developing pressure ulcer). The summary noted R87 was blind who exhibited anxiety, restlessness, and needed assist of one staff with all activities of daily living. The Tissue Tolerance Evaluation Sitting form (tool used to determine ability of the skin to endure the effects of pressure) dated 8/10/12, indicated no redness was noted after client has been sitting for two hours. The record lacked evidence of a tissue perfusion test was completed while R87 lay in bed. According to the nurses notes dated 8/13/12, R87 complained of pain while in physical therapy, but denied when nurse assessed. Per the note R87 was noted to "stage 2 pressure ulcer mid back curvature area measuring 0.5 cm [centimeter] x 0.3 cm, Allevyn dressing applied & [and] will change Q [every] 3 days & as needed." the note also indicated air mattress and every one hour repositioning was initiated. The medical record lacked evidence of monitoring the pressure ulcer, no additional measurement were listed. Record review further revealed R87 was admitted to hospice care on 8/22/12, and passed away on 8/24/12. The Admission Minimum Data Set (MDS) dated 8/22/12, identified R87 with severely impaired cognitive skills (brief interview mental status BIMS=7), with hallucinations and delusion present. The MDS also indicated R87 needed	F 314		

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F 314	Continued From page 63 one staff's extensive assistance with bed mobility and transfers, used wheel chair for locomotion. Per the MDS R87 was at risk for pressure ulcer, identified one stage 2 pressure ulcer present on admission, with date unknown. The Care Area Assessment dated 8/22/12 indicated R87 had "stage two pressure ulcer to mid back on spinal curvature", and identified R87 at risk for further skin breakdown. The CAA also indicated R87 was working with therapies, and improvement was expected with mobility. During interview on 1/31/13, at 10:59 a.m. the registered nurse (RN-C) who was also the TCU Clinical Coordinator, stated he was notified first on 8/13/12 regarding R87's pressure ulcer. The RN-C verified the pressure ulcer was not present at the time of the admission, and also remembered a wound care sheet was not started to monitor the pressure ulcer. The RN-C further explained staff was expected to complete tissue perfusion test within 24 hours of admission, in both laying and sitting position. Per the RN-C, R87 spent most of the time lying in bed, so he would have expected staff to complete a tissue tolerance in the bed also, since R87 was dependent on staff for bed mobility. The RN-C verified lack of tissue perfusion test while lying in bed, and explained that the repositioning interval would have to be determined based on the tissue tolerance result. The RN-C also verified the temporary care plan, the TCU care card, and acknowledged there were no interventions listed to prevent potential skin breakdown. Per the RN-C, R87 was repositioned as per standard of practice q 2 hours during the first 4 days of the admission.	F 314		

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F 314	Continued From page 64 During interview on 1/31/13, at 10:41 a.m. the MDS coordinator verified the inaccuracy of admission MDS (pressure ulcer coded as present upon admission) and explained that when she took the information from the admission assessment, she have not noticed that the entry regarding presence of the stage 2 pressure ulcer dated 8/13/12. During interview on 1/31/13, at 2:49 p.m. the director of the nursing stated staff was expected to assess residents upon admission, and implement interventions based on those assessments to prevent residents from skin breakdown. The Tissue Tolerance Evaluation policy with revision date 11/12, indicated "each resident who is dependent on bed and/ or chair mobility, will be monitored for tissue tolerance while lying and sitting: upon admission, with a change in condition". The policy also indicated once an individualized turning and repositioning schedule was determined the licensed nurse completed weekly skin checks to determine if intervals were still appropriate. The Care Plans policy with revision date 3/12, indicated "a paper copy of the Nursing Admission/Temporary Care Plan is completed by the admitting nurse". The policy also indicated that the nursing staff on the TCU "will utilize this form as their Care Card and make any necessary corresponding written notes on their assignment to ensure proper care delivery". The Skin Care Program policy with last review	F 314		

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F 314	Continued From page 65 dated 1/13, indicated "Any pressure and/or vascular ulcers noted are to have a Weekly Wound Flow sheet completed and scheduled to be completed in the care path on a weekly basis."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the indwelling Foley catheter tubing was anchored and secured with a strap (affixed to the leg) for 1 of 1 resident (R178) initiated for catheter use. Findings include: R178's diagnoses included Stage 4 pressure ulcer, dehydration, and malnutrition. The admission Minimum Data Set (MDS) dated 8/10/12, indicated R178 had severe cognitive impairment, required extensive physical assistance with transferring and toilet use, and had an indwelling Foley catheter. The Care Area Assessment (CAA) for Urinary Incont (incontinence) Indwelling catheter dated 8/16/12,	F 315		

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F 315	Continued From page 66 identified, "Currently has Foley catheter in place due to large coccyx pressure ulcer." Although the CAA identified pertinent risk factors, the CAA did not identify the Foley catheter tubing should be secured. R178's care plan for elimination dated 8/11/12, directed pertinent interventions to address the resident's Foley catheter including, "Catheter Positioning:- Secure indwelling cath [catheter] to leg (SP [suprapubic] cath to hip) w/ [with] cath strap or tape to avoid pulling on/dislodging cath AM & PM." The care plan further directed "Catheter change-SEE ORDERS FOR CATH SIZE, BALLOON, DRAINAGE TYPE Every 30 days." The Physician's Orders dated 12/3/12, indicated the physician had ordered R178 to have a "Catheter" for the diagnosis of "Osteomyelitis of buttock ulcer-want to avoid urine in wound" starting on 8/13/12. Although the care plan directed to refer to the Physician's Orders for the catheter size. The Physician's Orders lacked direction for the indwelling catheter tubing and balloon size. On 1/30/13, at 9:52 a.m. nursing assistants (NA-D and NA-E) were observed to enter R178's room after the licensed practical nurse (LPN)-B directed both NA staff to "boost" the resident in bed. While R178 was laid flat in the bed and prepared to be turned to the right side, the Foley catheter tubing was observed to be loosely moving against R178's thighs. Although the catheter tubing was connected to the drainage bag, the catheter tubing was not secured and anchored to prevent the potential pulling on the	F 315	As previously stated, a catheter strap has been added to R178 to secure Foley and included in care card and care plan. Staff educated on this. All other at risk residents have been reviewed to ensure repositioning needs are included on care path and care card. All other residents with catheters have been reviewed to ensure inclusion of catheter strap to secure tubing. To prevent recurrence, all Nursing Department staff in-serviced on above information. Random sample audit 2 Foley catheters per week to ensure tubing is secured. Clinical Manager and DON responsible.	3-13-13

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F 315	Continued From page 67 tubing inserted to the urethra. NA-D stated the strap to secure the catheter tubing was in the "drawer" of the night stand and stated, "I haven't dressed her yet." NA-D pointed to the top drawer of the night stand. At 10:13 a.m. the nurse manager (RN)-A was notified the catheter tubing was not secured. RN-A confirmed the catheter should have been secured. The undated Group 2 nursing assistant assignment sheets (provided by NA-D) at the time of the observations on 1/30/13, indicated R178 was "Incontinent" of bladder, did not identify R178 had an indwelling Foley catheter, was blank for "Toileting:" and lacked direction for care of the catheter, including securing the tubing to prevent pulling. The To Do List Report for LPN-B dated 1/30/13, identified R178 had a catheter and "Catheter Positioning: AM & PM Continuous Secure indwelling cath to leg (SP cath to hip) w/ cath strap or tape to avoid pulling on/dislodging cath." The facility's Catheter: Straight/Indwelling policy and procedure dated as reviewed 1/13, directed the technique for catheter insertion in a female resident as well as, "13. Connect the catheter end to a closed drainage system: use a catheter strap to prevent accidental pulling of the catheter."	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323		

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F 323	Continued From page 68 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 2 residents (R125) reviewed for alarms, received adequate supervision to reduce and prevent falls. In addition, the facility failed to implement the use of bed and chair alarms for R125 assessed to have generalized weakness and gait instability upon admission and after a fall on 1/25/13. In addition, the facility failed to ensure the doors to resident rooms were free from sharp edges to prevent potential injury for 4 of 4 residents (R27, R189, R178, R105) who resided in the rooms. Findings include: R125 was admitted on 11/7/12, to the transitional care unit (TCU) with diagnoses to include dementia (loss of memory) and left sided cerebrovascular accident (a condition that affects brain function due to the disturbance in the blood supply to the brain). On 11/30/12, R125 was then transferred to the long term care unit in the facility. The admission Minimum Data Set (MDS) dated 11/14/12, identified R125 as having no cognitive behaviors and requiring extensive staff assistance with bed mobility and transfers. R125's Brief Interview for Mental Status score was five (severe cognitive impairment). Review of the Care Area Assessment dated 11/20/12,	F 323		

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F 323	Continued From page 69 indicated R125 had physical limitations with impaired balance, gait, strength, and muscle strength therefore R125 required extensive physical assistance with transfers. R125's care plan 1/13/13, did not indicate the use of bed and chair alarms interventions as identified on Physical Device Assessment dated 11/30/12. On 1/31/13, at 9:30 a.m. R125 was observed in his wheelchair during the breakfast meal in the lower level south dining room without the chair alarm in place. On 1/31/13, at 10:37 a.m. R125 was observed lying on his bed without a bed alarm in place. R125 was continuously observed on 1/31/13, from 9:30 a.m. to 11:00 a.m. and on 2/1/13, from 8:30 a.m. to 9:30 a.m. R125 did not have bed and chair alarms in place. Review of the Physical Device Assessment dated 11/30/12, revealed bed and chair alarms were to be used for R125 to prevent falls due to generalized weakness and dementia. The undated nursing assistant care sheet did not indicate the use of bed and chair alarms interventions identified on 11/30/12. Review of the progress notes dated 1/25/13, indicated R125 witnessed fell in his room with a nursing assistant (NA) and family member (F)-A in the room. R125 had attempted to pick up a Kleenex box from the floor. The progress note did not indicate if the bed and chair alarms were in use at the time of the fall.	F 323	As previously stated, the care plan and care card for R125 have been updated to include use of mobility alarms in both bed and chair. All other residents with alarms have been reviewed to ensure this intervention is included in the care plan and the care card. All Nursing Department staff in-serviced on use and operation of mobility alarms. Random sample audits of 2 alarms per week for 90 days will be done to ensure ongoing compliance. Clinical Manager and DON responsible.	3-13-13

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F 323	Continued From page 70 Review of the Treatment/Procedures Administration Record dated 2/1/13, revealed staff nurses had signed off every shift R125 had bed and chair alarms from 1/1/13 to 1/31/13. On 2/1/13, at 9:33 a.m. interview with registered nurse (RN)-B revealed the staff ensured R125 had bed and chair alarms every shift. RN-B verified R125 did not have bed and chair alarms. On 2/1/13, at 10:37 a.m. RN-A verified went to R125's room to observe the bed and wheelchair. R125 did not have bed and chair alarms in place. RN-A also verified the care plan did not include the use of bed and chair alarms identified on Physical Device Assessment dated 11/30/12. On 02/1/13, at 10:55 a.m. RN-A was observed in the hallway with bed and chair alarms headed to R125's room. On 2/1/13, at 10:58 a.m. NA-B was not aware of the use of bed and chair alarms for R125 as NA-B had cared for R125 at least five times in the past month. In addition, NA-B verified the nursing assistant care sheet did not direct staff to ensure R125 had bed and chair alarms. Review of the Fall and Injury Reduction policy dated 12/00, indicated fall reduction measures included bed and wheelchair sensor alarms. The policy specified, "all interventions for fall and injury reduction were noted on the resident's plan of care and resident care card." Ripped plastic door coverings exposing a sharp edge were found on two resident room doors for R27, R189, R178, R105. An environmental tour was conducted on 1/31/13,	F 323		

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F 323	Continued From page 71 at 10:00 a.m. with the director of facility's and the director of housekeeping. Two resident room doors were found to have a stiff plastic-like covering over the bottom half of the room door. The covering had been ripped, exposing a sharp pointed edged that stuck out from the door. The sharp edge was at a height that could scrape a resident's leg. The director of facilities verified that the sharp points were a hazard and made arrangements for the doors to be fixed. He explained that an environmental tour would be completed periodically to locate and correct hazards such as the sharp points.	F 323	Room door plastic covers have been replaced for the identified two resident rooms. All other room doors have been checked and plastic covers replaced for priority areas. Remaining door covers will be replaced when product arrives (within 30 days).	3-13-13
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R194) was offered adequate fluids between meals to meet the resident's assessed minimum daily needs and to prevent potential dehydration. Findings include: On 1/28/13, at 6:41 p.m. R194 was initially observed during the stage one observations to have a dry mouth and dry lips. R194 was observed to have whitish colored debris in their mouth and was observed to be manipulating the debris with her tongue against the back of her teeth. R194 was unable to state when she had	F 327	The Maintenance Department shall conduct semi-annual inspections of all doors, replace damaged door protectors, fill in chips in wood and stain repaired areas. Director of Maintenance responsible.	

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\ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
\UGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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F 327	Continued From page 72 last had fluids. During continuous observations on 1/30/13, beginning at 7:23 a.m. and ending at 11:50 a.m. the following was observed: - At 7:23 a.m. the door to R194's room was open, R194 was observed to be laying bed and the room was dark. A covered blue colored mug was observed to be on the bedside stand with a straw inserted into the mug. The mug was full and a paper covering was observed to be on the end of the straw. The mug felt room temperature warm to the touch. The water mug was out of R194's reach. - At 7:40 a.m. a nursing assistant (NA)-C entered R194's room, closed the door, immediately left the room to retrieve a wash cloth and returned to the room. - At 8:10 a.m. NA-C wheeled R194 out of the room. R194 was observed to be fully dressed and was wheeled into the dining area and left at a tablet. No fluids were poured or offered to R194. R194 remained at the table without fluids poured until 8:47 a.m. - At 8:47 a.m. NA-E poured a cup of coffee and placed it in reach of R194 and assisted another resident in the dining area. R194 reached out for the coffee one time, but did not make contact with the cup or take a drink. Although there was a pitcher of water on the table, no water was served to R194 and no assistance to drink the coffee was offered. NA-E stated R194 could not pour own fluids. The other residents at the table were brought their breakfast trays and a covered breakfast tray was served to an empty space across from R194. - At 8:50 a.m. NA-C stood next to R194 and assisted him/her to drink a sip of coffee. NA-C	F 327	As previously stated, R194 has had intake monitoring and scheduled fluids added to care plan and care card to promote offering and encouraging fluids between meals. Additional documentation for additional fluids offered between meals has been added. All other at risk residents have had this added as well. Ongoing review of all other residents to occur at 90 day MDS assessment. To prevent recurrence, all Nursing Department staff in-serviced on above information. Random sample audit of 5 charts per week will be done for 90 days to ensure ongoing compliance. Clinical Manager and DON responsible.	3-13-13

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F 327	Continued From page 73 uncovered and placed R194's breakfast meal of pureed blueberry muffin, hash, eggs, a glass of milk, iced water, orange juice and a covered bowl of hot cereal on the table in front of R194 and left. R194 made no to attempt to initiate eating or drinking. - At 8:52 a.m. the blue mug was observed to remain unmoved on the bedside table, still contained the paper covering at the drinking end of the straw, the level of water in the mug was unchanged and the water mug remained warm to the touch (no ice). - At 8:54 a.m. R194 continued to look at the breakfast food and fluids and made no attempts to eat or drink. One staff (NA-E) remained in the dining area setting up the meal tray for the tablemate across from R194. R194's uncovered food was untouched, the bowl remained covered, and no fluids were offered or consumed. - At 9:01 a.m. NA-C stood next to R194 and fed two spoons of food to the resident directly to the left of R194. NA-C verbally cued R194 to eat and handed R194 a small glass of orange drink. R194 sipped at the small glass of orange drink. NA-C fed another spoonful of food to the tablemate on R194's left, walked around the table, poured and offered coffee to the resident on R194's right. R194 held the glass of orange drink. - At 9:03 a.m. NA-D sat next to R194 on the right of the resident, uncovered the bowl of hot cereal, stirred the cereal and began to assist R194 to eat. NA-C sat to the left of R194 and at 9:04 a.m. NA-E sat on the other side of the table. NA-D assisted R194 to eat spoonful ' s of hot cereal and stated, "Open, open bigger" to the resident. R194 would not open their mouth to eat. NA-D encouraged fluids which R194 accepted and drank readily.	F 327		

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F 327	Continued From page 74 - At 9:12 a.m. NA-D continued to encourage R194 to drink juice and left the table, went to a medication cart in the hallway. NA-D retrieved an orange and white colored carton, poured the fluid in a glass and brought it to the resident on R194's right. NA-D verbally encouraged R194 to continue to drink the orange drink. R194 hummed the song "Over There" and resisted eating spoonful ' s of food from NA-D, but continued to hold the glass while drinking. NA-D encouraged R194 to open their eyes. R194's eyes were observed to have dark circles around them and appeared sunken. NA-D and NA-E remained at R194's table. - At 9:20 a.m. NA-D stated to R194, "Drink your juice, it's medication for your sore heels." NA-D discussed with NA-E R194 potentially "throwing up." - At 9:23 a.m. NA-E assisted the other table mates away from the table. - At 9:25 a.m. NA-D fed the resident to R194's right a bit of food, and then wheeled the resident out of the dining area to a lounge area across from the nursing desk. NA-D then returned to the dining area, went to a computer kiosk mounted on the wall directly behind R194 and began entering in information into the computer. R194 remained at the table. - At 9:28 a.m. NA-D continued to enter information into the computer. R194's legs were observed to be extended straight out in the wheelchair with the left foot rotated inward and the heels of both feet resting on the front edge of the foot pedal. - At 9:31 a.m. NA-D and NA-C adjusted R194's leg position and NA-C wheeled R194 to the lounge area directly across from the nursing station. NA-D returned to the dining area and	F 327		

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F 327	Continued From page 75 began to place the soiled cover-up linens in a bag. A carton of Nutritional Juice Drink, Orange Flavored was observed amongst R194's glasses and was empty, all of R194's orange juice was consumed, a glass was observed to have pureed muffin mixed with milk and was half consumed, approximately 1/4 of the water and 1/4 of the coffee was consumed. NA-C stated the glasses held "120 cc (cubic centimeter)," stated R194 drank approximately "30 cc" from the other glasses and stated the carton contained the "orange juice" R194 had served. After reviewing the left over plate of food, NA-C stated R194 ate "25% of the meal." NA-C was unclear if R194 drank the orange drink, but confirmed R194 consumed approximately 120 cc of fluids. - At 10:00 a.m. R194 remained seated in the wheelchair at the nursing desk. R194 was observed to remain in the lounge area from 10:00 a.m. through approximately 11:50 p.m. without fluids offered. R194 was then transported to the Celebration of Life activity off of the unit. On 1/30/13, at 12:17 p.m. R194's blue water mug was observed to be unmoved from the bedside table in R194's room with the paper covering still attached to the drinking end of the straw. The level of the water was unchanged, the mug was room temperature warm to the touch and there was no ice in the water. R194 was then observed to be seated at their table in the dining area. A full covered glass of milk was observed to already serve to R194. No other fluids were served. The milk was not uncovered or offered to R194. - At 12:21 p.m. NA-D stated he was "not sure" where R194 went after breakfast, and stated he believed R194 was "at therapy" and he believed "they [therapy staff] were working with [R194's]	F 327		

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F 327	Continued From page 76	F 327		

foot pedals." NA-D stated he notified the licensed practical nurse (LPN)-B about her pain (with movement of the leg after the breakfast meal) and stated LPN-B informed him R194 had received "a pain medication."
- At 12:26 p.m. LPN-B stated she was not informed of R194 having pain after breakfast. LPN-B stated she was not sure if R194 was in therapies or if R194 was at an activity when the resident left the unit. LPN-B stated she would have offered R194 "prn [as needed] Tylenol [a mild analgesic]" if pain had been reported and confirmed no medications or fluids were offered to R194 since breakfast. LPN-B checked the computer on the medication cart and stated R194 was "due for Tylenol now."
- At 12:28 p.m. R194 was observed to have a plate of food uncovered and served at the lunch meal. NA-E sat next to R194 and verbally cued R194 to eat. R194's mouth was observed to have a heavy buildup of debris on the teeth and tongue, R194's saliva was thick and white colored, the lips were observed to be dry and R194 manipulated the mouth debris with her tongue. NA-E confirmed R194 had taken no bites of food or drank fluids and confirmed the above observation.
- At 12:25 p.m. the director of therapeutic recreation (DTR) confirmed R194 attended the Celebration of Life activity after breakfast. The DTR stated no fluids or snacks were served to R194 and stated the Chaplain brought R194 back to the "lounge."
- At 12:41 p.m. NA-E stated she did not give R194 any fluids except for breakfast and lunch. NA-E stated R194 had a "difficult time eating" and further stated, "She loves to drink fluids. She drinks and drinks and drinks fluids." NA-E

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F 327	Continued From page 77 gestured with her hands mimicking a cup and drinking motion (that R194 drank quickly and fast). - At 12:42 p.m. LPN-B stated she only gave R194 a supplement drink at 7:00 a.m. and stated it was mixed with R194's potassium medication. Although LPN-B stated she gave R194 a "10:00 supplement after breakfast," LPN-B could not recall the time the supplement was given to R194 and could not recall if R194 was in the dining room or in the lounge area when the supplement was given. LPN-B then stated the supplement was a "milk type supplement" and she thought the carton of supplement given to R194 by the NA staff "was for someone else." LPN-B stated several times, "I'm new to this unit. This morning was such a blur...I can't remember." LPN-B further stated R194 was "at risk for dehydration" and she had "noted a change" in her drinking and eating. LPN-B stated R194 was on an "I & O [intake and output]." - At 12:47 p.m. the Chaplain confirmed she transported R194 to the lounge area, stated she did not offer fluids or foods during the Celebration of Life activity or while in the lounge area. R194's diagnoses included dementia, glaucoma and hypertension. The admission Minimum Data Set (MDS) dated 9/20/12, indicated R194 had severe cognitive impairment, required extensive physical assistance from staff to eat and drink, was frequently incontinent of bladder, had no swallowing problems and received a diuretic (a drug that promotes the excretion of urine) daily. The Care Area Assessments (CAA's) for falls and pressure ulcers dated 9/26/12, identified R194 had "advanced dementia," and used a diuretic. The MDS Notes for "VCAA12" (section V, CAA	F 327		

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F 327	Continued From page 78 number 12, Nutritional Status) dated 9/26/12, identified R194 needed assistance at meals, used a diuretic and laxative which "may affect resident's appetite/P.O. [by mouth] intake." The MDS Note further indicated R194 was "At risk for wt. [weight] fluctuation, abnormal lab values, dehydration..." The MDS Note indicated, "Will proceed to Care Plan to monitor wt., hydration status, and P.O. intake of meals." The Nutritional Assessment Questionnaire dated 9/26/12, identified R194's average fluid intake was "~ [approximately] 221 ml/meal [milliliters per meal]" and estimated R194's daily fluid needs were 1600-1925 cc (25-30 cc/kg [cubic centimeters per kilogram] based on adjusted wt. of 141.1# [pounds])." The questionnaire indicated R194 required "staff assist for meals" and R194 would have a "variable P.O. intake of meals..." R194's ADL (activities of daily living) - Nutritional Needs questionnaire dated 10/5/12, consisted of a checklist which identified R194 required extensive assistance of one person to "Cue and encourage Resident to participate." The rest of the questionnaire including sections for food set up, eating aids, eating assistance techniques, special care needs and "Maintaining hydration" of the form was left blank. The quarterly MDS dated 12/12/12, indicated R194 had no changes in cognition, eating and drinking assistance, bladder continence, swallowing ability or diuretic use. The quarterly MDS indicated R194 had sustained a 5% weight loss in the past thirty days. R194's Nutritional Assessment Questionnaire	F 327		

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F 327	Continued From page 79 dated 12/19/12, identified R194 received the medication "Lasix [a diuretic medication]," pertinent diagnoses and R194 had a 7.5 % weight loss in 90 days. The questionnaire indicated R194's average fluid intake was "~183 ml/meal [a decrease of 38 cc's per meal]" The Nutrition Support/Nutritional supplement section indicated to provide "120 cc Plus 2 [a nutritional supplement] BID [twice daily] - consuming 100%" as well as to provide a fortified cereal with fortified milk with all meals. R194's daily fluid needs were calculated as "1850-2225 cc (25-30 cc/kg based on current wt.)." The ADL - Nutrition and Hydration questionnaire dated 9/26/12, and 12/12/12, both listed nutritional interventions in checklist form. The "Maintaining hydration" section of the form had "encourage intake of fluids" checked. A Quarterly Nutritional Note dated 12/12/12, referred to the Nutrition Questionnaire on 12/6/12 for full nutritional assessment. "No new Diagnosis identified - see Nutritional Note 9/26/12 for diagnosis. P.O. intake of meals has decreased since last assessment. Plan to increase supplement frequency, continue with other nutrition interventions, follow monthly as nutritional high risk until wt. stable x3 months, and follow prn." The Admission Nutrition Note dated 9/26/12, indicated R194's intake concerns were related to dementia and the intake was less than calculated needs. The 120 cc Plus 2 BID was started between meals and identified R194 as "at risk for dehydration,..." The assessment indicated to continue with current diet and to implement	F 327		

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F 327	Continued From page 80 interventions as listed above, to schedule facility height and reweigh, and follow per facility protocol. On 1/30/13, at 1:40 p.m. NA-C confirmed R194's bed side water mug was not changed during the day shift and the water at the bedside was from "the night shift." NA-C stated he usually changed the water at this time, and stated he did not give R194 any fluids and when asked when staff should offer fluids, the NA stated "with snacks." NA-C further stated he thought the LPN gave R194 fluids between meals. On 1/30/13, at 1:50 p.m. R194 was observed in bed, the call light was in R194's right hand, the blue covered water mug with the straw with paper still on the drinking end, was observed to be out of R194's reach on the night stand. The water level was unchanged; the water was warm and had no ice. On 1/30/13, at 2:03 p.m. LPN-B confirmed the water mug was out of reach of R194 and stated she had "noticed it earlier." LPN-B and the surveyor observed R194's mouth which appeared moist. LPN-B stated R194 was observed to drink fluids at lunch, but confirmed the tongue was heavily cracked. LPN-B checked R194's skin turgor (a skin test used to determine potential signs of dehydration) and indicated "she has poor skin turgor" and confirmed R194's eyes were "dark and sunken." LPN-B then stated R194 had "bad Glaucoma." During the observation with LPN-B, NA-C came into the room and replaced the water mug. The new water had ice in it, a straw and a paper sleeve at the drinking end of the straw. The old water mug was removed.	F 327		

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F 327	Continued From page 81 On 1/30/12, at 3:30 p.m. LPN-B provided intake totals of for the morning and afternoon on a hand written slip of paper. The intakes were as follows: "Breakfast bites & 240 cc Lunch 25% & 240 cc Supplements 120 cc @ 0700, 60 cc @ 1000 Total fluid for day shift 660" On 1/30/13, at approximately 3:35 p.m. the clinical manager (RN)-A was notified of R194 potentially not receiving fluids between meals. RN-A verified fluids should have been offered to R194 throughout the day. Review of the clinical record indicated no monitoring of the total intake or output for R194 was initiated in the electronic medical record (EMR) until 1/30/13. The first amount documented on 1/30/13, indicated R194 drank "900 cc." The interdisciplinary team (IDT) Progress Notes indicated the following: - On 1/29/13, at 1:52 p.m. a note indicated it was "harder" for R194 to swallow "med's [medications]" and described the resident's behaviors of clenching their teeth and R194 stating they felt "like throwing up." - Notes from 1/24/13, at 2:27 p.m. indicated R194 was "harder to give her med's too" and required ice cream to take them. - On 12/27/12, at 10:52 p.m. "Resident alert, stable, poor appetite for dinner fluid intake 200 cc." - On 12/13/12, at 10:24 p.m. "Resident had poor appetite for supper. Ate about 25% of her dinner. Medication was administered as scheduled. Was	F 327		

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F 327	Continued From page 82 effective." At 1:44 p.m. a note indicated, "Resident has poor appetite. C/o [complained of] sour taste in the mouth, needs coaching to swallow med's especially the capsule. Primary MD notified and obtained orders for swallow and speech eval. [evaluate] and treat." - On 9/20/12, at 14:12 "Resident is very pleasant to work with. Cooperative with all her cares and taking med's. Appetite has been very good with good fluid intake." R194's care plan for Nutrition/Hydration dated 12/19/12, identified R194 was at risk for nutrition/hydration problems because R194 required assistance with meals and "multiple medical diagnoses" including "Dementia." The care plan identified R194 had a significant weight loss over 30 days on 12/12/12. The care plan goal for R194 was to be free from signs and symptoms of dehydration. The interventions section directed: "amount eaten a.c. (after meals), bed time snack at hour of sleep, provide a regular diet" and "Encourage intake of fluids." On 1/31/13, at 9:37 a.m. the registered dietician (RD) stated R194 was on the nutrition risk because of an "ulcer," and stated the ulcer was healed "as of Friday." The RD stated R194 was at risk for dehydration. The RD stated on a quarterly basis, she "took a look at" R194's intake and stated residents with thickened liquids were put on "I&O." The RD further stated, "I get an alert for less than 800 cc in a day [an email alert to the RD]. The RD confirmed R194 was not on one of these alerts and stated, "[R194] is now." - When queried on how the RD would be notified if R194 had low fluid intakes, the RD stated, "Hopefully staff would notify me. [I] Met with staff	F 327		

