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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VJ0V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00017

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245397**

2.STATE VENDOR OR MEDICAID NO.
(L2) **255822000**

3. NAME AND ADDRESS OF FACILITY
(L3) **HAVENWOOD CARE CENTER**
(L4) **1633 DELTON AVENUE**
(L5) **BEMIDJI, MN** (L6) **56601**

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 **01/31/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **90** (L18)
13.Total Certified Beds **90** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE NE II 03/06/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/06/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245397

March 6, 2018

Mr. Brandon Bjerke, Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

Dear Mr. Bjerke:

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 January 14, 2018 the above facility is certified for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered

March 6, 2018

Mr. Brandon Bjerke, Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

RE: Project Number S5397028

Dear Mr. Bjerke:

On December 22, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 27, 2017. (42 CFR 488.422)

On December 22, 2017 we recommended to the Centers for Medicare and Medicaid Services (CMS) informed the following enforcement remedy be imposed:

- Civil money penalty for the deficiencies cited at, F684, F686, F689. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on December 5, 2017. The most serious deficiency was found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On January 31, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on December 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 14, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on December 5, 2017, as of January 14, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective January 14, 2018.

However, as we notified you in our letter of December 22, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 5, 2017.

In addition, this Department recommended to the CMS Region V Office that the following enforcement remedy be imposed:

• Civil money penalty for the deficiencies cited at , F684, F686, F689. (42 CFR 488.430 through 488.444)

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VJ0V

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(L4) **1633 DELTON AVENUE**
(L5) **BEMIDJI, MN** (L6) **56601**

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3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/05/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

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03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
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To (b) :

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___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE - NE II 01/05/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/10/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 22, 2017

Mr. Brandon Bjerke, Administrator
Havenwood Care Center
1633 Delton Avenue
Bemidji, MN 56601

RE: Project Number S5397028

Dear Mr. Bjerke:

On December 5, 2017, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on December 3, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104 Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - REMEDIES

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

- State Monitoring effective December 27, 2017. (42 CFR 488.422)

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

- Civil money penalty for the deficiency cited at F684. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F686. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F689. (42 CFR 488.430 through 488.444)

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

SUBSTANDARD QUALITY OF CARE

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

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

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Havenwood Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 5, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 5, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 5, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245397	A. BUILDING _____ B. WING _____	12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD CARE CENTER	1633 DELTON AVENUE BEMIDJI, MN 56601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A recertification survey was conducted 11/28/17, through 12/5/17. An extended survey was conducted by the Minnesota Department of Health on 12/1/17, through December 5, 2017. The survey resulted in an Immediate Jeopardy (IJ) at F0689 related to the facility's failure to identify and remove a malfunctioning full body mechanical lift from use which placed 10 residents who resided on the Walnut Grove unit and utilized the lift at significant risk for falls and potential serious injury and/or death. The facility administrator and director of nursing (DON) were notified of the IJ on 12/1/17, at 1:30 p.m., which began on 10/26/17, when the full body lift was first noted to be faulty by the maintenance staff and was returned to the unit for resident use and was observed to malfunction again on 11/30/17. The IJ was removed on 12/3/17, at 5:31 p.m., however, non-compliance remained at a scope and severity level of E. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		1/14/18

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

Electronically Signed | 01/01/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245397	A. BUILDING _____ B. WING _____	12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD CARE CENTER	1633 DELTON AVENUE BEMIDJI, MN 56601

(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 561	Continued From page 1 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide a choice to continue participation in a music program to it's entirety for 1 of 1 resident (R53) who was observed to have staff attempt to remove him from a music activity prior to its conclusion, in which the resident resisted.	F 561	F561 Self-Determination R53 was provided choices up until his death on 12/26/2017. All other residents will be provided with choices.	

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	245397	A. BUILDING _____ B. WING _____	12/05/2017

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F 561	Continued From page 2 Findings include R53's Physician Order Report provided by the facility on 12/4/17, included diagnoses of dementia without behavioral disturbance, confusion, macular degeneration, and cataracts. R53's quarterly Minimum Data Set (MDS) dated 11/8/17, indicated R53 had severe cognitive impairment and demonstrated inattention and disorganized thinking during the assessment period. The MDS further indicated R53 required extensive assistance from one staff member for locomotion on and off the unit. R53's Communication Care Area Assessment dated 8/15/17, indicated R53 rarely made self understood, was rarely able to understand others, and was at risk for behaviors, frustration, and unmet needs, along with decreased self-image and increased confusion. The CAA indicated staff would anticipate R53's needs. R53's care plan dated 8/23/17, indicated R53 required staff assistance to ambulate and wheelchair mobility. The plan directed staff to: - provide information from the activities calendar for opportunities to participate in activities. - assist R53 to be ready for and to take R53 to desired activities that included music events. -to explain all procedures prior to doing them. On 11/30/17, at 8:59 a.m. R53 was observed calmly seated in his wheelchair in the activity room listening to a piano player and singing. R53 was seated towards the middle of the room facing away from the performers while six to eight other residents sat directly in front of the performers.	F 561	All staff will be educated prior to 1/14/18 regarding providing choices to all residents. Education will include the choice to continue participation in activities until resident is ready to leave. The facility□s policy titled Resident Preferences and Choices was reviewed and revised on 1/1/18. Audits will be completed three times weekly, for 90 days, by the Activities Director to ensure residents are provided choices, specifically the choice to stay or leave an activity. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Activities Director is responsible for compliance with this regulation. Completion Date: 1/14/18	

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F 561	Continued From page 3	F 561		

-At 9:03 a.m. while the activity was in progress, activity aide (AA)-B walked up to R53, greeted him, and put R53's feet up onto the wheelchair foot peddles without explaining her intent. Once R53's feet were on the foot peddles, AA-B started to push R53's wheelchair out of the room, however, R53 put his feet back on the floor. AA-B informed R53 his feet needed to go back onto the peddles so he could be taken out of the activity room. AA-B placed R53's feet back onto the peddles and again attempted to push R53 out of the activity room, however, R53 again put his feet down onto the floor. AA-B put R53's back onto the peddles, informed R53 he was going to be escorted out of the activity room in which R53 again planted his feet onto the floor at which time AA-B asked R53 if he wanted to stay and listen to the music. R53 stated "YES." AA-B proceeded to wheel R53 over to a near-by table, sat next to R53, and placed Lincoln logs in-front of him.

-At 9:21 a.m. AA-B stated she was taking R53 out of the activity before it was finished because he was at risk for falls and could not be left alone. AA-B stated there was no one else to watch him while she helped other residents out of the program. AA-B stated R53 was always taken out of activity programs first regardless of his choice because of his need for staff supervision, however, residents that did not have safety concerns were allowed to stay through the entire activity. AA-B stated she had not attempted to find another staff member to provide assistance.

-At 1:42 p.m. R53's family member (FM)-C stated R53 loved to listen to music and really liked piano music. FM-C knew that staff had always removed R53 first from the activity but expected staff to offer R53 a choice to stay or leave the activity and

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F 561	Continued From page 4 not remove him, especially if he was enjoying it. On 12/1/17, at 7:17 a.m. licensed practical nurse (LPN)-D stated the nursing staff helped bring residents down to activities, and then activity staff would return the residents to their units. -At 8:52 a.m. the activity director (AD) confirmed R53 was not to be left unsupervised during the activity, however, was not aware R53 was always removed first from music activities due to the availability of staff assistance. AD stated R53 should have been given a choice to remain at the music activity as other options were available to maintain the supervision. On 12/4/17, at 8:56 a.m. director of nursing (DON) stated the activity aide should have asked R53 if he was ready to leave the activity and could have called someone else to stay with him or assist with escorting other residents so that R53 could stay through the entire music program. Facility policy was requested and not received.	F 561		
F 570 SS=C	Surety Bond-Security of Personal Funds CFR(s): 483.10(f)(10)(vi) §483.10(f)(10)(vi) Assurance of financial security. The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the surety bond contained sufficient funds to insure and protect the residents' trust fund which had the potential to	F 570	F570 Surety Bond □ Security of Personal Funds The surety bond active 5/1/17 to 5/1/19	1/5/18

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F 570	Continued From page 5 affect 49 of 71 residents who kept personal funds with the facility. Findings include: The facility Residents Trust Fund Report, dated 11/30/17, noted the current balance of the fund at $13,823 dollars. The facility's surety bond (legally binding contract protecting the trust fund), active from 5/1/17, to 5/1/19, contained a sum of $10,000 dollars. A sum which was inadequate to cover the current amount of the resident trust fund. During interview on 11/30/17, at 11:42 a.m. business office associate (BOA) acknowledged the surety bond was not enough to cover the current money in the trust fund. The BOA stated to be safe, the facility should have increased the amount of the surety bond, and proceeded to send an email directing to increase the surety bond's amount. The BOA further stated the surety bond was renewed every two years and the amount of the bond was not checked against the amount of the trust fund. The BOA stated the facility did not have a policy on the surety bond.	F 570	contained a sum of $10,000 whereas the current balance in the fund was $13,823. Effective 11/30/2017 the surety bond was increased to $20,000. A surety bond policy was created on 1/1/18. The business office manager will complete monthly audits, for 90 days, to ensure that the resident trust fund balance does not exceed the amount of the surety bond. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The business office manager is responsible for this deficiency. Corrective Date: 1/5/18	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		1/14/18

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F 578	Continued From page 6 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an advance directive was updated to reflect resident participation and current wishes for 1 or 1 resident (R30) who had a POLST (physician orders for life sustaining treatment).	F 578	F 578 Request/Refuse/Discontinue Treatment; Formulation Adv Dir R30□s POLST document will be reviewed and revised prior to 1/14/18 to ensure it reflects his wishes.	

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F 578	Continued From page 7 Findings Include: R30's annual Minimum Data Set (MDS), dated 10/2/17, indicated R30 had no cognitive impairment and had diagnoses of cerebral vascular accident (stoke), mental retardation, and received hemodialysis. R30's POLST (a form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive) signed 4/17/14, by his power of attorney (POA), indicated he wished to be a full code, wanting cardiopulmonary resuscitation (CPR) attempted. The POLST further indicated R30 wanted a trial of intubation attempted, IV (intravenous) and IM (intramuscular) antibiotics, IV fluids administered, and to consider tube feedings in the future due to failing health. The POLST identified R30's POA should be contacted for healthcare decisions, and directed, "A new POLST should be completed when the patient's treatment preferences change." A hospital Admission History and Physical, dated 8/25/15, identified R30 had been hospitalized after passing out during dialysis. During the hospitalization, R30's code status was discussed with his POA and the decision was made to change R30's code status to DNR (do not resuscitate, no CPR and no intubation). R30 returned to the facility on 8/27/15, with new orders for the DNR code status.	F 578	All other resident□s with POLST documents will be reviewed and revised as needed to ensure they match their current wishes prior to 1/14/18. Education will be provided to all charge nurses prior to 1/14/18 regarding the importance of checking POLST documents to ensure they reflect both the resident□s wishes and the physicians order. The facility□s hospital return checklist was also reviewed and revised on 12/11/17 to assure the code status order matches our previous code status form and if there are changes it includes directions on how to make changes to this document. The facility□s policy regarding Advanced Directives was reviewed and revised on 12/11/17 to include direction on updating the POLST/or any advanced directives with changes in condition as well as re-assessing advanced directives quarterly or per resident/family wishes. Audits will be completed on advanced care directives two times weekly, for 90 days, by the Director of Nursing or designee to ensure accuracy of advanced care directives. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance	

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F 578	Continued From page 8 R30's last Care Conference Review, dated 10/11/17, indicated R30 and his family attended, and his code status was DNR. There was no indication his POLST was discussed during the conference. R30's current medical record and face sheet, printed 11/29/17, identified the DNR (do not resuscitate) status. There was no documentation in R30's medical record indicating his POLST had been updated to include the change. During interview on 11/29/17, at 4:35 p.m. registered nurse (RN)-B stated R30's POLST came with him when he was originally admitted, but the code status had been changed after he was hospitalized in August of 2015. RN-B stated the admitting nurse usually had a conversation with the resident or family upon return to the facility to inquire if the code status had changed and the code status was also discussed during care conferences. However, only herself and the director of nursing (DON) were trained in completing the POLSTs, noting the admitting nurse was not trained in the POLST documentation. RN-B stated R30's change in directive should have been communicated so that R30's POLST could have and should have been updated to include the change in code status. During interview on 11/29/17, at 7:15 p.m. R30 stated he attended his care conferences and his brother (his POA) helped make hard healthcare decisions. R30 stated he and his brother had discussed CPR and he did not want it attempted. R30 could not remember the facility talking about his wishes, however, stated he was sure the facility would talk to him about tube feedings and	F 578	Committee will determine further auditing needs. The Director of Nursing is responsible for this deficiency. Corrective date: 1/14/18	

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F 578	Continued From page 9 such closer to the time he would need them. During interview on 12/1/17, at 12:02 p.m. the DON stated R30's POLST was missed and was still marked as full code. The DON stated advance directives should be reviewed quarterly at care conferences with the resident and family, and confirmed R30's POLST should have been changed with the change in condition. A facility policy entitled, Resuscitation Policies and Procedures, reviewed 4/15, identified resuscitation orders would be discussed upon admission with the physician and family/resident. The policy further indicated, if a resident was admitted with a living will (a type of advance directive), the physician would be notified for review before accepted into the medical record. The policy lacked any direction on updating the POLST/or any advanced directives with changes of condition or periodically re-assessing advance directives for resident/family wishes.	F 578		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);	F 580		1/14/18

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F 580	Continued From page 10 (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a physician was notified of a change in condition for 1 of 1	F 580	F 580 Notify of Changes R28□s physician and responsible party	