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	245493	A. BUILDING _____ B. WING _____	02/01/2013

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 327	Continued From page 83 earlier in the week regarding [R194] not chewing and just swallowing. So I alerted the nurse manager, and the speech therapist (SLP) and downgraded [R194's diet] puree. At the time [I] was not notified about [R194's] drinking at that point. Had not checked in with speech yet." - When asked how much fluids were provided to R194, the RD stated R194 was provided 1380 cc (without water) of fluids at meals as well as 8 ounces (oz) of fortified milk at all meals. The RD stated with water offered at the meal the total would be 1920 cc at meals, and R194 was offered a supplement total of 480 cc in a day. The RD stated R194's assessed daily fluid needs were 1800-2150 cc "based on current weight." - When the "Amount of Fluid Taken" information was reviewed, the RD stated R194's by mouth intake was "not good" and R194's fluid intake "fluctuated." The RD stated she did not see "good things" and the staff should have alerted her of the low fluid intake. "I would like them too [alert me]." The RD confirmed the 24 intake/output scheduled on 1/30/13, provided email alerts to the RD and stated R194's last labs were completed at the end of October. "We can request labs." The RD confirmed R194 was not on a hydration program, and stated if R194 where on a hydration program, the RD would have scheduled a suggested amount of fluids in the EMR. - The RD stated R194 should have been offered fluids sooner at the meals or had them "within reach to drink." The RD confirmed fluids should also have been offered "throughout the day" and stated the water placed at the bedside should have been in reach. The RD confirmed the fresh water mugs had ice in them when distributed to the resident's bedside.	F 327		

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F 327	Continued From page 84 On 1/31/13, at 10:51 a.m. the RD stated the average fluid intake per meal was 182 cc/meal over the last two months. The RD stated R194's supplement intake was almost 100% most times. The RD stated the calculated daily average fluid intake was 1026 cc per day. The RD confirmed the amounts were less than R194's estimated needs. The RD then stated the plan was to schedule 180 cc of fluids 5x/day to be offered and to be more accurate to see how much R194 was getting. The RD further stated R194 said "yes" to everything. On 2/1/13, at 7:44 a.m. R194 was observed to be lying in bed flat on his/her back, the blue covered water mug was out of reach and appeared full. R194 was observed to have a whitish colored thick sputum in the mouth and collected on R194's tongue. R194 smiled, showed the substance on the tongue. R194's lower and upper teeth were observed to be coated with a heavy buildup of whitish debris. When asked what the substance was, R194 stated, "I don't know." - At 7:47 a.m. LPN-C stated R194 "answers better" when in bed. LPN-C asked R194 about pain, the resident denied pain and held the medication. When LPN-C was alerted to R194's mouth debris LPN-C stated R194 was a "mouth breather," stated R194's "mouth was dry," stated R194 "usually had dryness" in the morning. - When asked if R194 could drink fluids if placed in reach, LPN-C stated R194 "will sometimes try to drink," and stated R194 was "sometimes" able to drink fluids without staff assistance. LPN-C stated R194 needed cuing to consistently drink. LPN-C confirmed the mug of water was out of reach of R194.	F 327		

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F 327	Continued From page 85 - At 7:58 a.m. RN-A confirmed the presence of debris in R194's mouth. RN-A confirmed R194's water glass was full and stated it should be offered to R194 by the night shift staff. RN-A initially stated the water was "just filled," but then confirmed the cup was warm and the water lacked ice. The blue mug was observed to have paper from the straw missing, the RN-A opened the mug and stated it was "nearly full." RN-A checked R194's skin turgor and stated the turgor response was less than one second and "good." RN-A stated he had "never seen how much debris" R194 had in his/her mouth in the morning and could not confirm if the amount of debris was "excessive." R194 was asked to open their mouth by RN-A and was observed to have a whitish yellow debris coating the bottom and top teeth, the tongue appeared dry, large pieces of the debris were observed to be coating the tongue on all sides and front to back of the mouth. R194 had the whitish debris and in the corners of the mouth. On 2/1/13, at 8:51 a.m. the physician for R194 was interviewed via telephone and stated R194 tended to retain fluids with due to congestive heart failure (CHF). The physician confirmed he was not informed of any hydration concerns and stated he would determine what labs to order based on "a facility report" such as a basic metabolic profile (BMP, a lab test which measured electrolyte levels in the body). The physician stated R194 was last seen by the nurse practitioner (NP) on 12/21/13. At 9:11 a.m. the MD stated the fluid requirements for R194 "may be less." The physician confirmed a lower amount of fluid intake was not discussed with the facility.	F 327		

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F 327	Continued From page 86 At 9:19 a.m. the NP was interviewed via telephone and stated she "wasn't notified" by the RD or facility of R194's hydration concerns. The NP stated, "I don't regularly follow [R194]" and stated she was "helping" the primary doctor. The NP stated she had discussed R194 with the MD before calling the surveyor and stated R194 does have a history of hyponatremia (low sodium levels). The NP stated R194's fluid needs "may be a little lower." The NP further stated, "I guess one thing would be checking a BMP." The NP confirmed there was no discussion with the facility regarding a fluid restriction prior to the phone call. The Augustana Care Corporation HYDRATION policy and procedure dated as revised on 10/2012, initially identified, "Policy: All residents will be provided with sufficient fluid* intake." The policy clarified, "Sufficient fluid is defined as the amount of fluid needed to prevent dehydration and maintain health in an individual." The procedure directed to identify risk factors for becoming dehydrated, such as but not limited to functional impairments that make it difficult to drink or reach fluids, dementia in which the resident "forgets" to drink or forgets how to drink, and "use of 9 or more medications including diuretics." The procedure further directed to keep water mugs next to the resident at all times unless contraindicated, assist and cue the resident to drink fluids frequently, and provide alternatives to the resident. The procedure directed to monitor the resident for dry skin and mucous membranes, cracked lips, as well as lab values.	F 327		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 87 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medications were addressed on the care plan for 7 of 10 residents (R73, R67, R194, R189, R52, R41, R184). Findings include: R73 received the medications of Lithium	F 329		

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F 329	Continued From page 88 Carbonate (an antimanic medication used to stabilize mood), Remeron (an antidepressant) and Celexa (an antidepressant) without target behavior monitoring for the use of the medications. In addition, the facility failed to care plan for the use of these medications. R73 had diagnoses to include diabetes mellitus, bipolar disorder and Parkinson's. The admission Minimum Data Set (MDS) dated 1/7/13, indicated R73 had severe cognitive impairment and was identified to receive the following classes of medications: antianxiety, antidepressant and a diuretic. The Care Area Assessment (CAA) for Psychotropic Medication Use V05 dated 1/11/13, consisted of a checklist which identified R73 used an "antianxiety" and "antidepressant" medication. Although the rest of the checklist was blank, the Analysis of Findings section of the CAA indicated, "Resident uses psychotropic medications daily. There are measures in place for nursing to monitor for adverse side effects and update MD [medical doctor], social services [SS] to monitor for behaviors and the pharmacist to review medication regimen." The section, "Document reasons care plan will/will not be developed:" indicated, "Monitoring of adverse side effects daily." The CAA lacked identification of the specific medications associated with antianxiety and antidepressant, lacked identification of the target behaviors being monitored for the use of these medications and was incomplete. The Physician Orders dated 1/7/13, indicated R73 received the following medications: - Lithium Carbonate 450 milligrams (mg) oral (PO) tablet controlled release daily for diagnosis of bipolar disorder;	F 329	As previously stated, R73's care plan has been updated to address use of Lithium Carbonate , Remeron and Celexa including indications for use, efficacy, target behavior monitoring, non-pharmacologic interventions and side effect monitoring.	3-13-13

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F 329	Continued From page 89 - Remeron 7.5 mg PO at HS (hour of sleep) for the diagnosis of bipolar disorder; - Celexa 40 mg PO daily for diagnosis of bipolar disorder. Review of R73's care plan dated as effective from 1/11/13 to 4/18/13, indicated R73's ordered psychoactive medications of Lithium, Remeron and Celexa were not identified on the care plan. The care plan and clinical record lacked evidence of indications for the use of the medications, target behavior monitoring associated with the use of the medications. The care plan did not identify side effect monitoring and lacked direction for non-pharmacological interventions to address potential target behaviors. R73's Medication Administration Record (MAR) for January 2013, indicated Lithium, Remeron and Celexa were administered daily as ordered. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R73's medication regimen. The consultant pharmacist stated she noted the labs for R73's Lithium levels were from the hospital and it was on her schedule to address the labs with the facility on her next visit. The consultant pharmacist confirmed a medication regimen of Lithium, Remeron and Celexa was appropriate for treatment of bipolar disorder. The consultant pharmacist verified the medications were not addressed on the care plan and stated she "hadn't gotten to them yet." On 2/1/14 at 3:04 p.m. the registered nurse (RN) -A confirmed the care plan did not include specifics, which included risks, target behaviors,	F 329		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 90 non-pharmacological interventions and the indications for the use of the psychoactive medications. R67 received the medications Effexor XR (antidepressant), Trazodone HCl (an antidepressant medication used for sleep), as needed (PRN) Xanax (a short acting benzodiazepine) without indications for the use of the medications. The clinical record lacked parameters for the use of the PRN Xanax. In addition, R67 received the medications Actos and Glucotrol XL (both medications used to treat diabetes) and Tegretol (anti-seizure medication) which were not addressed on the care plan. R67's diagnoses included diabetes mellitus, depressive disorder, anxiety state, and insomnia. The annual MDS dated 8/29/12, indicated R67 had moderate cognitive impairment and identified R67 received the following medications: an antipsychotic, an antianxiety and an antidepressant. The CAA for Psychotropic Medication Use V05 dated 9/5/12, consisted of a checklist which identified R67 received an antipsychotic, antianxiety and antidepressant medication. The checklist indicated R67 was at increased risk for falls, depression (from use of antipsychotic) and anxiolytics (antianxiety). The Analysis of Findings section indicated, "Potential for alteration due to side effects related to use of psychotropic medication daily. Resident admitted to CV [Chapel View] with Dx [diagnosis] of Depression & Sleep Disturbance. As well as Rx [prescription] treatment of Effexor XR Tegretol & Trazodone HS. No noted adverse side effects related to use of antidepressant. Measures in	F 329	R67's care plan has been updated to address use of Effexor, Trazadone, Xanax, Actos and Glucotrol including indications for use, efficacy, and target behavior monitoring , non-pharmacologic interventions, sleep monitoring, and side effect monitoring for psychotropics.	3-13-13

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F 329	Continued From page 91 place for nursing to monitor side effects and update the NP [nurse practitioner]/MD." The Physician Orders dated 1/28/13, indicated R67 had the following medications ordered: - Effexor XR 150 mg PO extended release 24 hour capsule twice daily (BID). The orders directed, "Take with food may sprinkle on applesauce. Do not cut/crush/chew For Depression New order 9/9/11 OBTAIN CONSENT PRIOR TO ADMINISTRATION." - Tegretol 200 mg tablet PO daily (given at 8:00 a.m.) and 100 mg tablet PO Daily (given at 4:00 p.m.) for diagnosis of convulsions; - Trazodone HCl 50 mg tablet PO at HS and 25 mg as needed (PRN) one time "q [every] night if 50 mg scheduled dose is not effective" for the diagnosis of insomnia. - Actos (a drug to treat type two diabetes) 30 mg tablet PO daily for diagnosis of type two diabetes mellitus; - Glucotrol XL 10 mg extended release tablet PO daily; - Xanax 0.25 mg table PO three times daily (TID) PRN for "Anxiety." The orders lacked parameters for when to administer the PRN medication. Review of the Medication Administration Records (MARs) for December 2012 and January 2013 indicated all R67's above scheduled medications were give as ordered. The PRN Xanax was administered seven times in December 2012 and twelve times in January 2013; the PRN Trazodone was given once in December 2012 and three times in January 2013. R67's care plan hand dated as effective 9/12/12 through 12/11/12, identified the above diagnoses	F 329		

TEMENT OF DEFICIENCIES I PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 329	Continued From page 92 as risk factors. Although the care plan identified "MOOD - Diagnosis of Depression with Anxiety State receives Antidepressant," the care plan lacked development to address risks associated with the use of Effexor XR, Trazodone and Xanax. In addition, the care plan lacked resident specific target behavior monitoring for the efficacy of the medication, indications for the ongoing use of the medications and non-pharmacological interventions to address the target behaviors. In addition, the care plan did not address R67's use of diabetic medications or the use of anti-seizure medications, including but not limited to the risks associated with the medications, potential side effects, types and frequency of seizures, monitoring to hyper/hypoglycemia and monitoring for efficacy of the medications. The care plan did not address R67's sleeping patterns, use of Trazodone for sleep, monitoring for sleep, as well as resident specific non-pharmacological interventions to promote sleep for R67. On 1/31/13, at 2:43 p.m. the RN-B and licensed practical nurse (LPN)-D both stated they did not update or change the care plans. RN-B stated a behavior note was written in the progress notes for R67. Both nurses confirmed the care plans did not address medications and verified the lack of parameters for the use of the PRN Xanax. On 2/1/13, at 3:12 p.m. the RN-A confirmed R67's medications were not addressed on the care plan. R194 received the medication Paxil (an antidepressant) without care planning and monitoring for the efficacy of the medication. In	F 329		

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F 329	Continued From page 93 addition, R194 received Neurontin (a drug used for treatment of neuropathic pain), Tylenol (a drug used to treat mild to moderate pain), oxycodone (a narcotic medication), Voltaren (a transdermal gel used to treat pain) and Lasix (a diuretic medication) without developing a care plan to address the use of these medications. R194's diagnoses included depressive disorder, generalized pain, and idiopathic peripheral neuropathy. The admission MDS dated 9/20/12, indicated R194 had severe cognitive impairment and received an antidepressant and diuretic medication. The CAA for Psychotropic Medication Use V05 dated 9/26/12, consisted of a checklist which indicated R194 used an "antidepressant." The Analysis of Findings section of the form indicated, "Resident takes paxil [sic] for depression, there measures in place for nursing to monitor side effects and update the MD, social services to monitor behaviors and pharmacist to review medication regimen use." The Physician Orders dated 12/26/12, directed to give R194 the following medications: - Paxil 10 mg PO tablet daily for diagnosis of depressive disorder; - Lasix 30 mg tablet PO daily; - Voltaren 2 gtts (drops) transdermal gel (jelly) one time PRN; On 1/30/13, the Physician Orders directed: - Neurontin 200 mg PO TID for pain; - Tylenol 1000 mg PO TID for pain; - Oxycodone 2.5 mg PO q (every) six hours as needed (PRN) for pain. The orders lacked parameters for the use of the PRN medication. Such as when to administer Voltaren two drops transdermal Gel (jelly) and	F 329	R194's care plan has been updated to address use of Paxil, Neurontin, Tylenol, Oxycodone, Voltaren and Lasix including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring for psychotropics.	3-13-13

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F 329	Continued From page 94 when to administer the PRN Oxycodone. R194's care plan dated 10/12/12, and 1/25/13, did not address the use of Paxil, did not identify the use of a Lasix, and did not identify the use of Neurontin, Tylenol, Oxycodone, or Voltaren for pain. In addition, the clinical record lacked evidence of monitoring for the efficacy of the Paxil, did not address the potential side effects of the medications, did not address the risks associated with the use of the medications, such as the risks of dehydration with the use of Lasix, the risk of falls with the use of Paxil and Oxycodone. On 2/1/13, at 3:09 p.m. the RN-B reviewed the care plan and confirmed Paxil and the above medications were not addressed in the care plan. On 2/1/13, at approximately 2:22 p.m. the consultant pharmacist was contacted via telephone and stated the Paxil was for inappropriate sexual behaviors and stated she thought the Paxil was discontinued and changed to Zoloft. At 3:09 p.m. the RN-A confirmed the care plan did not address the above medications and confirmed the PRN medications for pain lacked parameters for use. R189 lacked indications for the ongoing use of Haldol (an antipsychotic), including target behavior monitoring and parameters for the as needed (PRN) use of Haldol. In addition, R189's care plan did not address the use of Trazodone (antidepressant drug used for sleep) or the use of	F 329		

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F 329	Continued From page 95 Haldol. The significant change MDS dated 1/9/13, indicated R189 had moderate cognitive impairment, had no mood or behavior problems, and was given an antidepressant medication. The CAA for Psychotropic Medication Use V05 dated 1/16/13, checklist identified R189 used an antipsychotic medication, but failed to identify the use of an antidepressant medication as indicated by the MDS. The Analysis of Findings section of the form indicated, "Resident has depression, takes Trazodone. Measures are in place for adverse side effects to be monitored and reported to MD [medical doctor], pharmacist to review medication regimen." The section "Document reasons care plan will/will not be developed:" indicated, "Already in care path." The MDS assessment failed to identify the use of an antipsychotic medication, the CAA failed to identify the complete psychoactive medication regimen, such as the use of Haldol and PRN Haldol, the indications for the use of the Haldol, the use of Trazodone for sleep. A hospice order dated 11/27/12, directed to decrease the Haldol from 0.5 mg BID to 0.5 mg once daily at HS. "May continue PRN Haldol 0.5 mg every 6 hours as needed for breakthrough anxiety." The clinical record lacked evidence of the evaluation of breakthrough anxiety, such as the resident specific symptoms of breakthrough anxiety. The Physician Orders dated 12/3/12, indicated R189 received the following medications: - Trazodone HCl 50 mg PO tablet every HS for the diagnosis insomnia;	F 329	R189's Haldol was discontinued. Care plan has been updated to address the use of Trazadone including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring .	3-13-13

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F 329	Continued From page 96 - haloperidol lactate (Haldol) 0.5 mg tablet PO daily for "anxiety" and 0.5 mg concentrate PO every six hours PRN repeating for "delirium agitation." - On 12/31/12, R189 was discharged from the Hospice program for "no longer meeting hospice criteria." The Medication Administration Records (MARs) for January 2013, December 2012, and November 2012 indicated the above scheduled medications were administered as ordered. The November 2012 MAR indicated PRN Haldol was administered 16 times; the December 2012 MAR indicated the PRN Haldol was administered five times; the last PRN dose given was on 12/9/12. R189's checklist care plan for ADL Function/Rehabilitation dated 10/16/12, checked that R189 received "Psychoactive Medication that impairs ability." Further review of the 10/16/13, checklist care plan and the care plan dated 1/23/13, indicated the care plans did not identify the use of Haldol or Trazodone, lacked indications for the use of the medications, the risks associated with the use of the psychotropic medications, monitoring for efficacy of the medications. In addition, the care plan and clinical record lacked evidence a target behavior, such as the resident specific symptoms of R189's delirium were identified and monitored. The care plan lacked development of non-pharmacological interventions to address the target behaviors, such as interventions to promote sleep or to address anxiety and delirium. On 2/1/13, at approximately 3:00 p.m. the LPN-B confirmed the clinical record lacked evaluation of	F 329		

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F 329	Continued From page 97 R189's sleep patterns. On 2/1/13, the RN-A confirmed the findings and verified the care plan did not address the use of the medications. R52 lacked adequate monitoring of behaviors to determine current status and develop adequate interventions. R52 received Seroquel (an anti-psychotic medication) for a diagnosis of depression with psychosis and anxiety. An annual MDS assessment, completed 10/24/12, indicated no behaviors and no change in behavior since the last assessment. Therefore, a CAA was not indicated for R52. However, an annual assessment nursing note, dated 10/24/12, indicated R52 received an anti-psychotic medication for mood and behavior stability. The note indicated that staff was to monitor effectiveness of the medication and behaviors and update the attending physician as needed. Also, a pharmacy review was to be completed monthly and the care plan would be reviewed. On 2/1/13 at 2:30 p.m. social worker (SW)-A was interviewed. He indicated that the facility was initially tracking behaviors, for R52, of fear of leaving the room and mocking other residents. The medical record contained evidence of behavior charting for April-October of 2012. According to SW-A, they stopped monitoring due to the behaviors not happening. The medical record lacked evidence of monitoring of specific behaviors for R52 related to Seroquel use. SW-A indicated that to review R52's current behavioral status, he would go through note by note to	F 329	R52's care plan has been updated to address use of Seroquel including indications for us, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring.	3-13-13

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F 329	Continued From page 98 determine if any behaviors had been documented. He went on to explain that the facility would discuss resident status three weeks prior to the MDS assessment date. He explained that they would go through progress notes to determine behaviors charted and that the behavior tracking was not in a consolidated area. The mood and behavior tracking during the annual MDS completed 10/24/12, was incomplete with only one day ' s worth of documentation. No documentation was provided for the for the following MDS assessment dated 1/13/13. On 2/1/13, at 3:00 p.m. trained medical assistant (TMA)-A indicated he was not aware of how to document behaviors for residents on psychotropic medications, but later found out that it would be completed through the care touch program. At approximately the same time RN-A stated that she would write a summary note to document behaviors. On 4/16/12, the pharmacist indicated that R52 had been receiving Seroquel for depression and psychosis, although there was only one mention in the nursing notes of R52 feeling depressed and no mention of anxiety or other behavioral symptoms. Given the lack of psychotic or depressive symptoms, the pharmacist recommended a trial dose reduction of Seroquel. Furthermore, the pharmacist recommended updating the care plan in regard to adjustment to the new roommate as it had been four months since the roommate moved in. On 2/1/13, at 2:30 p.m. the pharmacist stated that the physician had addressed the Seroquel issue and had elected to not adjust the dosage due to long standing psych	F 329		

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F 329	Continued From page 99 issues. The POC indicated a focus problem of repetitive health concerns, such as dizziness, related to psychosis and anxiety, a history of fear of leaving the room and frequent mocking of other residents. The goal was for R52 to take medications as ordered. Interventions were to write a behavior summary note and " help R52 with adjustment to floor and routine changes; re-direct from inappropriate behavior; provide cues and encourage participation; provide verbal reminders related to behavior; monitor attention seeking behavior and changes in cognition; and to speak calmly with simple terms. " R41 was admitted to the facility on 1/11/11, with diagnoses including dementia, anxiety, malaise and fatigue. The physician's orders sheet dated 1/7/13, noted an order for Risperdal (an antipsychotic) 0.5 mg to be given daily at bedtime for neuropathic condition. The Risperdal start date was 3/21/12. R41 also took Celexa 40 mg daily for depression and Lorazepam (antianxiety medication) 0.5 mg every 6 hours as needed for anxiety. R41 took Risperdal without adequate monitoring. During daily observations from 1/29/13 through 2/1/13, the resident appeared calm, pleasant, social, and exhibited no agitation or anxiety. The Annual MDS dated 11/14/12, noted R41 had had no mood indicators, and had no behaviors. The CAA dated 11/14/12, indicated R41 used psychotropic medications, there were measures	F 329		

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F 329	Continued From page 100 in place for nursing to monitor for adverse side effects, social services to monitor behaviors and the pharmacist to review medications. Per the CAA "No adverse effects exhibited during this time." When interviewed on 2/1/13, at 11:29 a.m. the LPN-B stated she did not know what target behaviors were monitored for R41's neuropathic condition, and Risperdal use. The physician progress note dated 11/06/12, noted R41 had a history of "neurotic excoriation" and was on Risperdal for it. The Mood and behavioral record for January 2013 and December 2012 indicated target behavior "repeated requests to go to the bathroom with very short periods of time", and did not include monitoring of the excoriations. The RN- B was interviewed on 2/1/13, at 2:05 p.m. The RN-B stated R41 used to scratch self, and remembered that just few weeks before R41 had a scratch on her hand, and three staff observed R41 scratching self. Observation of R41's skin on 2/1/13, at 2:10 p.m. revealed small skin abrasion on R41's right outer below the knee area. Per the RN-B R41 scratched mainly her arms and hand. The RN-A was interviewed on 2/1/13, at 2:35 p.m. and verified there was no target behavior monitoring in place for the Risperdal use to include R41's skin condition, excoriation, and scratching self.	F 329	R41's care plan has been updated to address use of Risperdal, Celexa and Lorazepam including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring .	3-13-13

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F 329	Continued From page 101 R184 used Xanax, however, the facility did not monitor R184s anxiety status. R184 was admitted to the facility on 12/14/12, with diagnoses which included anxiety, rib fractures, depression and congestive heart failure. The physician's order sheet dated 1/10/13, noted an order for Xanax 0.5 mg twice daily PRN for anxiety. Review of the Medication Administration record indicated in January 2013, R184 took Xanax 5 times. The medical record lacked evidence of mood and behavior monitoring to indicate the need for the anti-anxiety medication, The Admission MDS dated 12/27/12, noted R184 had no mood indicators and had no behaviors. During daily observations from 1/29/13 through 2/1/13, the resident appeared calm, pleasant, social, and exhibited no agitation or anxiety. The care plan dated 1/2/13, did not indicate use of the Xanax, and did not identify non pharmacological interventions implemented when R184 exhibited signs and symptoms of anxiety, distress. During interview on 2/1/13, at 11:32 a.m. the LPN-B stated R184 requested to take Xanax when R184 felt anxious or when R148 had shortness of breath. The LPN-B verified a mood/behavior record was not initiated to monitor R184's anxiety.	F 329	R184's care plan has been updated to address use of Xanax including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring . R98's care plan has been updated to reflect current status of continence and behavioral factors affecting this have been added. To correct this issue, the policy has been revised to reflect inclusion of medications in the care plan for indications for use, efficacy, target behavior monitoring, non-pharmacologic interventions and side effects. All remaining residents will be reviewed at the next MDS assessment scheduled. Audits sample of 5 charts per month for 90 days will be done to ensure compliance. Social Services, Clinical Managers and DON responsible.	3-13-13

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F 329	Continued From page 102 During interview on 2/1/13, at 10:15 a.m. RN-A verified there was no target behavior monitoring in place for the Xanax use, and acknowledged lack of comprehensive care plan for anxiety. The Psychotropic Medication Monitoring policy with review date 1/2013, indicated "Behaviors/Moods are monitored by each shift on the Behavior/Mood Record. See policy #[number]1985." The Behavior/Mood Monitoring Record policy dated as revised on 8/12, indicated, "The Behavior/Mood Monitoring Record is used to ascertain the presence of, and the frequency of behavior and mood symptoms, for identifying resident care needs and implementing the plan of care." The procedure directed, "2) When a resident exhibits moods/behaviors and is on any psychotropic, antidepressant, antianxiety, or sleep aide, this must be monitored." The procedure directed the mood/behavior record would be "initiated" by the nurse manager and directed the specifics for nursing staff to observe and document, such as the number of times, the number of interventions used to modify the behavior, and the results. The procedure directed to evaluate the behavior/mood data, complete a summary of the data including an analysis of the efficacy of the interventions. The procedure further directed, "If interventions are shown to be ineffective revision of interventions used are indication and to be implemented and documented on the resident's care plan, NAR [nursing assistant, registered] care sheet, and Behavior/Mood Monitoring Record." The Psychotropic Medication Monitoring policy	F 329		

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F 329	Continued From page 103 dated as reviewed 1/2013, directed, "Psychotropic Medications will be monitored for appropriateness. Assessment of Psychotropic side effects will be done each shift by a licensed nurse." The procedure identified "unnecessary drugs," including: excessive dose, excessive duration, without adequate monitoring, and without adequate indications for use. The procedure further directed, "2. A care plan should be developed with the resident/family/caregivers /interdisciplinary team that maximizes patient function and well-being."	F 329		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced	F 425		

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F 425	Continued From page 104 by: Based on observation, interview, and document review, the facility failed to ensure residents were not given expired insulin. In addition, the facility did not properly date the insulin bottle with the date it was opened to identify the expiration of insulin for 1 of 2 residents (R66) who received insulin during medication administration observations. Findings include: R66 received multiple doses of expired insulin. On 1/30/13, at 8:29 a.m. during the morning medication pass, the registered nurse (RN)-B prepared 15 units of scheduled Lantus insulin (used to treat diabetes) for R66 from the Lantus insulin vial. The insulin bottle was not labeled with a readable open date. The Lantus insulin was delivered from the pharmacy on 11/15/12. The RN-B was not able to read the date when the insulin vial was opened. When RN-B was questioned about the open vial insulin and the expiration date RN-B stated she did not know how many days the Lantus insulin was good for after it had been opened. The RN-A walked by at that time, and stated he could not read the date when the Lantus insulin vial was opened. The RN-B proceeded to look for another Lantus insulin vial for R66 in the medication cart and medication room, confirmed there was no other Lantus vial in use for R66, and the insulin delivered on 11/15/12, was used for R66. The RN-A stated the Lantus insulin expired 28 days after opening, verified the pharmacy delivery date 11/15/12, and stated R66 might have received expired insulin for over a month.	F 425	Insulin for R66 was replaced during survey. All other multi dose vials were reviewed for expiration dates. To prevent recurrence, night shift has been assigned to check all multi dose vials weekly for expiration dates. Random sample of 2 multi dose vials will be done of each med cart monthly for 90 days to ensure ongoing compliance. Clinical Managers and DON responsible.	3-13-13