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F 580	Continued From page 11 resident (R28) who had developed, fever, vomiting and decreased lung sounds. The facility's failure to contact the physician resulted in actual harm for R28 who required hospitalization for pneumonia, sepsis and dehydration. In addition, the facility failed to notify the physician of the development and/or worsening of a pressure ulcer for 2 of 3 residents (R58, R54) reviewed for pressure ulcers, and failed to notify the physician of the increase in lower extremity edema with the development of a ruptured blister and weeping skin for 1 of 2 residents (R58) reviewed for non-pressure related skin conditions. Findings include: R28's physician was not notified of a change of condition. R28's quarterly Minimum Data Set (MDS) dated 10/2/17, indicated R28 had diagnoses of Alzheimer's dementia, aphasia (inability to speak), and a stroke. R28 was not able to communicate or make decisions on her own. The assessment indicated R28 was totally dependent upon staff for all activities of daily living. On 11/29/17, at 12:50 p.m. family member (FM)-A and FM-B requested to speak to the State agency surveyor regarding a concern. FM-B stated FM-A and FM-B had been out of town in June 2017, and upon returning home, had stopped at the facility to see R28. When they arrived at the facility, they found R28 with a high fever, she was lethargic and unable to drink. They approached registered nurse (RN)-D, the charge nurse, and requested to have R28 seen in the emergency department, however, RN-D refused to assist the	F 580	has been updated regarding any changes in condition. R58□s physician was notified of the worsening of her wound on 11/30/17. R58 passed away on 12/01/17. R54□s physician was notified on 11/23/17 of the development of the pressure ulcer on her bottom. R54□s responsible party has been notified of changes in condition as well. All other resident□s physicians and family/responsible party will be notified of changes in condition as they occur. Education was provided to RN-D. All other charge nurses will be educated prior to 1/14/18 regarding the importance of notifying physicians and family/responsible parties with resident changes in condition. The facility□s policy regarding Resident Incidents/Change In Resident Health Status was reviewed and revised on 12/11/17. The facility□s policy titled Pressure Ulcers in Long Term Care will be reviewed and revised prior to 1/14/18. The facility□s Skin Care Protocol Policy was reviewed and revised on 12/30/17. Audits will be completed three times weekly, for 90 days, on resident progress notes by the Director of Nursing or	

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F 580	Continued From page 12 family with transportation to the hospital. FM-B stated RN-D told them that R28's primary physician had ordered an antibiotic earlier that day and R28 was not to go the hospital for an evaluation. When requested again by the family, RN-D refused to contact the physician again or to assist in transferring R28 to the hospital. FM-A became tearful as FM-B stated an unidentified staff member obtained the phone number for the transportation company so that R28 could be transported to the hospital. FM-B contacted the transportation company and had R28 transferred to the emergency room without assistance from the facility. While at the hospital, R28 was diagnosed with sepsis (a life-threatening illness caused by your body's response to an infection) and subsequently required a three day hospitalization for intravenous therapy (IV). FM-B stated the emergency room physician informed the family that if R28 had not been started on IV therapy that day, she would have died by morning. FM-B stated she had reported the concern to the facility administrator, however, the administrator supported the actions of RN-D. Review of R28's Progress Notes revealed the following information: -On 6/20/17, at 3:35 p.m. indicated R28 had experienced an emesis prior to lunch, R28's temperature was noted to be 101.0 degrees Fahrenheit (F). R28 had another emesis at lunch and R28's temperature was "around 102" degrees F. After lunch, R28 was noted to have wheezes (whistling or rattling sound in the chest, as a result of obstruction in the air passages). R28's primary physician was called and an antibiotic was ordered for twice a day for ten days for possible aspiration (entry of material from the	F 580	designee to ensure resident□s physicians and family/responsible parties are notified of changes in condition. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing is responsible for this deficiency. Corrective date: 1/14/18	

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oropharynx or gastrointestinal tract into the larynx (voice box) and lower respiratory tract).

-At 4:59 p.m. indicated R28's temperature at 2:20 p.m. was 100.9 degrees F. R28 was lethargic, skin was hot and moist to the touch, cheeks were red and R28 was only taking sips of fluids. Will continue to monitor.

-At 5:01 p.m. indicated R28's temperature was 101.6 at 3:00 p.m. and was given Tylenol. R28 was seated in wheelchair, and received the first does of the antibiotic. FM-A and FM-B had requested R28 be evaluated in the emergency room. The charge nurse was informed of the request.

-At 5:07 p.m. RN was called down R28's unit. "Husband looks angry" when RN walking towards him. FM-A and FM-B both requested to have R28 sent immediately to the hospital. FM-B had stated to the RN "just look at her." RN explained to FM-A and FM-B that R28's physician had ordered resident to stay at facility and had also ordered an antibiotic to be started for possible aspiration. FM-A stated he did not care what the physician had ordered or said. RN informed FM-A and FM-B that if they wanted R28 sent to the hospital that it was their choice and they had every right to do so but she would not be arranging rides or taking part of the situation due to having no doctor's order. The note further indicated the RN attempted to explain to FM-A and FM-B the reasoning for keeping R28 at the facility was due to the hospital or emergency room (ER) not doing anything more that what the facility was currently doing for R28 "here and now." FM-B had questioned R28's breathing and oxygen in which the RN indicated R28's oxygen level was 91%

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and that she would receive oxygen if her levels went below 90%. FM-A became angry, red in the face, pointing finger, and hollering at the RN. RN called the ER charge nurse to give a "little heads up" on the situation. The note lacked evidence an assessment of R28's condition was completed at the time of the family request and also lacked evidence of any attempts to contact R28's primary physician or an "on call" physician regarding the family's wishes.

-6:01 p.m. R28 left facility via MediVan. RN notified the ED that the resident was on her way with family.

-9:41 p.m. RN received call from the ER which informed the facility R28 was "really sick," was started on an intravenous antibiotic, had a nasogastric tube inserted, and R28 was septic therefore was admitted to the hospital.

Review of R28's Physician's Orders dated 6/20/17, included an order for Augmentin (antibiotic) 875-125 milligrams twice a day for ten days. The orders did not direct the staff to keep R28 at the facility and not to refrain from hospital transfers.

R28's Uniform Code Level Direction for Cardiopulmonary Resuscitation form dated 5/16/13, indicated the family had determined that no interventions were to be made in the event of a cardiac or respiratory arrest. Other conditions were to be treated as medically appropriate. The family had not restricted any other medical treatments in the event of an emergency. They had not refused further hospitalizations.

The Hospital Triage Chief Complaint

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documentation dated 6/20/17, indicated R28 arrived at the emergency room with family complaints of fatigue. Family reported when they arrived at the facility, R28 was observed hanging over the side of her chair with her tongue hanging out. R28 was not responding to family and her tongue was white and dry appearing. R28 had recently been treated for pneumonia and had been vomiting.

The Emergency Room note dated 6/20/17, indicated R28's white blood count was elevated to 29.400 (normal number of WBCs in the blood is 4,500 to 11,000 a high number indicates the body's reaction to fight infection). R28 was admitted to the hospital with a diagnosis of pneumonia.

The hospital Progress Note dated 6/22/17, indicated R28 had diagnoses of aspiration pneumonia and mild dehydration.

R28's Hospital Discharge Summary dated 6/23/17, indicated R28 required hospitalization for the provisional diagnosis of aspiration pneumonia with sepsis and clinical dehydration. R28 received IV fluids and antibiotics, her temperature had returned to normal, she was alert and was able to swallow food comfortably. R28 was to continue on oral antibiotics for a total of 10 additional days.

On 12/1/17, at 7:10 a.m. LPN-D stated if a family member requested a resident to go to the hospital, she would check on the resident, notify the charge nurse, and make arrangements to assist to transfer the resident to the hospital.

On 12/1/17, at 7:30 a.m. RN-A stated if a family

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member requested to send a resident to the hospital, the resident was to be assessed, a physician (either the resident's primary physician or the "on call" physician) was to be contacted and the facility staff were to assist with the transfer. RN-A stated she was aware of the concern on 6/20/17, with R28's family request to be transferred to the hospital. RN-A stated ultimately R28 was seen in the hospital and admitted and verified it was the family's right to have the resident seen in the emergency room if they wished.

On 12/1/17, at 8:22 a.m. RN-B stated if a family member wished to have a resident seen in the emergency room, the staff were to complete an assessment, contact the primary physician or "on call" physician and obtain an order to transfer the resident to the hospital for further evaluation per the family request. RN-B stated R28 had a history of aspiration pneumonia and on 6/20/17, R28 was started on an oral antibiotic due to possible recurring aspiration. RN-B stated R28 had not been physically evaluated by the primary physician on 6/20/17, rather due to the physician knowing R28's history or aspiration pneumonia and previous treatments, and R28 having been recently treated with an antibiotic for aspiration pneumonia, R28's physician had instructed the facility to treat R28 at the facility, had ordered an antibiotic and requested to not send R28 to the emergency room. RN-B confirmed the instructions to refrain from hospital transfer/evaluation had not been written as a physician's order in R28's medical record. R28's primary physician and the family had discussed hospitalizations in the past and there was a verbal agreement to treat R28 at the facility versus in the acute hospital. RN-B stated she had attempted

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to contact R28's family on 6/20/17, to notify them of her deterioration however, she was unable to reach the family and did not document her attempts to contact the family in R28's record. Upon review of the 6/20/17 documentation, RN-B stated it would have been beneficial for RN-D to have completed an assessment of R28's condition, contact a physician and assist to transfer R28 to the emergency room per the family request.

-At 8:52 a.m. the director of nurses (DON) stated if a family member wished to have their loved one evaluated by the emergency room physician, the staff were to assess the resident, contact a physician and assist to make the arrangements to transfer the resident to the hospital. The DON stated she would not expect the staff to refuse to transfer a resident when the family requested.

-At 8:56 a.m. RN-C stated if a family member requested to have their loved one transferred to the hospital, she would complete a resident assessment, contact the primary physician or the on call physician, and make the arrangements to transfer to the hospital.

-At 9:03 a.m. the DON stated R28's primary physician was notified of R28's vomiting, fever and wheezes on 6/20/17, and had ordered R28 a new antibiotic. R28's primary physician prefers the residents of the facility to be treated in the facility and staff were to inform him of any changes. The DON confirmed R28's medical record did not contain a physician's order to refrain from hospitalizations and stated it was an understating between the primary physician and the facility to refrain from hospitalizations. The DON confirmed RN-D's documentation lacked an

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assessment of R28's condition on 6/20/17, and verified RN-D did not attempt to notify a physician of any potential changes in R28's condition.
Upon review of the progress note dated 6/20/17, at 6:01 p.m. the DON stated she was unaware the documentation clearly indicated RN-D refused to assist FM-A and FM-B to transfer R28 to the emergency room for an evaluation and stated that was not the facility's normal practice. The DON stated she had talked to RN-D about the actions on 6/20/17, and directed RN-D and the rest of the staff to assist with transfers to the hospital per the family choice. However, the DON stated she had not documented the directive nor had she provided any type of formal training to the staff rather during shift to shift report, she had directed the staff to remind each other to follow family requests. The DON stated she had not considered R28's response to requested care on 6/20/17, to be neglectful.

-At 9:21 a.m. the DON and state agency attempted to contact RN-D without success.

-At 9:49 a.m. the facility administrator reviewed RN-D's documentation from 6/20/17, at 5:07 p.m. and stated he was unaware RN-D had not assessed R28 at the time of the family request, had refused to contact a physician, or assist the family in transferring R28 to the hospital. The administrator confirmed R28's physician should have been notified of R28's change of condition, however, had not considered the lack of response to R28's family request or lack of further assessment related to R28's decline in condition to be neglectful.

On 12/4/17, at 4:00 p.m. RN-D stated it was her understanding R28 had been started on a new

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antibiotic and she was not to be sent to the emergency room as they could not do anything differently than what was being done at the facility. RN-D confirmed R28's medical record did not contain a physician's order to refrain from hospital evaluations. RN-D stated on 6/20/17, when FM-A had requested R28 be sent to the emergency, FM-A was angry and threatening towards her so she had to walk away from the situation. RN-D stated she did not feel she had the time to assess R28 or to help with the transfer as the family had already made the arrangements and left with R28. RN-D stated she had called the emergency room regarding R28's family request, however, she had not attempted to contact a physician. RN-D stated she did not consider her response to R28's condition or family request to be neglectful

The Resident Incidents/change in Resident Health Status date 4/2015, directed staff to provide continued care for a resident when they become acutely ill. The policy directed the charge nurse to assess the illness, notify family and physician of any changes, assist with transfers to the hospital as needed and update the resident's care plan as needed.
R58 was identified to have a deteriorating pressure ulcer, increased lower extremity edema and the presence of a new non pressure related wound and the physician was not notified of these changes.

R58's Care Center Diagnosis Sheet signed by the physician on 8/14/17, included diagnoses of history of stage one pressure ulcer, chronic kidney disease stage 5 requiring dialysis, hypertension, history of deep vein thrombosis, and peripheral vascular disease.

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R58's nursing progress note dated 11/11/17, indicated both lower extremities were swollen, weeping, and had a fluid filled blister which had recently ruptured. A dressing was applied to the ruptured blister area and a wound dressing change schedule was set up to include dressing changes for both legs. However, R58's medical record lacked evidence of physician notification of the right leg wound, the increase in leg edema (swelling), blister formation, and weeping of fluid in the legs.

R58's E-Z Graph Wound Assessment dated 11/23/17, indicated R58 had a stage two pressure ulcer (partial loss of the first layer of skin) on the coccyx which measured 1.7 centimeters (cm) by 1.3 cm with a depth of 0.1 cm with no odor present and no slough (yellow or white tissue that can be stringy or thick and adheres to the tissue bed), and had tan scab like formation over part of the wound.

R58's E-Z Graph Wound Assessment System 11/28/17, indicated R58's stage two coccyx pressure ulcer measured 3.5 cm by 1.5 cm with no depth recorded. The assessment also indicated the pressure ulcer worsened and had eschar/slough present along with odor. However, R58's medical record lacked evidence the physician was notified that the wound had worsened and had the presence of an odor.

On 11/29/17, at 12:00 p.m. R58 was observed seated in the recliner with both legs in the dependent position, edema was noted from ankle to mid-calf area, bilaterally. The left leg had large scales of dry skin on the foot and ankle.