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F 425	Continued From page 105 The physician's order last dated 1/17/13, indicated Lantus 15 units subcutaneously daily, with start date 11/2/12. During interview on 2/1/13, at 9:05 p.m. the director of nursing (DON) stated staff was expected to date the multi dose vials such as insulin with date when they were opened, follow the medication expiration guidelines. The DON further explained the table with different medication expiration guidelines was laminated and posted in the medication room for easy reference. During interview on 2/1/13, at 1:45 p.m. the consultant pharmacist (CP) stated the Lantus insulin expired 28 days after opening, so date when opened was required. Per the CP if the open date was missed, or unreadable for some reason, staff supposed to consider as open date the pharmacy delivery date. The CP further explained that R66's Lantus insulin was considered expired on 12/13/12, and R66 received expired insulin daily from 12/13/12 until 12/30/12. The Lantus insulin package insert indicated the vial should be kept up to 28 days after initial use. The Pharmaceutical Administration Policy dated 3/12, indicated "Insulin vials will be dated when opened and replaced in 28 days from the date opened, or according to manufacturer ' s recommendation." The policy also indicated expired mediations were removed from storage area and destroyed according to policy.	F 425		

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F 425	Continued From page 106 The undated Medication Storage and Expiration Guidelines policy indicated Insulin vials needed "date when opened", and the expiration date was "28 days after 1st use."	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility's consultant pharmacist failed to identify and report irregularities such as qualitative (target)behavior monitoring for ongoing use of psychotropic medications and parameters for as needed (PRN) medications; in addition, the consultant pharmacist failed to identify the lack of care planning for psychotropic, diuretic, pain and diabetic medications for 6 of 10 residents (R41, R184, R73, R67, R194, R189) in sample reviewed for unnecessary medications. Findings include: R41 took Risperdal without adequate monitoring. R41 was admitted to the facility on 1/11/11, with	F 428		

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ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	02/01/2013

AME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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F 428	Continued From page 107 diagnoses to include dementia, anxiety, malaise and fatigue. The Physician Orders dated 1/7/13, noted an order for Risperdal 0.5 milligrams (mg) to be given daily at bedtime for Neuropathic condition. The Risperdal start date was 3/21/12. R41 also took Celexa (antidepressant) 40 mg daily for depression and lorazepam (antianxiety medication) 0.5 mg every six hours as needed for anxiety. R41 received Risperdal without adequate monitoring. During daily observations from 1/29/13 through 2/1/13, R41 appeared calm, pleasant, social, and exhibited no agitation or anxiety. The annual Minimum Data Set (MDS) dated 11/14/12, noted R41 had no mood indicators or behaviors problems. The Care Area Assessment (CAA) dated 11/14/12, indicated R41 used psychotropic medications, there were measures in place for nursing to monitor for adverse side effects, social services to monitor behaviors and the pharmacist to review medications. The CAA indicated, "No adverse effects exhibited during this time." On 2/1/13, at 11:29 a.m. the licensed practical nurse (LPN-B) stated she did not know what target behaviors were monitored for R41's neuropathic condition and Risperdal use. The physician progress note dated 11/06/12, noted R41 had a history of "neurotic excoriation" and was on Risperdal for it.	F 428	As previously stated, R41's care plan has been updated to address use of Risperdal, including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring.	3-13-13

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F 428	Continued From page 108 R41's Mood and Behavioral record for January 2013 and December 2012, indicated the target behavior "repeated requests to go to the bathroom with very short periods of time", and did not include monitoring of the excoriations. On 2/1/13, at 2:05 p.m. the registered nurse (RN-B) stated R41 used to scratch themselves and remembered that just few weeks before, R41 had a scratch on her hand, and three staff observed R41 scratching self. Observation of R41's skin on 2/1/13, at 2:10 p.m. revealed small skin abrasion on R41's right outer leg below the knee area. RN-B stated R41 scratched mainly her arms and hand. The Clinical Coordinator/ registered nurse (RN-A) was interviewed on 2/1/13, at 2:35 p.m. and verified there was no target behavior monitoring in place for the Risperdal use to include R41's skin condition, excoriation, and scratching self. The monthly Consultant Pharmacist Reports dated 3/26/12 through 1/15/13 did not identify lack of target behavior monitoring for the ongoing use of the Risperdal. During interview on 2/1/13, at 1:47 p.m. the Consultant Pharmacist (CP) stated R41 took Risperdal for neurotic excoriations, acknowledged she have not identified lack of appropriate target behavior monitoring for the psychotropic medication use. R184 used Xanax for anxiety, however the facility did not monitor R184's anxiety status.	F 428		

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F 428	Continued From page 109 R184 was admitted to the facility on 12/14/12 with diagnoses which included anxiety, rib fractures, depression and congestive heart failure. The physician's order sheet dated 1/10/13 noted an order for Xanax (antianxiety medication) 0.5 mg twice daily as needed (PRN) for anxiety. Review of the Medication Administration record indicated in January 2013, R184 took Xanax 5 times. There was inadequate documentation in the medical record of mood and behavior monitoring to indicate the need for the anti-anxiety medication. The Admission MDS dated 12/27/12, noted R184 had no mood indicators and had no behaviors. During daily observations from 1/29/13 through 2/1/13, R184 appeared calm, pleasant, social, and exhibited no agitation or anxiety. The care plan dated 1/2/13, did not indicate use of the Xanax, and did not identify non pharmacological interventions implemented when R184 exhibited signs and symptoms of anxiety, distress. During interview on 2/1/13, at 11:32 a.m. the LPN-B stated R184 requested to take Xanax when R184 felt anxious or when R148 had shortness of breath. During interview on on 2/1/13, at 10:15 a.m. the RN-A verified there was no target behavior monitoring in place for the Xanax use, and acknowledged lack of comprehensive care plan for anxiety. Per the RN-A the Consultant	F 428	R184's care plan has been updated to address use of Xanax including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring .	3-13-13

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F 428	Continued From page 110 Pharmacist reviewed residents medications, and wrote recommendations, which than the facility staff acted upon. The monthly Consultant Pharmacist Report dated 1/22/13 did not identify lack of target behavior monitoring for the ongoing use of the Risperdal. During interview on 2/1/13, at 1:49 p.m. the Consultant Pharmacist (CP) stated R184 took Xanax for anxiety. The CP explained she usually gave a couple of days to staff while they worked on the care plan. When reminded that R184 resided in the facility for over a month and a half the CP stated she "missed identifying the lack of mood and behavior monitoring". The consultant pharmacist failed to identify the lack of resident specific target behavior monitoring for R73's medications of Lithium Carbonate (an antimanic medication used to stabilize mood), Remeron (an antidepressant) and Celexa (an antidepressant) In addition, the consultant pharmacist failed to identify the lack of care plan for the use of these medications. R73 had diagnoses to include diabetes mellitus, bipolar disorder and Parkinson's. The Physician Orders dated 1/7/13, indicated R73 received the following medications: - Lithium Carbonate (mood stabilizer) 450 milligrams (mg) oral (PO) tablet controlled release daily for diagnosis of bipolar disorder; - Remeron (an antidepressant) 7.5 mg PO at HS (hour of sleep) for the diagnosis of bipolar disorder; - Celexa 40 mg PO daily for diagnosis of bipolar disorder.	F 428	R73's care plan has been updated to address use of Lithium Carbonate , Remeron and Celexa including indications for use, efficacy, target behavior monitoring, non-pharmacologic interventions and side effect monitoring.	3-13-13

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F 428	Continued From page 111 Review of R73's care plan dated as effective from 1/11/13 to 4/18/13, indicated R73's ordered psychoactive medications of Lithium, Remeron and Celexa were not identified on the care plan. The care plan and clinical record lacked evidence of indications for the use of the medications, target behavior monitoring associated with the use of the medications. The care plan did not identify side effect monitoring and lacked direction for non-pharmacological interventions to address potential target behaviors. R73's Medication Administration Record (MAR) for January 2013, indicated Lithium, Remeron and Celexa were administered daily as ordered. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R73's medication regimen. The consultant pharmacist stated she noted the labs for R73's Lithium levels were from the hospital and it was on her schedule to address the labs with the facility on her next visit. The consultant pharmacist confirmed a medication regimen of Lithium, Remeron and Celexa was appropriate for treatment of bipolar disorder. The consultant pharmacist verified the medications were not addressed on the care plan and stated she "hadn't gotten to them [antidepressant, antianxiety medications] yet." The consultant pharmacist failed to identify the lack of resident specific target behavior monitoring and the indications for use of R67's Effexor XR (antidepressant), Trazodone HCl (an antidepressant medication used for sleep), and	F 428		

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F 428	Continued From page 112 as needed (PRN) Xanax (a short acting benzodiazepine). The consultant pharmacist failed to identify the lack of parameters for the use of the PRN Xanax. In addition, the consultant pharmacist failed to identify the lack of care planning for the medications Actos and Glucotrol XL (both medications used to treat diabetes) and Tegretol (antiseizure medication). R67's diagnoses included diabetes mellitus, depressive disorder, anxiety state, and insomnia. The Physician Orders dated 1/28/13, indicated R67 had the following medications ordered: - Effexor XR (antidepressant) 150 milligrams (mg) oral (PO) extended release 24 hour capsule twice daily (BID). The orders directed, "Take with food may sprinkle on applesauce. Do not cut/crush/chew For Depression New order 9/9/11 OBTAIN CONSENT PRIOR TO ADMINISTRATION." - Tegretol (anti-seizure medication) 200 mg tablet PO daily (given at 8:00 a.m.) and 100 mg tablet PO Daily (given at 4:00 p.m.) for diagnosis of convulsions; - Trazodone HCl (antidepressant used for sleep) 50 mg tablet PO at HS (hour of sleep) and 25 mg as needed (PRN) one time "q [every] night if 50 mg scheduled dose is not effective" for the diagnosis of insomnia. - Actos (a drug to treat type two diabetes) 30 mg tablet PO daily for diagnosis of type two diabetes mellitus; - Glucotrol XL (a drug to treat type two diabetes) 10 mg extended release tablet PO daily; - Xanax (a short acting benzodiazepine) 0.25 mg table PO three times daily (TID) PRN for "Anxiety." The orders lacked parameters for when	F 428	R67's care plan has been updated to address use of Effexor, Trazadone, Xanax, Actos and Glucotrol including indications for use, efficacy, and target behavior monitoring , non-pharmacologic interventions, sleep monitoring, and side effect monitoring for psychotropics.	3-13-13

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F 428	Continued From page 113 to administer the PRN medication. Review of the Medication Administration Records (MARs) for December 2012 and January 2013 indicated all R67's above scheduled medications were give as ordered. The PRN Xanax was administered seven times in December 2012 and twelve times in January 2013; the PRN Trazodone was given once in December 2012 and three times in January 2013. R67's care plan hand dated as effective 9/12/12 through 12/11/12, identified the above diagnoses as risk factors. Although the care plan identified "MOOD - Diagnosis of Depression with Anxiety State receives Antidepressant," the care plan lacked development to address risks associated with the use of Effexor XR, Trazodone and Xanax. In addition, the care plan lacked resident specific target behavior monitoring for the efficacy of the medication, indications for the ongoing use of the medications and non-pharmacological interventions to address the target behaviors. In addition, the care plan did not address R67's use of diabetic medications or the use of antiseizure medications, including but not limited to the risks associated with the medications, potential side effects, types and frequency of seizures, monitoring to hyper/hypoglycemia and monitoring for efficacy of the medications. The care plan did not address R67's sleeping patterns, use of Trazodone for sleep, monitoring for sleep, as well as resident specific non-pharmacological interventions to promote sleep for R67. A consultant pharmacist recommendation dated 5/8/12, recommended a potential taper of the R67's Trazodone, the physician response on the	F 428		

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F 428	Continued From page 114 same form indicated a clinical rational why not to taper the dose. A consultant pharmacist recommendation dated 9/13/12, recommended to check the Tegretol lab level, liver function and complete blood count (CBC) due to the R67 receiving Tegretol and Actos. The response section indicated the physician ordered labs to be completed on 1/28/13. On 1/31/13, at 2:43 p.m. the registered nurse (RN)-B and licensed practical nurse (LPN)-D both stated they did not update or change the care plans. RN-B stated a behavior note was written in the progress notes for R67. Both nurses confirmed the care plans did not address medications and verified the lack of parameters for the use of the PRN Xanax. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R67's medication regimen. The consultant pharmacist stated she thought the Xanax was "possibly" used for "tremoring" and confirmed the indication for use was anxiety. The consultant pharmacist stated on 3/2012, she requested a decrease of the Trazodone and the physician declined a reduction due to "panic attacks" and it was "coming up on a year" to determine if a reduction was warranted. The consultant pharmacist verified there were no parameters for the use of Xanax and verified the medications were not addressed on the care plan. The consultant pharmacist stated she "hadn't gotten to them [antidepressant, antianxiety medications] yet." When asked if she reviewed to determine if diabetic medications	F 428		

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F 428	Continued From page 115 were care planned for, the consultant pharmacist stated, "I don't get involved with diuretics or insulin" and stated she "assumed" the facility knew they needed to be care planned. On 2/1/13, at 3:12 p.m. the nurse manager (RN) -A confirmed R67's medications were not addressed on the care plan. The consultant pharmacist failed to identify the lack of resident specific target mood monitoring and care planning for R194's Paxil (an antidepressant). The consultant pharmacist failed to identify the lack of care planning for the pain medications Neurontin (a drug used for treatment of neuropathic pain), Tylenol (a drug used to treat mild to moderate pain), Voltaren (a transdermal gel used to treat pain) and failed to identify the lack of care planning for Lasix (a diuretic medication). The consultant pharmacist failed to identify parameters for the potential use of as needed (PRN) Voltaren. R194's diagnoses included depressive disorder, generalized pain, and idiopathic peripheral neuropathy. The Physician Orders dated 12/26/12, directed to give R194 the following medications: - Paxil 10 milligrams (mg) oral (PO) tablet daily for diagnosis of depressive disorder; - Lasix 30 mg tablet PO daily; - Neurontin 100 mg PO three times daily (TID) for idiopathic neuropathy; - Tylenol 1,000 mg PO four times daily (QID) for generalized pain; - Voltaren 2 gtts (drops) transdermal gel (jelly)	F 428	R194's care plan has been updated to address use of Paxil, Neurontin, Tylenol, Oxycodone, Voltaren and Lasix including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring for psychotropics.	3/13/13

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F 428	Continued From page 116 one time as needed (PRN); On 1/30/13, the Physician Orders directed changes to R194's pain medications of: - Neurontin 200 mg PO TID (three times daily) for pain; - Tylenol 1000 mg PO TID for pain; Although R194 had the order for PRN Voltaren and had orders to increase pain medications, including the addition of the narcotic oxycodone, the PRN Voltaren lacked parameters for when to give the medication. R194's care plan dated 10/12/12, and 1/25/13, did not address the use of Paxil, did not identify the use of a Lasix, and did not identify the use of Neurontin, Tylenol, or Voltaren for pain. In addition, the clinical record lacked evidence of monitoring for the efficacy of the Paxil, did not address the potential side effects of the medications, did not address the risks associated with the use of the medications, such as the risks of dehydration with the use of Lasix, the risk of falls with the use of Paxil. On 2/1/13, at 3:09 p.m. the registered nurse (RN) -B reviewed the care plan and confirmed Paxil and the above medications were not addressed in the care plan. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R194's medication regimen. When asked if the consultant pharmacist had noted Paxil was not care planned, the consultant pharmacist verified she was aware of the lack of care planning and stated she "hadn't gotten to them [antidepressant, antianxiety medications] yet." When asked if she reviewed to determine if	F 428		

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F 428	Continued From page 117 other medications, such as a diuretic or pain medications were care planned, the consultant pharmacist stated, "I don't get involved with diuretics or insulin" and stated she "assumed" the facility knew they needed to be care planned. The consultant pharmacist failed to identify the lack of care planning for R189's use of Trazodone (antidepressant drug used for sleep). R189's diagnoses included insomnia. The Physician Orders dated 12/3/12, indicated R189 received the following medications: - Trazodone HCl 50 milligrams (mg) oral (PO) tablet every HS for the diagnosis insomnia; The Medication Administration Records (MARs) for January 2013, December 2012, and November 2012 indicated the above scheduled medication was administered as ordered. R189's checklist care plan for ADL Function/Rehabilitation dated 10/16/12, checked that R189 received "Psychoactive Medication that impairs ability." Further review of the 10/16/13, checklist care plan and the care plan dated 1/23/13, indicated the care plans did not identify the use of Trazodone, lacked indications for the use of the medication, the risks associated with the use of the psychotropic medication, monitoring for efficacy of the medication. The care plan lacked development of non-pharmacological interventions to address the target behaviors, such as interventions to promote sleep or to address anxiety and delirium.	F 428	R189's care plan has been updated to address the use of Trazadone including indications for use, efficacy, and target behavior monitoring, non-pharmacologic interventions and side effect monitoring . Social Services, Clinical Manager and DON responsible. To correct this issue, the policy has been revised to reflect inclusion of medications in the care plan for indications for use, efficacy, target behavior monitoring, non-pharmacologic interventions and side effects. All remaining residents will be reviewed at the next MDS assessment scheduled. Audits sample of 5 charts per month for 90 days will be done to ensure compliance. Social Services, Clinical Managers and DON responsible.	3-13-13

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F 428	Continued From page 118 On 2/1/13, at approximately 3:00 p.m. the licensed practical nurse (LPN)-B confirmed the clinical record lacked evaluation of R189's sleep patterns. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R189's Trazodone. When asked if the consultant pharmacist had noted Trazodone was not care planned, the consultant pharmacist verified she was aware of the lack of care planning and stated she "hadn't gotten to them [antidepressant, antianxiety medications] yet." The Pharmacy Consultant Services Policy with last review date 9/23/03, indicated the CP was responsible to "Complete, at least monthly, a drug regimen review as outlined by regulation for each resident and report irregularities to the Director of Nursing Services and attending physician, and as necessary the Quality improvement Committee."	F 428		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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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 441	Continued From page 119 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Loch, Eva Based on observation, interview and document review, the facility failed to ensure the nasal cannula oxygen (O2) tubing and nebulizer masks used for medication administration were stored in a sanitary manner to help prevent the potential transmission of disease or respiratory infection. This practice had the potential to affect 3 of 5 residents (R2, R41, R184) who used O2 and nebulizer. Findings include:	F 441	F441 Nebulizer tubing was changed for R2 and oxygen tubing was changed for R41 and R184. Policy has been revised to include weekly facility wide tubing changes on Tuesday nights including both oxygen and nebulizer tubing. Bags are adhered to the oxygen tanks for storage of tubing. Policy for rinsing and storage of nebulizer cups and tubing has been reviewed with staff. All Nursing Department staff in-serviced on this policy change. Random audits will be done on 5 rooms weekly for 90 days to ensure ongoing compliance. Clinical Managers and DON responsible.	3-13-13

PARTMENT OF HEALTH AND HUMAN SERVICES
NTERS FOR MEDICARE & MEDICAID SERVICES

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	02/01/2013

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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F 441	Continued From page 120 On 1/28/13, at 11:45 a.m. the initial environmental tour was completed, and the following was observed: - In R2's room a nebulizer mask was observed facing down on the bedside table. The mask had streaks of yellowish matter and the tubing was not dated. - In R41's room a large O2 tank was observed by the window with two oxygen tubing's wrapped around the tank. One of the two nasal cannulas was observed to be lying directly on the top of the tank with the nare prongs (the part of the cannula which enters the nose) in contact with the dial used to set the O2 flow. The nare prongs of the cannula were soiled with a yellow matter. - In R184's room a large O2 tank was observed between the bed and window. Two sets of O2 tubing with nasal cannulas were observed to be hanging on the side of the O2 tank. The prongs if the nasal cannula were observed to touch the side of the tank. Both sets of O2 tubing were not labeled with the date when they were last changed. On 1/30/13, at 11:58 a.m. the licensed practical nurse (LPN)-A verified the O2 tubing used by R184 was not stored in sanitary manner and could not tell when the O2 tubing was initiated to be used. LPN-A explained oxygen and nebulizer tubing was changed weekly, and stated staff were supposed to date them and usually they kept the nasal cannulas in a plastic bag to avoid contamination. On 1/30/13, at 12:05 p.m. the registered nurse (RN-B) did not know if there was a system in place for to storing the nasal cannulas when they	F 441		

'ARTMENT OF HEALTH AND HUMAN SERVICES
ITERS FOR MEDICARE & MEDICAID SERVICES

MENT OF DEFICIENCIES LAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	02/01/2013

E OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

4) ID EFIX AG	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
= 441	Continued From page 121 were not in use or how often the O2 tubing was changed. RN-B verified R41's acknowledged the nasal cannula was soiled with nasal secretions, and verified the O2 tubing was not stored in sanitary manner on the O2 tank. RN-B stated R41 used the O2 only as needed, and R41 did not O2 for almost a month. The infection control nurse was not available for interview. On 2/1/13, at 2:26 p.m. the director of nursing (DON) stated staff were expected to change the O2 tubing weekly and label them with the date when changed. The DON further explained the nebulizer machine's tubing and mask needed to be changed weekly, and dated when changed. The DON stated the masks were rinsed after each use and air dried on a towel or paper towel. The Oxygen (O2) Administration policy dated 1/13, indicated "Humidifier bottles, tubing, cannulas, masks will be changed and labeled on a weekly (and PRN [as needed] basis) as scheduled on the treatment section of the resident's computerized care path." The Nebulizer Machine Cleaning policy dated 3/12 indicated after each use "1. Disconnect the oxygen tubing and set aside 2. Disassemble the nebulizer 3. Rinse each piece with warm water 4. Let air-dry on a clean paper towel or cloth". The policy also indicated "Change entire nebulizer cup out weekly."	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		

PARTMENT OF HEALTH AND HUMAN SERVICES
NTERS FOR MEDICARE & MEDICAID SERVICES

EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING _____ B. WING _____	02/01/2013

ME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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F 465	Continued From page 122 The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure toilets in shared resident bathrooms were kept clean and free of stains. This practice had the potential to affect 12 of 12 residents (R186, R52, R19, R67, R110, R155, R98, R160, R146, R184, R147, R155) who resided in the rooms adjoining the shared bathrooms. Findings include: An environmental tour was held on 1/31/13, at 10:00 a.m. with the facility's director and the the director of housekeeping present throughout the tour. During the tour, three toilets on the 1st floor were observed to have dark streaking around the inside of the bowl and black debris under the rim on the inside of the toilet. The toilets were observed to be shared between two double occupancy rooms. At the time of the tour, the housekeeping director verified the toilets required cleaning to remove the stains and debris. The housekeeping director verified toilet cleaning was part of daily housekeeping.	F 465	Identified toilets have been cleaned and are stain free. To prevent recurrence, toilets will be cleaned daily by assigned housekeeping staff and a daily check off will be completed by the assigned housekeeping staff to assure task has been completed. Housekeeping Director will do random monthly audits of 10 resident rooms to assure daily cleaning of toilets and cleaning practices are completed. Housekeeping Director shall conduct an in-service for all housekeeping employees on proper cleaning practices. New cleaning chemicals will be introduced at this training. Director of Housekeeping responsible.	3-13-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245493	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD** **HOPKINS, MN 55343**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Augustana Chapel View Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 2-story split level building was determined to be of Type II(000) construction. It has a partial basement and is fully fire sprinkler protected. The facility has a 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 capacity of 118 beds and had a census of 108 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 6089

February 19, 2013

Ms. Mary Roy, Administrator
Augustana Chapel View Care Center
615 Minnetonka Mills Road
Hopkins, Minnesota 55343

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5493023

Dear Ms. Roy:

The above facility was surveyed on January 28, 2013 through February 1, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

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

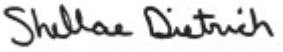
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5493s13lic.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00727	A. BUILDING _____ B. WING _____	02/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AUGUSTANA CHAPEL VIEW CARE CENTER	**615 MINNETONKA MILLS ROAD HOPKINS, MN 55343**

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 1/28/13, through 2/1/13, surveyors of this Department's staff visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Certification Program; PO Box 64900, Saint Paul, MN 55164-0900	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with	2 555		

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2 555	Continued From page 2 responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a care plan was developed to address the use of medications for 6 of 10 residents (R73, R67, R194, R189, R41, R184) reviewed for un-necessary medications; failed to develop a care plan to address pain for 1 of 1 resident (R194) initiated for pain management; failed to develop a care plan for 1 of 3 residents (R98) to reflect incontinence care. Findings include: R73's care plan was not developed to address the use of Lithium Carbonate (an antimanic medication used to stabilize mood), Remeron (an antidepressant) and Celexa (an antidepressant). R73 had diagnoses to include diabetes mellitus, bipolar disorder and Parkinson's. The admission Minimum Data Set (MDS) dated 1/7/13, indicated R73 had severe cognitive impairment and was identified to receive the following classes of medications: antianxiety, antidepressant and a diuretic. The Care Area Assessment (CAA) for Psychotropic Medication Use VO5 dated 1/11/13, consisted of a checklist which identified R73 used an "antianxiety" and "antidepressant" medication. Although the rest of the checklist was blank, the Analysis of Findings section of the CAA indicated, "Resident uses psychotropic medications daily. There are measures in place for nursing to	2 555		

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2 555	Continued From page 3 monitor for adverse side effects and update MD [medical doctor], social services to monitor for behaviors and the pharmacist to review medication regimen." The section, "Document reasons care plan will/will not be developed:" indicated, "Monitoring of adverse side effects daily." The CAA lacked identification of the specific medications associated with antianxiety and antidepressant, lacked identification of the target behaviors being monitored for the use of these medications and was incomplete. The Physician Orders dated 1/7/13, indicated R73 received the following medications: - Lithium Carbonate 450 milligrams (mg) oral (PO) tablet controlled release daily for diagnosis of bipolar disorder; - Remeron 7.5 mg PO at HS (hour of sleep) for the diagnosis of bipolar disorder; - Celexa 40 mg PO daily for diagnosis (Dx) of bipolar disorder. Review of R73's care plan dated as effective from 1/11/13 to 4/18/13, indicated R73's ordered psychoactive medications of Lithium, Remeron and Celexa were not identified on the care plan. The care plan and clinical record lacked evidence of indications for the use of the medications, target behavior monitoring associated with the use of the medications. The care plan did not identify side effect monitoring and lacked direction for non-pharmacological interventions to address potential target behaviors. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R73's medication regimen. The consultant pharmacist verified the medications were not addressed on the care plan and stated she "hadn't gotten to them yet."	2 555		

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2 555	Continued From page 4 On 2/1/14 at 3:04 p.m. the registered nurse (RN) -A confirmed the care plan did not include specifics, including risks, target behaviors, non-pharmacological interventions and the indications for the use of the psychoactive medications. R67's care plan did not address the medications Effexor XR (antidepressant), Trazodone HCl (an antidepressant medication used for sleep), as needed (PRN) Xanax (a short acting benzodiazepine), Actos and Glucotrol XL (both medications used to treat diabetes) and Tegretol (anti-seizure medication). R67's diagnoses included diabetes mellitus, depressive disorder, anxiety state, and insomnia. The annual MDS dated 8/29/12, indicated R67 had moderate cognitive impairment and identified R67 received the following medications: an antipsychotic, an antianxiety and an antidepressant. The CAA for Psychotropic Medication Use V05 dated 9/5/12, consisted of a checklist which identified R67 received an antipsychotic, antianxiety and antidepressant medication. The checklist indicated R67 was at increased risk for falls, depression (from use of antipsychotic) and anxiolytics (antianxiety). The Analysis of Findings section indicated, "Potential for alteration due to side effects related to use of psychotropic medication daily. Resident admitted to CV with Dx of Depression & Sleep Disturbance. As well as Rx [prescription] treatment of Effexor XR, Tegretol & Trazodone HS. No noted adverse side effects related to use of antidepressant. Measures in place for nursing to monitor side effects and update the NP [nurse practitioner]/	2 555		