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On 11/29/17, at 6:09 p.m. R58's lower extremities were observed to be edematous. The right leg wound was observed with registered nurse (RN)-G. The wound measured approximately 2.0 inch by 0.5 inch with a depth of approximately 0.1 cm. A thin layer of yellowish/green slough was observed in the lower area of the wound.

On 11/29/17, at 7:15 p.m. R58's coccyx wound was visualized with RN-C. The pressure ulcer had varying levels of depth, had a very strong foul odor, slight undermining (when the tissue under the wound edges becomes eroded, resulting in a a pocket beneath the skin at the wound's edge) and a small area of white slough at the top of the wound and dark reddish/brown drainage on the dressing. RN-C stated the wound was "way worse" than when she had previously observed it on 11/23/17, and had furthered worsened since the 11/28/17, documented assessment.

R58's E-Z Graph Wound Assessment dated 11/30/17, indicated the right shin wound measured 5.0 cm by 1.0 cm, depth could not be determined because it was covered with slough.

On 11/30/17, at 12:10 p.m. RN-C confirmed R58's physician had not been notified of the change in the pressure ulcer and stated the physician should have been notified when the wound was fist noted to have worsened. In addition, RN-C stated she was not aware of R58's increase in edema, blister formation, or the right leg wound and verified R58's physician should have also been informed about the increase in edema and the presence of a new wound.

On 12/4/17, at 8:39 a.m. the DON stated R58's primary physician should have been notified of

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the worsening pressure ulcer and the skin integrity changes, as soon as possible.

R54's admission MDS dated 10/17/17, indicated R54 had diagnoses which included stroke, diabetes mellitus, hypertension and history of transient ischemic attacks. The MDS indicated R54 had severe cognitive impairment, required extensive assistance with bed mobility, transferring, ambulation, toileting and bathing. The MDS also indicated R54 had a two stage 2 pressure ulcers, one which was present on admission, and utilized a pressure reducing device in the bed (not chair), turning and positioning program, and received pressure ulcer care.

R54's Pressure Ulcer CAA dated 10/24/17, indicated R54 spent most time in the bed or wheelchair, required staff assist for bed mobility, was frequently incontinent of bowel and bladder and had two stage 2 pressure ulcers present upon admission. R54 was at risk for the worsening of the pressure sores, the development of additional pressure ulcers, discomfort and gangrene/sepsis and was complicated by R54's weakness/fatigue, dementia, diabetes, and incontinence. Staff directed to turn and reposition R54 hourly and to complete weekly rounds until ulcers were healed.

R54's care plan dated 10/25/17, indicated R54 had a potential for alteration in skin integrity related to history of a stroke, and inability to ambulate, transfer, turn and reposition, sit up or lie down and place legs into bed independently. Staff were directed to turn and reposition R54 every hour, utilize an alternating pressure mattress, and to monitor skin for red areas. The

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care plan did not address the presence of the two stage 2 pressure ulcers.

R54's temporary care plan identified a problem dated 10/11/17, which indicated R54 had open areas on right buttocks, coccyx/sacrum, and directed staff to provide a pressure relief mattress, Laniseptic (added 10/24), Mepilex dressing every 3rd day and as needed (PRN) (no date when added), Roho pressure redistribution cushion to wheelchair (added 11/22/17), and nutritional supplements to promote healing such as Vit C, Diabetshield, Thera-M, Glucerna and Promod.

R54's Braden Scale dated 10/14/17, indicated R54 was at risk for the development of pressure ulcers.

Review of Skin Condition Reports from 11/12 to -12-4/17, indicated pressure ulcers reopened on 11/12/17, and the MD was not notified until 11/23/17.

11/13/17:
Reopened
Skin Condition Report -reopened possibly from lying on back at ER (emergency room) on 11/10.
APP (alternating pressure mattress) applied - continue with diabetic shake - Glucerna - Promod - Mepilex instead of Laniseptic, MVI (multi-vitamin) and vitamin C.
EZ Graph - right coccyx and right buttocks - started Sacral Mepilex instead of Laniseptic - coded as DTI (deep tissue injury).
Area measures 7.5 cm x 5.5 cm with 2.5 cm purple pink color and 0.2 cm depth.
There was no physician (MD) notification of the newly developed pressure ulcer.

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11/22/17:
Skin Condition Report - reinforced hourly turn and positioning - took off APP - got new Embrace mattress - Roho for w/c - has Foley now (urine retention) - MD faxed.
EZ Graph - 7.5 x 5.5 area - PU 3.1 x 2 x 0.2 eschar to right buttock.

11/28/17:
Skin Condition Report - the outer perimeter of the right buttocks is smaller - eschar unchanged - called MD due to no response from fax - continue with Mepilex dressing.
EZ Graph - 2.5 x 2.5 eschar right buttocks - 7 cm area discolored.

12/4/17:
Skin Condition Report - not yet documented at time of survey.
EZ Graph - 3 x 2 cm scab - additional slough since last exam - undermining along edge of scabbed area. 0.4 cm depth. 6.5 c 7.5 area.

Wound Round Documentation:
12/04/17: Wound note: "Assessed wound after resident finished her breakfast in conjunction with her turning schedule. The Mepilex had been changed yesterday according to the label of the dressing, and yet there was already a foul odor upon removal of resident's dressing, and the dressing was saturated throughout the bottom 1/2 with heavy purulent tan drainage. Cleansed the wound with dermaclenz and patted dry. The area covered with eschar is beginning to undermine on the proximal wound edge, with a depth of 0.4 cm. There is more adherent yellowish white slough below the area of eschar, which now measures 3 cm x 2 cm. The irregular area that is open and

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more surface in nature distal to the eschar on the right buttock is smaller in total area and still showing signs of improvement. Tried to call MD office for advice, but had to leave message. Tried to get resident in today to the wound clinic due to the decline, but there spaces were all full, and the MD that was there could not add a visit, he had another clinic to get to at lunch. Due to concern of the speed of decline in the wound along with the odor, felt that the wound should be seen by a provider today, so called back and was able to schedule an office visit for resident to be seen by Dr. [name] PA, [PA name], this afternoon at 1:40 PM. Medivan will pick her up between 1:10 and 1:20. Family is in agreement and son will accompany. Son called resident's husband (his dad)on his own cell to update while this writer was present and he is OK with the transfer. Instructed the CNA about the appt., but to make sure she did not get her up too soon due to length of time she will be on the Roho cushion. Asked on the clinic form whether resident should have a wound culture or antibiotics and asked for advice on what dressing to use. Also notified them that she is still resistive to turning despite regular turning, she starts to roll herself toward her back. Asked if the indwelling cath should remain in place or not. Will send resident to the appt. and watch for new orders as a result of today's appt. Also mentioned that she continues to have intermittent abdominal discomfort. This morning she c/o [complained of] abdominal discomfort, but denied discomfort in the buttocks. Went back later to assess abdomen, and bowel sounds were active, and abdomen at that time was soft and non-tender; "it feels much better" and resident smiled. She had, however, already started to roll toward her back and assisted to reposition again."

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11/28/17: Wound Rounds: "Assessed resident's sacral area and right buttock early yesterday morning with dressing change. The eschar found last week remains firmly fixed next to the right buttock crease. Actually, the perimeter of the rest of the open area that has no eschar has actually improved since last week with the switch to the Embrace mattress and Roho chair cushion. Will continue with the sacral mepilex because of this, but will reattempt to get wound clinic involved due to the presence of this eschar. Discussed this with resident's husband this morning due to his previous reluctance for her to attend appts, but he is willing to have her go to the wound clinic if we get the order. The fax that was sent Monday was returned to us with no response from the MD, so called to get this rectified. See wound notebook for measurements of area. Resident has been willing to eat better in the past few days. She seems to do better when her family visits."

11/23/17: RN note: "Writer did fax MD regarding resident's wound to sacral area. Writer informed MD what staff is currently doing to facilitate wound healing, and asked if he had any suggestions. Writer has asked MD if resident should see Wound care, and have a prealbumin lab completed."

11/22/17: Wound Rounds: "Assessed the area on resident's sacrum and right buttock again this week during Mepilex change with [name], DON. The sacral area is now larger instead of smaller, and brown eschar is beginning to cover the area, which increased somewhat to 3.1 x 2 cm. The area that had been purplish, the surface skin separated and now some areas throughout are reddish pink surface, but mostly open. See wound notebook for all measurements. Additional

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measures needed to be taken. Was able to get a Roho cushion for this resident, which was placed in w/c and adjusted by [name], OT. The APP mattress will be removed, since the area had worsened. Had found that the first Embrace mattress was not the brand name "Embrace", but a substitute called "pressure relief"; maintenance now has received brand new in the package Embrace mattress which was placed on resident's bed. Hourly turns were reinforced to staff, although resident often rolls herself from side where staff has her positioned onto her back despite being propped with pillows when staff leaves the room. Resident has been insisting to eat in bed, but there are some shearing forces in play there with resident sliding down, so reeducated resident and staff that sitting on the roho cushion in w/c for meals is preferable, then returning to side in bed within the proper turning time frame is imperative. She is on diabetishield 1 box twice daily; promod; Glucerna 4x daily, thera-M and Vitamin C. Her most recent prealbumin in October was 15, which was below normal range, so these measures were instituted at that time. Will continue with the sacral Mepilex at that time and if still no improvement with all additional measures next week, will contact MD for suggestions."

11/13/17: Wound Rounds: "Due to reports of resident's skin breakdown, assessed resident's buttocks for the wound round book early this AM. Her left buttock remains intact. Her right buttock has worsened and has reopened since last Friday, 11/10, per [name], LPN, who visualized the area on Friday when assisting staff to toilet resident. The proximal margin is the top of the right buttock crease. There is a dark red area that had no drainage that appeared as a shallow ulcer

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with no drainage measuring 2.5 cm x1.5 cm x 0.2 cm. Extending from this is an additional area that is purplish in color but 5.5 x 6.5 in additional measurement of mostly intact skin. There was an abraded area within this purple area that measured 0.5 x 0.2 that had scant bloody drainage. Decision was made to remove resident's brief that had been in place; washed and dried the area and left the brief off, since resident has had a foley catheter in place since her visit to the ER on Friday night,to attempt to keep the area from becoming moist again from perspiration. A soaker was carefully placed under the resident. After about an hour, at the next repositioning, [name], LPN placed a sacral comfort foam border dressing over the entire area to prevent shearing forces. Will change this every 3 days and PRN. Will continue with the hourly turns. Resident is tolerating the APP mattress, and turning, in fact turned her to her left side and went back to check her and she was sound asleep and looked comfortable within 15 minutes. Resident denied stomach discomfort this AM and ate at least 1/2 of her breakfast; was able to feed herself. Concern for this worsening over the weekend; resident had spent Friday evening in the ER, not sure of her turning and repositioning at that time." (However, the MD was not notified of the development of pressure ulcer on 11/10/17, nor when the pressure ulcer worsened on 11/13/17.)

11/12/17: LPN note: "temp 100.1, writer gave PRN Tylenol at 7am, writer noted resident is tired but did say a few words to writer, noted residents wound to buttocks is worse and is open and bruising around it, Staff is repositioning resident from side to side every hr and applying barrier cream as needed."

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F 580	Continued From page 29 On 11/30/17, at 1:32 p.m. RN-C was interviewed and verified the pressure ulcers have worsened and believes that it re-developed when she was sent to the ER on 11/10 and was on gurney for long period of time. On 12/04/17, at 9:02 a.m. RN-C verified the odor to the pressure ulcers and stated she contacted the MD to send to the clinic as the pressure ulcers may be infected and have worsened. She also verified that there was not a fax to the MD when the pressure ulcers opened on 11/12 or when she assessed on 11/13/17, and changed treatment. RN-C added she probably did this but did not document it, and she changed the order to Mepilex dressing without contacting the MD. The Skin Care Protocol policy and procedure revised 4/15, section titled "with onset of all ulcers" directed staff to initiate wound flow sheet/EZ graph and to document on the following every week: -location -size (length, width, depth, undermining or tunneling -color -odor -exudate -skin condition around wound -wound edges -wound bed appearance -only stage pressure related ulcers. Other ulcers are considered partial or full thickness. -assess for causative factor and implement intervention to prevent an injury from occurring again -initate Braden's scale and do weekly unit healed.	F 580		

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Once healed do Braden every week for four weeks.
-wound rounds weekly
-pain assessment
-review chart and discuss with physician to determine type and etiology of ulcer. Venous ulcer described as shallow weeping lesions with irregular wound edges. Leg hyperpigmentation, edema and palpable pulses.
-notify family and physician about change in skin condition and current treatment plan
-obtain and review labs
-assure resident receives multivitamin with zinc and vitamin C at least daily
-notify registered dietician
-document in nurses notes daily by LPN and weekly by the RN
-if no improvement in two weeks, update physician and change plan of care.
-start pressure relieving devices (wheelchair, recliner and bed)

The undated Pressure Ulcers in Long Term Care policy section titled "Other Skin Concerns" identified a Stasis Ulcer as a destruction of tissue resulting from the stoppage or slowing of the normal blood flow to an area. This causes a back up in fluid causing congestion. The section titled "Assessment Of Other Skin Concerns" directed the documented identification of the type of wound, the site, the size (width, length, depth, and condition of surrounding tissue) in centimeters, and if exudate. The policy Appendix described edema as a local or generalized condition in which the body tissues contain and excessive amount of tissue fluid. Exudate was described as fluid that leaks from injured tissue which may be oozing pus or serum. The policy went on to direct staff on how to measure for the

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F 580	Continued From page 31 extent of peripheral edema.	F 580		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report and investigate an allegation of neglect of care to the State agency (SA) for 1 of 1 incident reviewed in which a family member voiced concern regarding the lack of staff response to a resident's (R28) deteriorating health condition. Findings include: R28's quarterly Minimum Data Set (MDS) dated 10/2/17, indicated R28 had diagnoses of Alzheimer's dementia, aphasia (inability to speak), and a stroke. R28 was not able to communicate or make decisions on her own. The assessment indicated R28 was totally dependent upon staff for all activities of daily	F 600	F 600 Free from Abuse and Neglect Minnesota Department of Health investigated facility's lack of report to the OHFC regarding R28. The Minnesota Department of Health directed the facility not to report at this time. A formal investigation was completed on 1/1/18. All other incidents of abuse, neglect, misappropriation of resident property and exploitation will be reported according to the facility's policy. The facility's Abuse Prevention Prohibition Policy was reviewed on 12/28/17.	1/14/18