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2 555	Continued From page 5 MD." The Physician Orders dated 1/28/13, indicated R67 had the following medications ordered: - Effexor XR 150 mg PO extended release 24 hour capsule twice daily (BID). The orders directed, "Take with food may sprinkle on applesauce. Do not cut/crush/chew For Depression New order 9/9/11 OBTAIN CONSENT PRIOR TO ADMINISTRATION." - Tegretol 200 mg tablet PO daily (given at 8:00 a.m.) and 100 mg tablet PO Daily (given at 4:00 p.m.) for diagnosis of convulsions; - Trazodone HCl 50 mg tablet PO at HS and 25 mg PRN one time "q [every] night if 50 mg scheduled dose is not effective" for the diagnosis of insomnia. - Actos 30 mg tablet PO daily for diagnosis of type two diabetes mellitus; - Glucotrol XL (a drug to treat type two diabetes) 10 mg extended release tablet PO daily; - Xanax 0.25 mg table PO three times daily (TID) PRN for "Anxiety." The orders lacked parameters for when to administer the PRN medication. R67's care plan hand dated as effective 9/12/12 through 12/11/12, identified the above diagnoses as risk factors. Although the care plan identified "MOOD - Diagnosis of Depression with Anxiety State receives Antidepressant," the care plan lacked development to address risks associated with the use of Effexor XR, Trazodone and Xanax. In addition, the care plan lacked resident specific target behavior monitoring for the efficacy of the medication, indications for the ongoing use of the medications and non-pharmacological interventions to address the target behaviors. In addition, the care plan did not address R67's use of diabetic medications or the use of anti-seizure medications, including but not limited to the risks	2 555		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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2 555	Continued From page 6 associated with the medications, potential side effects, types and frequency of seizures, monitoring to hyper/hypoglycemia and monitoring for efficacy of the medications. The care plan did not address R67's sleeping patterns, use of Trazodone for sleep, monitoring for sleep, as well as resident specific non-pharmacological interventions to promote sleep for R67. On 1/31/13, at 2:43 p.m. the RN-B and licensed practical nurse (LPN)-D both stated they did not update or change the care plan. RN-B stated a behavior note was written in the progress notes for R67. Both nurses confirmed the care plans did not address medications and verified the lack of parameters for the use of the PRN Xanax. On 2/1/13, at 3:12 p.m. the RN-A confirmed R67's medications were not addressed on the care plan. R194 care plan did not address the use of Paxil (an antidepressant), Neurontin (a drug used for treatment of neuropathic pain), Tylenol (a drug used to treat mild to moderate pain), oxycodone (a narcotic medication), Voltaren (a transdermal gel used to treat pain) and Lasix (a diuretic medication). In addition, the care plan was not developed to address R194's pain, including interventions identified in the assessments. R194's diagnoses included depressive disorder, generalized pain, and idiopathic peripheral neuropathy. The admission MDS dated 9/20/12, indicated R194 had severe cognitive impairment and received an antidepressant and diuretic medication. The CAA for Psychotropic Medication Use V05 dated 9/26/12, consisted of a checklist which indicated R194 used an "antidepressant."	2 555		

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	00727	A. BUILDING _____ B. WING _____	02/01/2013

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2 555	Continued From page 7 The Analysis of Findings section of the form indicated, "Resident takes paxil [sic] for depression, there measures in place for nursing to monitor side effects and update the MD, social services to monitor behaviors and pharmacist to review medication regimen use." The Physician Orders dated 12/26/12, directed to give R194 the following medications: - Paxil 10 mg PO tablet daily for diagnosis of depressive disorder; - Lasix 30 mg tablet PO daily; - Voltaren 2 gtts (drops) transdermal gel (jelly) one time PRN; On 1/30/13, the Physician Orders directed: - Neurontin 200 mg PO TID for pain; - Tylenol 1000 mg PO TID for pain; - Oxycodone 2.5 mg PO q six hours PRN for pain. The orders lacked parameters for the use of the PRN medication. Such as when to administer Voltaren two drops transdermal Gel (jelly) and when to administer the PRN Oxycodone. Pain Identification/Review checklist form dated 1/30/13, indicated R194 had non-verbal sounds of pain, vocal complaints of pain, facial expressions, protective body movements/postures, and restlessness. The checklist identified R194 had a condition or diagnosis "that usually causes pain," R194 received treatments or procedures from which pain can be anticipated, and R194 received medications or non-medication interventions for pain. The checklist indicated R194 was asked if she had pain in the last five days and stated "no." A hand written note under the question asking R194 to rate her pain on a 0-10 scale (zero = no pain, 10= the worst pain you can imagine) indicated, "I don't have pain resident answered."	2 555		

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2 555	Continued From page 8 Although the form identified pertinent pain information, the assessment lacked evidence R194's pain was assessed with movement. R194's care plan dated 10/12/12, and 1/25/13, did not address the use of Paxil, did not identify the use of a Lasix, and did not identify the use of Neurontin, Tylenol, Oxycodone, or Voltaren for pain. In addition, the clinical record lacked evidence of monitoring for the efficacy of the Paxil, did not address the potential side effects of the medications, did not address the risks associated with the use of the medications, such as the risks of dehydration with the use of Lasix, the risk of falls with the use of Paxil and Oxycodone. In addition, the care plan did not identify the assessed indicators of pain, such as pain with movement; did not direct non-pharmacological interventions to address pain, such as the use of heat or cold and did not address the parameters for use of the PRN pain medications. On 2/1/13, at 3:09 p.m. the RN-B reviewed the care plan and confirmed Paxil and the above medications were not addressed in the care plan. On 2/1/13, at approximately 2:22 p.m. the consultant pharmacist was contacted via telephone and stated the Paxil was for inappropriate sexual behaviors and stated she thought the Paxil was discontinued and changed to Zoloft. At 3:09 p.m. the RN-A confirmed the care plan did not address the above medications. R189 did not address the ongoing use of Haldol (an antipsychotic), including target behavior	2 555		

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2 555	Continued From page 9 monitoring and parameters for the PRN use of Haldol. In addition, the care plan did not address the use of Trazodone. The significant change MDS dated 1/9/13, indicated R189 had moderate cognitive impairment, had no mood or behavior problems, and was given an antidepressant medication. The CAA for Psychotropic Medication Use V05 dated 1/16/13, checklist identified R189 used an antipsychotic medication, but failed to identify the use of an antidepressant medication as indicated by the MDS. The Analysis of Findings section of the form indicated, "Resident has depression, takes Trazodone. Measures are in place for adverse side effects to be monitored and reported to MD, pharmacist to review medication regimen." The section "Document reasons care plan will/will not be developed:" indicated, "Already in care path." The MDS assessment failed to identify the use of an antipsychotic medication, the CAA failed to identify the complete psychoactive medication regimen, such as the use of Haldol and PRN Haldol, the indications for the use of the Haldol, the use of Trazodone for sleep. The Physician Orders dated 12/3/12, indicated R189 received the following medications: - Trazodone HCl 50 mg PO one tablet every HS for the diagnosis insomnia; - haloperidol lactate (Haldol) 0.5 mg tablet PO daily for "anxiety" and 0.5 mg concentrate PO every six hours PRN repeating for "delirium agitation." The Medication Administration Records (MARs) for January 2013, December 2012, and November 2012 indicated the above scheduled medications were administered as ordered. The	2 555		

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2 555	Continued From page 10 November 2012 MAR indicated PRN Haldol was administered 16 times; the December 2012 MAR indicated the PRN Haldol was administered five times; the last PRN dose given was on 12/9/12. R189's checklist care plan for activities of daily living (ADL) Function/Rehabilitation dated 10/16/12, checked that R189 received "Psychoactive Medication that impairs ability." Further review of the 10/16/13, checklist care plan and the care plan dated 1/23/13, indicated the care plans did not identify the use of Haldol or Trazodone, lacked indications for the use of the medications, the risks associated with the use of the psychotropic medications, monitoring for efficacy of the medications. In addition, the care plan and clinical record lacked evidence a target behavior, such as the resident specific symptoms of R189's delirium were identified and monitored. The care plan lacked development of non-pharmacological interventions to address the target behaviors, such as interventions to promote sleep or to address anxiety and delirium. On 2/1/13, the RN-A confirmed the findings and verified the care plan did not address the use of the medications. R80 had the diagnosis of diabetes mellitus, received the medications Lantus (a long-acting insulin), Actos and Glipizide (drugs used to treat diabetes mellitus) and lacked development of a care plan to address R80's treatment of diabetes mellitus. In addition, R80's care plan lacked development to include the medication Paxil. The annual MDS dated 12/26/12, indicated R80 had moderate cognitive impairment, had an active diagnosis of diabetes mellitus and received	2 555		

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2 555	Continued From page 11 insulin injections. The CAA for pressure ulcers dated 1/2/13, identified R80 had the diagnosis of diabetes. The Augustana Chapel View Care Center MDS Notes for VCAA12 dated 2/14/12, identified R80 had an alteration in nutritional status, required a therapeutic diet due to diabetes mellitus and identified R80 was at risk for hypo/hyperglycemia as well as weight loss due to the diagnosis. The Physician Orders dated 2/1/13, indicated R80 received the following medications for diabetes: - Lantus 14 units (U) subcutaneous (SQ) solution at the hour of sleep (HS); - Glipizide 10 mg PO tablet daily; - Actos 30 mg PO tablet daily; - Paxil 20 mg tablet PO daily for diagnoses of depression, dementia, "in appropriate external behaviors." The Physician Orders further directed interventions to address diabetes of: - Blood Glucose monitoring four times daily (QID); - File nails every two weeks on Wednesday. R80's care plan, hand dated as effective 7/26/12, through 10/1212, failed to identify a diabetes focus including but not limited to, use of diabetic medications, risks associated with the medications, monitoring for blood glucose, diabetic nail care, monitoring for signs and symptoms of hypo/hyperglycemia. In addition, the care plan did not address the use of Paxil, including the indications for the use of Paxil, the risks associated with psychoactive medication use and monitoring for side effects. On 2/1/13, the RN-A confirmed the findings and verified the care plan did not address the use of the medications.	2 555		

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2 555	Continued From page 12 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 555		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan for 1 of 2 sampled residents (R125) was revised to address the use of bed and chair alarms and the facility failed to develop care planning sufficient to meet the needs of newly admitted residents, prior to completion of the first comprehensive assessment and care plan for 1 of 2 residents (R87) identified with pressure areas.	2 560		

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2 560	Continued From page 13 Findings include: R125 was admitted on 11/7/12, with diagnoses which included dementia (loss of memory) and left sided cerebrovascular accident (a condition that affects brain function due to the disturbance in the blood supply to the brain) to the transitional care unit (TCU). On 11/30/12, R125 was transferred to the long term care unit. R125's care plan dated 1/13/12, did not indicate the use of bed and chair alarms interventions as identified on Physical Device Assessment dated 11/30/12. On 1/31/13, at 9:30 a.m. R125 was observed in his wheelchair during the breakfast meal in the lower level south dining room without the chair alarm in place. On 1/31/13, at 10:37 a.m. R125 was observed lying on his bed without a bed alarm in place. R125 was continuously observed on 1/31/13, from 9:30 a.m. to 11:00 a.m. and on 2/1/13, from 8:30 a.m. to 9:30 a.m. R125 did not have bed and chair alarms in place. Review of the Physical Device Assessment dated 11/30/12, revealed bed and chair alarms were to be used for R125 to prevent falls due to generalized weakness and dementia. The undated long term care unit nursing assistant care sheet did not indicate the use of bed and chair alarms interventions identified on 11/30/12. Review of the Treatment/Procedures Administration Record dated 2/1/13, revealed staff nurses had signed off every shift from 1/1/13	2 560		

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2 560	Continued From page 14 to 1/31/13 R125 had bed and chair alarms. On 2/1/13, at 9:33 a.m. interview with registered nurse (RN)-B revealed the staff ensured R125 had bed and chair alarms every shift. RN-B went to R125's room to observe bed and chair alarms. RN-B verified R125 did not have bed and chair alarms. On 2/1/13, at 10:37 a.m. RN-A went to R125's room to observe the bed and wheelchair alarms. RN-A verified R125 did not have the bed and chair alarms in place. RN-A also verified the care plan did not include the use of bed and chair alarms identified on Physical Device Assessment dated 11/30/12. On 2/1/13, at 10:55 a.m. RN-A was observed in the hallway with bed and chair alarms headed to R125's room. On 2/1/13, at 10:58 a.m. NA-B was not aware of the use of bed and chair alarms for R125 as NA-B had cared for R125 at least five times in the past month. In addition, NA-B verified the nursing assistant care sheet for the long term care unit did not direct staff to ensure R125 had bed and chair alarms. Review of the Fall and Injury Reduction policy dated 12/00, indicated fall reduction measures included bed and wheelchair sensor alarms. The policy specified, "All interventions for fall and injury reduction were noted on the resident's plan of care and resident care card." R125's care plan dated 1/13/12, did not indicate the use of bed and chair alarms interventions. R87 was admitted to the facility from an acute care hospital on 8/9/12, with diagnoses which included back pain, hypertension, osteoporosis, aortic stenosis and history of compression	2 560		

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2 560	Continued From page 15 fractures. The interagency transfer form the hospital dated 8/4/12, indicated R87's main complaint was back pain due to degenerative disk disease, with past medical history of vertebral compression fracture, thoracic kyphosis and osteoporosis. Per the form, R87 lived alone independently prior hospitalization and ambulated with assistance of a walker while in the hospital. R87's hospital physical examination indicated "no jaundice or cyanosis or rash", intact skin. The physician's note dated 8/7/12, also indicated there were "no areas of skin breakdown". The nursing admission and temporary care plan completed upon admission dated 8/9/12, skin assessment body diagram identified past surgical incision sites, and bruising. No skin breakdown was identified on R87's back. The summary dated 8/13/12, written with a different colored pen indicated "noted mid back o/a [open area] stage 2 (pressure ulcer) - curved area of the spine". The admission assessment and the note from 8/13/12, were not signed by staff that completed the assessments. Per the physical functioning assessment, R87 needed one staff assistance with bed mobility, transfers, walking, toileting, bathing and grooming. Although staff identified R87's need for assistance with bed mobility and transfers, the temporary care plan for skin integrity was left blank, and did not identify a repositioning time interval. The Transitional Care Unit (TCU) care card used by staff to provide cares to dated 8/9/12, for turning and repositioning was left blank. The TCU care card was updated on 8/13/12, with interventions including: air mattress, blue boots and Allevyn dressing (used to treat wounds) to mid back Stage 2 pressure ulcer. The care card update of 8/13/12, still lacked evidence	2 560		

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2 560	Continued From page 16 of how often R87 was to be turned and repositioned. The Tissue Tolerance Evaluation Sitting form (tool used to determine ability of the skin to endure the effects of pressure) dated 8/10/12, indicated no redness was noted after client has been sitting for two hours. The record lacked evidence of a tissue perfusion test was completed while R87 laid in bed. The Braden scale/Comprehensive Skin Risk Evaluation assessment completed upon admission, dated 8/9/12, noted a score of 18, 16 or lower indicated risk for developing pressure ulcer. The summary noted R87 was blind who exhibited anxiety, restlessness, and needed assist of one staff with all activities of daily living. According to the nurses notes dated 8/13/12, R87 complained of pain while in physical therapy, but denied when nurse assessed. Per the note R87 was noted to "stage 2 pressure ulcer mid back curvature area measuring 0.5 cm [centimeter] x 0.3 cm, Allevyn dressing applied & [and] will change Q [every] 3 days & as needed." The note also indicated air mattress and every one hour repositioning was initiated. The card card for the TCU unit was not revised with the new repositioning times. During interview on 1/31/12, at 10:59 a.m. the clinical coordinator/ registered nurse (RN-C)stated he was notified first on 8/13/12, regarding R87's pressure ulcer. The RN-C verified the pressure ulcer was not present at the time of the admission. Per the RN-C R87 was repositioned as per standard of practice every two hours during the first four days of the admission. The RN-C also verified the temporary	2 560		

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2 560	Continued From page 17 care plan and the TCU care card lacked evidence of interventions listed to prevent potential skin breakdown. During interview on 1/31/12, at 2:49 p.m. the director of the nursing stated staff were expected to assess residents upon admission, and implement interventions based on those assessments to prevent residents from skin breakdown. The Care Plans policy with a revision date of 3/12, indicated, "a paper copy of the Nursing Admission/Temporary Care Plan is completed by the admitting nurse." The policy also indicated the nursing staff on the TCU "will utilize this form as their Care Card and make any necessary corresponding written notes on their assignment to ensure proper care delivery." Suggested method of correction: The director of nursing could provide training to all mangers, and others involved in care plan development, to ensure that staff understand how to individualize the care plans. Additionally, the director of nursing or designee could ensure that care plans are reviewed to determine if all issues are appropriately addressed on the care plans. Time period for correction: 30 days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		

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2 565	Continued From page 18 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the care plan was followed for 3 of 8 residents (R189, R194, R178). Findings include: R189 was not provided oral cares or both hearing aids as directed by the care plan. R189's diagnoses included hearing loss, mixed hearing loss and debility. R189's care plan for Sensory Perception/Expression dated 10/9/12, identified R189 had a hearing aid for both the right and left ear, directed to encourage R189 to wear the hearing aid, assist to insert/remove/change the batteries. The activities of daily living (ADL) Functional/Rehabilitation care plan dated 10/16/12, identified R189 required assistance with bathing, dressing and grooming due to "end stage debility" psychoactive medications and weakness. The goal identified, "Res. will have all ADL functions complete w/ [with] staff assistance for the next 90 days." The care plan directed, "Set up all supplies and encourage Res to participate as far able." The care plan identified R189 required one staff assistance, including "Brush teeth/dentures." The care plan for Communication directed to "Observe for hearing deficit/changes." The care plan had a check in "Hearing aid(s)" and the right and left. On 1/30/13, the following was noted: - At 7:23 a.m. R189's was observed to be in bed with the door open and the room dark. - At 7:31 a.m. the licensed practical nurse (LPN) -B entered the room and gave "Synthroid [thyroid	2 565		

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2 565	Continued From page 19 replacement] " to R189 and left the room. - From 7:31 a.m. to 8:14 a.m. not staff entered the room. - At 8:14 a.m. a nursing assistant (NA)-C entered the room, spoke with the roommate and asked if she was "ready for breakfast." NA-C greeted R189; NA-E entered the room, spoke with NA-C and left the room closing the door. NA-C remained in the room. - At 8:21 a.m. the door opened and the roommate ambulated out of the room with NA-C. R189 was observed to still be in bed. NA-C closed the door to the room and remained in the room to assist R189. - At 8:25 a.m. NA-C was observed to assist R189 with morning cares. The left hearing aid was observed to be in and NA-C was assisting R189. NA-C was observed to assist R189 with changing of her incontinence product and dressing. NA-C stated R189 "does more for herself." At the time, the surveyor asked NA-C were R189's right hearing aid was. NA-C confirmed the right hearing aid was not in the ear and asked R189 very loudly "Where is your hearing aid?!" R189 stated, "I didn't quite get that." NA-C asked the question again even louder. R189 pointed to her right ear and stated, "It's missing, I don't know where it is." R189 pointed to her left ear and the NA stated loudly, "Your hearing aid is in!" NA-C checked the hearing aid and continued to dress R189, assisted R189 to transfer to the wheelchair, then proceeded to dispose of the incontinence product and make the bed. NA-C stated, "She brushes her teeth after breakfast." NA-C left the room. R189 was transported to the dining area shortly after. - At 12:03 p.m. the surveyor used the white board to ask R189 if she had received assistance with denture/oral cares after breakfast. R189 stated no one helped her brush her teeth. Confirmed	2 565		

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2 565	Continued From page 20 NA-C was the staff "who was taking care of me" in the morning. R189 denied brushing her dentures/teeth herself. - At 12:21 p.m. NA-D denied assisting R189 with oral cares and stated she was assigned to "[NA-C's name]." - At 1:29 p.m. R189 was observed to be brushing her teeth, with a visitor providing assistance. The visitor stated they were a nursing assistant from a "home care" company that was hired privately to provide "companionship" to R189. The visitor stated R189 "told me she hasn't brushed her teeth since she's been here." The visitor stated she assisted R189 with her oral care. At approximately 1:40 p.m. NA-C was interviewed and stated he thought R189 was able to "do it [denture/oral cavity cleaning] herself." NA-C stated the supplies were in the bedside table and confirmed he did not use the white board to communicate with the resident. NA-C confirmed he did not report the missing hearing aide. On 1/30/13, at 3:30 p.m. the nurse manager (RN)-A and social worker (SW)-A both were interviewed and stated R189 did not require the use of the white board and stated they had "tested" her hearing and stated R189 was able to hear. Both denied any concerns being communicated regarding communication or hearing problems. RN-A stated R189 should have been set up for oral cares and NA-C should have assisted R189. SW-A stated he was not aware R189 was missing a hearing aide. On 2/1/13, at 10:40 a.m. SW-A was interviewed and stated "one hearing aid" was in the nursing cart and "one in her ear." SW-A confirmed R189 arrived with both hearing aids. SW-A confirmed the therapeutic recreation staff did the hearing	2 565		

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2 565	Continued From page 21 assessment and documented R189 had two hearing aids when she first arrived. SW-A stated R189 kept "removing the left hearing aid" because it was "squeaking." SW-A stated staff did not check the hearing aid for function, was unclear if the family was notified of a hearing aid problem and unclear how long it had been since R189 had the hearing aide removed and placed in the medication cart. R194 did not have fluids encouraged between meals as directed by the care plan. R194's diagnoses included dementia and glaucoma. R194's care plan for Nutrition/Hydration dated 12/19/12, identified R194 was at risk for nutrition/hydration problems because R194 required assistance with meals and "multiple medical diagnoses" which included "Dementia." The care plan identified R194 had a significant weight loss over 30 days on 12/12/12. The care plan goal for R194 was to be free from signs and symptoms of dehydration. The interventions section directed: "amount eaten a.c. [after meals], bed time snack at hour of sleep, provide a regular diet" and "Encourage intake of fluids." During continuous observations on 1/30/13, beginning at 7:23 a.m. and ending at 11:50 a.m. R194 covered blue mug at the bedside was observed to be out of the resident's reach, full, room temperature warm and to still have the paper on the drinking end of the straw while R194 was in bed. R194 was not offered fluids until the breakfast and lunch meals and was not provided opportunities for fluid intake, such as after care or while sitting in the lounge area.	2 565		

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2 565	Continued From page 22 On 1/30/13, at approximately 3:35 p.m. the RN-A verified fluids should have been offered to R194 throughout the day. On 2/1/13, at 7:44 a.m. R194 was observed to be lying in bed flat on his/her back, the blue covered water mug was out of reach and appeared full. - At 7:47 a.m. when LPN-C was asked if R194 could drink fluids if placed in reach, LPN-C stated R194 "will sometimes try to drink," and stated R194 was "sometimes" able to drink fluids without staff assistance. LPN-C stated R194 needed cuing to consistently drink. LPN-C confirmed the mug of water was out of reach of R194. - At 7:58 a.m. RN-A confirmed R194's water glass was full and stated it should have been offered to R194 by the night shift staff. RN-A initially stated the water was "just filled," but then confirmed the cup was warm and the water lacked ice. The blue mug was observed to have paper from the straw missing, RN-A opened the mug and stated it was "nearly full." R178 was not provided every one hour repositioning and did not have the indwelling Foley catheter tubing secured as directed by the care plan. R178's diagnoses included stage IV pressure ulcer and dehydration. R178's care plan for Elimination dated 8/11/12, directed pertinent interventions to address the resident's Foley catheter including, "Catheter Positioning: - Secure indwelling cath [catheter] to leg (SP [suprapubic] cath to hip) w/ [with] cath strap or tape to avoid pulling on/dislodging cath AM & PM." The Skin care plan dated 12/17/12, identified the resident had a stage IV pressure ulcer located on the sacrum. The care plan interventions section had	2 565		

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2 565	Continued From page 23 an undated hand written note which directed, "Turn, reposition, OFF-load Q 1 Hr." The care plan further directed to use the draw sheet for repositioning. During continuous observations on 1/30/13, beginning at 7:23 a.m. and ending at 9:52 p.m. R178 was observed to not be offloaded (repositioned) for three hours and seven minutes. At 9:52 a.m. NA-D and NA-E were observed to enter R178's room after the LPN-B directed both NA staff to "boost" the resident in bed. While R178 was laid flat in the bed and prepared to be turned to the right side, the Foley catheter tubing was observed to be loosely moving against R178's thighs. Although the catheter tubing was connected to the drainage bag, the catheter tubing was not secured and anchored to prevent the potential pulling on the tubing inserted to the urethra. NA-D stated the strap to secure the catheter tubing was in the "drawer" of the night stand and stated, "I haven't dressed her yet." NA-D pointed to the top drawer of the night stand. At 10:13 a.m. the RN-A was notified of R178 going for three hours and seven minutes without offloading and the catheter tubing not secured. RN-A confirmed R178 should have been offloaded for one full minute every one hour and the catheter tubing should have been secured. The Augustana Chapel View Care Center Skin Care Program policy and procedure dated 1/13, identified, "...A resident who has pressure sores will receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing..." The policy directed to complete the facility's various assessment forms, to identify risk factors and to note the risk factors on the care plan and nursing assistant	2 565		

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2 565	Continued From page 24 care sheet. The procedure directed, "a. Turning and repositioning every 2 hours or more frequently as needed by resident skin status. Utilize pillows and positioning devices to decrease pressure over bony prominences." Suggested method of correction: The director of nursing could provide training to all mangers, and others involved in implementation of the care plan to ensure that staff understand how to utilize the care plans. Additionally, the director of nursing or designee could ensure that care plans are reviewed to determine if all issues are appropriately addressed on the care plans. Time period for correction: 30 days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R194) initiated for pain and observed to have	2 830		

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2 830	Continued From page 25 lower extremity pain which manifested with movement, was assessed for pain with movement; In addition, the facility failed to ensure staff reported an observed episode of pain with movement to the licensed practical nurse (LPN) to have it treated in a timely manner, including the use of as needed (PRN) topical Voltaren (used to treat pain or inflammation caused by arthritis) and the facility failed to ensure 1 of 2 residents (R125) reviewed for alarms received adequate supervision to reduce and prevent falls. In addition, the facility failed to implement the use of bed and chair alarms for R125 assessed to have generalized weakness and gait instability upon admission and after a fall on 1/25/13. Findings include: Pain: R194's diagnoses included dementia, idiopathic peripheral neuropathy, osteoarthrosis, pain in limb, and generalized pain. The admission Minimum Data Set (MDS) dated 9/20/12, indicated R194 had severe cognitive impairment, required extensive physical assistance from staff activities of daily living (ADLs), was on a scheduled pain regimen, did not receive as needed pain medications and had no pain when interviewed. The Care Area Assessments (CAA's) for pain did not trigger. On 1/30/13, R194 was observed: - At 7:23 a.m. through 8:10 a.m. R194 was observed to be in her room in bed until 7:40 a.m. A nursing assistant (NA)-C entered the room at that time for morning cares. The door was closed. R194 appeared calm and relaxed while lying in bed. - At 8:10 a.m. R194 was wheeled out of the room by NA-C and to the dining area for the breakfast	2 830		

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2 830	Continued From page 26 meal. From 8:10 a.m. until 9:28 a.m. R194 remained at the breakfast meal in the wheelchair. R194 did not appear to be in pain. - At 9:28 a.m. NA-D was observed to enter information into a computer kiosk on the wall directly behind R194. R194's legs were observed to be extended straight out in the wheelchair with the left foot rotated inward and the heels of both feet resting on the front edge of the foot pedal. R194 had light blue padded booties on both feet. - At 9:31 a.m. the nursing assistant (NA)-D noted the positioning of R194's left leg and adjusted it. R194 stated loudly, "Careful! That hurts so bad! It hurts so bad!" when NA-D moved the left leg. R194's left leg was observed to be rotated inward, the knee bent slightly in and the lower leg extended laterally from midpoint. The right leg was observed to be extended straight out, the right heel resting on the edge of the foot pedal. NA-D moved R194 from the breakfast table and faced the wheelchair towards the center aisle of the dining area, then returned to entering information into the computer kiosk on the wall. R194 sat in the wheelchair and made rapid anxious moaning noises which gradually reduced to a repeated humming. R194 was observed to be gripped the armrests tightly while the left leg was adjusted. NA-D asked NA-C if R194's wheelchair was a "new chair," NA-C stated it was the "same chair." NA-D and NA-C discussed R194's positioning. NA-C moved R194's left leg. R194 loudly yelled, "Ow, ow, ow! Help me!" NA-D pointed to the foot pedals and stated to NA-C, "They're far apart." NA-D then approached the licensed practical nurse (LPN)-B at the medication cart directly outside the dining area and in the hallway. NA-D explained to LPN-B immediately after R194 had called out in pain, that another resident had "a shower," read a piece of paper from the medication cart, obtained	2 830		