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F 600	Continued From page 32 living. On 11/29/17, at 12:50 p.m. family member (FM)-A and FM-B requested to speak to the State agency surveyor regarding a concern. FM-B stated FM-A and FM-B had been out of town in June 2017, and had stopped at the facility to see R28 upon returning home. When they arrived at the facility, they found R28 with a high fever, was lethargic and unable to drink. They approached registered nurse (RN)-D, the charge nurse, and requested to have R28 seen in the emergency department, however, RN-D refused to assist the family with transportation to the hospital. FM-B stated RN-D told them that R28's primary physician had ordered an antibiotic earlier that day and R28 was not to go the hospital. When requested again by the family, RN-D refused to contact the physician again or to assist in transferring R28 to the hospital. FM-A became tearful as FM-B stated an unidentified staff member obtained the phone number for the transportation company so that R28 could be transported to the hospital. FM-B contacted the transportation company and had R28 transferred to the emergency room without assistance from the facility. While at the hospital, R28 was diagnosed with sepsis (a life-threatening illness caused by your body's response to an infection) and subsequently required a three day hospitalization for antibiotic intravenous therapy (IV). FM-B stated the emergency room physician informed the family that if R28 had not been started on IV therapy that day, she would have died by morning. FM-B stated she had reported the concern to the facility administrator, however, the administrator supported the actions of RN-D. Review of R28's Progress Notes revealed the following information:	F 600	RN-D had informal education on 6/21/17 and again on 12/4/17. RN-D was formally educated on 12/28/17. All charge nurses will be educated on the expectation of assisting residents/family members with requests of transfers to the clinic or ER by 1/14/18. All charge nurses were informally educated on 6/21/17 regarding the expectation of assisting residents/family members with requests of transfers to the clinic or ER. All staff will be educated on the facility's Abuse Prevention Prohibition Policy by 1/14/18. The Abuse Prevention Prohibition Policy identifies reportable incidents and requirements for reporting timelines. Audits will be completed daily, for 90 days, on resident progress notes by the Director of Nursing or designee to ensure residents to ensure incidents of abuse, neglect, misappropriation of resident property and exploitation are reported according to the facility's policy. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Administrator is responsible for this deficiency. Corrective date: 1/14/18	

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-On 6/20/17, at 3:35 p.m. indicated R28 had experienced an emesis prior to lunch, R28's temperature was noted to be 101.0 degrees Fahrenheit (F). R28 had another emesis at lunch and R28's temperature was "around 102" degrees F. After lunch, R28 was noted to have wheezes (whistling or rattling sound in the chest, as a result of obstruction in the air passages). R28's primary physician was called and an antibiotic was ordered for twice a day for ten days for possible aspiration (entry of material from the oropharynx or gastrointestinal tract into the larynx (voice box) and lower respiratory tract).

-At 4:59 p.m. indicated R28's temperature at 2:20 p.m. was 100.9 degrees F. R28 was lethargic, skin was hot and moist to the touch, cheeks were red and R28 was only taking sips of fluids. Will continue to monitor.

-At 5:01 p.m. indicated R28's temperature was 101.6 at 3:00 p.m. and was given Tylenol. R28 was seated in wheelchair, and received the first does of the antibiotic. FM-A and FM-B had requested R28 be evaluated in the emergency room. The charge nurse was informed of the request.

-At 5:07 p.m. RN was called down R28's unit. "Husband looks angry" when RN walking towards him. FM-A and FM-B both requested to have R28 sent immediately to the hospital. FM-B had stated to the RN "just look at her." RN explained to FM-A and FM-B that R28's physician had ordered resident to stay at facility and had also ordered an antibiotic to be started for possible aspiration. FM-A stated he did not care what the physician had ordered or said. RN informed FM-A and

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FM-B that if they wanted R28 sent to the hospital that it was their choice and they had every right to do so but she would not be arranging rides or taking part of the situation due to having no doctor's order. The note further indicated the RN attempted to explain to FM-A and FM-B the reasoning for keeping R28 at the facility was due to the hospital or emergency room (ER) not doing anything more that what the facility was currently doing for R28 "here and now." FM-B had questioned R28's breathing and oxygen in which the RN indicated R28's oxygen level was 91% and that she would receive oxygen if her levels went below 90%. FM-A became angry, red in the face, pointing finger, and hollering at the RN. RN called the ER charge nurse to give a "little heads up" on the situation. The note lacked evidence an assessment of R28's condition was completed at the time of the family request and also lacked evidence of any attempts to contact R28's primary physician or an "on call" physician regarding the family's wishes.

-6:01 p.m. R28 left facility via MediVan. RN notified the ED that the resident was on her way with family.

-9:41 p.m. RN received call from the ER which informed the facility R28 was "really sick," was started on an intravenous antibiotic, had a nasogastric tube inserted, and R28 was septic therefore, was admitted to the hospital.

Review of R28's Physician's Orders dated 6/20/17, included an order for Augmentin (antibiotic) 875-125 milligrams twice a day for ten days. The orders did not direct the staff to keep R28 at the facility and not to refrain from hospital transfers.

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R28's Progress note dated 6/23/17, indicated R28 returned to the facility.

R28's care plan initiated on 6/4/13, did not direct the staff to refrain from transferring R28 to the hospital.

R28's Uniform Code Level Direction for Cardiopulmonary Resuscitation form dated 5/16/13, indicated the family had determined that no interventions were to be made in the event of a cardiac or respiratory arrest. Other conditions were to be treated as medically appropriate. The family had not restricted any other medical treatments including further hospitalizations, in the event of an emergency.

R28's Emergency Room Note dated 6/20/17, indicated R28's white blood count was elevated to 29.400 (normal number of WBCs in the blood is 4,500 to 11,000 a high number indicates the body's reaction to fight infection). R28 was admitted to the hospital with a diagnosis of pneumonia.

R28's Hospital Discharge Summary dated 6/23/17, indicated R28 required hospitalization for the provisional diagnosis of aspiration pneumonia with sepsis and clinical dehydration. R28 received IV fluids and antibiotics, her temperature had returned to normal, she was alert and was able to swallow food comfortably. R28 was to continue on oral antibiotics for a total of 10 additional days.

On 12/1/17, at 7:30 a.m. RN-A confirmed she was aware of the 6/20/17, concern with R28's family request to have R28 transferred to the

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hospital and stated ultimately R28 had been seen in the hospital and was subsequently admitted. RN-A stated it was the family's right to have R28 evaluated in the emergency room, if they wished.

On 12/1/17, at 8:22 a.m. RN-B stated if a family member wished to have a resident seen in the emergency room, the staff were to complete an assessment, contact the primary physician or "on call" physician and obtain an order to transfer the resident to the hospital for further evaluation per the family request. RN-B stated R28 had a history of aspiration pneumonia and on 6/20/17, R28 was started on an oral antibiotic due to possible recurring aspiration. RN-B stated R28 had not been physically evaluated by the primary physician on 6/20/17. Rather due to the physician knowing R28's history or aspiration pneumonia and previous treatments, and R28 having been recently treated with an antibiotic for aspiration pneumonia, R28's physician had instructed the facility to treat R28 at the facility, had ordered an antibiotic and requested to not send R28 to the emergency room. RN-B confirmed the instructions to refrain from hospital transfer/evaluation had not been written as a physician's order in R28's medical record. R28's primary physician and the family had discussed hospitalizations in the past and there was a verbal agreement to treat R28 at the facility versus in the acute hospital. RN-B stated she had attempted to contact R28's family on 6/20/17, to notify them of her deterioration however, she was unable to reach the family and did not document her attempts to contact the family in R28's record. Upon review of the 6/20/17 documentation, RN-B stated it would have been beneficial for RN-D to have completed an assessment of R28's condition, contact a physician and assist to

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transfer R28 to the emergency room per the family request.

-At 9:03 a.m. the DON stated R28's primary physician was notified of R28's vomiting, fever and wheezes on 6/20/17, and ordered R28 a new antibiotic. R28's primary physician prefers the residents of the facility to be treated in the facility and staff were to inform him of any changes. The DON confirmed R28's medical record did not contain a physician's order to refrain from hospitalizations and stated it was an understating between the primary physician and the facility to refrain from hospitalizations. The DON confirmed RN-D's documentation lacked an assessment of R28's condition on 6/20/17, and verified RN-D did not attempt to notify a physician of any potential changes in R28's condition.
Upon review of the progress note dated 6/20/17, at 6:01 p.m. the DON stated she was unaware the documentation clearly indicated RN-D refused to assist FM-A and FM-B to transfer R28 to the emergency room for an evaluation and stated that was not the facility's normal practice. The DON stated she had talked to RN-D about the actions on 6/20/17, and directed RN-D and the rest of the staff to assist with transfers to the hospital per the family choice. However, the DON stated she had not documented the directive nor had she provided any type of formal training to the staff rather during shift to shift report, she had directed the staff to remind each other to follow family requests. The DON stated she had not considered R28's response to requested care on 6/20/17, to be neglectful therefore, the State agency was not notified.

-At 9:21 a.m. the DON and SA surveyor attempted to contact RN-D without success.

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-At 9:35 a.m. the licensed social worker (LSW) stated she was aware of the concern on 6/20/17, with R28's family request to have R28 evaluated at the hospital. The LSW stated she understood R28 had been seen in the emergency room and had been admitted to the hospital. The LSW was unaware neglect of care had occurred.

-At 9:49 a.m. the facility administrator reviewed RN-D's documentation from 6/20/17, at 5:07 p.m. and stated he was unaware RN-D had not assessed R28 at the time of the family request or refusal to contact a physician or assist the family in transferring R28 to the hospital. The administrator stated he felt RN-D's documentation showed frustration and it was his understanding that the family had not allowed RN-D time to assess R28 prior to them transferring R28 to the hospital. The administrator stated the DON had investigated the concern from the family, however, confirmed there was no documentation related to the investigation or indication additional staff training/coaching had been provided. The administrator stated he had not considered the lack of response to R28's family request or lack of further assessment related to R28's condition to be neglect, therefore, the SA had not been notified and a formal investigation had not been completed.

On 12/4/17, at 4:00 p.m. RN-D stated on 6/20/17, it was her understanding R28 had been started on a new antibiotic and she was not to be sent to the emergency room as they could not do anything differently than what was being done at the facility. RN-D confirmed R28's medical record did not contain a physician's order to

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F 600	Continued From page 39 refrain from hospital evaluations. RN-D stated on 6/20/17, when FM-A had requested R28 be sent to the emergency, FM-A was angry and threatening towards her so she had to walk away from the situation. RN-D stated she did not feel she had the time to assess R28 or to help with the transfer as the family had already made the arrangements and left with R28. RN-D stated she had called the emergency room regarding R28's family request, however, she had not attempted to contact a physician. RN-D stated she did not consider her response to R28's condition or family request to be neglectful. The Abuse Prevention / Prohibition Program dated 11/1/17, defined neglect as the failure of the facility, its employees or service provided to providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy identified neglect as untreated medical condition. The policy also indicated the facility was to report neglect with injury within two hours and neglect without injury within 24 hours to the State agency, investigate the concern, and document the findings of the investigation and report the results of the investigation to the SA.	F 600		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		1/14/18

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F 607	Continued From page 40 §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize their Abuse Prevention/Prohibition Program policy related to the reporting and investigating of an allegation of neglect of care for 1 of 1 resident (R28) who had a decline in condition and the staff failed to respond. Findings include: The Abuse Prevention/Prohibition Program dated 11/1/17, defined neglect as the failure of the facility, its employees or service provided to providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy identified neglect as untreated medical condition. The policy also indicated the facility was to report neglect with injury within two hours and neglect without injury within 24 hours to the State agency (SA), to investigate the concern and document the findings of the investigation, and report the results of the investigation to the SA. R28's quarterly Minimum Data Set (MDS) dated 10/2/17, indicated R28 had diagnoses of Alzheimer's dementia, aphasia (inability to speak), and a stroke. R28 was not able to communicate or make decisions on her own. The assessment indicated R28 was totally dependent upon staff for all activities of daily living.	F 607	F 607 Develop/Implement Abuse/Neglect Policies Minnesota Department of Health investigated facility's lack of report to the OHFC regarding R28. The Minnesota Department of Health directed the facility not to report at this time. A formal investigation was completed on 1/1/18. All other incidents of abuse, neglect, misappropriation of resident property and exploitation will be reported according to the facility's policy. The facility's Abuse Prevention Prohibition Policy was reviewed on 12/28/17. RN-D had informal education on 6/21/17 and again on 12/4/17. RN-D was formally educated on 12/28/17. All charge nurses will be educated on the expectation of assisting residents/family members with requests of transfers to the clinic or ER by 1/14/18. All charge nurses were informally educated on 6/21/17 regarding the expectation of assisting residents/family members with requests of transfers to the clinic or ER. All staff will be educated on the facility's Abuse Prevention Prohibition Policy by	

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F 607	Continued From page 41 On 11/29/17, at 12:50 p.m. family member (FM)-A and FM-B requested to speak to the SA surveyor regarding a concern. FM-B stated FM-A and FM-B had been out of town in June 2017, and upon returning home, had stopped at the facility to see R28. When they arrived at the facility, they found R28 with a high fever, lethargy and was unable to drink. They approached registered nurse (RN)-D, the charge nurse, and requested to have R28 seen in the emergency department, however, RN-D refused to assist the family with transportation to the hospital. FM-B stated RN-D told them R28's primary physician had ordered an antibiotic earlier that day and R28 was not to go the hospital. When requested again by the family, RN-D refused to contact the physician again or to assist in transferring R28 to the hospital. FM-A became tearful as FM-B stated an unidentified staff member obtained the phone number for the transportation company so that R28 could be transported to the hospital. FM-B contacted the transportation company and had R28 transferred to the emergency room without assistance from the facility. While at the hospital, R28 was diagnosed with sepsis (a life-threatening illness caused by your body's response to an infection) and subsequently required a three day hospitalization for antibiotic intravenous therapy (IV). FM-B stated the emergency room physician informed the family that if R28 had not been started on IV therapy that day, she would have died by morning. FM-B stated she had reported the concern to the facility administrator, however, the administrator supported the actions of RN-D. Review of R28's Progress Notes revealed the following information:	F 607	1/14/18. The Abuse Prevention Prohibition Policy identifies reportable incidents and requirements for reporting timelines. Audits will be completed daily, for 90 days, on resident progress notes by the Director of Nursing or designee to ensure incidents of abuse, neglect, misappropriation of resident property and exploitation are reported according to the facility's policy. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Administrator is responsible for this deficiency. Corrective date: 1/14/18	

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-On 6/20/17, at 3:35 p.m. indicated R28 had experienced an emesis prior to lunch, R28's temperature was noted to be 101.0 degrees Fahrenheit (F). R28 had another emesis at lunch and R28's temperature was "around 102" degrees F. After lunch, R28 was noted to have wheezes (whistling or rattling sound in the chest, as a result of obstruction in the air passages). R28's primary physician was called and an antibiotic was ordered for twice a day for ten days for possible aspiration (entry of material from the oropharynx or gastrointestinal tract into the larynx (voice box) and lower respiratory tract).