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2 830	Continued From page 27 a blood pressure (BP) machine and took another resident's (R73's) BP. NA-D asked LPN-B if she was "through with him" and wheeled R73 down the hallway with the BP machine. NA-C returned to the dining area and began bagging linens after wheeling R194 to the lounge area directly across from the nursing station. - From 10:00 a.m. to 11:50 a.m. R194 remained in the lounge area, was not administered any medications. R194 did not move either lower extremity and hummed to herself. At 11:50 a.m. R194 remained in the wheelchair unmoved until R194 was wheeled to the Celebration of Life activity off the unit. The Comprehensive Pain Data Collection and Assessment dated 9/16/12, identified R194 had "bilateral leg pain," was disoriented to place and time, that R194 "denied pain" but was able to report pain and be understood. The assessment indicated the pain was the "Reason she was admitted to hospital and now brought here," and rest/repositioning/medication made the pain "better." The assessment identified "movement" made the pain worse and goals for pain management were for R194 to sleep comfortably, have comfort with movement, comfort at rest, stay alert and perform activities. R194's care plan for Pain Management dated 10/4/12, identified R194 had generalized pain, osteoarthritis and received scheduled medications for pain management. The care plan directed to offer repositioning, scheduled pain medications. The care plan identified scheduled Tylenol (a mild analgesic). Although the physician's orders directed to administer scheduled Neurontin (used to nerve pain) and PRN Voltaren (nonsteroidal anti-inflammatory drug) topical medications for pain, the care plan	2 830		

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2 830	Continued From page 28 did not identify the use of Neurontin for pain and lacked direction for when to administer the as needed (PRN) Voltaren. The care plan lacked pertinent assessed information regarding R194's pain, such as the location and intensity of the pain, that R194's pain manifested with movement, or non-verbal indicators of pain such as grimace, furrowed eye brows or calling out. The ADL - Pain Interventions form dated 10/5/12, indicated to "offer repositioning" and "Scheduled pain medication" of Tylenol. The Pain identification/Review dated 12/6/12, consisted of a check list which identified non-verbal sounds such as crying, whining, gasping, moaning or groaning; R194 would express vocal complaints of pain such as "that hurts, ouch, stop;" R194 had facial expressions of pain such as grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw; protective body movements and restlessness. The review identified R194 received "treatments or procedures from which pain can be anticipated;" the review indicated R194 had occasional pain in the last five days, but R194 was unable to rate their pain. The quarterly MDS dated 12/12/12, indicated no changes in R194's pain status. Physician Orders for R194 dated 12/26/12, indicated R194 received the following medications for pain control beginning on 9/14/12: - Tylenol 1000 milligrams (mg) by mouth (PO) four times daily (QID) for generalized pain; - Neurontin 100 mg capsule PO three times daily (TID) for idiopathic peripheral neuropathy; - Voltaren (a topical medication used to treat	2 830		

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2 830	Continued From page 29 pain) two drops transdermal gel (jelly) as needed [PRN] topically to medial and inner left knee. The Monitoring Assessments Report (MRS) dated 11/1/12 to 2/1/13, for "Pain" indicated: - November 2012 R194 had "moderate pain" once and "slight pain" once "during dressing change to (L) [left];" - December 2012 R194 had pain five times, "slight pain" three times and "moderate" pain two times; - January 2013 R194 had two episodes of "slight pain." The MRS dated 11/1/12 to 2/1/13, for "Pain Scale 1-10" indicated: November 2012 R194 had: - 30 times in that timeframe rated the pain as "1- Mild Pain," - Four times the pain was rated as "2- [no description]," - Four times R194's pain was rated at "3- [no description]," - Two times at "4- [no description]," and two times at "5- moderate pain;" December 2012 R194 had: - 37 times the pain was rated as "1- Mild Pain," - Five times the pain was rated at "2-," - Five times the pain was rated at "3-," - Three times the pain was rated at "4-," and - Nine times the pain was rated at "5- Moderate Pain." January 2013 R194 had: - 25 times the pain was rated as "1- Mild Pain," - Six times the pain was rated at "2-," - Eight times the pain was rated at "3-," and - Three times the pain was rated at "4-." Notes indicated the pain occurred during "wound" care and/or treatment.	2 830		

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2 830	Continued From page 30 The Medication Administration Records (MARs) for November 2012 through January 2013 indicated no doses of the PRN Voltaren were administered to R194. Further review of the January 2013 MAR indicated R194 was given Oxycodone 2.5 mg on 1/30/13 and 1/31/13. The clinical record lacked evidence PRN Voltaren was offered or attempted to address R194's pain. The nursing Progress Note dated 1/30/13, written at 4:56 p.m. by RN-A indicated, "It was brought to writers attention that resident was experiencing some degree of pain earlier in the day. Pain Review was completed. Did not identify any pain issues. However as writer was reviewing resident's medication regime [sic], noted that resident was receiving [sic] 4000Mg [milligrams] of tylenol as well as neurontin 300 Mg daily; both medications in ivided [sic] doses. Writer spoke to resident's physician in reference to same. Physician decided to make some changes. See new physician's orders." Although the note indicated R194 did not have pain, the clinical record lacked rational for the addition of a narcotic medication and did not address assessment of R194's pain in the lower extremities with movement. In addition, the clinical record lacked evidence the PRN Voltaren use was reviewed or the use of non-pharmacological pain control interventions, such as cold or heat. On 2/1/13, review of the In-House Attending Physician's Order Form indicated on 1/30/13, R194's pain regimen was changed to Neurontin was increased to 200 mg PO TID for pain; Tylenol was decreased to 1000 mg PO TID and a new order for Oxycodone (a narcotic pain mediation) 2.5 mg PO every six hours PRN for pain was given. The physician's orders lacked	2 830		

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2 830	Continued From page 31 parameters when to administer PRN Oxycodone and when to administer PRN Voltaren. Review of R194's undated Group 1 sheet indicated pertinent information directing R194's care to the NA staff such as monitoring the skin, assistance required, diet and safety information. The form lacked information related R194's pain, such as when R194 had pain, or to report to the nurse in charge immediately if R194 had pain. On 1/30/13, at 12:21 p.m. NA-D stated he was not sure where R194 went after breakfast, believed R194 was at therapy and stated he believed they were working with her foot pedals. NA-D stated he notified LPN-B about R194's pain and LPN-B informed him R194 had "received a pain medication." On 1/30/13, at 12:25 p.m. the director of therapeutic recreation (DTR) confirmed R194 attended the Celebration of Life activity after breakfast and confirmed no fluids or snacks were served to R194. The DTR stated the chaplain brought R194 back to the unit and the "lounge." On 1/30/13, at 12:26 p.m. LPN-B contradicted NA-D's statements and stated she was not informed of R194 having pain after breakfast. LPN-B stated she was not sure if R194 was in therapies or if R194 was at an activity when she left the unit. LPN-B stated she would have offered R194 "PRN [as needed] Tylenol" and confirmed no Tylenol was offered to R194 since breakfast. LPN-B checked the computer and stated R194 was "due for [a scheduled] Tylenol now." LPN-B confirmed she was not aware R194 did not have a PRN Tylenol order. LPN-B confirmed she was not aware R194 had a PRN topical Voltaren order.	2 830		

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2 830	Continued From page 32 On 1/30/13, at 12:47 p.m. the chaplain confirmed she transported R194 to the lounge area, stated R194 was not offer fluids or foods and stated she usually parked R194 in the same location "to protect her feet." On 1/30/13, at approximately 3:35 p.m. the nurse manager (RN)-A was notified of the episode when R194 verbalized she had pain and the lack of pain reporting to LPN-B. RN-A stated the pain should have been reported immediately. On 2/1/13, at 7:47 a.m. while at the medication cart LPN-C was observed to be preparing medications. LPN-C was observed to place a tablet in a medication cup with applesauce. LPN-C stated she was going to give R194 "PRN Oxycodone." LPN-C stated she liked to offer the medication to R194 while the resident was in bed. LPN-C stated R194 "answers better" while she was in bed and confirmed she had not been in R194's room yet to assess her pain. LPN-C reviewed the computer on the medication cart and explained R194's pain medications had changed and explained the medication changes. LPN-C did not mention any changes to R194's PRN Voltaren. When in the room, LPN-C asked R194 if she had pain, R194 denied pain verbally and LPN-C stated the narcotic medication would be held. At no time during the observations did R194 move her lower extremities on her own, LPN-D did not move R194's lower extremities and LPN-C did not ask if R194 had pain with movement. The PRN Voltaren was not offered for pain control. On 1/30/12, at 7:58 a.m. when R194 was lying in bed and before any movement, RN-A asked R194 if she had pain, the resident stated "no."	2 830		

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2 830	Continued From page 33 When RN-A asked R194 her name, the resident stated "[R194's first name.]" The surveyor then requested RN-A to assess R194's lower extremities with movement. When RN-A lifted the right leg, R194's eye brows furrowed suddenly, but the resident denied pain. When RN-A bent the right leg slightly, the resident made a moaning sound, grimaced, when RN-A asked if she had pain, R194 stated "yes." When the left leg was lifted by RN-A and RN-A asked the resident if they had pain, R194 did not answer. When RN-A bent the left leg at the knee, R194 stated she had pain "Be careful!" and made a moaning sound. During the movements of the lower extremities, R194 had moved both hands from either side of the body to the sides of the bed and held onto the edges of the bed and blankets tightly during RN-A's assessment of the lower extremities. RN-A verified R194 had pain with movement in the lower extremities. On 2/1/13, at approximately 8:15 a.m. RN-A stated he had informed LPN-C of R194's pain medication changes. When asked if R194 was pre-medicated for pain before movement of the extremities, such as during morning cares; RN-A stated if R194 were to "call out for cares," he would expect the NA to report the pain to the LPN and a medication administered. When asked if the pain assessments included observations of R194 during cares or movement, RN-A stated observations of cares "were included." RN-A was unclear why the PRN Oxycodone was ordered and stated the scheduled Tylenol was decreased because R194 could not "have anymore Tylenol" and the Neurontin was increased because "the Tylenol was decreased." RN-A stated he directed LPN-C to administer the Oxycodone medication due to the assessed pain with movement. RN-A further stated he assessed R194 prior to notifying	2 830		

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2 830	Continued From page 34 the physician of R194 having pain after breakfast and provided a Pain Identification/Review checklist form (printed off from the electronic medical record (EMR) and completed by hand) dated 1/30/13, and completed by RN-A. Pain Identification/Review checklist form dated 1/30/13, indicated R194 had non-verbal sounds of pain, vocal complaints of pain, facial expressions, protective body movements/postures, and restlessness. The checklist identified R194 had a condition or diagnosis "that usually causes pain," R194 received treatments or procedures from which pain can be anticipated, and R194 received medications or non-medication interventions for pain. The checklist indicated R194 was asked if she had pain in the last five days and stated "no." A hand written note under the question asking R194 to rate her pain on a 0-10 scale (zero = no pain, 10= the worst pain you can imagine) indicated, "I don't have pain resident answered." Although the form identified pertinent pain information, the assessment lacked evidence R194's pain was assessed with movement. On 2/1/13, at 9:11 a.m. R194's physician (MD) was interviewed by telephone. When the MD was asked what his expectations were when R194 was assessed for pain, the MD stated he would expect a "multidimensional approach," and gave examples such as "asking, looking for a grimace, and observing form mood changes." The Pain Management/Assessment policy and procedure dated as reviewed and revised on 11/12, identified the pain assessment on admission including, "3. Pain management will proceed with continual monitoring through the admission process and ongoing throughout stay."	2 830		

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2 830	Continued From page 35 The Ongoing Pain Management Procedure section of the procedure directed to "Utilize non-pharmacological interventions for pain management if appropriate," to ensure medication used to treat chronic pain optimally should be administered on a scheduled basis around the clock with medication ordered PRN for breakthrough pain. The procedure directed, "3. Acute and chronic pain require continual assessment of the pain management regimen. Whenever the results of a pain assessment reveal that a resident's pain is not being managed, the primary physician should be notified immediately." The procedure further directed to update the care plan as needed, update the pain management information on the NA resident care cards and further directed, "6. Staff from all departments should report resident's requests for pain medication or expression of pain to the nurse in charge immediately." Falls: R125 was admitted on 11/7/12, with diagnoses which included dementia (loss of memory) and left sided cerebrovascular accident (a condition that affects brain function due to the disturbance in the blood supply to the brain). The admission minimum data set dated 11/14/12, identified R125 as having no cognitive behaviors and requiring extensive staff assistance with bed mobility and transfers. R125's Brief Interview for Mental Status score was five (severe cognitive impairment). Review of the Care Area Assessment dated 11/20/12, indicated R125 had physical limitations with impaired balance, gait, strength, and muscle strength therefore R125 required extensive physical assistance with transfers. R125's care plan 1/13/12, did not	2 830		

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2 830	Continued From page 36 indicate the use of bed and chair alarms interventions as identified on Physical Device Assessment dated 11/30/12. On 1/31/13, at 9:30 a.m. R125 was observed in his wheelchair during the breakfast meal in the lower level south dining room without the chair alarm in place. On 1/31/13, at 10:37 a.m. R125 was observed lying on his bed without a bed alarm in place. R125 was continuously observed on 1/31/13, from 9:30 a.m. to 11:00 a.m. and on 2/1/13, from 8:30 a.m. to 9:30 a.m. R125 did not have bed and chair alarms in place. Review of the Physical Device Assessment dated 11/30/12, revealed bed and chair alarms were to be used for R125 to prevent falls due to generalized weakness and dementia. The undated nursing assistant care sheet did not indicate the use of bed and chair alarms interventions identified on 11/30/12. Review of the progress notes dated 1/25/12, indicated R125 witnessed fell in his room with a nursing assistant (NA) and family member (F)-A in the room. R125 had attempted to pick up a Kleenex box from the floor. The progress note did not indicate if the bed and chair alarms were in use at the time of the fall. Review of the Treatment/Procedures Administration Record dated 2/1/13, revealed staff nurses had signed off every shift R125 had bed and chair alarms from 1/1/13 to 1/31/13. On 2/1/13, at 9:33 a.m. interview with registered	2 830		

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2 830	Continued From page 37 nurse (RN)-B revealed the staff ensured R125 had bed and chair alarms every shift. RN-B verified R125 did not have bed and chair alarms. On 2/1/13, at 10:37 a.m. RN-A verified went to R125's room to observe the bed and wheelchair. R125 did not have bed and chair alarms in place. RN-A also verified the care plan did not include the use of bed and chair alarms identified on Physical Device Assessment dated 11/30/12. On 02/1/13, at 10:55 a.m. RN-A was observed in the hallway with bed and chair alarms headed to R125's room. On 02/1/13, at 10:58 a.m. NA-B was not aware of the use of bed and chair alarms for R125 as NA-B had cared for R125 at least five times in the past month. In addition, NA-B verified the nursing assistant care sheet did not direct staff to ensure R125 had bed and chair alarms. Review of the Fall and Injury Reduction policy dated 12/00, indicated fall reduction measures included bed and wheelchair sensor alarms. The policy specified, "all interventions for fall and injury reduction were noted on the resident's plan of care and resident care card." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and re-educate all staff on the policies and procedures to ensure resident safety. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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2 905	Continued From page 38	2 905		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R178, R87) reviewed for pressure ulcers, were provided the necessary care and services to promote healing, prevent potential development of new pressure ulcers and to prevent further development of current pressure ulcers. Findings include: Although R178 had a Stage 4 (Full thickness tissue loss with exposed bone, tendon, or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) sacral/coccyx pressure ulcer and was assessed and care planned to be repositioned every one hour, R178 was not off loaded (repositioned) from 6:45 a.m. to 9:52 a.m. (three hours and seven minutes). During continuous observations on 1/30/13, beginning at 7:23 a.m. and ending at 9:52 p.m. the following was observed: - At 7:23 a.m. R178's room door was observed to be open, the room was dark and the bed was in	2 905		

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2 905	Continued From page 39 the low position. R178 was observed to be sleeping on her back and the head of the bed (HOB) was observed to in the up position approximately 20-30 degrees. From 7:23 a.m. to 7:43 a.m. no staff entered the room and R178 made no position changes. - At 7:43 a.m. a licensed practical nurse (LPN)-B entered the room, roused R178 and raised the HOB to 90 degrees. LPN-B assessed R178 for pain and stated she was giving R178 "Synthroid [thyroid replacement]." LPN-B encouraged R178 to drink water after giving the medication, turned off the lights and left the room. R178's HOB was left in the 90 degree position. From 7:43 a.m. to 8:56 a.m. no staff entered R178's room, the lights remained off, R178 made no position change and the HOB remained up in the 90 degree position. - At 8:56 a.m. two nursing assistants (NA-C and NA-D) entered R178's room. NA-C and NA-D lowered the HOB to a flat position, raised the bed up and grasped the lift sheet under R178 from both sides. NA-C and NA-D slid R178 up towards the HOB in one motion, R178's back and bottom slid up the air mattress surface approximately four inches. NA-D then immediately raised the HOB up to a 45 degrees angle. The over bed table was moved into place and a breakfast tray was placed on the table and NA-C left the room. NA-D washed their hands, applied a clothing protector to R178, and prepared the breakfast tray of a hardboiled egg (cut up by NA-D), a bowl of hot cereal; three covered cups containing water, orange juice, milk, and coffee. A pillow was placed under R178's left arm, but her coccyx area was not lifted off the surface of the bed. NA-D stated R178 was "boosted up" in the bed and confirmed she was not offloaded from pressure. NA-D then left R178's room. From 8:56 a.m. to 9:52 a.m. no staff entered the room. R178's bed remained at a 45 degree position while she ate	2 905		

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2 905	Continued From page 40 breakfast. - At 9:43 a.m. NA-C stated R178 was last offloaded when NA-C started the shift at 6:45 a.m. NA-C stated R178 required repositioning "every two hours." - At 9:49 a.m. LPN-B was asked how frequently R178 was off loaded by the surveyor. LPN-B checked a sheet on top of the medication cart and asked the surveyor, "Offloaded? What does that mean?" LPN-B confirmed she did not know the meaning of "off-loading," and then told NA-D and NA-E to "boost up" R178 and "place a pillow underneath" R178. - At 9:52 a.m. NA-D and NA-E removed the pillow from under R178's left arm, lowered the HOB and prepared to turn R178 on the right side. NA-D stated, "I haven't dressed her yet." R178's skin on the back was observed to be intact and free of redness, the sacral/coccyx area was observed to be covered with a large Tegaderm (A thin, clear sterile dressing that keeps out water, dirt and germs, yet lets skin breathe) dressing extending from the lower back, from the left him and across the left buttock, covering the entire sacral area. A tube connected to a wound vac (a device used to apply negative pressure to a wound to promote healing) on the bedside table was observed to extend from the left hip/buttock area of the dressing. NA-D confirmed the dressing was for a pressure ulcer. NA-D then placed a pillow completely under R178's back and relieved pressure from the coccyx area. NA-D placed the HOB up 45 degrees. R178 was not provided offloading from pressure from 6:45 a.m. until 9:52 a.m. (three hours and seven minutes). The Group 2 NA assignment sheet identified R178 had an air mattress on the bed, wore pressure relief boots in bed, identified R178 was incontinent of bowel and bladder, had fragile skin	2 905		

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2 905	Continued From page 41 which "Bruises and tears very easily," and R178 required "A-1 [assistance of one staff] to "Turn/reposition: " The assignment sheet indicated, "Skin risk: Monitor skin for redness, bruises, open areas and report to nurse." Although the assignment sheet identified pertinent skin information, the assignment sheet did not direct the frequency R178 required offloading. In addition, although R178 had extensive dressings to cover a stage IV pressure ulcer, the assignment sheet directed, "Apply lanaseptic to coccyx and peri-area after each incontinence." Review of the To Do List for LPN-B dated 1/30/13, provided directions for R178's pressure ulcer dressing changes and information on R178's wound vac. The To Do List directed, "Off-load Continuous Q [every] 1 hour," "Avoid HOB > [greater than] 30 degrees," "PREVENTATIVE SKIN CARE... Turn and reposition pt [patient] Q 1 hour - dx [diagnosis] pressure ulcer," and "TURN/REPOSITION q [every] shift Continuous and off load Q 1 Hr." On 1/30/13, at 10:13 a.m. the nurse manager (RN)-A was notified of R178 going for three hours and seven minutes without off loading, RN-A stated since R178 had a pressure ulcer, R178 required "every one hour repositioning." On 1/30/13, at 10:59 a.m. RN-A provided the Skin Care Program policy and stated an offload from pressure would be for "a complete full minute." RN-A again verified R178 should have been "repositioned every hour." RN-A confirmed R178's HOB needed to be up for meals, but then added the HOB should have been lowered to "about 30 degrees" after the medication was administered and after the meal. RN-A confirmed	2 905		

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2 905	Continued From page 42 the HOB should not have been left up at 90 degrees and stated, "Lowering it back down would have been the reasonable thing to do." RN-A confirmed LPN-B and the NA staff "should know" what offloading was, including full relief of pressure for "one minute." RN-A reviewed the Skin Care Program policy and stated "the repositioning should be determined by the assessment and care plan" and pointed to the sections of the policy which directed this. RN-A stated R178 did not move and stated R178 should have been propped up off the sacrum. On 1/30/13, at 11:11 a.m. LPN-B and RN-A were observed to change R178's sacral dressing and wound vac tubing. The dressings, foam and tubing were removed, revealing a Stage 4 pressure ulcer located on the upper left aspect of R178's sacral area. The ulcer edges were pink and granulated (pink or red tissue with shiny, moist, granular appearance), a moderate amount of drainage was noted on the dressings. At 11:24 a.m. RN-A flushed the ulcer with normal saline and described the drainage returns as a "moderate amount of serosanguinous [consisting of both blood and serous fluid]" drainage. RN-A inserted a sterile Q-tip into the wound and stated the ulcer had 1.5 centimeter (cm) x 1.4 cm of tunneling at "six to twelve o'clock." RN-A described the wound base as "pink" and covered with granulation tissue. The wound dimensions were 1.8 cm wide x 1.5 cm long, with approximately 2 cm reddish pink area surrounding the wound. RN-A reapplied the Tegaderm dressings, wound vac materials and stated the wound had improved. Review of the wound monitoring data dated 1/4/13, thru 1/25/13, indicated progressive healing and improvement of the ulcer.	2 905		

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2 905	Continued From page 43 R178's diagnoses included stage IV pressure ulcer, cellulitis, and malnutrition. The admission Minimum Data Set (MDS) dated 8/10/12, indicated R178 had severe cognitive impairment, required extensive physical assistance with bed mobility, had an indwelling Foley catheter and R178 was continent of bowel. The MDS indicated R178 was at risk for developing pressure ulcers and had an unstageable pressure ulcer with slough (yellow or white tissue that adheres to the ulcer bed in strings, or thick clumps, or is mucinous). The Care Area Assessment (CAA) for pressure ulcers dated 8/16/12, identified R178 had a "coccyx pressure ulcer wound infection." The CAA description of the wound included the wound bed was covered with "60% slough," had exudate/necrotic tissue and underlying osteomyelitis bone infection which required intravenous (IV) antibiotics. The CAA identified R178 required staff assistance "to move sufficiently to relieve pressure over any one site," was confined to the bed or chair all or most of the time, needed a special mattress or seat cushion to reduce or relieve pressure, and R178 required a regular schedule of turning. The CAA identified, "Patient was admitted with an unstageable pressure ulcer to coccyx area. Remains at risk for decline/further alterations due to bowel incontinence, imp [impaired] functional mobility, potential for friction and shear, cognitive deficits, wound infection, IV abx's [antibiotics], use of O2 [oxygen]." Although the CAA identified the need for a repositioning schedule, the CAA did not address R178's specific assessed repositioning needs. Although R178 had a pressure area on admission, the Braden Scale/Comprehensive Skin Risk Evaluation dated 9/28/12, identified R178 was at "low risk" of developing pressure	2 905		

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	00727	A. BUILDING _____ B. WING _____	02/01/2013

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2 905	Continued From page 44 ulcers. The summary section of the form directed to "Identify INTERVENTIONS needed, put them in place and schedule them on care path:" The summary indicated, "Resident has an indwelling cath [catheter], but is incontinent of bowel. Resident is able to respond and ask for what she needs. Resident is chairfast. Appetite is fair. Resident does need assistance to move up in bed." The evaluation did not address R178's pressure ulcer or repositioning needs. The Tissue Tolerance Evaluation Laying dated 10/10/12 and 10/19/12, indicated R178 could tolerate a "2 hour interval" of repositioning, identified R178 had a pressure reduction device in the chair and indicated, "Writer checked resident and no new areas of concern noted at this time," after the two hour interval. The evaluation did not identify that R178 had a stage IV pressure ulcer or that R178 may require one hour repositioning due to having a stage IV pressure ulcer. The quarterly MDS dated 10/28/12, indicated R178's cognition had improved to be cognitively intact and continued to require extensive physical assistance for bed mobility. The MDS indicated R178 was frequently incontinent of bowel and the pressure ulcer had progressed from unstageable to a stage IV pressure ulcer measuring 2.5 cm wide x 3.5 cm long with a 3.5 cm depth. The MDS indicated the ulcer had granulation tissue as the most severe tissue type in the ulcer. The Physician's Orders dated 12/3/12, directed, "Avoid HOB > 30 degrees." beginning on 8/14/12. The orders further directed, "FYI: Limit sitting to only meals." ADL - Skin Integrity Interventions questionnaire	2 905		

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2 905	Continued From page 45 dated 12/17/12, consisted of a checklist which identified R178 required a pressure redistribution cushion on her chair and redistribution mattress on the bed. The checklist indicated to apply house lotion to her body after the weekly bath, to bathe R178 with mild soap, to rinse/dry well. The questionnaire identified, "pressure ulcer; treatment/interventions per order." R178's care plan dated 12/17/12, identified the resident had a stage IV pressure ulcer located on the sacrum. The care plan interventions section had an undated hand written note which directed, "Turn, reposition, OFF-load Q 1 Hr." The care plan further directed to use the draw sheet for repositioning. At 11:52 a.m. RN-A stated the redness was from the "Tegaderm" and explained the pressure ulcer was present on admission. RN-A stated within the last month, the last wound clinic consult informed the facility R178 would not need to return "because the wound was healing so well." At 1:40 p.m. NA-C confirmed R178 was not assisted with repositioning or offloading outside the time NA-C assisted NA-D to "boost" R178 at 8:56 a.m. On 1/31/13, at 1:20 p.m. RN-A stated the Tissue Tolerance "automatically" started at two hours and it was "null and void" due to R178 having a Stage 4 pressure ulcer. The Augustana Chapel View Care Center Skin Care Program policy and procedure dated 1/13, identified, "...A resident who has pressure sores will receive the necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing..." The policy directed	2 905		

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2 905	Continued From page 46 to complete the facility's various assessment forms, to identify risk factors and to note the risk factors on the care plan and nursing assistant care sheet. The procedure directed, "a. Turning and repositioning every 2 hours or more frequently as needed by resident skin status. Utilize pillows and positioning devices to decrease pressure over bony prominences." The facility failed to provide services to prevent the development of a pressure ulcer for R87, who developed a stage two pressure ulcer (partial thickness tissue loss) within four days of the admission. A review of R87's the closed medical record revealed lack of comprehensive skin assessment upon admission, and lack of temporary care plan with interventions to prevent potential skin breakdown. R87 was admitted to the facility from an acute care hospital on 8/9/12, with diagnoses which included back pain, hypertension, osteoporosis, aortic stenosis and history of compression fractures. The interagency transfer form from the hospital dated 9/4/12, indicated R87's main complaint was back pain due to degenerative disk disease, with past medical history of vertebral compression fracture, thoracic kyphosis and osteoporosis. Per the form R87 lived alone independently prior hospitalization and ambulated with assistance of a walker while in the hospital. R87's hospital physical examination indicated "no jaundice or cyanosis or rash", intact skin. The physician's note dated 8/7/12 also indicated there were "no areas of skin breakdown". The physician's hospital discharge summary dated 8/9/12 indicated R87 was discharged with instructions for: occupational and physical therapy, long term nursing home placement and palliative care management.	2 905		

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2 905	Continued From page 47 The nursing admission and temporary care plan completed upon admission dated 8/9/12/ skin assessment body diagram identified past surgical incision sites, and bruising. No skin breakdown was identified on R87's back. The summary dated 8/13/12, written with a different colored pen indicated "noted mid back o/a [open area] stage 2 (pressure ulcer) - curved area of the spine". The admission assessment and the note from 8/13/12 were not signed by staff that completed the assessments. Per the physical functioning assessment, R87 needed one staff assist with bed mobility, transfers, walking, toileting, bathing and grooming. Although staff identified R87's need for assistance with bed mobility and transfers, the temporary care plan for skin integrity was left blank, and did not identify a repositioning time interval. The Transitional Care Unit (TCU) care card used by staff to provide cares to dated 8/9/12 for turning and repositioning was left blank. The TCU care card was updated on 8/13/12 with interventions including: air mattress, blue boots and Allevyn dressing (used to treat wounds) to mid back Stage 2 pressure ulcer. The Braden scale/Comprehensive Skin Risk Evaluation assessment completed upon admission, dated 8/9/12, noted a score of 18 (total score of 19-18 indicated mild risk for developing pressure ulcer). The summary noted R87 was blind who exhibited anxiety, restlessness, and needed assist of one staff with all activities of daily living. The Tissue Tolerance Evaluation Sitting form (tool used to determine ability of the skin to endure the effects of pressure) dated 8/10/12,	2 905		

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2 905	Continued From page 48 indicated no redness was noted after client has been sitting for two hours. The record lacked evidence of a tissue perfusion test was completed while R87 lay in bed. According to the nurses notes dated 8/13/12, R87 complained of pain while in physical therapy, but denied when nurse assessed. Per the note R87 was noted to "stage 2 pressure ulcer mid back curvature area measuring 0.5 cm [centimeter] x 0.3 cm, Allevyn dressing applied & [and] will change Q [every] 3 days & as needed." the note also indicated air mattress and every one hour repositioning was initiated. The medical record lacked evidence of monitoring the pressure ulcer, no additional measurement were listed. Record review further revealed R87 was admitted to hospice care on 8/22/12, and passed away on 8/24/12. The Admission Minimum Data Set (MDS) dated 8/22/12, identified R87 with severely impaired cognitive skills (brief interview mental status BIMS=7), with hallucinations and delusion present. The MDS also indicated R87 needed one staff's extensive assistance with bed mobility and transfers, used wheel chair for locomotion. Per the MDS R87 was at risk for pressure ulcer, identified one stage 2 pressure ulcer present on admission, with date unknown. The Care Area Assessment dated 8/22/12 indicated R87 had "stage two pressure ulcer to mid back on spinal curvature", and identified R87 at risk for further skin breakdown. The CAA also indicated R87 was working with therapies, and improvement was expected with mobility. During interview on 1/31/13, at 10:59 a.m. the	2 905		

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2 905	Continued From page 49 clinical coordinator/ registered nurse (RN-C) stated he was notified first on 8/13/12 regarding R87's pressure ulcer. The RN-C verified the pressure ulcer was not present at the time of the admission. The RN-C also remembered a wound care sheet was not started to monitor the pressure ulcer. The RN-C further explained staff was expected to complete tissue perfusion test within 24 hours of admission, in both laying and sitting position. Per the RN-C, R87 spent most of the time lying in bed, so he would have expected staff to complete a tissue tolerance in the bed also, since R87 was dependent on staff for bed mobility. The RN-C verified lack of tissue perfusion test while lying in bed, and explained that the repositioning interval would have to be determined based on the tissue tolerance result. The RN-C also verified the temporary care plan, the TCU care card, and acknowledged there were no interventions listed to prevent potential skin breakdown. Per the RN-C, R87 was repositioned as per standard of practice q 2 hours during the first 4 days of the admission. During interview on 1/31/13, at 10:41 a.m. the MDS coordinator verified the inaccuracy of admission MDS (pressure ulcer coded as present upon admission) and explained that when she took the information from the admission assessment, she have not noticed that the entry regarding presence of the stage 2 pressure ulcer dated 8/13/12. During interview on 1/31/13, at 2:49 p.m. the director of the nursing stated staff was expected to assess residents upon admission, and implement interventions based on those assessments to prevent residents from skin breakdown.	2 905		

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2 905	Continued From page 50 The Tissue Tolerance Evaluation policy with revision date 11/12, indicated "each resident who is dependent on bed and/ or chair mobility, will be monitored for tissue tolerance while lying and sitting: upon admission, with a change in condition". The policy also indicated once an individualized turning and repositioning schedule was determined the licensed nurse completed weekly skin checks to determine if intervals were still appropriate. The Care Plans policy with revision date 3/12, indicated "a paper copy of the Nursing Admission/Temporary Care Plan is completed by the admitting nurse". The policy also indicated that the nursing staff on the TCU "will utilize this form as their Care Card and make any necessary corresponding written notes on their assignment to ensure proper care delivery". The Skin Care Program policy with last review dated 1/13, indicated "Any pressure and/or vascular ulcers noted are to have a Weekly Wound Flow sheet completed and scheduled to be completed in the care path on a weekly basis." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure residents are repositioned according to the care plan. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 905		

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2 910	Continued From page 51	2 910		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the indwelling Foley catheter tubing was anchored and secured with a strap (affixed to the leg) for 1 of 1 resident (R178) initiated for catheter use. Findings include: R178's diagnoses included Stage 4 pressure ulcer, dehydration, and malnutrition. The admission Minimum Data Set (MDS) dated 8/10/12, indicated R178 had severe cognitive impairment, required extensive physical assistance with transferring and toilet use, and had an indwelling Foley catheter. The Care Area Assessment (CAA) for Urinary Incont (incontinence) Indwelling catheter dated 8/16/12,	2 910		

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2 910	Continued From page 52 identified, "Currently has Foley catheter in place due to large coccyx pressure ulcer." Although the CAA identified pertinent risk factors, the CAA did not identify the Foley catheter tubing should be secured. R178's care plan for elimination dated 8/11/12, directed pertinent interventions to address the resident's Foley catheter including, "Catheter Positioning:- Secure indwelling cath [catheter] to leg (SP [suprapubic] cath to hip) w/ [with] cath strap or tape to avoid pulling on/dislodging cath AM & PM." The care plan further directed "Catheter change-SEE ORDERS FOR CATH SIZE, BALLOON, DRAINAGE TYPE Every 30 days." The Physician's Orders dated 12/3/12, indicated the physician had ordered R178 to have a "Catheter" for the diagnosis of "Osteomyelitis of buttock ulcer-want to avoid urine in wound" starting on 8/13/12. Although the care plan directed to refer to the Physician's Orders for the catheter size. The Physician's Orders lacked direction for the indwelling catheter tubing and balloon size. On 1/30/13, at 9:52 a.m. nursing assistants (NA-D and NA-E) were observed to enter R178's room after the licensed practical nurse (LPN)-B directed both NA staff to "boost" the resident in bed. While R178 was laid flat in the bed and prepared to be turned to the right side, the Foley catheter tubing was observed to be loosely moving against R178's thighs. Although the catheter tubing was connected to the drainage bag, the catheter tubing was not secured and anchored to prevent the potential pulling on the tubing inserted to the urethra. NA-D stated the strap to secure the catheter tubing was in the	2 910		

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2 910	Continued From page 53 "drawer" of the night stand and stated, "I haven't dressed her yet." NA-D pointed to the top drawer of the night stand. At 10:13 a.m. the nurse manager (RN)-A was notified the catheter tubing was not secured. RN-A confirmed the catheter should have been secured. The undated Group 2 nursing assistant assignment sheets (provided by NA-D) at the time of the observations on 1/30/13, indicated R178 was "Incontinent" of bladder, did not identify R178 had an indwelling Foley catheter, was blank for "Toileting:" and lacked direction for care of the catheter, including securing the tubing to prevent pulling. The To Do List Report for LPN-B dated 1/30/13, identified R178 had a catheter and "Catheter Positioning: AM & PM Continuous Secure indwelling cath to leg (SP cath to hip) w/ cath strap or tape to avoid pulling on/dislodging cath." The facility's Catheter: Straight/Indwelling policy and procedure dated as reviewed 1/13, directed the technique for catheter insertion in a female resident as well as, "13. Connect the catheter end to a closed drainage system: use a catheter strap to prevent accidental pulling of the catheter." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents with indwelling catheters have a medical justification for it's continued use. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance.	2 910		

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2 910	Continued From page 54 TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R189) reviewed for activities of daily living (ADLs) was offered denture and oral cavity cleaning and provided their left hearing aid. Findings include: During the stage one observation and interview on 1/28/13, at 4:49 p.m. R189 requested the surveyor conduct the entire interview by writing questions on a white board with a marker, R189	2 915		

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2 915	Continued From page 55 read the questions and responded verbally. R189 was observed to have a hearing aide in the left ear and stated she could not hear with her right ear. R189 stated the facility staff "never have" assisted her to brush her dentures. R189 described her dentures as "glued in" and "painted with" a substance. R189 stated several times during the interview staff had not assisted to clean her mouth. At 4:50 p.m. R189 provided the surveyor with a flashlight from her bedside dresser. R189's dentures and oral cavity were observed to have whitish colored debris noted at the front bases of the dentures. At 8:40 p.m. R189 stated she was unclear where her right hearing aid was and stated it was "missing." R189 further stated she had reported the hearing aid missing (was unclear how long ago), that staff "looked for it" but the hearing aid was "still missing." R189 stated the hearing aid used to be stored "at the nursing desk." R189's diagnoses included mixed hearing loss and debility. The significant change Minimum Data Set (MDS) dated 10/9/12, indicated R189 moderate cognitive impairment, required limited physical assistance from staff for dressing and personal hygiene, and identified to have no oral or dental problems. The MDS identified R189 had moderate difficulty hearing (speaker had to increase volume and speak distinctly) and used a hearing aid. The Sensory Expression (hearing, speech, vision) questionnaire dated 10/9/12, identified R189 had a right and left hearing aid and indicated to "Talk into (R) [right] ear." The checklist further indicated, "Encourage to wear hearing aide(s), Assist to insert hearing aide(s), Assist to remove hearing aide(s), Assist to change HA (hearing aide) batteries as needed." An attached Progress	2 915		

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2 915	Continued From page 56 Note dated 10/9/12, recapitulated the checklist information and identified R189 had "bilateral hearing aids" and "hearing loss/mixed hearing loss" and the dry erase board was an "additional means of communicating with staff and family." "Res admits that she is HOH (hard of hearing) and it is better to talk into (R) ear." The significant change MDS dated 1/9/13, indicated R189 required more extensive physical assistance with dressing and grooming, but continued to have moderately impaired cognition, use a hearing aid and have moderate difficulty hearing. The Care Area Assessment (CAA) for ADL Functional Status dated 1/16/13, indicated R189 was off of Hospice, identified R189 required extensive assistance with dressing and personal hygiene. The CAA identified "Contributing factors include: ...impaired functional mobility and hearing loss which makes it hard to communicate. Potential for decline D/T [due to] the same risk factors." Although the CAA identified R189 required extensive assistance with personal hygiene, the CAA did not address R189's denture/oral cavity care needs. The Augustana Chapel View Care Center MDS Notes for VCAA11 dated 1/9/13, indicated, "Due to hearing loss and vision loss, resident finds it difficult to do her favorite activities of reading and listening to music." The note further indicated, "Res [resident] also likes listening to music but d/t severe hearing loss, can no longer hear the music to enjoy it. TR [therapeutic recreation] staff have offered headphones to use with personal radio, but res says they are not loud enough to hear the music." The MDS note for VCAA04 dated 1/9/13, indicated, "Due to severe hearing loss, res has troubles communicating with others as she may miss part or all of the spoken	2 915		

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	00727	A. BUILDING _____ B. WING _____	02/01/2013

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2 915	Continued From page 57 messages/intent of the message. Res uses a dry erase board and marker to communicate with visitors and staff. This severe hearing loss puts resident at risk for social isolation and depression." The note identified R189 declined "invite and encouragement" to attend activities due to hearing loss. The VCAA04 MDS Note further directed, "Increase voice volume, speak clearly, remove distractions, use dry erase board." The MDS Notes did not address R189's use of hearing aids. The Sensory Expression (hearing, speech, vision) questionnaire dated 1/10/13, identified the same checklist hearing aid information as the previous questionnaire dated 10/9/12. The attached note dated 1/10/13, identified R189 continued to have moderately impaired hearing. The note indicated, "She said she has bilateral hearing aids but never wears them. Res stated to writer that she prefers communicating with the speaker writes on a dry erase board." The note indicated R189 communicated well verbally. The note identified R189's hearing loss as "severe" and indicated R189 declined invites to activities due to the hearing loss. R189's care plan for Sensory Perception/Expression dated 10/9/12, identified R189 had a hearing aid for both the right and left ear, directed to encourage R189 to wear the hearing aid, assist to insert/remove/change the batteries. The ADL Functional/ Rehabilitation care plan dated 10/16/12, identified R189 required assistance with bathing, dressing and grooming due to "end stage debility" psychoactive medications and weakness. The goal identified, "Res. will have all ADL functions complete w/ [with] staff assistance for the next 90 days." The care plan directed, "Set up all supplies and	2 915		

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2 915	Continued From page 58 encourage Res to participate as far able." The care plan identified R189 required one staff assistance, including "Brush teeth/dentures." The care plan for Communication directed to "Observe for hearing deficit/changes." The care plan had a check in "Hearing aide(s)" and the right and left. Although the care plan identified the use of right and left hearing aids, the care plan did not address storage of the hearing aids. On 1/30/13, the following was noted: - At 7:23 a.m. R189's was observed to be in bed with the door open and the room dark. - At 7:31 a.m. the licensed practical nurse (LPN)-B entered the room and gave "Synthroid [thyroid replacement] " to R189 and left the room. - From 7:31 a.m. to 8:14 a.m. not staff entered the room. - At 8:14 a.m. a nursing assistant (NA)-C entered the room, spoke with the roommate and asked if she was "ready for breakfast." NA-C greeted R189; NA-E entered the room, spoke with NA-C and left the room closing the door. NA-C remained in the room. - At 8:21 a.m. the door opened and the roommate ambulated out of the room with NA-C. R189 was observed to still be in bed. NA-C closed the door to the room and remained in the room to assist R189. - At 8:25 a.m. NA-C was observed to assist R189 with morning cares. The left hearing aid was observed to be in and NA-C was assisting R189. NA-C was observed to assist R189 with changing of her incontinence product and dressing. NA-C stated R189 "does more for herself." At the time, the surveyor asked NA-C were R189's right hearing aid was. NA-C confirmed the right hearing aid was not in the ear and asked R189 very loudly "Where is your hearing aid?!" R189 stated, "I didn't quite get that." NA-C asked the	2 915		

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2 915	Continued From page 59 question again even louder. R189 pointed to her right ear and stated, "It's missing, I don't know where it is." R189 pointed to her left ear and the NA stated loudly, "Your hearing aid is in!" NA-C checked the hearing aid and continued to dress R189, assisted R189 to transfer to the wheelchair, then proceeded to dispose of the incontinence product and make the bed. NA-C stated, "She brushes her teeth after breakfast." NA-C left the room. R189 was transported to the dining area shortly after. - At 12:03 p.m. the surveyor used the white board to ask R189 if she had received assistance with denture/oral cares after breakfast. R189 stated no one helped her brush her teeth. Confirmed NA-C was the staff "who was taking care of me" in the morning. R189 denied brushing her dentures/teeth herself. - At 12:21 p.m. NA-D denied assisting R189 with oral cares and stated she was assigned to "[NA-C's name]." - At 1:29 p.m. R189 was observed to be brushing her teeth, with a visitor providing assistance. The visitor stated they were a nursing assistant from a "home care" company that was hired privately to provide "companionship" to R189. The visitor stated R189 "told me she hasn't brushed her teeth since she's been here." The visitor stated she assisted R189 with her oral care. At approximately 1:40 p.m. NA-C stated he thought R189 was able to "do it [denture/oral cavity cleaning] herself." NA-C stated the supplies were in the bedside table and confirmed he did not use the white board to communicate with the resident. NA-C confirmed he did not report the missing hearing aide. On 1/30/13, at 3:30 p.m. the nurse manager (RN) -A and social worker (SW)-A were interviewed	2 915		

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2 915	Continued From page 60 and both stated R189 did not require the use of the white board and stated they had "tested" her hearing and stated R189 was able to hear. Both denied any concerns being communicated regarding communication or hearing problems. RN-A stated R189 should have been set up for oral cares and NA-C should have assisted R189. SW-A stated he was not aware R189 was missing a hearing aide. On 2/1/13, at 10:40 a.m. SW-A stated "one hearing aid" was in the nursing cart and "one in her ear." SW-A confirmed R189 arrived with both hearing aids. SW-A confirmed the therapeutic recreation staff did the hearing assessment and documented R189 had two hearing aids when she first arrived. SW-A stated R189 kept "removing the left hearing aid" because it was "squeaking." SW-A stated staff did not check the hearing aid for function, was unclear if the family was notified of a hearing aid problem and unclear how long it had been since R189 had the hearing aide removed and placed in the medication cart. SUGGESTED METHOD OF CORRECTIONS: The Director of Nursing or her designee could develop policies and procedures for activities of daily living, including oral care and placement of hearing aids. The Director of Nursing or her designee could educate the appropriate staff on the policy and procedure for activities of daily living, including oral care and placement of hearing aids. The Director of Nursing or her designee could develop systems of monitoring to ensure ongoing compliance. TIME FRAME FOR CORRECTIONS: Twenty-one (21) days.	2 915		

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2 940	Continued From page 61	2 940		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R194) was offered adequate fluids between meals to meet the residents assessed minimum daily needs and to prevent potential dehydration. Findings include: On 1/28/13, at 6:41 p.m. R194 was initially observed during the stage one observations to have a dry mouth and dry lips. R194 was observed to have whitish colored debris in their mouth and was observed to be manipulating the debris with her tongue against the back of her teeth. R194 was unable to state when she had last had fluids. During continuous observations on 1/30/13, beginning at 7:23 a.m. and ending at 11:50 a.m. the following was observed: - At 7:23 a.m. the door to R194's room was open, R194 was observed to be laying bed and the room was dark. A covered blue colored mug was observed to be on the bedside stand with a straw inserted into the mug. The mug was full and a paper covering was observed to be on the end of the straw. The mug felt room temperature warm to the touch. The water mug was out of R194's reach. - At 7:40 a.m. a nursing assistant (NA)-C entered	2 940		

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2 940	Continued From page 62 R194's room, closed the door, immediately left the room to retrieve a wash cloth and returned to the room. - At 8:10 a.m. NA-C wheeled R194 out of the room. R194 was observed to be fully dressed and was wheeled into the dining area and left at a tablet. No fluids were poured or offered to R194. R194 remained at the table without fluids poured until 8:47 a.m. - At 8:47 a.m. NA-E poured a cup of coffee and placed it in reach of R194 and assisted another resident in the dining area. R194 reached out for the coffee one time, but did not make contact with the cup or take a drink. Although there was a pitcher of water on the table, no water was served to R194 and no assistance to drink the coffee was offered. NA-E stated R194 could not pour own fluids. The other residents at the table were brought their breakfast trays and a covered breakfast tray was served to an empty space across from R194. - At 8:50 a.m. NA-C stood next to R194 and assisted him/her to drink a sip of coffee. NA-C uncovered and placed R194's breakfast meal of pureed blueberry muffin, hash, eggs, a glass of milk, iced water, orange juice and a covered bowl of hot cereal on the table in front of R194 and left. R194 made no to attempt to initiate eating or drinking. - At 8:52 a.m. the blue mug was observed to remain unmoved on the bedside table, still contained the paper covering at the drinking end of the straw, the level of water in the mug was unchanged and the water mug remained warm to the touch (no ice). - At 8:54 a.m. R194 continued to look at the breakfast food and fluids and made no attempts to eat or drink. One staff (NA-E) remained in the dining area setting up the meal tray for the tablemate across from R194. R194's uncovered	2 940		

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2 940	Continued From page 63 food was untouched, the bowl remained covered, and no fluids were offered or consumed. - At 9:01 a.m. NA-C stood next to R194 and fed two spoons of food to the resident directly to the left of R194. NA-C verbally cued R194 to eat and handed R194 a small glass of orange drink. R194 sipped at the small glass of orange drink. NA-C fed another spoonful of food to the tablemate on R194's left, walked around the table, poured and offered coffee to the resident on R194's right. R194 held the glass of orange drink. - At 9:03 a.m. NA-D sat next to R194 on the right of the resident, uncovered the bowl of hot cereal, stirred the cereal and began to assist R194 to eat. NA-C sat to the left of R194 and at 9:04 a.m. NA-E sat on the other side of the table. NA-D assisted R194 to eat spoonful ' s of hot cereal and stated, "Open, open bigger" to the resident. R194 would not open their mouth to eat. NA-D encouraged fluids which R194 accepted and drank readily. - At 9:12 a.m. NA-D continued to encourage R194 to drink juice and left the table, went to a medication cart in the hallway. NA-D retrieved an orange and white colored carton, poured the fluid in a glass and brought it to the resident on R194's right. NA-D verbally encouraged R194 to continue to drink the orange drink. R194 hummed the song "Over There" and resisted eating spoonful ' s of food from NA-D, but continued to hold the glass while drinking. NA-D encouraged R194 to open their eyes. R194's eyes were observed to have dark circles around them and appeared sunken. NA-D and NA-E remained at R194's table. - At 9:20 a.m. NA-D stated to R194, "Drink your juice, it's medication for your sore heels." NA-D discussed with NA-E R194 potentially "throwing up." - At 9:23 a.m. NA-E assisted the other table	2 940		

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2 940	Continued From page 64 mates away from the table. - At 9:25 a.m. NA-D fed the resident to R194's right a bit of food, and then wheeled the resident out of the dining area to a lounge area across from the nursing desk. NA-D then returned to the dining area, went to a computer kiosk mounted on the wall directly behind R194 and began entering in information into the computer. R194 remained at the table. - At 9:28 a.m. NA-D continued to enter information into the computer. R194's legs were observed to be extended straight out in the wheelchair with the left foot rotated inward and the heels of both feet resting on the front edge of the foot pedal. - At 9:31 a.m. NA-D and NA-C adjusted R194's leg position and NA-C wheeled R194 to the lounge area directly across from the nursing station. NA-D returned to the dining area and began to place the soiled cover-up linens in a bag. A carton of Nutritional Juice Drink, Orange Flavored was observed amongst R194's glasses and was empty, all of R194's orange juice was consumed, a glass was observed to have pureed muffin mixed with milk and was half consumed, approximately 1/4 of the water and 1/4 of the coffee was consumed. NA-C stated the glasses held "120 cc (cubic centimeter)," stated R194 drank approximately "30 cc" from the other glasses and stated the carton contained the "orange juice" R194 had served. After reviewing the left over plate of food, NA-C stated R194 ate "25% of the meal." NA-C was unclear if R194 drank the orange drink, but confirmed R194 consumed approximately 120 cc of fluids. - At 10:00 a.m. R194 remained seated in the wheelchair at the nursing desk. R194 was observed to remain in the lounge area from 10:00 a.m. through approximately 11:50 p.m. without fluids offered. R194 was then transported to the	2 940		

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2 940	Continued From page 65 Celebration of Life activity off of the unit. On 1/30/13, at 12:17 p.m. R194's blue water mug was observed to be unmoved from the bedside table in R194's room with the paper covering still attached to the drinking end of the straw. The level of the water was unchanged, the mug was room temperature warm to the touch and there was no ice in the water. R194 was then observed to be seated at their table in the dining area. A full covered glass of milk was observed to already serve to R194. No other fluids were served. The milk was not uncovered or offered to R194. - At 12:21 p.m. NA-D stated he was "not sure" where R194 went after breakfast, and stated he believed R194 was "at therapy" and he believed "they [therapy staff] were working with [R194's] foot pedals." NA-D stated he notified the licensed practical nurse (LPN)-B about her pain (with movement of the leg after the breakfast meal) and stated LPN-B informed him R194 had received "a pain medication." - At 12:26 p.m. LPN-B stated she was not informed of R194 having pain after breakfast. LPN-B stated she was not sure if R194 was in therapies or if R194 was at an activity when the resident left the unit. LPN-B stated she would have offered R194 "prn [as needed] Tylenol [a mild analgesic]" if pain had been reported and confirmed no medications or fluids were offered to R194 since breakfast. LPN-B checked the computer on the medication cart and stated R194 was "due for Tylenol now." - At 12:28 p.m. R194 was observed to have a plate of food uncovered and served at the lunch meal. NA-E sat next to R194 and verbally cued R194 to eat. R194's mouth was observed to have a heavy buildup of debris on the teeth and tongue, R194's saliva was thick and white colored, the lips were observed to be dry and	2 940		

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2 940	Continued From page 66 R194 manipulated the mouth debris with his/her tongue. NA-E confirmed R194 had taken no bites of food or drank fluids and confirmed the above observation. - At 12:25 p.m. the director of therapeutic recreation (DTR) confirmed R194 attended the Celebration of Life activity after breakfast. The DTR stated no fluids or snacks were served to R194 and stated the Chaplin brought R194 back to the "lounge." - At 12:41 p.m. NA-E stated she did not give R194 any fluids except for breakfast and lunch. NA-E stated R194 had a "difficult time eating" and further stated, "She loves to drink fluids. She drinks and drinks and drinks fluids." NA-E gestured with her hands mimicking a cup and drinking motion (that R194 drank quickly and fast). - At 12:42 p.m. LPN-B stated she only gave R194 a supplement drink at 7:00 a.m. and stated it was mixed with R194's potassium medication. Although LPN-B stated she gave R194 a "10:00 supplement after breakfast," LPN-B could not recall the time the supplement was given to R194 and could not recall if R194 was in the dining room or in the lounge area when the supplement was given. LPN-B then stated the supplement was a "milk type supplement" and she thought the carton of supplement given to R194 by the NA staff "was for someone else." LPN-B stated several times, "I'm new to this unit. This morning was such a blur...I can't remember." LPN-B further stated R194 was "at risk for dehydration" and she had "noted a change" in her drinking and eating. LPN-B stated R194 was on an "I & O [intake and output]." - At 12:47 p.m. the Chaplin confirmed she transported R194 to the lounge area, stated she did not offer fluids or foods during the Celebration of Life activity or while in the lounge area.	2 940		

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2 940	Continued From page 67 R194's diagnoses included dementia, glaucoma and hypertension. The admission Minimum Data Set (MDS) dated 9/20/12, indicated R194 had severe cognitive impairment, required extensive physical assistance from staff to eat and drink, was frequently incontinent of bladder, had no swallowing problems and received a diuretic (a drug that promotes the excretion of urine) daily. The Care Area Assessments (CAA's) for falls and pressure ulcers dated 9/26/12, identified R194 had "advanced dementia," and used a diuretic. The MDS Notes for "VCAA12" (section V, CAA number 12, Nutritional Status) dated 9/26/12, identified R194 needed assistance at meals, used a diuretic and laxative which "may affect resident's appetite/P.O. [by mouth] intake." The MDS Note further indicated R194 was "At risk for wt. [weight] fluctuation, abnormal lab values, dehydration..." The MDS Note indicated, "Will proceed to Care Plan to monitor wt., hydration status, and P.O. intake of meals." The Nutritional Assessment Questionnaire dated 9/26/12, identified R194's average fluid intake was "~ [approximately] 221 ml/meal [milliliters per meal]" and estimated R194's daily fluid needs were 1600-1925 cc (25-30 cc/kg [cubic centimeters per kilogram] based on adjusted wt. of 141.1# [pounds])." The questionnaire indicated R194 required "staff assist for meals" and R194 would have a "variable P.O. intake of meals..." R194's ADL (activities of daily living) - Nutritional Needs questionnaire dated 10/5/12, consisted of a checklist which identified R194 required extensive assistance of one person to "Cue and encourage Resident to participate." The rest of the questionnaire including sections for food set up, eating aids, eating assistance techniques,	2 940		

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AUGUSTANA CHAPEL VIEW CARE CENTER	615 MINNETONKA MILLS ROAD HOPKINS, MN 55343

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2 940	Continued From page 68 special care needs and "Maintaining hydration" of the form was left blank. The quarterly MDS dated 12/12/12, indicated R194 had no changes in cognition, eating and drinking assistance, bladder continence, swallowing ability or diuretic use. The quarterly MDS indicated R194 had sustained a 5% weight loss in the past thirty days. R194's Nutritional Assessment Questionnaire dated 12/19/12, identified R194 received the medication "Lasix [a diuretic medication]," pertinent diagnoses and R194 had a 7.5 % weight loss in 90 days. The questionnaire indicated R194's average fluid intake was "~183 ml/meal [a decrease of 38 cc's per meal]" The Nutrition Support/Nutritional supplement section indicated to provide "120 cc Plus 2 [a nutritional supplement] BID [twice daily] - consuming 100%" as well as to provide a fortified cereal with fortified milk with all meals. R194's daily fluid needs were calculated as "1850-2225 cc (25-30 cc/kg based on current wt.)." The ADL - Nutrition and Hydration questionnaire dated 9/26/12, and 12/12/12, both listed nutritional interventions in checklist form. The "Maintaining hydration" section of the form had "encourage intake of fluids" checked. A Quarterly Nutritional Note dated 12/12/12, referred to the Nutrition Questionnaire on 12/6/12 for full nutritional assessment. "No new Diagnosis identified - see Nutritional Note 9/26/12 for diagnosis. P.O. intake of meals has decreased since last assessment. Plan to increase supplement frequency, continue with other nutrition interventions, follow monthly as nutritional high risk until wt. stable x3 months, and	2 940		