-At 4:59 p.m. indicated R28's temperature at 2:20 p.m. was 100.9 degrees F. R28 was lethargic, skin was hot and moist to the touch, cheeks were red and R28 was only taking sips of fluids. Will continue to monitor.

-At 5:01 p.m. indicated R28's temperature was 101.6 at 3:00 p.m. and was given Tylenol. R28 was seated in wheelchair, and received the first does of the antibiotic. FM-A and FM-B had requested R28 be evaluated in the emergency room. The charge nurse was informed of the request.

-At 5:07 p.m. RN was called down R28's unit. "Husband looks angry" when RN walking towards him. FM-A and FM-B both requested to have R28 sent immediately to the hospital. FM-B had stated to the RN "just look at her." RN explained to FM-A and FM-B that R28's physician had ordered resident to stay at facility and had also ordered an antibiotic to be started for possible aspiration. FM-A stated he did not care what the physician had ordered or said. RN informed FM-A and FM-B that if they wanted R28 sent to the hospital

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that it was their choice and they had every right to do so but she would not be arranging rides or taking part of the situation due to having no doctor's order. The note further indicated the RN attempted to explain to FM-A and FM-B the reasoning for keeping R28 at the facility was due to the hospital or emergency room (ER) not doing anything more that what the facility was currently doing for R28 "here and now." FM-B had questioned R28's breathing and oxygen in which the RN indicated R28's oxygen level was 91% and that she would receive oxygen if her levels went below 90%. FM-A became angry, red in the face, pointing finger, and hollering at the RN. RN called the ER charge nurse to give a "little heads up" on the situation. The note lacked evidence an assessment of R28's condition was completed at the time of the family request and also lacked evidence of any attempts to contact R28's primary physician or an "on call" physician regarding the family's wishes.

-6:01 p.m. R28 left facility via MediVan. RN notified the ED that the resident was on her way with family.

-9:41 p.m. RN received call from the ER which informed the facility R28 was "really sick," was started on an intravenous antibiotic, had a nasogastric tube inserted, and R28 was septic therefore was admitted to the hospital.

Review of R28's Physician's Orders dated 6/20/17, included an order for Augmentin (antibiotic) 875-125 milligrams twice a day for ten days. The orders did not direct the staff to keep R28 at the facility and not to refrain from hospital transfers.

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-On 6/23/17, R28 returned to the facility.

R28's care plan initiated on 6/4/13, did not direct the staff to refrain from transferring R28 to the hospital.

R28's Uniform Code Level Direction for Cardiopulmonary Resuscitation form dated 5/16/13, indicated the family had determined that no interventions were to be made in the event of a cardiac or respiratory arrest. Other conditions were to be treated as medically appropriate. The family had not restricted any other medical treatments including further hospitalizations, in the event of an emergency.

R28's Emergency Room Note dated 6/20/17, indicated R28's white blood count was elevated to 29.400 (normal number of WBCs in the blood is 4,500 to 11,000 a high number indicates the body's reaction to fight infection). R28 was admitted to the hospital with a diagnosis of pneumonia.

R28's Hospital Discharge Summary dated 6/23/17, indicated R28 required hospitalization for the provisional diagnosis of aspiration pneumonia with sepsis and clinical dehydration. R28 received IV fluids and antibiotics, her temperature had returned to normal, she was alert and was able to swallow food comfortably. R28 was to continue on oral antibiotics for a total of 10 additional days.

On 12/1/17, at 7:30 a.m. RN-A confirmed she was aware of the 6/20/17, concern with R28's family request to have R28 transferred to the hospital and stated ultimately R28 had been seen in the hospital and was subsequently admitted.

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RN-A stated it was the family's right to have R28 evaluated in the emergency room, if they wished.

On 12/1/17, at 8:22 a.m. RN-B stated if a family member wished to have a resident seen in the emergency room, the staff were to complete an assessment, contact the primary physician or on call physician and obtain an order to transfer the resident to the hospital for further evaluation per the family request. RN-B stated R28 had a history of aspiration pneumonia and on 6/20/17, R28 had been started on an oral antibiotic. RN-B confirmed R28 had not been evaluated by the primary physician on 6/20/17, rather the primary physician was familiar with R28's care and R28 had recently been treated with an antibiotic for aspiration pneumonia therefore R28's primary physician had instructed the facility to treat R28 at the facility and to not send R28 to the emergency room. RN-B confirmed the instructions to refrain from hospital transfer/evaluation had not been written as a physician's order in R28's medical record. R28's primary physician and the family had discussed hospitalizations in the past and there was a verbal agreement to treat R28 at the facility verses in the acute hospital. RN-B stated she had attempted to contact R28's family on 6/20/17, to notify them of her deterioration, however, she was unable to reach the family and did not document her attempts to contact the family in the R28's record. Upon review of the 6/20/17, documentation, RN-B stated it would have been beneficial for RN-D to have completed an assessment of R28's condition, contact a physician and to assist to transfer R28 to the emergency room per the family request.

- At 9:03 a.m. the DON stated R28's primary physician was notified of R28's vomiting, fever

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and wheezes on 6/20/17, and ordered R28 a new antibiotic. R28's primary physician prefers the residents of the facility to be treated in the facility and staff were to inform him of any changes. The DON confirmed R28's medical record did not contain a physician's order to refrain from hospitalizations and stated it was an understating between the primary physician and the facility to refrain from hospitalizations. The DON confirmed RN-D's documentation lacked an assessment of R28's condition on 6/20/17, and verified RN-D did not attempt to notify a physician of any potential changes in R28's condition. Upon review of the progress note dated 6/20/17, at 6:01 p.m. the DON stated she was unaware the documentation clearly indicated RN-D refused to assist FM-A and FM-B to transfer R28 to the emergency room for an evaluation and stated that was not the facility's normal practice. The DON stated she had talked to RN-D about the actions on 6/20/17, and directed RN-D and the rest of the staff to assist with transfers to the hospital per the family choice. However, the DON stated she had not documented the directive nor had she provided any type of formal training to the staff rather during shift to shift report, she had directed the staff to remind each other to follow family requests. The DON stated she had not considered R28's response to requested care on 6/20/17, to be neglectful therefore, the SA was not notified.

- At 9:21 a.m. the DON and SA surveyor attempted to contact RN-D without success.

- At 9:35 a.m. the licensed social worker (LSW) stated she was aware of the concern on 6/20/17, in regards to R28's family request to have R28 evaluated at the hospital be denied. The LSW

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stated she understood R28 had been seen in the emergency room and was subsequently admitted to the hospital. The LSW was unaware of any concerns related to neglect of care.

- At 9:49 a.m. the facility administrator reviewed RN-D's documentation from 6/20/17, at 5:07 p.m. and stated he was unaware RN-D had not assessed R28 at the time of the family request or refusal to contact a physician or assist the family in transferring R28 to the hospital. The administrator stated he felt RN-D's documentation showed frustration and it was his understanding that the family had not allowed RN-D time to assess R28 prior to them transferring R28 to the hospital. The administrator stated the DON had investigated the concern from the family, however, confirmed there was no documentation related to the investigation nor indication additional staff training/coaching had been provided. The administrator stated he had not considered the lack of response to R28's family request or lack of further assessment related to R28's condition to be neglect, therefore, the SA had not been notified and a formal investigation had not been completed.

On 12/4/17, at 4:00 p.m. RN-D stated on 6/20/17, it was her understanding R28 had been started on a new antibiotic and she was not to be sent to the emergency room as they could not do anything differently than what was being done at the facility. RN-D confirmed R28's medical record did not contain a physician's order to refrain from hospital evaluations. RN-D stated on 6/20/17, when FM-A had requested R28 be sent to the emergency, FM-A was angry and threatening towards her so she had to walk away

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F 607	Continued From page 48 from the situation. RN-D stated she did not feel she had the time to assess R28 or to help with the transfer as the had family made the arrangements and left with R28. RN-D stated she had called the emergency room regarding R28's family request, however, she had not attempted to contact a physician. RN-D stated she did not consider her response to R28's condition or family request to be neglectful.	F 607		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately complete the Minimum Data Set (MDS) and complete a comprehensive assessment for 1 of 1 resident (R44) who smoked which was not identified on the MDS and was observed to smoke without the completion of an assessment to determine the resident's ability to smoke safely. Findings include: R44 was observed on 11/28/17, at 11:15 a.m. to exit the facility, enter the center courtyard, remove a cigarette pack from his sweatshirt, light a cigarette and continue to smoke and extinguish the cigarette without difficulty. On 11/29/17, at 5:57 p.m. R44 was again observed in the courtyard safely smoking. R44's annual dated 5/7/17, Section J1300 which identified tobacco use, was blank. R44's quarterly	F 641	F 641 Accuracy of Assessments R44's MDS assessment dated 5/7/17 reflected the fact that he smoked. R44's care plan was updated on 12/29/17. A new smoking assessment was completed on R44 on 12/1/17. Assessments will be completed upon admission, quarterly, and with significant change in condition for R44 and all other residents that smoke. A signature section was added to the Smoking Assessment during the survey. No other residents smoke in the facility currently. The facility's Smoking Policy was	1/14/18

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F 641	Continued From page 49 MDS dated 10/23/17, indicated R44 had mild cognitive impairment and required minimal supervision with activities of daily living. Section J1300 was not a required area for review on the quarterly MDS. R44's hospital Discharge Summary Note dated 9/7/17, indicated R44 was a smoker. R44's Resident Smoking Assessments dated 3/14/17, 8/7/17, and 11/1/17, all indicated R44 smoked and had been assessed for smoking, however, the assessments were unsigned which indicated they were incomplete. On 11/30/17, at 12:30 p.m. registered nurse (RN)-B stated R44 smoked during the aforementioned dates and confirmed the assessments were not complete and failed to address R44's smoking. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/17, Section J1300 directed staff to identify resident tobacco use and to code Section J1300 a "1" indicating yes, the resident used tobacco in some form during the reference period. The rationale for this section was to either alert staff to discuss smoking cessation with the resident or to develop a care plan which allowed for safe and environmental accommodations of resident smoking preferences. The undated Smoking Policy, indicated the residents had the right to smoke. The policy directed the staff to complete a comprehensive assessment of the residents ability to smoke on a quarterly basis.	F 641	reviewed and revised on 12/28/17. Education will be provided to all charge nurses regarding updating the resident's care plan if they smoke. Audits will be completed two times weekly, for 90 days, by the Director of Nursing or designee on care plans to ensure they are updated with resident's desire to smoke. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Social Worker is responsible for this deficiency. Corrective date: 1/14/18	

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F 656	Continued From page 50	F 656		
F 656 SS=E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate	F 656		1/14/18

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F 656	Continued From page 51 entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop care plans for 1 of 1 resident (R44) who smoked, for 1 of 1 resident (R23) with identified dental concerns related to loose teeth, and for 2 of 2 residents (R58, R54) who had identified skin and pressure ulcer concerns. Findings include: R44's care plan dated 10/25/17, did not address R44's wish to smoke or indicate if R44 was able to do so safely. On 11/28/17, at 11:15 a.m. R44 was observed to exit the facility, enter the center courtyard, remove a cigarette pack from his sweatshirt and light a cigarette. R44 was observed to smoke the cigarette and extinguish it into an appropriate receptacle without difficulty. On 11/29/17, at 5:57 p.m. R44 was again observed in the courtyard, safely smoking. On 11/30/17, at 12:30 p.m. registered nurse (RN)-B confirmed R44's care plan did not address R44's wishes or ability to smoke. The undated Smoking Policy, indicated the residents had the right to smoke. The policy directed the staff to complete a comprehensive assessment of the residents ability to smoke on a quarterly basis. A second undated smoking	F 656	F 656 Develop/Implement Comprehensive Care Plan R44□s care plan was updated on 12/29/17 to reflect his desire to smoke. R23□s care plan was updated on 12/29/17 to reflect her history of loose teeth. R58 passed away on 12/01/17. R54□s care plan has been updated to reflect pressure ulcers. No other residents were identified as smoking currently. All residents care plans will be reviewed and revised as needed to include dental concerns and skin/pressure ulcer concerns prior to 1/14/18. The facility□s Smoking Policy was reviewed and revised on 12/28/17. The facility□s policy title Nursing Care Plans was reviewed on 12/12/17. Education will be provided to all charge nurses prior to 1/14/18 to ensure care plans are updated with the resident□s	

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F 656	Continued From page 52 policy indicated the residents ability to smoke would be addressed on the care plan and revised as needed. R23's Referral Form from the dentist dated 6/28/17, indicated R23 had 2 very loose lower teeth, seemed to handle removing these teeth when the time is right, no further treatment planned. R23's annual Minimum Data Set (MDS) dated 7/4/17, indicated R23 had moderate cognitive impairment and required extensive assist from one staff person to perform personal hygiene. The MDS indicated R23 had inflamed, bleeding gums or loose natural teeth. R23's Dental Care Area Assessment (CAA) dated 7/6/17, indicated the CAA was triggered due to loose natural teeth, R23 had been seen by the dentist on 6/28/17, with no new orders related to loose teeth, and R23 had an order for staff to assist and encourage better brushing. The CAA also indicated R23 was at risk for increased discomfort, infection, lesions, bleeding, swelling, and weight loss complicated by dementia, mental retardation, and periodontal disease, a care plan would be developed. R23's care plan dated 9/19/17, indicated R23 required lots of encouragement to complete oral care and directed staff to brush teeth with interproximal brush on all upper teeth and concentrate toothbrush along gum line. The care plan did not address R23's loose teeth or the risk of potential complications identified in the Dental CAA.	F 656	desire to smoke, dental issues related to loose natural teeth, and skin/pressure ulcer concerns. Audits will be completed two times weekly, for 90 days, by the Director of Nursing or designee on care plans to ensure they are updated with resident□s desire to smoke, dental issues related to loose natural teeth, and skin/pressure ulcer concerns. Audits will be completed two times weekly, for 90 days, by the Director of Nursing or designee on CAAs to ensure care plans are developed if a concern is identified. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing is responsible for this deficiency. Corrective Date: 1/14/18	

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On 11/28/17, R23 reported her bottom teeth were very loose and they hurt and proceeded to show the State agency surveyor her loose bottom two teeth. R23's gum area around the teeth appeared to be slightly irritated and swollen. R23 stated her teeth started to bother her sometime last week and she was waiting for staff to set up a dental appointment for her because she wanted them pulled out

On 12/4/17, at 8:32 a.m. director of nursing (DON) verified R23's care plan failed to address her loose teeth and should have.