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2 940	Continued From page 69 follow prn." The Admission Nutrition Note dated 9/26/12, indicated R194's intake concerns were related to dementia and the intake was less than calculated needs. The 120 cc Plus 2 BID was started between meals and identified R194 as "at risk for dehydration,..." The assessment indicated to continue with current diet and to implement interventions as listed above, to schedule facility height and reweigh, and follow per facility protocol. On 1/30/13, at 1:40 p.m. NA-C confirmed R194's bed side water mug was not changed during the day shift and the water at the bedside was from "the night shift." NA-C stated he usually changed the water at this time, and stated he did not give R194 any fluids and when asked when staff should offer fluids, the NA stated "with snacks." NA-C further stated he thought the LPN gave R194 fluids between meals. On 1/30/13, at 1:50 p.m. R194 was observed in bed, the call light was in R194's right hand, the blue covered water mug with the straw with paper still on the drinking end, was observed to be out of R194's reach on the night stand. The water level was unchanged; the water was warm and had no ice. On 1/30/13, at 2:03 p.m. LPN-B confirmed the water mug was out of reach of R194 and stated she had "noticed it earlier." LPN-B and the surveyor observed R194's mouth which appeared moist. LPN-B stated R194 was observed to drink fluids at lunch, but confirmed the tongue was heavily cracked. LPN-B checked R194's skin turgor (a skin test used to determine potential signs of dehydration) and indicated "she has poor	2 940		

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2 940	Continued From page 70 skin turgor" and confirmed R194's eyes were "dark and sunken." LPN-B then stated R194 had "bad Glaucoma." During the observation with LPN-B, NA-C came into the room and replaced the water mug. The new water had ice in it, a straw and a paper sleeve at the drinking end of the straw. The old water mug was removed. On 1/30/12, at 3:30 p.m. LPN-B provided intake totals of for the morning and afternoon on a hand written slip of paper. The intakes were as follows: "Breakfast bites & 240 cc Lunch 25% & 240 cc Supplements 120 cc @ 0700, 60 cc @ 1000 Total fluid for day shift 660" On 1/30/13, at approximately 3:35 p.m. the clinical manager (RN)-A was notified of R194 potentially not receiving fluids between meals. RN-A verified fluids should have been offered to R194 throughout the day. Review of the clinical record indicated no monitoring of the total intake or output for R194 was initiated in the electronic medical record (EMR) until 1/30/13. The first amount documented on 1/30/13, indicated R194 drank "900 cc." The interdisciplinary team (IDT) Progress Notes indicated the following: - On 1/29/13, at 1:52 p.m. a note indicated it was "harder" for R194 to swallow "med's [medications]" and described the resident's behaviors of clenching their teeth and R194 stating they felt "like throwing up." - Notes from 1/24/13, at 2:27 p.m. indicated R194 was "harder to give her med's too" and required ice cream to take them. - On 12/27/12, at 10:52 p.m. "Resident alert,	2 940		

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2 940	Continued From page 71 stable, poor appetite for dinner fluid intake 200 cc." - On 12/13/12, at 10:24 p.m. "Resident had poor appetite for supper. Ate about 25% of her dinner. Medication was administered as scheduled. Was effective." At 1:44 p.m. a note indicated, "Resident has poor appetite. C/o [complained of] sour taste in the mouth, needs coaching to swallow med's especially the capsule. Primary MD notified and obtained orders for swallow and speech eval. and treat." - On 9/20/12, at 14:12 "Resident is very pleasant to work with. Cooperative with all her cares and taking med's. Appetite has been very good with good fluid intake." R194's care plan for Nutrition/Hydration dated 12/19/12, identified R194 was at risk for nutrition/hydration problems because R194 required assistance with meals and "multiple medical diagnoses" including "Dementia." The care plan identified R194 had a significant weight loss over 30 days on 12/12/12. The care plan goal for R194 was to be free from signs and symptoms of dehydration. The interventions section directed: "amount eaten a.c. (after meals), bed time snack at hour of sleep, provide a regular diet" and "Encourage intake of fluids." On 1/31/13, at 9:37 a.m. the registered dietician (RD) stated R194 was on the nutrition risk because of an "ulcer," and stated the ulcer was healed "as of Friday." The RD stated R194 was at risk for dehydration. The RD stated on a quarterly basis, she "took a look at" R194's intake and stated residents with thickened liquids were put on "I&O." The RD further stated, "I get an alert for less than 800 cc in a day [an email alert to the RD]. The RD confirmed R194 was not on one of these alerts and stated, "[R194] is now."	2 940		

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2 940	Continued From page 72 - When queried on how the RD would be notified if R194 had low fluid intakes, the RD stated, "Hopefully staff would notify me. [I] Met with staff earlier in the week regarding [R194] not chewing and just swallowing. So I alerted the nurse manager, and the speech therapist (SLP) and downgraded [R194's diet] puree. At the time [I] was not notified about [R194's] drinking at that point. Had not checked in with speech yet." - When asked how much fluids were provided to R194, the RD stated R194 was provided 1380 cc (without water) of fluids at meals as well as 8 ounces (oz) of fortified milk at all meals. The RD stated with water offered at the meal the total would be 1920 cc at meals, and R194 was offered a supplement total of 480 cc in a day. The RD stated R194's assessed daily fluid needs were 1800-2150 cc "based on current weight." - When the "Amount of Fluid Taken" information was reviewed, the RD stated R194's by mouth intake was "not good" and R194's fluid intake "fluctuated." The RD stated she did not see "good things" and the staff should have alerted her of the low fluid intake. "I would like them too [alert me]." The RD confirmed the 24 intake/output scheduled on 1/30/13, provided email alerts to the RD and stated R194's last labs were completed at the end of October. "We can request labs." The RD confirmed R194 was not on a hydration program, and stated if R194 where on a hydration program, the RD would have scheduled a suggested amount of fluids in the EMR. - The RD stated R194 should have been offered fluids sooner at the meals or had them "within reach to drink." The RD confirmed fluids should also have been offered "throughout the day" and stated the water placed at the bedside should have been in reach. The RD confirmed the fresh water mugs had ice in them when distributed to	2 940		

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2 940	Continued From page 73 the resident's bedside. On 1/31/13, at 10:51 a.m. the RD stated the average fluid intake per meal was 182 cc/meal over the last two months. The RD stated R194's supplement intake was almost 100% most times. The RD stated the calculated daily average fluid intake was 1026 cc per day. The RD confirmed the amounts were less than R194's estimated needs. The RD then stated the plan was to schedule 180 cc of fluids 5x/day to be offered and to be more accurate to see how much R194 was getting. The RD further stated R194 said "yes" to everything. On 2/1/13, at 7:44 a.m. R194 was observed to be lying in bed flat on his/her back, the blue covered water mug was out of reach and appeared full. R194 was observed to have a whitish colored thick sputum in the mouth and collected on R194's tongue. R194 smiled, showed the substance on the tongue. R194's lower and upper teeth were observed to be coated with a heavy buildup of whitish debris. When asked what the substance was, R194 stated, "I don't know." - At 7:47 a.m. LPN-C stated R194 "answers better" when in bed. LPN-C asked R194 about pain, the resident denied pain and held the medication. When LPN-C was alerted to R194's mouth debris LPN-C stated R194 was a "mouth breather," stated R194's "mouth was dry," stated R194 "usually had dryness" in the morning. - When asked if R194 could drink fluids if placed in reach, LPN-C stated R194 "will sometimes try to drink," and stated R194 was "sometimes" able to drink fluids without staff assistance. LPN-C stated R194 needed cuing to consistently drink. LPN-C confirmed the mug of water was out of reach of R194. - At 7:58 a.m. RN-A confirmed the presence of	2 940		

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2 940	Continued From page 74 debris in R194's mouth. RN-A confirmed R194's water glass was full and stated it should be offered to R194 by the night shift staff. RN-A initially stated the water was "just filled," but then confirmed the cup was warm and the water lacked ice. The blue mug was observed to have paper from the straw missing, the RN-A opened the mug and stated it was "nearly full." RN-A checked R194's skin turgor and stated the turgor response was less than one second and "good." RN-A stated he had "never seen how much debris" R194 had in his/her mouth in the morning and could not confirm if the amount of debris was "excessive." R194 was asked to open their mouth by RN-A and was observed to have a whitish yellow debris coating the bottom and top teeth, the tongue appeared dry, large pieces of the debris were observed to be coating the tongue on all sides and front to back of the mouth. R194 had the whitish debris and in the corners of the mouth. On 2/1/13, at 8:51 a.m. the physician for R194 was interviewed via telephone and stated R194 tended to retain fluids with due to congestive heart failure (CHF). The physician confirmed he was not informed of any hydration concerns and stated he would determine what labs to order based on "a facility report" such as a basic metabolic profile (BMP, a lab test which measured electrolyte levels in the body). The physician stated R194 was last seen by the nurse practitioner (NP) on 12/21/13. At 9:11 a.m. the MD stated the fluid requirements for R194 "may be less." The physician confirmed a lower amount of fluid intake was not discussed with the facility. At 9:19 a.m. the NP was interviewed via telephone and stated she "wasn't notified" by the RD or facility of R194's hydration concerns. The	2 940		

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2 940	Continued From page 75 NP stated, "I don't regularly follow [R194]" and stated she was "helping" the primary doctor. The NP stated she had discussed R194 with the MD before calling the surveyor and stated R194 does have a history of hyponatremia (low sodium levels). The NP stated R194's fluid needs "may be a little lower." The NP further stated, "I guess one thing would be checking a BMP." The NP confirmed there was no discussion with the facility regarding a fluid restriction prior to the phone call. The Augustana Care Corporation HYDRATION policy and procedure dated as revised on 10/2012, initially identified, "Policy: All residents will be provided with sufficient fluid* intake." The policy clarified, "Sufficient fluid is defined as the amount of fluid needed to prevent dehydration and maintain health in an individual." The procedure directed to identify risk factors for becoming dehydrated, such as but not limited to functional impairments that make it difficult to drink or reach fluids, dementia in which the resident "forgets" to drink or forgets how to drink, and "use of 9 or more medications including diuretics." The procedure further directed to keep water mugs next to the resident at all times unless contraindicated, assist and cue the resident to drink fluids frequently, and provide alternatives to the resident. The procedure directed to monitor the resident for dry skin and mucous membranes, cracked lips, as well as lab values. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise policies and procedures for evaluating residents at risk for dehydration and provide additional training to staff. A designated staff could monitor the system.	2 940		

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2 940	Continued From page 76 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 940		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the nasal	21390		

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21390	Continued From page 77 cannula oxygen (O2) tubing and nebulizer masks used for medication administration were stored in a sanitary manner to help prevent the potential transmission of disease or respiratory infection. This practice had the potential to affect 3 of 5 residents (R2, R41, R184) who used O2 and nebulizer. Findings include: On 1/28/13, at 11:45 a.m. the initial environmental tour was completed, and the following was observed: - In R2's room a nebulizer mask was observed facing down on the bedside table. The mask had streaks of yellowish matter and the tubing was not dated. - In R41's room a large O2 tank was observed by the window with two oxygen tubing's wrapped around the tank. One of the two nasal cannulas was observed to be lying directly on the top of the tank with the nare prongs (the part of the cannula which enters the nose) in contact with the dial used to set the O2 flow. The nare prongs of the cannula were soiled with a yellow matter. - In R184's room a large O2 tank was observed between the bed and window. Two sets of O2 tubing with nasal cannulas were observed to be hanging on the side of the O2 tank. The prongs if the nasal cannula were observed to touch the side of the tank. Both sets of O2 tubing were not labeled with the date when they were last changed. On 1/30/13, at 11:58 a.m. the licensed practical nurse (LPN)-A verified the O2 tubing used by R184 was not stored in sanitary manner and could not tell when the O2 tubing was initiated to be used. LPN-A explained oxygen and nebulizer tubing was changed weekly, and stated staff were	21390		

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21390	Continued From page 78 supposed to date them and usually they kept the nasal cannulas in a plastic bag to avoid contamination. On 1/30/13, at 12:05 p.m. the registered nurse (RN-B) did not know if there was a system in place for to storing the nasal cannulas when they were not in use or how often the O2 tubing was changed. RN-B verified R41's acknowledged the nasal cannula was soiled with nasal secretions, and verified the O2 tubing was not stored in sanitary manner on the O2 tank. RN-B stated R41 used the O2 only as needed, and R41 did not O2 for almost a month. The infection control nurse was not available for interview. On 2/1/13, at 2:26 p.m. the director of nursing (DON) stated staff were expected to change the O2 tubing weekly and label them with the date when changed. The DON further explained the nebulizer machine's tubing and mask needed to be changed weekly, and dated when changed. The DON stated the masks were rinsed after each use and air dried on a towel or paper towel. The Oxygen (O2) Administration policy dated 1/13, indicated "Humidifier bottles, tubing, cannulas, masks will be changed and labeled on a weekly (and PRN [as needed] basis) as scheduled on the treatment section of the resident's computerized care path." The Nebulizer Machine Cleaning policy dated 3/12 indicated after each use "1. Disconnect the oxygen tubing and set aside 2. Disassemble the nebulizer 3. Rinse each piece with warm water 4. Let air-dry on a clean paper towel or cloth". The policy also indicated "Change entire nebulizer cup	21390		

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21390	Continued From page 79 out weekly." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure resident oxygen tubing and nebulizer equipment was appropriately identified, cleaned and maintained. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21390		
21400	MN Rule 4658.0810 Subp. 1 Resident Tuberculosis Program Subpart 1. Pursuant to Minnesota Rule 4658.0040, and as defined in Minnesota Department of Health Informational Bulletin 09-02 Tuberculosis Prevention and Control Guidelines:Nursing Homes, Minnesota Rule 4658.0810 Subpart 1 Resident Tuberculosis Program is waived. Conditions of Waver: - All residents must receive baseline TB screening within 72 hours of admission or within 3 months prior to admission. TB Screening must include an assessment of the resident's risk factors for TB, and any current TB symptoms, and a two-step TST or a single interferon gamma release assay (IGRA) for M. tuberculosis (e.g., QuantiFERON ® TB Gold or TB Gold In Tube, T-SPOT ®.TB). Routine serial TB screening of residents may be done at the discretion of the infection control team.	21400		

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21400	Continued From page 80 - All reports and copies of resident tuberculin skin tests (TSTs), results from IGRAs for M. tuberculosis, medical evaluations, and chest radiograph results must be maintained in the resident's medical record. Consult current CDC recommendations for the diagnosis of TB for recommended follow-up of residents who display signs or symptoms of active TB disease. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure tuberculosis (TB) screening was completed according to the Centers for Disease Control (CDC) guidelines for 2 of 5 residents (R125 and R206) who were reviewed for TB screening. Findings include: The facility failed to assess/read the results of the first and second step of the tuberculin skin test (TST), also called Mantoux test for R206 and failed to assess/read the results of the second step of TST for R125. R206 was admitted to the facility on 10/23/12, and was given the first step TST on 10/23/12. The medical record lacked documentation that the result for TST was read to identify the degree of reaction for the test. The second step of the TST was administered on 11/7/12, however the	21400		

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21400	Continued From page 81 result was not read. R125 was admitted to the facility on 11/7/12, and was given the first step TST on 11/7/12, that was read "0.00 mm [millimeter] on 11/9/12. The second step TST was administered on 11/20/12, and the medical record lacked evidence that result was read to identify the degree of reaction for the test. The infection control nurse (ICN) was interviewed on 1/30/12, at 1:10 p.m. regarding the facility practices for administration and documentation of the TB testing. The ICN stated the TST test needed to be assessed/read 48-72 hours after it was given. The ICN reviewed R125's and R206's medical record, and verified that the second step of the TST test was not read for R125 and that both TST's were not read for R206. The ICN stated she was not aware R125's and R206's TST tests were not read. The facility's Tuberculosis Screening: Tuberculin Skin Test (TST) Procedure with revision date 05/12, indicated "The Mantoux skin test is read 48-72 hours after injection." the procedure also noted "Any test that has not been read after 72 hours is not valid-repeat test." SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could review and revise the current policies/procedures for screening of residents for TB including assessing for risk factors, screening for signs and symptoms of active TB disease, and correctly reading and documenting the results of the TST in the medical records. The DON or designee could educate the appropriate staff on the policies/procedures and the Quality Assurance committee could randomly audit records to	21400		

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21400	Continued From page 82 ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21400		
21525	MN Rule 4658.1305 A.B.C Pharmacist Service Consultation A nursing home must employ or obtain the services of a pharmacist currently licensed by the Board of Pharmacy who: A. provides consultation on all aspects of the provision of pharmacy services in the nursing home; B. establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and C. determines that drug records are accurately maintained and that an account of all controlled drugs is maintained. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents did not receive expired insulin. In addition, the facility did not properly date the insulin bottle with the date when it was opened to identify correct expiration date for 1 of 2 residents (R66) who received insulin during medication administration observations. Findings include: R66 had received multiple doses of expired insulin. On 1/30/12, at 8:29 a.m. during the morning medication pass, the registered nurse (RN-B)	21525		

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21525	Continued From page 83 prepared 15 units of scheduled Lantus insulin (used to treat diabetes) for R66 from the Lantus insulin vial. The insulin bottle was not labeled with a readable open date. The Lantus insulin was delivered from the pharmacy on 11/15/12. The RN-B was not able to read the date when the insulin vial was opened. When RN-B was questioned about the open vial insulin and the expiration date RN-B stated she did not know how many days the Lantus insulin was good for after it had been opened. The clinical manager/registered nurse (RN-A) walked by at that time, and stated he could not read the date when the Lantus insulin vial was opened. The RN-B proceeded to look for another Lantus insulin vial for R66 in the medication cart and medication room, confirmed there was no other Lantus vial in use for R66, and the insulin delivered on 11/15/13 was used for R66. The RN-A stated the Lantus insulin expired 28 days after opening, verified the pharmacy delivery date 11/15/12, and stated R66 might have received expired insulin for over a month. The physician's order last dated 1/17/13, indicated Lantus 15 units subcutaneously daily, with start date 11/2/12. During interview on 2/1/13, at 9:05 p.m. the director of nursing (DON) stated staff was expected to date the multi dose vials such as insulin with date when they were opened, follow the medication expiration guidelines. The DON further explained the table with different medication expiration guidelines was laminated and posted in the medication room for easy reference. During interview on 2/1/13, at 1:45 p.m. the consultant pharmacist (CP) stated the Lantus	21525		

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21525	Continued From page 84 insulin expired 28 days after opening, so date when opened was required. Per the CP if the open date was missed, or unreadable for some reason, staff supposed to consider as open date the pharmacy delivery date. The CP further explained that R66's Lantus insulin was considered expired on 12/13/12, and R66 received expired insulin daily from 12/13/12 until 12/30/12. The Lantus insulin package insert indicated the vial should be kept up to 28 days after initial use. The Pharmaceutical Administration Policy dated 3/12, indicated "Insulin vials will be dated when opened and replaced in 28 days from the date opened, or according to manufacturer ' s recommendation." The policy also indicated expired mediations were removed from storage area and destroyed according to policy. The undated Medication Storage and Expiration Guidelines policy indicated Insulin vials needed "date when opened", and the expiration date was "28 days after 1st use". SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise the policy and procedures for monthly pharmacy reviews and provide appropriate education for all involved staff. He/She could work with the Administrator to contract with a pharmacist to provide monthly reviews. The quality assurance committee could audit records to ensure compliance. The DON could review the policies and procedures for monthly pharmacy reviews. She/He could work with the pharmacist and the physicians to establish a system to ensure the reviews are acted upon in a timely manner.	21525		

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21525	Continued From page 85 TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21525		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required	21530		

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21530	Continued From page 86 by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility's consultant pharmacist failed to identify and report irregularities such as qualitative (target)behavior monitoring for ongoing use of psychotropic medications and parameters for as needed (PRN) medications; in addition, the consultant pharmacist failed to identify the lack of care planning for psychotropic, diuretic, pain and diabetic medications for 6 of 10 residents (R41, R184, R73, R67, R194, R189) in sample reviewed for unnecessary medications. Findings include: R41 took Risperdal without adequate monitoring. R41 was admitted to the facility on 1/11/11, with diagnoses to include dementia, anxiety, malaise and fatigue. The Physician Orders dated 1/7/13, noted an order for Risperdal 0.5 milligrams (mg) to be given daily at bedtime for Neuropathic condition. The Risperdal start date was 3/21/12. R41 also took Celexa (antidepressant) 40 mg daily for depression and lorazepam (antianxiety medication) 0.5 mg every six hours as needed for anxiety. R41 received Risperdal without adequate monitoring. During daily observations from 1/29/13 through 2/1/13, R41 appeared calm, pleasant, social, and	21530		

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21530	Continued From page 87 exhibited no agitation or anxiety. The annual Minimum Data Set (MDS) dated 11/14/12, noted R41 had no mood indicators or behaviors problems. The Care Area Assessment (CAA) dated 11/14/12, indicated R41 used psychotropic medications, there were measures in place for nursing to monitor for adverse side effects, social services to monitor behaviors and the pharmacist to review medications. The CAA indicated, "No adverse effects exhibited during this time." On 2/1/13, at 11:29 a.m. the licensed practical nurse (LPN)-B stated she did not know what target behaviors were monitored for R41's neuropathic condition and Risperdal use. The physician progress note dated 11/6/12, noted R41 had a history of "neurotic excoriation" and was on Risperdal for it. R41's Mood and Behavioral record for January 2013 and December 2012, indicated the target behavior "repeated requests to go to the bathroom with very short periods of time", and did not include monitoring of the excoriations. On 2/1/13, at 2:05 p.m. the registered nurse (RN) -B stated R41 used to scratch themselves and remembered that just few weeks before, R41 had a scratch on her hand, and three staff observed R41 scratching self. Observation of R41's skin on 2/1/13, at 2:10 p.m. revealed small skin abrasion on R41's right outer leg below the knee area. RN-B stated R41 scratched mainly her arms and hand. The RN)-A was interviewed on 2/1/13, at 2:35	21530		

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21530	Continued From page 88 p.m. and verified there was no target behavior monitoring in place for the Risperdal use to include R41's skin condition, excoriation, and scratching self. The monthly Consultant Pharmacist Reports dated 3/26/12 through 1/15/13 did not identify lack of target behavior monitoring for the ongoing use of the Risperdal. During interview on 2/1/13, at 1:47 p.m. the Consultant Pharmacist (CP) stated R41 took Risperdal for neurotic excoriations, acknowledged she have not identified lack of appropriate target behavior monitoring for the psychotropic medication use. R184 used Xanax for anxiety, however the facility did not monitor R184's anxiety status. R184 was admitted to the facility on 12/14/12 with diagnoses which included anxiety, rib fractures, depression and congestive heart failure. The physician's order sheet dated 1/10/13 noted an order for Xanax (antianxiety medication) 0.5 mg twice daily as needed (PRN) for anxiety. Review of the Medication Administration record indicated in January 2013, R184 took Xanax 5 times. There was inadequate documentation in the medical record of mood and behavior monitoring to indicate the need for the anti-anxiety medication. The Admission MDS dated 12/27/12, noted R184 had no mood indicators and had no behaviors. During daily observations from 1/29/13 through	21530		

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21530	Continued From page 89 2/1/13, R184 appeared calm, pleasant, social, and exhibited no agitation or anxiety. The care plan dated 1/2/13, did not indicate use of the Xanax, and did not identify non pharmacological interventions implemented when R184 exhibited signs and symptoms of anxiety, distress. During interview on 2/1/13, at 11:32 a.m. the LPN-B stated R184 requested to take Xanax when R184 felt anxious or when R148 had shortness of breath. During interview on on 2/1/13, at 10:15 a.m. the RN-A verified there was no target behavior monitoring in place for the Xanax use, and acknowledged lack of comprehensive care plan for anxiety. Per the RN-A the Consultant Pharmacist reviewed residents medications, and wrote recommendations, which than the facility staff acted upon. The monthly Consultant Pharmacist Report dated 1/22/13 did not identify lack of target behavior monitoring for the ongoing use of the Risperdal. During interview on 2/1/13, at 1:49 p.m. the Consultant Pharmacist (CP) stated R184 took Xanax for anxiety. The CP explained she usually gave a couple of days to staff while they worked on the care plan. When reminded that R184 resided in the facility for over a month and a half the CP stated she "missed identifying the lack of mood and behavior monitoring". The Pharmacy Consultant Services Policy with last review date 9/23/03, indicated the CP was responsible to "Complete, at least monthly, a drug regimen review as outlined by regulation for each	21530		

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21530	Continued From page 90 resident and report irregularities to the Director of Nursing Services and attending physician, and as necessary the Quality improvement Committee." The consultant pharmacist failed to identify the lack of resident specific target behavior monitoring for R73's medications of Lithium Carbonate (an antimanic medication used to stabilize mood), Remeron (an antidepressant) and Celexa (an antidepressant) In addition, the consultant pharmacist failed to identify the lack of care plan for the use of these medications. R73 had diagnoses to include diabetes mellitus, bipolar disorder and Parkinson's. The Physician Orders dated 1/7/13, indicated R73 received the following medications: - Lithium Carbonate (mood stabilizer) 450 milligrams (mg) oral (PO) tablet controlled release daily for diagnosis of bipolar disorder; - Remeron (an antidepressant) 7.5 mg PO at HS (hour of sleep) for the diagnosis of bipolar disorder; - Celexa 40 mg PO daily for diagnosis of bipolar disorder. Review of R73's care plan dated as effective from 1/11/13 to 4/18/13, indicated R73's ordered psychoactive medications of Lithium, Remeron and Celexa were not identified on the care plan. The care plan and clinical record lacked evidence of indications for the use of the medications, target behavior monitoring associated with the use of the medications. The care plan did not identify side effect monitoring and lacked direction for non-pharmacological interventions to address potential target behaviors.	21530		

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21530	Continued From page 91 R73's Medication Administration Record (MAR) for January 2013, indicated Lithium, Remeron and Celexa were administered daily as ordered. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R73's medication regimen. The consultant pharmacist stated she noted the labs for R73's Lithium levels were from the hospital and it was on her schedule to address the labs with the facility on her next visit. The consultant pharmacist confirmed a medication regimen of Lithium, Remeron and Celexa was appropriate for treatment of bipolar disorder. The consultant pharmacist verified the medications were not addressed on the care plan and stated she "hadn't gotten to them [antidepressant, antianxiety medications] yet." The consultant pharmacist failed to identify the lack of resident specific target behavior monitoring and the indications for use of R67's Effexor XR (antidepressant), Trazodone HCl (an antidepressant medication used for sleep), and as needed (PRN) Xanax (a short acting benzodiazepine). The consultant pharmacist failed to identify the lack of parameters for the use of the PRN Xanax. In addition, the consultant pharmacist failed to identify the lack of care planning for the medications Actos and Glucotrol XL (both medications used to treat diabetes) and Tegretol (antiseizure medication). R67's diagnoses included diabetes mellitus, depressive disorder, anxiety state, and insomnia. The Physician Orders dated 1/28/13, indicated R67 had the following medications ordered: - Effexor XR (antidepressant) 150 milligrams	21530		

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21530	Continued From page 92 (mg) oral (PO) extended release 24 hour capsule twice daily (BID). The orders directed, "Take with food may sprinkle on applesauce. Do not cut/crush/chew For Depression New order 9/9/11 OBTAIN CONSENT PRIOR TO ADMINISTRATION." - Tegretol (anti-seizure medication) 200 mg tablet PO daily (given at 8:00 a.m.) and 100 mg tablet PO Daily (given at 4:00 p.m.) for diagnosis of convulsions; - Trazodone HCl (antidepressant used for sleep) 50 mg tablet PO at HS (hour of sleep) and 25 mg as needed (PRN) one time "q [every] night if 50 mg scheduled dose is not effective" for the diagnosis of insomnia. - Actos (a drug to treat type two diabetes) 30 mg tablet PO daily for diagnosis of type two diabetes mellitus; - Glucotrol XL (a drug to treat type two diabetes) 10 mg extended release tablet PO daily; - Xanax (a short acting benzodiazepine) 0.25 mg table PO three times daily (TID) PRN for "Anxiety." The orders lacked parameters for when to administer the PRN medication. Review of the Medication Administration Records (MARs) for December 2012 and January 2013 indicated all R67's above scheduled medications were give as ordered. The PRN Xanax was administered seven times in December 2012 and twelve times in January 2013; the PRN Trazodone was given once in December 2012 and three times in January 2013. R67's care plan hand dated as effective 9/12/12 through 12/11/12, identified the above diagnoses as risk factors. Although the care plan identified "MOOD - Diagnosis of Depression with Anxiety State receives Antidepressant," the care plan lacked development to address risks associated	21530		