R58's quarterly MDS dated 11/6/17, indicated R58 had moderate cognitive impairment, required extensive physical assist from one staff member for bed mobility and transfers, was at risk for pressure ulcers and at the time of assessment had an un-stageable pressure ulcer.

On 11/29/17, at 7:15 p.m. RN-C and RN-G were observed to transfer R58 to bed. R58's coccyx was covered with a foam dressing. RN-C removed the dressing which had a moderate amount of reddish/brown drainage on it and exposed a pressure ulcer on R58's coccyx. The wound had a very strong foul odor with varying levels of depth, slight undermining (when the tissue under the wound edges becomes eroded, resulting in a pocket beneath the skin at the wound's edge) and had small area of white slough (yellow or white tissue that can be stringy or thick and adheres to the tissue bed) at the top of the wound.

R58's nursing orders dated 11/15/17, identified the coccyx wound as right buttock open area and

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instructed staff to cleanse and pat completely dry, apply a foam dressing, change every three days and as needed until healed.

R58's care plan provided by the facility on 12/4/17, indicated R58 had a history of pressure ulcers, however, failed to identify the presence of an actual stage II pressure ulcer and interventions.

On 12/4/17, at 8:39 a.m. director of nursing (DON) stated there should have been a care plan developed to reflect the presence of the stage II pressure ulcer.

R58's Physician Order Report dated 9/11/17-11/13/17, stamped "Nursing Orders Only" and signed as reviewed by the RN (no physician signature) on 11/15/17, revealed the following orders:

-11/11/17, Left lower extremity: Apply ABD (12 x 12 inch x one inch bandage) pads, wrap with roll gauze/Kerlix, and secure with tape, twice a day. Notify the charge nurse when weeping has subsided, or when healed or worsened. Twice a day.

-11/11/17, Right lower extremity: Wound cleanse, pat dry, apply non-adhesive dressing pad with a dab of Bacitracin, cover lower extremity with ABD pads due to weeping, roll with gauze/Kerlix, and secure with tape, twice a day. Notify charge nurse if worsening or when healed. When weeping subsides dressing can be changed daily instead of twice daily.

R58's nursing progress note dated 11/11/17, indicated both lower extremities were swollen,

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F 656	Continued From page 55	F 656		

weeping and R58 may have had a blood/fluid blister on her right lower extremity that had recently ruptured. Treatment for legs was set up for twice a day until swelling and weeping had subsided. Blood/fluid drainage was noted on dressing approximately 45 minutes after application. R58 was seated in her recliner with feet elevated. R58 was encouraged to elevate her legs as much as possible. The note did not include the size of the wound or indicate if R58's physician had been notified. In addition, no further documentation related to R58's edema or shin wound was noted in the medical record until 11/30/17.

R58's E-Z Graph Wound Assessment dated 11/30/17, indicated the right shin wound measured 5.0 cm by 1.0 cm, depth could not be determined because it was covered with slough.

R58's care plan dated as last reviewed 11/8/17, indicated R58 had a potential for alteration in skin integrity related to history of pressure ulcers, chronic kidney disease and valvular hear disease, however, failed to identify and address the actual non-pressure related wound care directives.

On 12/4/17, at 8:39 a.m. the DON stated there should have been a care plan developed for the care and management of the wound on the right lower extremity.

R54's admission MDS dated 10/17/17, indicated R54 had diagnoses which included stroke, diabetes mellitus, hypertension and history of transient ischemic attacks. The MDS indicated R54 had severe cognitive impairment, required extensive assistance with bed mobility, transferring, ambulation, toileting and bathing.

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The MDS also indicated R54 had a two stage 2 pressure ulcers, one which was present on admission, and utilized a pressure reducing device in the bed (not chair), turning and positioning program, and received pressure ulcer care.

R54's care plan dated 10/25/17, indicated R54 had a potential for alteration in skin integrity related to history of a stroke, and inability to ambulate, transfer, turn and reposition, sit up or lie down and place legs into bed independently. Staff were directed to turn and reposition R54 every hour, utilize an alternating pressure mattress, and to monitor skin for red areas. The care plan did not address the presence of the two stage 2 pressure ulcers.

R54's temporary care plan identified a problem dated 10/11/17, which indicated R54 had open areas on right buttocks, coccyx/sacrum, and directed staff to provide a pressure relief mattress, Laniseptic (added 10/24), Mepilex dressing every 3rd day and as needed (PRN) (no date when added), Roho pressure redistribution cushion to wheelchair (added 11/22/17), and nutritional supplements to promote healing such as Vit C, Diabetshield, Thera-M, Glucerna and Promod. However, the information on the temporary care plan should have been added to the comprehensive care plan following the completion of the admission MDS.

On 11/30/17 at 1:32 p.m. RN-C was interviewed and verified the care plan did not include the open pressure ulcers, nor was the care plan updated with revisions when the pressure ulcers re-developed. RN-C stated the pressure ulcers

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F 656	Continued From page 57 were on the temporary care plan which was located in a 3 ring binder at the nurse's desk. She stated (with the DON present) that she thought that was going to be the practice, to add to the temporary care plan. Facility policy Nursing Care Plans last revised 4/17/17, included the following: The goal of the policy was to evaluate resident restorative potential, establish goals, and coordinate staff and resident efforts toward meeting those goals in order to provide an individualized nursing care plan that will promote the continuity of resident care. The policy also included, the plan shall be reviewed and revised by a team of qualified persons after each assessment, Using the information from the MDS and the resident's CAA's, the MDS nurse will develop a detailed, individualized care plan for the resident, and The care plan will be updated with changes in condition and as needed	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident.	F 657		1/14/18

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F 657	Continued From page 58 (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to revise the care plan for lower extremity edema (swelling) for 1 of 2 residents (R58) reviewed for alteration in skin integrity. Finding included. R58's care plan dated as last reviewed 11/8/17, indicated the following: -Potential for fluid overload and alteration in circulation status with a goal R58 would not have excess fluid. Staff were directed to send to dialysis as ordered, medicate as ordered, in emergency staff would give Kayexalate as ordered if unable to attend dialysis, and to maintain adequate nutrition and hydration by providing dietary "decub" program. -Decreased mobility and was unable to ambulate R58's Checklist for Skin Risk Factors and Interventions form dated 5/2/17, indicated R58	F 657	F657 Care Plan Timing and Revision R58 passed away on 12/01/17. All residents care plans will be reviewed and revised as needed to include alteration in skin integrity and the appropriate nursing interventions (edema checks, TEDs, ace wraps) prior to 1/14/18. All residents on dialysis will have a plan in place to monitor their fluid balance on non-dialysis days prior to 1/14/18. The facility□s policy titled Nursing Care Plans was reviewed on 12/12/17. Education will be provided to all charge nurses prior to 1/14/18 to ensure care plans are updated with alteration in skin integrity. Education will also be provided to include the interventions outlined in the	

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F 657	Continued From page 59 had lower extremity concerns of signs and symptoms of arterial disease (PVD) such as cold extremity, thin and shiny skin and also arterial insufficiency concerns. The staff were directed to optimize blood flow to extremity, keep legs in neutral position, prevent trauma, proper fitting footwear, pressure reduction to heels, monitor weight/labs with a written note indicating dialysis would monitor labs, pad, protect and/or apply skin prep to fragile skin, encourage mobility and ambulation. R58's nursing progress note dated 11/11/17, indicated both lower extremities were swollen, weeping and R58 may have had a blood/fluid blister on her right lower extremity that had recently ruptured. Treatment for legs was set up for twice a day until swelling and weeping had subsided. Blood/fluid drainage was noted on dressing approximately 45 minutes after application. R58 was seated in her recliner with feet elevated. R58 was encouraged to elevate her legs as much as possible. No further documentation related to R58's edema or shin wound was noted in the medical record until 11/30/17. R58's care plan failed to address actual monitoring of the lower extremity edema even though R58 had a history of edema resulting in fluid filled blisters on the left leg on 4/4/17, according to a physician's communication and after the increase in edema, weeping, blister formation and rupture identified in the 11/11/17, progress note. In addition, the care plan did not include the interventions outlined on the Checklist for Skin Risk Factors and Interventions or how fluid balance would be monitored on non-dialysis days.	F 657	Checklist for Skin Risk Factors and Interventions and putting a plan in place to monitor resident□s fluid status on non-dialysis days. Audits will be completed two times weekly, for 90 days, by the Director of Nursing or Designee on care plans to ensure they are updated with concerns related to alteration in skin integrity and monitoring fluid status. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or designee is responsible for this deficiency. Corrective Date: 1/14/18	

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R58's signed physician orders dated 11/17/17, included knee high Ted compression stockings to both lower extremities on in the morning and off at night (start date of 5/10/17).
R58's standing orders signed by the physician on 8/17/16, directed staff to apply Ted compression stockings or ace wraps, as needed. The order did not describe or direct parameters for when the ace wraps should used instead of the the Ted compression stockings.

On 11/28/17, at 2:42 p.m. R58 was observed seated in her recliner with legs in dependent (down) position with white Ted compression stockings on bilaterally. Slight edema (swelling) was noted in both ankle areas. An ABD (12 inch x 12 inch x 1 inch dressing) dressing was visible on her right shin area. No dressing visible on the left leg.

On 11/29/17, at 12:00 p.m. R58 was observed seated in her recliner with legs down. R58's compression stockings were not on. Edema was noted in both lower extremities from ankle to mid calf area. R58's left leg had large scales of dry skin on the foot and ankle. The right mid shin had an ABD dressing on secured with gauze. The left shin area had a dime size superficial wound with clear, yellow tinged fluid running down R58's leg. R58 stated her leg had been weeping all morning.

-At 6:09 p.m. R58 was observed in her recliner, both legs were noted to be edematous and weeping. Registered nurse (RN)-G entered the room and R58 reported to RN-G that her left leg had been weeping all day.

On 11/29/17, at 6:17 p.m. RN-G stated R58's legs

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F 657	Continued From page 61	F 657		

wept on and off, and at times, wept a lot.

On 11/30/17, at 7:09 a.m. R58 was observed seated in the recliner with her legs down. The compression socks were not on. R58 stated staff did not put them on and did not offer to put them on. Both legs were noted to be edematous.

On 11/30/17, at 12:10 p.m. RN-C stated R58 had a history of edema, weeping legs, and blisters. RN-C confirmed R58's medical record lacked monitoring of the condition of R58's legs and stated she was not aware of the wound to right leg and increased edema. RN-C stated if compression socks did not fit R58's legs due to the increased edema, nurses were to use ace wraps per the standing physician orders.

On 12/1/17, at 7:13 a.m. LPN-D stated R58's right shin wound was from a ruptured fluid filled blister which ruptured when R58's compression stockings were applied. LPN-D confirmed nursing had not been monitoring the amount of R58's edema.

On 12/4/17, at 8:39 a.m. the DON stated R58's edema management should have been identified in the care plan.

Facility policy Nursing Care Plans last revised 4/17/17, included the following: The goal of the policy was to evaluate resident restorative potential, establish goals, and coordinate staff and resident efforts toward meeting those goals in order to provide an individualized nursing care plan that will promote the continuity of resident care. The policy also included, the plan shall be reviewed and revised by a team of qualified persons after each assessment, Using the

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F 657	Continued From page 62 information from the MDS and the resident's CAA's, the MDS nurse will develop a detailed, individualized care plan for the resident, and The care plan will be updated with changes in condition and as needed	F 657		
F 659 SS=E	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral hygiene cares for 1 of 5 resident (R5) as directed by the care plan; failed to provide wound treatment and the application of compression stockings or ace wraps as directed by the care plan for 1 of 5 residents (R58) reviewed. Lastly, the facility failed to provide timely repositioning and incontinence cares as directed by the care plan for 1 of 5 (R45) residents reviewed Findings include: R5 was not provided oral hygiene as directed by the care plan. R5's Care Planning Report dated 11/21/17, indicated R5 had self-care deficits related to Alzheimer's disease and had the inability to complete dressing, bathing or personal hygiene independently. The care plan directed staff to	F 659	F 659 Qualified Persons R5 has been receiving oral hygiene as directed by her care plan. R58 passed away on 12/1/17. R45 has been receiving turning/repositioning and incontinent care as directed by his care plan. The facility will ensure all residents are receiving oral hygiene as directed by their care plan. The facility will ensure residents with wounds receive wound care treatment and application of compression stockings or ace wraps as directed by their care plan.	1/14/18

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F 659	Continued From page 63 complete personal hygiene and to brush her teeth. On 11/30/17, at 8:47 a.m. R5 was observed seated in her wheelchair in the dining room when nursing assistant (NA)-C and NA-M assisted R5 to the resident bathroom on the Maple Lane Unit and assist her to the toilet. While on the toilet, the NAs proceeded to provide cares to R5. During cares, a toothbrush was noted to placed near the wash basin filled with soapy water. NA-C was observed to bump R5's toothbrush causing it to fall into the basin of soapy water. NA-C removed the toothbrush from the water and placed it on the sink. After assisting R5 to wash up and get dressed, NA-C combed her hair and assisted NA-M to transfer R5 back into her wheelchair. NA-C gathered the supplies used and soiled linens, straightened up the bathroom and brought the items to the soiled linen utility room. NA-M positioned R5 in her wheelchair and into the common living room area next to the bird aviary. At no time during the cares did NA-C or NA-M offer or provide R5 oral hygiene, nor did the NA's obtain a clean toothbrush. On 11/30/17, at 9:25 a.m. NA-C verified she had not provided oral hygiene for R5 and should have obtained a clean tooth brush after it was dropped and provided the oral cares. On 11/30/17, at 11:59 a.m. the director of nursing (DON) confirmed staff should provide oral hygiene as part of a.m. cares as directed by the care plan. R58's was not provided every one hour repositioning/adequate offloading assistance or two staff assist transfers as directed by the care plan.	F 659	The facility will ensure residents receive timely repositioning and incontinence care as directed by their plan of care. Education will be provided to all nursing assistants prior to 1/14/18 regarding the importance of following resident's individualized care plans for oral hygiene, application of TED socks, turning/repositioning, transfers and incontinent care. Nursing assistants will also receive education on reperfusion of tissue. Education will also be provided on documentation. Education will be provided to all nurses prior to 1/14/18 regarding the application of ace wraps and following orders for wound care. Education will also be provided on documentation. The Care Plan Policy was reviewed on 12/12/17. Audits will be completed seven times weekly, for 30 days, and then three times weekly, for 60 days,to ensure nursing assistants are following resident's individualized care plans for oral hygiene, application of TEDs socks/ace wraps, turning/repositioning, transfers and incontinent care. Audits will be completed seven times weekly, for 30 days, and then three times weekly, for 60 days, to ensure wound care is provided per the residents care plan. The results of these audits will be	

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F 659	Continued From page 64 R58's care plan dated 12/8/16, indicated R58 had decreased physical mobility related to osteomyelitis, weakness, chronic pain, and spinal stenosis and directed two staff to assist with transfers. The care plan also indicated R58 had a potential for alteration in skin integrity related to history of pressure ulcers, chronic kidney disease, and valvular heart disease and directed staff to encourage R58 to turn and reposition every one hour and as needed, and to provide education when R58 refused. During a continuous observation on 11/29/17, from 1:47 p.m. until 7:15 p.m. the following was observed: -At 1:47 p.m. R58 was seated in her recliner on a flat firm pillow with her legs in the dependent position (not elevated). -At 2:38 p.m. an unidentified staff member delivered clean linen to R58's room, exited and did not offer repositioning. -At 2:41 p.m. NA-K entered the room and immediately exited. R58 remained in the recliner, sleeping. NA-K did not offer or attempt to reposition R58. -At 2:55 p.m. NA-K peaked into R58's room and exited. -At 3:15 p.m. trained medication assistant (TMA)-B, entered the room and asked R58 if she wanted her eye drops. TMA-B did not offer or attempt to reposition R58 and walked back out of the room. -At 4:49 p.m. NA-L entered the room, informed R58 it was dinnertime, applied a transfer belt around R58's waist, picked R58 up and quickly transferred R58 into the wheelchair. NA-L did not offer or encourage R58 to stand long enough to ensure tissue reperfusion nor had NA-L sought	F 659	reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or designee is responsible for this deficiency. Corrective date: 1/14/18	

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additional staff assistance to assist with R58's transfer.
-At 5:39 p.m. NA-K and TMA-B applied the transfer belt and quickly assisted R58 back to her reclining chair. Neither NA-K or TMA-B offered or encouraged R58 to stand or lay down in order to ensure reperfusion of tissue.
-At 6:05 p.m. TMA-B entered the room and slightly elevated the chair's footrest.
-At 7:08 p.m. RN-C stated in order for R58 to sustain tissue perfusion in the coccyx area, R58 would have to be off of the coccyx for greater than one minute. RN-C confirmed R58 was not allowed enough time to ensure tissue perfusion during the transfers.
-At 7:15 p.m. RN-C offered repositioning to R58 in which R58 accepted. RN-C and RN-G proceeded to transfer R58 into bed. R58 was not provided/offered adequate repositioning/offload assistance for five hours and thirty minutes.

-At 5:20 p.m. RN-C verified R58's care plan directed two staff assitance was required for transfers and stated the care plan should have been followed.

-At 5:39 p.m. NA-K stated R58 required two staff for transfers.

On 11/30/17, at 7:26 a.m. NA-J was observed to place a transfer belt around R58's waist and transfer R58 into the wheelchair. NA-J stated two staff were supposed to transfer R58 but staff had always just transferred R58 with one staff member.

On 12/4/17, at 8:39 a.m. the DON confirmed R58's care plan indicated R58 was to be repositioned every hour and staff should have

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offered or attempted repositioning and allowed for at least two minutes of pressure relief in order to allow for tissue reperfusion. Additionally, the DON also confirmed R58's care plan indicated two staff were required for resident transfers. The DON verified R58's care plan should have been implemented, as directed.

R58 was not assisted with the application of Ted compression stockings or wound treatment as directed by the ADL (activities of daily living) flowsheet and/or nursing orders.

R58's signed physician orders dated 11/17/17, directed the application of knee high Ted compression stockings to both lower extremities, on in the morning and off at night.

R58's Physician Order Report dated 9/11/17-11/13/17, and stamped "Nursing Orders Only" and signed as reviewed by the RN (no physician signature) on 11/15/17, revealed the following orders:

-11/11/17, Left lower extremity: Apply ABD (12 x 12 inch x one inch bandage) pads, wrap with roll gauze/Kerlix, and secure with tape, twice a day. Notify the charge nurse when weeping has subsided, or when healed or worsened. Twice a day.
-11/11/17, Right lower extremity: Wound cleanse, pat dry, apply non-adhesive dressing pad with a dab of Bacitracin, cover lower extremity with ABD pads due to weeping, roll with gauze/Kerlix, and secure with tape, twice a day. Notify charge nurse if worsening or when healed. When weeping subsides dressing can be changed daily instead of twice daily.

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R58's Activities of Daily Living Flowsheet directed staff to apply the compression stockings to both legs in the morning and take them off at night. The documentation revealed R58 had not utilized the compression stocking as ordered on six occasions in October 2017, and 24 days in November 2017. The record lacked documentation of rationale why the stockings were not applied.

On 11/28/17, at 2:42 p.m. R58 was observed seated in her recliner with legs in dependent (down) position with compression stockings on bilaterally. Slight edema (swelling) was noted in both ankle areas. An ABD dressing was visible on her right shin area. No dressing visible on the left leg.

On 11/29/17, at 12:00 p.m. R58 was observed seated in her recliner with legs down. R58's compression stockings were not on. Edema was noted in both lower extremities from ankle to mid calf area. The right mid shin had an ABD dressing on secured with gauze. The left shin did not have a dressing, had a dime size superficial wound with clear, yellow tinged fluid running down R58's leg. R58 stated her leg had been weeping all morning.

-At 6:09 p.m. R58 was observed in her recliner, both legs were noted to be edematous and weeping. RN-G entered the room and R58 reported to RN-G that her left leg had been weeping all day. RN-G proceeded to donne gloves and removed the right shin dressing exposing a wound which measured approximately 2.0 inch by 0.5 inch with a depth of approximately 0.1 centimeter (cm). RN-G

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sprayed cleanser on the wound and dried it with a clean 4x4 gauze. RN-G applied a non adherent gauze dressing directly on the wound and covered it with an ABD dressing and secured it with a gauze wrap. RN-G did not apply the Bacitracin per nursing orders. RN-G then applied the left shin dressing change per nursing orders.

-at 6:17 p.m. RN-G stated R58's legs wept on and off, and at times, wept a lot. RN-G stated R58's compression stockings should have been applied and the dressing change have been completed as directed.

On 11/30/17, at 7:09 a.m. R58 was observed seated in the recliner with her legs down. The compression socks were not on. R58 stated staff did not put them on and did not offer to put them on. Both legs were noted to be edematous.

-At 8:45 a.m. licensed practical nurse (LPN)-D was observed to complete R58's lower extremity wound care. LPN-D washed her hands, donned gloves, removed the right shin dressing, and proceeded to spray wound cleanser on the wound, pat it dry, and applied an ABD dressing and gauze. LPN-D removed the left leg shin dressing and left it to remain open to air. LPN-D failed to apply Bacitracin to the right shin wound and failed to apply the left shin dressing per nursing orders.

-At 12:10 p.m. RN-C stated R58 had a history of edema, weeping legs, and blisters. RN-C stated she was not aware of the increased edema and if the compression socks did not fit R58's legs due to the increased edema, nurses were to use ace wraps per standing order.

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On 12/4/17, at 8:39 a.m. the DON confirmed the orders for the lower extremity dressings and Ted stockings and stated they should have been followed, as directed.

R45 was not provided timely assistance with repositiong and incontinence cares as directed by the care plan.

R45's care plan dated 10/31/17, indicated R45 was at risk for skin breakdown, was incontinent of bowel and bladder, and directed staff to assist with repositiong, transfers on and off the toilet, and to provide incontinence care every two hours.

On 11/29/17, at 4:25 p.m. NA-E was observed to assist R45 to the restroom. R45 was continuously observed from 4:34 p.m. until 7:46 p.m. and the followed was noted:
-At 4:38 p.m. R45 was seated in a wheelchair next to the Walnut Grove nurse's station.
-At 5:19 p.m. R45 wheeled into the Walnut Grove dining room.
-At 5:47 p.m. NA-E assisted R45 with the meal. An odor of diarrhea stool/ bowel movement (BM) was noted near R45's table.
-At 6:17 p.m. NA-E wheeled R45 out of the dining room and into the television lounge on Walnut Grove. The BM odor continued to be present by R45.
-At 7:45 p.m. RN-B walked by R45 and confirmed an odor of BM. RN-B proceeded to wheel R45 to his room. While seated in the wheelchair, BM was observed on R45's sweat pants in the groin area. RN-B confirmed R45 was soiled.
-At 7:46 p.m. R45 was assisted to ambulate to the bathroom by RN-B and NA-E. R45's pants and incontinent brief were saturated with loose BM and urine. His skin was clear and intact.

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F 659	Continued From page 70 R45's wheelchair was equipped with a pressure redistribution cushion. NA-E stated she would assist R45 with a shower and confirmed R45 had not been assisted to the restroom or repositioned since 4:25 p.m. a total of 3 hours and 20 minutes earlier. On 11/30/17, at 12:37 p.m. RN-B confirmed R45 was to be assisted with repositioning and incontinence cares every two hours as directed by the care plan. The Nursing Care Plans policy and procedure revised 4/17, indicated the resident care plan includes not only physician's orders and nursing care plans, but multidisciplinary team planning that includes all activities and therapies and involvement of the resident and significant social others.	F 659		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral hygiene cares for 1 of 5 residents (R5) observed who was dependent on staff for oral hygiene. Findings include:	F 677	F 677 ADL Care Provided for Dependent Residents R5 has been receiving oral hygiene as directed by her care plan. The facility will ensure all residents receive oral hygiene as directed by their care plan.	1/14/18

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F 677	Continued From page 71 R5's annual Minimum Data Set (MDS) dated 8/29/17, indicated R5 had severe cognitive impairment and diagnoses which included Alzheimer's disease and anxiety. The MDS also indicated R5 required total assist of one person for dressing, toilet use and personal hygiene. R5's Care Planning Report dated 11/21/17, indicated R5 had self-care deficits related to Alzheimer's disease and had the inability to complete dressing, bathing or personal hygiene independently. The care plan directed staff to complete personal hygiene and to brush her teeth. On 11/30/17, at 8:47 a.m. R5 was observed seated in her wheelchair in the dining room when nursing assistant (NA)-C and NA-M assisted R5 to the resident bathroom on the Maple Lane Unit and assist her to the toilet. While on the toilet, the NAs proceeded to provide cares to R5. During cares, a toothbrush was noted to placed near the wash basin filled with soapy water. NA-C was observed to bump R5's toothbrush causing it to fall into the basin of soapy water. NA-C removed the toothbrush from the water and placed it on the sink. After assisting R5 to wash up and get dressed, NA-C combed her hair and assisted NA-M to transfer R5 back into her wheelchair. NA-C gathered the supplies used and soiled linens, straightened up the bathroom and brought the items to the soiled linen utility room. NA-M positioned R5 in her wheelchair and into the common living room area next to the bird aviary. At no time during the cares did NA-C or NA-M offer or provide R5 oral hygiene, nor did the NAs obtain a clean toothbrush. On 11/30/17, at 9:25 a.m. NA-C verified she had	F 677	Education will be provided to all nursing assistants prior to 1/14/18 regarding the importance of offering oral hygiene as directed by the resident's care plan. The Oral Hygiene Policy was reviewed on 12/27/17. Audits will be completed seven times weekly, for 30 days, and then three times weekly, for 60 days,by the director of nursing or designee on various shifts to ensure oral hygiene is completed as directed by the resident's care plan. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or designee is responsible for this deficiency. Corrective Date: 1/14/18	