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21530	Continued From page 93 with the use of Effexor XR, Trazodone and Xanax. In addition, the care plan lacked resident specific target behavior monitoring for the efficacy of the medication, indications for the ongoing use of the medications and non-pharmacological interventions to address the target behaviors. In addition, the care plan did not address R67's use of diabetic medications or the use of antiseizure medications, including but not limited to the risks associated with the medications, potential side effects, types and frequency of seizures, monitoring to hyper/hypoglycemia and monitoring for efficacy of the medications. The care plan did not address R67's sleeping patterns, use of Trazodone for sleep, monitoring for sleep, as well as resident specific non-pharmacological interventions to promote sleep for R67. A consultant pharmacist recommendation dated 5/8/12, recommended a potential taper of the R67's Trazodone, the physician response on the same form indicated a clinical rational why not to taper the dose. A consultant pharmacist recommendation dated 9/13/12, recommended to check the Tegretol lab level, liver function and complete blood count (CBC) due to the R67 receiving Tegretol and Actos. The response section indicated the physician ordered labs to be completed on 1/28/13. On 1/31/13, at 2:43 p.m. the registered nurse (RN)-B and licensed practical nurse (LPN)-D both stated they did not update or change the care plans. RN-B stated a behavior note was written in the progress notes for R67. Both nurses confirmed the care plans did not address medications and verified the lack of parameters for the use of the PRN Xanax.	21530		

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21530	Continued From page 94 On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R67's medication regimen. The consultant pharmacist stated she thought the Xanax was "possibly" used for "tremoring" and confirmed the indication for use was anxiety. The consultant pharmacist stated on 3/2012, she requested a decrease of the Trazodone and the physician declined a reduction due to "panic attacks" and it was "coming up on a year" to determine if a reduction was warranted. The consultant pharmacist verified there were no parameters for the use of Xanax and verified the medications were not addressed on the care plan. The consultant pharmacist stated she "hadn't gotten to them [antidepressant, antianxiety medications] yet." When asked if she reviewed to determine if diabetic medications were care planned for, the consultant pharmacist stated, "I don't get involved with diuretics or insulin" and stated she "assumed" the facility knew they needed to be care planned. On 2/1/13, at 3:12 p.m. the nurse manager (RN) -A confirmed R67's medications were not addressed on the care plan. The consultant pharmacist failed to identify the lack of resident specific target mood monitoring and care planning for R194's Paxil (an antidepressant). The consultant pharmacist failed to identify the lack of care planning for the pain medications Neurontin (a drug used for treatment of neuropathic pain), Tylenol (a drug used to treat mild to moderate pain), Voltaren (a transdermal gel used to treat pain) and failed to identify the lack of care planning for Lasix (a diuretic medication). The consultant pharmacist failed to	21530		

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21530	Continued From page 95 identify parameters for the potential use of as needed (PRN) Voltaren. R194's diagnoses included depressive disorder, generalized pain, and idiopathic peripheral neuropathy. The Physician Orders dated 12/26/12, directed to give R194 the following medications: - Paxil 10 milligrams (mg) oral (PO) tablet daily for diagnosis of depressive disorder; - Lasix 30 mg tablet PO daily; - Neurontin 100 mg PO three times daily (TID) for idiopathic neuropathy; - Tylenol 1,000 mg PO four times daily (QID) for generalized pain; - Voltaren 2 gtts (drops) transdermal gel (jelly) one time as needed (PRN); On 1/30/13, the Physician Orders directed changes to R194's pain medications of: - Neurontin 200 mg PO TID (three times daily) for pain; - Tylenol 1000 mg PO TID for pain; Although R194 had the order for PRN Voltaren and had orders to increase pain medications, including the addition of the narcotic oxycodone, the PRN Voltaren lacked parameters for when to give the medication. R194's care plan dated 10/12/12, and 1/25/13, did not address the use of Paxil, did not identify the use of a Lasix, and did not identify the use of Neurontin, Tylenol, or Voltaren for pain. In addition, the clinical record lacked evidence of monitoring for the efficacy of the Paxil, did not address the potential side effects of the medications, did not address the risks associated with the use of the medications, such as the risks of dehydration with the use of Lasix, the risk of falls with the use of Paxil.	21530		

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21530	Continued From page 96 On 2/1/13, at 3:09 p.m. the registered nurse (RN) -B reviewed the care plan and confirmed Paxil and the above medications were not addressed in the care plan. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R194's medication regimen. When asked if the consultant pharmacist had noted Paxil was not care planned, the consultant pharmacist verified she was aware of the lack of care planning and stated she "hadn't gotten to them [antidepressant, antianxiety medications] yet." When asked if she reviewed to determine if other medications, such as a diuretic or pain medications were care planned, the consultant pharmacist stated, "I don't get involved with diuretics or insulin" and stated she "assumed" the facility knew they needed to be care planned. The consultant pharmacist failed to identify the lack of care planning for R189's use of Trazodone (antidepressant drug used for sleep). R189's diagnoses included insomnia. The Physician Orders dated 12/3/12, indicated R189 received the following medications: - Trazodone HCl 50 milligrams (mg) oral (PO) tablet every HS for the diagnosis insomnia; The Medication Administration Records (MARs) for January 2013, December 2012, and November 2012 indicated the above scheduled medication was administered as ordered. R189's checklist care plan for ADL Function/Rehabilitation dated 10/16/12, checked	21530		

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21530	Continued From page 97 that R189 received "Psychoactive Medication that impairs ability." Further review of the 10/16/13, checklist care plan and the care plan dated 1/23/13, indicated the care plans did not identify the use of Trazodone, lacked indications for the use of the medication, the risks associated with the use of the psychotropic medication, monitoring for efficacy of the medication. The care plan lacked development of non-pharmacological interventions to address the target behaviors, such as interventions to promote sleep or to address anxiety and delirium. On 2/1/13, at approximately 3:00 p.m. the licensed practical nurse (LPN)-B confirmed the clinical record lacked evaluation of R189's sleep patterns. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R189's Trazodone. When asked if the consultant pharmacist had noted Trazodone was not care planned, the consultant pharmacist verified she was aware of the lack of care planning and stated she "hadn't gotten to them [antidepressant, antianxiety medications] yet." SUGGESTED METHOD OF CORRECTION: The consultant pharmacist or designee could develop, review, and/or revise policies and procedures to ensure medication irregularities are identified and reported to the DON and the physician. The consultant pharmacist or designee could educate all appropriate staff on the policies and procedures. The consultant pharmacist or designee could develop monitoring systems to ensure ongoing compliance.	21530		

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21530	Continued From page 98 TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21530		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the medications were addressed on the care plan for 7 of 10 residents (R73, R67, R194, R189, R52, R41, R184). Findings include:	21535		

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21535	Continued From page 99 R73 received the medications of Lithium Carbonate (an antimanic medication used to stabilize mood), Remeron (an antidepressant) and Celexa (an antidepressant) without target behavior monitoring for the use of the medications. In addition, the facility failed to care plan for the use of these medications. R73 had diagnoses to include diabetes mellitus, bipolar disorder and Parkinson's. The admission Minimum Data Set (MDS) dated 1/7/13, indicated R73 had severe cognitive impairment and was identified to receive the following classes of medications: antianxiety, antidepressant and a diuretic. The Care Area Assessment (CAA) for Psychotropic Medication Use VO5 dated 1/11/13, consisted of a checklist which identified R73 used an "antianxiety" and "antidepressant" medication. Although the rest of the checklist was blank, the Analysis of Findings section of the CAA indicated, "Resident uses psychotropic medications daily. There are measures in place for nursing to monitor for adverse side effects and update MD [medical doctor], social services [SS] to monitor for behaviors and the pharmacist to review medication regimen." The section, "Document reasons care plan will/will not be developed:" indicated, "Monitoring of adverse side effects daily." The CAA lacked identification of the specific medications associated with antianxiety and antidepressant, lacked identification of the target behaviors being monitored for the use of these medications and was incomplete. The Physician Orders dated 1/7/13, indicated R73 received the following medications: - Lithium Carbonate 450 milligrams (mg) oral (PO) tablet controlled release daily for diagnosis of bipolar disorder;	21535		

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21535	Continued From page 100 - Remeron 7.5 mg PO at HS (hour of sleep) for the diagnosis of bipolar disorder; - Celexa 40 mg PO daily for diagnosis of bipolar disorder. Review of R73's care plan dated as effective from 1/11/13 to 4/18/13, indicated R73's ordered psychoactive medications of Lithium, Remeron and Celexa were not identified on the care plan. The care plan and clinical record lacked evidence of indications for the use of the medications, target behavior monitoring associated with the use of the medications. The care plan did not identify side effect monitoring and lacked direction for non-pharmacological interventions to address potential target behaviors. R73's Medication Administration Record (MAR) for January 2013, indicated Lithium, Remeron and Celexa were administered daily as ordered. On 2/1/13, at approximately 2:22 p.m. the facility's consultant pharmacist was contacted via telephone regarding R73's medication regimen. The consultant pharmacist stated she noted the labs for R73's Lithium levels were from the hospital and it was on her schedule to address the labs with the facility on her next visit. The consultant pharmacist confirmed a medication regimen of Lithium, Remeron and Celexa was appropriate for treatment of bipolar disorder. The consultant pharmacist verified the medications were not addressed on the care plan and stated she "hadn't gotten to them yet." On 2/1/14 at 3:04 p.m. the registered nurse (RN) -A confirmed the care plan did not include specifics, which included risks, target behaviors, non-pharmacological interventions and the indications for the use of the psychoactive	21535		

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21535	Continued From page 101 medications. R67 received the medications Effexor XR (antidepressant), Trazodone HCl (an antidepressant medication used for sleep), as needed (PRN) Xanax (a short acting benzodiazepine) without indications for the use of the medications. The clinical record lacked parameters for the use of the PRN Xanax. In addition, R67 received the medications Actos and Glucotrol XL (both medications used to treat diabetes) and Tegretol (anti-seizure medication) which were not addressed on the care plan. R67's diagnoses included diabetes mellitus, depressive disorder, anxiety state, and insomnia. The annual MDS dated 8/29/12, indicated R67 had moderate cognitive impairment and identified R67 received the following medications: an antipsychotic, an antianxiety and an antidepressant. The CAA for Psychotropic Medication Use V05 dated 9/5/12, consisted of a checklist which identified R67 received an antipsychotic, antianxiety and antidepressant medication. The checklist indicated R67 was at increased risk for falls, depression (from use of antipsychotic) and anxiolytics (antianxiety). The Analysis of Findings section indicated, "Potential for alteration due to side effects related to use of psychotropic medication daily. Resident admitted to CV [Chapel View] with Dx [diagnosis] of Depression & Sleep Disturbance. As well as Rx [prescription] treatment of Effexor XR Tegretol & Trazodone HS. No noted adverse side effects related to use of antidepressant. Measures in place for nursing to monitor side effects and update the NP [nurse practitioner]/MD." The Physician Orders dated 1/28/13, indicated	21535		

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21535	Continued From page 102 R67 had the following medications ordered: - Effexor XR 150 mg PO extended release 24 hour capsule twice daily (BID). The orders directed, "Take with food may sprinkle on applesauce. Do not cut/crush/chew For Depression New order 9/9/11 OBTAIN CONSENT PRIOR TO ADMINISTRATION." - Tegretol 200 mg tablet PO daily (given at 8:00 a.m.) and 100 mg tablet PO Daily (given at 4:00 p.m.) for diagnosis of convulsions; - Trazodone HCl 50 mg tablet PO at HS and 25 mg as needed (PRN) one time "q [every] night if 50 mg scheduled dose is not effective" for the diagnosis of insomnia. - Actos (a drug to treat type two diabetes) 30 mg tablet PO daily for diagnosis of type two diabetes mellitus; - Glucotrol XL 10 mg extended release tablet PO daily; - Xanax 0.25 mg table PO three times daily (TID) PRN for "Anxiety." The orders lacked parameters for when to administer the PRN medication. Review of the Medication Administration Records (MARs) for December 2012 and January 2013 indicated all R67's above scheduled medications were give as ordered. The PRN Xanax was administered seven times in December 2012 and twelve times in January 2013; the PRN Trazodone was given once in December 2012 and three times in January 2013. R67's care plan hand dated as effective 9/12/12 through 12/11/12, identified the above diagnoses as risk factors. Although the care plan identified "MOOD - Diagnosis of Depression with Anxiety State receives Antidepressant," the care plan lacked development to address risks associated with the use of Effexor XR, Trazodone and Xanax. In addition, the care plan lacked resident	21535		

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21535	Continued From page 103 specific target behavior monitoring for the efficacy of the medication, indications for the ongoing use of the medications and non-pharmacological interventions to address the target behaviors. In addition, the care plan did not address R67's use of diabetic medications or the use of anti-seizure medications, including but not limited to the risks associated with the medications, potential side effects, types and frequency of seizures, monitoring to hyper/hypoglycemia and monitoring for efficacy of the medications. The care plan did not address R67's sleeping patterns, use of Trazodone for sleep, monitoring for sleep, as well as resident specific non-pharmacological interventions to promote sleep for R67. On 1/31/13, at 2:43 p.m. the RN-B and licensed practical nurse (LPN)-D both stated they did not update or change the care plans. RN-B stated a behavior note was written in the progress notes for R67. Both nurses confirmed the care plans did not address medications and verified the lack of parameters for the use of the PRN Xanax. On 2/1/13, at 3:12 p.m. the RN-A confirmed R67's medications were not addressed on the care plan. R194 received the medication Paxil (an antidepressant) without care planning and monitoring for the efficacy of the medication. In addition, R194 received Neurontin (a drug used for treatment of neuropathic pain), Tylenol (a drug used to treat mild to moderate pain), oxycodone (a narcotic medication), Voltaren (a transdermal gel used to treat pain) and Lasix (a diuretic medication) without developing a care plan to address the use of these medications.	21535		

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21535	Continued From page 104 R194's diagnoses included depressive disorder, generalized pain, and idiopathic peripheral neuropathy. The admission MDS dated 9/20/12, indicated R194 had severe cognitive impairment and received an antidepressant and diuretic medication. The CAA for Psychotropic Medication Use V05 dated 9/26/12, consisted of a checklist which indicated R194 used an "antidepressant." The Analysis of Findings section of the form indicated, "Resident takes paxil [sic] for depression, there measures in place for nursing to monitor side effects and update the MD, social services to monitor behaviors and pharmacist to review medication regimen use." The Physician Orders dated 12/26/12, directed to give R194 the following medications: - Paxil 10 mg PO tablet daily for diagnosis of depressive disorder; - Lasix 30 mg tablet PO daily; - Voltaren 2 gtts (drops) transdermal gel (jelly) one time PRN; On 1/30/13, the Physician Orders directed: - Neurontin 200 mg PO TID for pain; - Tylenol 1000 mg PO TID for pain; - Oxycodone 2.5 mg PO q (every) six hours as needed (PRN) for pain. The orders lacked parameters for the use of the PRN medication. Such as when to administer Voltaren two drops transdermal Gel (jelly) and when to administer the PRN Oxycodone. R194's care plan dated 10/12/12, and 1/25/13, did not address the use of Paxil, did not identify the use of a Lasix, and did not identify the use of Neurontin, Tylenol, Oxycodone, or Voltaren for pain. In addition, the clinical record lacked evidence of monitoring for the efficacy of the Paxil, did not address the potential side effects of the medications, did not address the risks	21535		

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21535	Continued From page 105 associated with the use of the medications, such as the risks of dehydration with the use of Lasix, the risk of falls with the use of Paxil and Oxycodone. On 2/1/13, at 3:09 p.m. the RN-B reviewed the care plan and confirmed Paxil and the above medications were not addressed in the care plan. On 2/1/13, at approximately 2:22 p.m. the consultant pharmacist was contacted via telephone and stated the Paxil was for inappropriate sexual behaviors and stated she thought the Paxil was discontinued and changed to Zoloft. At 3:09 p.m. the RN-A confirmed the care plan did not address the above medications and confirmed the PRN medications for pain lacked parameters for use. R189 lacked indications for the ongoing use of Haldol (an antipsychotic), including target behavior monitoring and parameters for the as needed (PRN) use of Haldol. In addition, R189's care plan did not address the use of Trazodone (antidepressant drug used for sleep) or the use of Haldol. The significant change MDS dated 1/9/13, indicated R189 had moderate cognitive impairment, had no mood or behavior problems, and was given an antidepressant medication. The CAA for Psychotropic Medication Use V05 dated 1/16/13, checklist identified R189 used an antipsychotic medication, but failed to identify the use of an antidepressant medication as indicated by the MDS. The Analysis of Findings section of the form indicated, "Resident has depression,	21535		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 106 takes Trazodone. Measures are in place for adverse side effects to be monitored and reported to MD [medical doctor], pharmacist to review medication regimen." The section "Document reasons care plan will/will not be developed:" indicated, "Already in care path." The MDS assessment failed to identify the use of an antipsychotic medication, the CAA failed to identify the complete psychoactive medication regimen, such as the use of Haldol and PRN Haldol, the indications for the use of the Haldol, the use of Trazodone for sleep. A hospice order dated 11/27/12, directed to decrease the Haldol from 0.5 mg BID to 0.5 mg once daily at HS. "May continue PRN Haldol 0.5 mg every 6 hours as needed for breakthrough anxiety." The clinical record lacked evidence of the evaluation of breakthrough anxiety, such as the resident specific symptoms of breakthrough anxiety. The Physician Orders dated 12/3/12, indicated R189 received the following medications: - Trazodone HCl 50 mg PO tablet every HS for the diagnosis insomnia; - haloperidol lactate (Haldol) 0.5 mg tablet PO daily for "anxiety" and 0.5 mg concentrate PO every six hours PRN repeating for "delirium agitation." - On 12/31/12, R189 was discharged from the Hospice program for "no longer meeting hospice criteria." The Medication Administration Records (MARs) for January 2013, December 2012, and November 2012 indicated the above scheduled medications were administered as ordered. The November 2012 MAR indicated PRN Haldol was administered 16 times; the December 2012 MAR	21535		

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21535	Continued From page 107 indicated the PRN Haldol was administered five times; the last PRN dose given was on 12/9/12. R189's checklist care plan for ADL Function/Rehabilitation dated 10/16/12, checked that R189 received "Psychoactive Medication that impairs ability." Further review of the 10/16/13, checklist care plan and the care plan dated 1/23/13, indicated the care plans did not identify the use of Haldol or Trazodone, lacked indications for the use of the medications, the risks associated with the use of the psychotropic medications, monitoring for efficacy of the medications. In addition, the care plan and clinical record lacked evidence a target behavior, such as the resident specific symptoms of R189's delirium were identified and monitored. The care plan lacked development of non-pharmacological interventions to address the target behaviors, such as interventions to promote sleep or to address anxiety and delirium. On 2/1/13, at approximately 3:00 p.m. the LPN-B confirmed the clinical record lacked evaluation of R189's sleep patterns. On 2/1/13, the RN-A confirmed the findings and verified the care plan did not address the use of the medications. The Behavior/Mood Monitoring Record policy dated as revised on 8/12, indicated, "The Behavior/Mood Monitoring Record is used to ascertain the presence of, and the frequency of behavior and mood symptoms, for identifying resident care needs and implementing the plan of care." The procedure directed, "2) When a resident exhibits moods/behaviors and is on any psychotropic, antidepressant, antianxiety, or sleep aide, this must be monitored." The	21535		

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21535	Continued From page 108 procedure directed the mood/behavior record would be "initiated" by the nurse manager and directed the specifics for nursing staff to observe and document, such as the number of times, the number of interventions used to modify the behavior, and the results. The procedure directed to evaluate the behavior/mood data, complete a summary of the data including an analysis of the efficacy of the interventions. The procedure further directed, "If interventions are shown to be ineffective revision of interventions used are indication and to be implemented and documented on the resident's care plan, NAR [nursing assistant, registered] care sheet, and Behavior/Mood Monitoring Record." The Psychotropic Medication Monitoring policy dated as reviewed 1/2013, directed, "Psychotropic Medications will be monitored for appropriateness. Assessment of Psychotropic side effects will be done each shift by a licensed nurse." The procedure identified "unnecessary drugs," including: excessive dose, excessive duration, without adequate monitoring, and without adequate indications for use. The procedure further directed, "2. A care plan should be developed with the resident/family/caregivers/interdisciplinary team that maximizes patient function and well-being." R52 lacked adequate monitoring of behaviors to determine current status and develop adequate interventions. R52 received Seroquel (an anti-psychotic medication) for a diagnosis of depression with psychosis and anxiety. An annual MDS assessment, completed 10/24/12, indicated no behaviors and no change in behavior since the last assessment. Therefore, a CAA was not indicated for R52. However, an annual	21535		

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21535	Continued From page 109 assessment nursing note, dated 10/24/12, indicated R52 received an anti-psychotic medication for mood and behavior stability. The note indicated that staff was to monitor effectiveness of the medication and behaviors and update the attending physician as needed. Also, a pharmacy review was to be completed monthly and the care plan would be reviewed. On 2/1/13 at 2:30 p.m. social worker (SW)-A was interviewed. He indicated that the facility was initially tracking behaviors, for R52, of fear of leaving the room and mocking other residents. The medical record contained evidence of behavior charting for April-October of 2012. According to SW-A, they stopped monitoring due to the behaviors not happening. The medical record lacked evidence of monitoring of specific behaviors for R52 related to Seroquel use. SW-A indicated that to review R52's current behavioral status, he would go through note by note to determine if any behaviors had been documented. He went on to explain that the facility would discuss resident status three weeks prior to the MDS assessment date. He explained that they would go through progress notes to determine behaviors charted and that the behavior tracking was not in a consolidated area. The mood and behavior tracking during the annual MDS completed 10/24/12, was incomplete with only one day ' s worth of documentation. No documentation was provided for the for the following MDS assessment dated 1/13/13. On 2/1/13, at 3:00 p.m. trained medical assistant (TMA)-A indicated he was not aware of how to document behaviors for residents on psychotropic medications, but later found out that it would be completed through the care touch program. At	21535		

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21535	Continued From page 110 approximately the same time RN-A stated that she would write a summary note to document behaviors. On 4/16/12, the pharmacist indicated that R52 had been receiving Seroquel for depression and psychosis, although there was only one mention in the nursing notes of R52 feeling depressed and no mention of anxiety or other behavioral symptoms. Given the lack of psychotic or depressive symptoms, the pharmacist recommended a trial dose reduction of Seroquel. Furthermore, the pharmacist recommended updating the care plan in regard to adjustment to the new roommate as it had been four months since the roommate moved in. On 2/1/13, at 2:30 p.m. the pharmacist stated that the physician had addressed the Seroquel issue and had elected to not adjust the dosage due to long standing psych issues. The POC indicated a focus problem of repetitive health concerns, such as dizziness, related to psychosis and anxiety, a history of fear of leaving the room and frequent mocking of other residents. The goal was for R52 to take medications as ordered. Interventions were to write a behavior summary note and " help R52 with adjustment to floor and routine changes; re-direct from inappropriate behavior; provide cues and encourage participation; provide verbal reminders related to behavior; monitor attention seeking behavior and changes in cognition; and to speak calmly with simple terms. " R41 was admitted to the facility on 1/11/11, with diagnoses including dementia, anxiety, malaise and fatigue. The physician's orders sheet dated 1/7/13, noted	21535		

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21535	Continued From page 111 an order for Risperdal (an antipsychotic) 0.5 mg to be given daily at bedtime for neuropathic condition. The Risperdal start date was 3/21/12. R41 also took Celexa 40 mg daily for depression and Lorazepam (antianxiety medication) 0.5 mg every 6 hours as needed for anxiety. R41 took Risperdal without adequate monitoring. During daily observations from 1/29/13 through 2/1/13, the resident appeared calm, pleasant, social, and exhibited no agitation or anxiety. The Annual MDS dated 11/14/12, noted R41 had had no mood indicators, and had no behaviors. The CAA dated 11/14/12, indicated R41 used psychotropic medications, there were measures in place for nursing to monitor for adverse side effects, social services to monitor behaviors and the pharmacist to review medications. Per the CAA "No adverse effects exhibited during this time." When interviewed on 2/1/13, at 11:29 a.m. the LPN-B stated she did not know what target behaviors were monitored for R41's neuropathic condition, and Risperdal use. The physician progress note dated 11/06/12, noted R41 had a history of "neurotic excoriation" and was on Risperdal for it. The Mood and behavioral record for January 2013 and December 2012 indicated target behavior "repeated requests to go to the bathroom with very short periods of time", and did not include monitoring of the excoriations. The RN- B was interviewed on 2/1/13, at 2:05 p.m. The RN-B stated R41 used to scratch self,	21535		

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21535	Continued From page 112 and remembered that just few weeks before R41 had a scratch on her hand, and three staff observed R41 scratching self. Observation of R41's skin on 2/1/13, at 2:10 p.m. revealed small skin abrasion on R41's right outer below the knee area. Per the RN-B R41 scratched mainly her arms and hand. The RN-A was interviewed on 2/1/13, at 2:35 p.m. and verified there was no target behavior monitoring in place for the Risperdal use to include R41's skin condition, excoriation, and scratching self. R184 used Xanax, however, the facility did not monitor R184s anxiety status. R184 was admitted to the facility on 12/14/12, with diagnoses which included anxiety, rib fractures, depression and congestive heart failure. The physician's order sheet dated 1/10/13, noted an order for Xanax 0.5 mg twice daily PRN for anxiety. Review of the Medication Administration record indicated in January 2013, R184 took Xanax 5 times. The medical record lacked evidence of mood and behavior monitoring to indicate the need for the anti-anxiety medication, The Admission MDS dated 12/27/12, noted R184 had no mood indicators and had no behaviors. During daily observations from 1/29/13 through 2/1/13, the resident appeared calm, pleasant, social, and exhibited no agitation or anxiety.	21535		

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21535	Continued From page 113 The care plan dated 1/2/13, did not indicate use of the Xanax, and did not identify non pharmacological interventions implemented when R184 exhibited signs and symptoms of anxiety, distress. During interview on 2/1/13, at 11:32 a.m. the LPN-B stated R184 requested to take Xanax when R184 felt anxious or when R148 had shortness of breath. The LPN-B verified a mood/behavior record was not initiated to monitor R184's anxiety. During interview on 2/1/13, at 10:15 a.m. RN-A verified there was no target behavior monitoring in place for the Xanax use, and acknowledged lack of comprehensive care plan for anxiety. The Psychotropic Medication Monitoring policy with review date 1/2013, indicated "Behaviors/Moods are monitored by each shift on the Behavior/Mood Record. See policy #[number]1985." The Behavior/Mood Monitoring Record policy dated as revised on 8/12, indicated, "The Behavior/Mood Monitoring Record is used to ascertain the presence of, and the frequency of behavior and mood symptoms, for identifying resident care needs and implementing the plan of care." The procedure directed, "2) When a resident exhibits moods/behaviors and is on any psychotropic, antidepressant, antianxiety, or sleep aide, this must be monitored." The procedure directed the mood/behavior record would be "initiated" by the nurse manager and directed the specifics for nursing staff to observe and document, such as the number of times, the number of interventions used to modify the behavior, and the results. The procedure directed	21535		

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21535	Continued From page 114 to evaluate the behavior/mood data, complete a summary of the data including an analysis of the efficacy of the interventions. The procedure further directed, "If interventions are shown to be ineffective revision of interventions used are indication and to be implemented and documented on the resident's care plan, NAR [nursing assistant, registered] care sheet, and Behavior/Mood Monitoring Record." The Psychotropic Medication Monitoring policy dated as reviewed 1/2013, directed, "Psychotropic Medications will be monitored for appropriateness. Assessment of Psychotropic side effects will be done each shift by a licensed nurse." The procedure identified "unnecessary drugs," including: excessive dose, excessive duration, without adequate monitoring, and without adequate indications for use. The procedure further directed, "2. A care plan should be developed with the resident/family/caregivers /interdisciplinary team that maximizes patient function and well-being." Suggested method of corrections: The director of nursing and other members of the interdisciplinary team could ensure that target behaviors for all resident on psychotropic medications have been determined and are adequately monitored. Furthermore, the director of nursing could provide training for all staff on the importance of monitoring behaviors and completing required documentation. Time period for correction: 30 days.	21535		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must	21695		

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21695	Continued From page 115 provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure toilets in shared resident bathrooms were kept clean and free of stains. This practice had the potential to affect 12 of 12 residents (R186, R52, R19, R67, R110, R155, R98, R160, R146, R184, R147, R155) who resided in the rooms adjoining the shared bathrooms. Findings include: An environmental tour was held on 1/31/13, at 10:00 a.m. with the facility's director and the the director of housekeeping present throughout the tour. During the tour, three toilets on the 1st floor were observed to have dark streaking around the inside of the bowl and black debris under the rim on the inside of the toilet. The toilets were observed to be shared between two double occupancy rooms. At the time of the tour, the housekeeping director verified the toilets required cleaning to remove the stains and debris. The housekeeping director verified toilet cleaning was part of daily housekeeping. Suggested method of corrections: The director of housekeeping could review cleanliness of toilets on a periodic basis to ensure all daily cleaning activities are completed. Additionally the director	21695		

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21695	Continued From page 116 could provide training to staff on the cleaning standards for the facility. Time period for correction: 14 days.	21695		