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F 677	Continued From page 72 not provided oral hygiene for R5 and should have obtained a clean tooth brush after it was dropped and provided R5 oral cares. On 11/30/17, at 11:59 a.m. the director of nursing (DON) confirmed staff should provide oral hygiene as part of a.m. cares as directed by the care plan.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently provide activities according to the assessed need for 3 of 3 residents (R5, R46, R10) who had cognitive impairment and was observed not to be provided daily activities and one to one activity visits according to their assessed need. Findings include: R5's annual Minimum Data Set (MDS) dated 8/29/17, indicated R5 had severe cognitive impairment and diagnoses which included Alzheimer's disease and anxiety. The MDS also	F 679	F679 Activities Meet Interest/Needs Each Resident R5, R46, and R10 will be provided activities and one to one activity visits according to their assessed need. All other residents will be reviewed to ensure they are provided activities and one to one activity visits according to their assessed need prior to 1/14/18. Education will be provided to all activities staff regarding the provision of activities	1/14/18

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F 679	Continued From page 73 indicated R5 required total assist of one person for dressing, toilet use, personal hygiene and it was very important for R5 to do favorite activities. R5 was able to communicate needs and understand others. R5's Vulnerable Adult care plan dated 11/15/13, indicated alteration in thought process with potential for anxiety related to Alzheimer's dementia, psychosis, bipolar, depression, short and long term memory deficit, wandered, verbally and physically abusive, history of throwing objects, anxiety regarding where her parents are, severe crying episodes and attempts to elope. Staff were directed to provide encouragement to participate in group and independent activities but respect her preference to select the activities she desired to engage in and her level of participation. Staff to assist resident to be ready for and/or take to desired activities which targeted music, spiritual, outdoor in warm/nice weather, a wide variety of games, art and craft projects especially painting, pet visits and beauty shop. Staff to provide calendar and supply items for resident as requested or needed for independent activities and personal use such as art and craft items and projects, games and playing cards, jigsaw puzzles, and additional items as requested. Additional resident centered 1:1 activities would be provided if resident showed lack of interest in participating in group activities. Activity staff to provide 1:1 visits per schedule. R5 resided on the secured memory care unit. R5's Activity Assessment Form dated 2016, indicated R5 enjoyed participating in a wide variety of games and socializing together, crafts, was a willing participant with various craft/art activities, walks throughout the day, was a very	F 679	and one to one activity visits according to each resident's assessed needs, and documentation of resident participation in activities and one to one visits prior to 1/14/18. The activity policy Residents with Special Needs was reviewed and revised on 12/30/17. Audits will be completed by the Activities Director of resident activity attendance record sheets and one to one activity attendance logs for 20 residents weekly, for 90 days, to ensure residents are receiving activities and one to one activity visits according to their assessed need. Observational audits will be completed five times weekly to ensure the activities staff are present on the memory care unit providing activities during their scheduled work hours. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Activities Director or designee is responsible for compliance with this regulation. Completion date: 1/14/18.	

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good singer and loved singing and listening to music especially old time country, bluegrass and spiritual hymns, reads a little bit, spirituality was very important to her, outings with family, loved being outdoors during nice weather, liked old time movies including westerns and TV series such as, "I Love Lucy", was sociable and loved being with others, helps others around the table during games/crafts, therapy dogs, loved to have hair done at beauty shop, small/large groups, one to ones, and independent time with family and spiritual singing. A hand written entry indicated "1:1 schedule daily." Goal was to participate in three out of the room activities per week.

The Maple unit November 2017, activity calendar was observed posted on the wall between the dining area and living room. The calendar indicated the following activities would be provided for the Maple Lane unit residents, however, were not observed to be provided:

-11/28/17- 4:00 p.m. coffee and current events
-11/29/17-4:00 p.m. coffee and current events and at 6:00 p.m. story-time
-All other events were off the unit.

R5's weekly Checklist and Log indicated R5 was to attend three out of room activities per week and 1:1 visits daily. Review of R5's activity documentation revealed the following:

-Week of 11/26/17-12/2/17, revealed R5 was provided one, one to one visit. The rest of the week was blank.
-Week of 11/20-11/26/17: R5 was provided five one to one visits.
-Week of 11/13-11/19/17, indicated seven one to one visits was provided.

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-Week of 11/6-11/11, indicated seven one to ones was provided.
-Week of 10/23/17, indicated five one to one visits were provided.
-Week of 10/15/17, indicated five one to one visits were provided.

On 11/28/17, from 8:30 a.m. until 11:00 a.m. R5 was observed to remain in the living room area, seated in her wheelchair. The TV was on but R5 did not appear to be watching it. At 11:00 a.m. R5 was assisted into the dining room for lunch.

On 11/29/17, from 1:00 p.m. to 4:30 p.m. R5 was continuously observed in the living room, seated in her wheelchair. Although R5 was provided toileting and repositioning cares during this time period, she was not provided any type of activity assistance.
-At 5:00 p.m. R5 was observed in the dining room during the supper meal.
-At 5:30 p.m. R5 was assisted back into the living room.
-At 6:00 p.m. staff removed R5 from the living room and provided toileting cares and returned R5 to the living room where she remained until 7:30 p.m. Throughout this observation, R5 was not provided or engaged in any type of activity and no activity staff were observed on the unit providing activities to any resident.

R46's annual MDS dated 10/23/17, indicated R46 had severe cognitive impairment and diagnoses which included dementia, anxiety disorder and depression. The MDS also indicated R46 required extensive assist with all activities of daily living, and was not able to answer questions related to preferences.

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R46's Care Planning Report dated 10/25/17, indicated R46 had alteration in thought process with potential for anxiety related to dementia. Goal indicated res would participate in one to one visits daily and additional resident centered one to one activities would be provided if R46 declined participation in group activities. R46 resided on the secured Maple Lane unit.

R46's Activity Assessment Form dated 2016, indicated R5 had not been interested in arts and crafts in the past but might be willing to try if she could sit still very long "doesn't like to sit still very long." R46 Enjoyed old time rock and roll and sometimes a bit of old county music, likes to listen to piano music, reads magazines and the newspaper once in a while, is catholic which was "somewhat" important to her to attend these services, liked to be outside when the weather was nice, kept up with the news sometimes, however at her own discretion, liked to watch a variety of different programming just did not usually watch the whole show due to sitting very long. Loves all kinds of pets and really enjoyed the pet visits, enjoyed small and large group activities, one to ones and also independent activities. "daily 1:1" was hand written on the assessment form.

R46's weekly activity Checklist and Log indicated R46 was to participate in one to one visits daily. Review of R46's activity documentation revealed the following:

-Week of 11/26/17, to 12/2/17: R46 was provided two one to one visits.
-Week of 11/20- 11/26/17: R46 was provided four one to one visits.

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F 679	Continued From page 77 -Week of 11/13- 11/19/17, R46 was provided seven one to one visits. -Week of 11/6-11/11/17, indicated R46 was provided seven daily one to ones. -Week of 10/30/17, indicated three one to one activities was provided. -Week of 10/23/17, indicated R46 was provided five one to one visits. -Week of 10/15/17, indicated R46 was provided four one to one visits. On 11/28/17, from 8:30 a.m. until 10:43 a.m. R46 was observed to ambulate around the Maple Lane unit and had occasional crying outbursts. No type of activity was observed to be provided. On 11/29/17, from 1:00 p.m.. until 4:30 p.m. and from 5:30 p.m. until 7:00 p.m.. R46 was observed to ambulate throughout the unit. Throughout the observations, R46 was not observed to be engaged in or offered any type of activity. On 11/30/17, from 1:00 p.m. until 3:30 p.m. R46 was observed to ambulate throughout the unit. R46 was not observed to be offered or provided any type of activity. On 11/30/17, at 11:59 a.m. the director of nursing (DON) stated she was surprised no activity staff had been on the unit because one activity staff person was scheduled to work specifically in the unit from 1:00 p.m. to 8:00 p.m. daily which was implemented as part of their plan of correction from last year. -At 1:15 p.m. nursing assistant (NA)-C stated sometimes she worked 12 hour shifts on the unit and when working, there was no staff from activities present. NA-C stated if an activity staff	F 679		

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member did show up on the unit, they would take four of the higher functioning residents to an off the unit activity and the remaining residents on the unit had nothing to do and were not provided any type of activity.

On 12/1/17, at 8:51 a.m. registered nurse (RN)-A stated an activity person was supposed to be on the unit from 1:00 p.m. to 8:00 p.m. everyday and confirmed this had not occurred. RN-A stated R46 wandered frequently around the unit and exhibited frequent weeping episodes and stated staff were working on medication adjustments with her. RN-A confirmed R5 enjoyed several activities and stated it would greatly benefit the unit if the activity staff person was available during that time frame as that was when staff had noticed an increase in resident behaviors.

-At 3:02 p.m. NA-U stated she had been at work since 6:00 a.m. and often worked p.m. shifts. NA-U stated there was no activity staff on the unit from 1:00 to 8:00 p.m. as indicated and felt the residents on the unit were bored and the unit staff did not have the time to provide activities for them.

-At 3:14 p.m. licensed practical nurse (LPN)-E confirmed there was no activity staff member on the unit from 1:00 p.m. to 8:00 p.m. as indicated and stated it would be a tremendous help if activity staff were available to help occupy the residents. LPN-E stated if an activity staff member did show up on the unit, they would take the four higher functioning residents to an off the unit activity and there was no activity provided for the lower functioning residents remaining on the unit. LPN-E stated the unit was so short staffed they did not have time to provide activities.

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F 679	Continued From page 79 -At 3:30 p.m. the activity director (AD) stated there was an activity staff person scheduled to work on the Maple Lane unit from 1:00 p.m. until 8:00 p.m. everyday. The AD was informed of the lack of an activity staff member on the unit during the following observed times: 11/28/17: 8:00 a.m. until 4:30 p.m. No activity staff observed on the unit. 11/29/17: 10:00 a.m. until 8:00 p.m. No activity staff observed on the unit. 11/30/17: 7:30 a.m.-3:30 p.m. No activity staff observed on the unit. 12/1/17: 7:00 a.m. 3:30 p.m. No activity staff observed on the unit. The AD stated all of the resident activity documentation on the Maple Lane unit was completed which indicated it was provided, therefore she was unsure why the staff were saying no activity staff was present on the unit everyday from 1:00 p.m. to 8:00 p.m. When asked if she had personally checked to see if activity staff were present on the unit or not, the AD stated she worked from 8:00 a.m. to 4:30 p.m. therefore she was unable to check on activity staff presence on the unit after 4:30 p.m. The AD stated the activity staff person should have been providing spontaneous as well as other types of activities, as needed, to all the residents on the unit. The AD stated she had hired an activity aide for the unit who would be starting on Monday. Following discussion with the AD regarding no activity staff observed to be present on the unit, an activity staff person arrived to the unit with an activity cart and offered puzzles and cards to residents.	F 679		

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On 12/3/17, at 11:15 a.m. the DON stated she was unsure as to why the activity staff were not providing activities on the unit as they should have been or why the activity documentation reflected completion of activities for the residents on the unit when the unit staff are stating the activity staff were not providing activities to the residents on the unit. The DON stated she would be discussing the concern with the AD.

On 12/3/17, from 1:00 p.m. until 5:30 p.m. No activity staff were observed on the unit.
R10's quarterly MDS dated 9/10/17, identified a severe cognitive impairment with diagnoses of Alzheimer's dementia and depression.

R10's Preferences for Customary Routine and Activities, dated 9/8/17, indicated it was "very important" for R10 to do his favorite activities.

R10's Activity Assessment Form, dated 2017, identified an activity goal of participating in three activities weekly and, "Staff provide 2 1:1 (one to one) per week." The form noted R10's one to one visits could include, "snacks, storytime, being read to, pet visits, likes old westerns, books, newspapers, and magazines, radio playing his favorite music."

R10's current care plan, dated 9/12/17, indicated he had alteration in thought processes, the potential for anxiety, short and long term memory loss, and impaired cognition. The care plan noted R10's activities would target coffee and snacks, personal radio with CD's, visiting, story time and being read to, and napping. The care plan further directed, "Staff will provided 1:1 visits per schedule."

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An untitled 1:1 schedule, undated, indicated R10 was scheduled for one 1:1 visit per week on Sundays. R10 was not scheduled for two 1:1 visits as identified in his activity assessment.

The Record of One-To-One Activities, reviewed from 1/17, to 11/17, revealed the following:

-R10 received five visits in January.
-No visits were recorded in February.
-R10 received two visits in March.
-R10 received three visits in April.
-R10 received five visits in May.
-R10 received two visits in June.
-R10 received three visits in July.
-R10 received one visit in August.
-R10 received one visit in September.
-No visits were recorded in October.
-R10 received one visit in November.

On 11/28/17, at 9:23 a.m. R10 was observed lying in bed, sleeping.
-At 10:22 a.m. R10 was being assisted with breakfast in his room.
-At 2:12 p.m. R10 was awake and lying bed.
-At 3:57 p.m. R10 was seated in his wheelchair. An unidentified staff member assisted R10 into the day room and positioned him in front of the television with three other residents. R10 was observed with his eyes closed, not watching the TV. No activities were provided to R10.

On 11/29/17, at 10:48 a.m. R10 was observed seated in his wheelchair while being assisted by an unidentified staff member to the day room and was positioned in front of the TV, where another resident was watching Bonanza. R10's eyes were closed and he was not watching TV.
-At 12:55 p.m. R10 was again taken to the day

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room and positioned in front of the TV. R10's head was tilted forward and he appeared to be sleeping. R10 remained in the day room until 1:23 p.m., when he was transferred into bed. R10 remained in bed until 5:36 p.m. when he was assisted to the dining room for supper. After supper, at 6:43 p.m., R10 was again observed in bed sleeping. No activities were provided to R10.

On 11/30/17, at 8:13 a.m. R10 was observed in bed, awake, and being assisted with breakfast.
-At 9:44 a.m. R10 remained in bed, awake and looking around his room, at his hands, and out his window.
-At 11:43 a.m. R10 was in the day room, seated in his wheelchair, in front of the TV. A couple of minutes later, R10 was taken into the dining room for lunch.
-At 12:34 p.m. R10 was in the dining room interacting with his family. No activities were provided to R10.

On 11/30/17, at 9:50 a.m. LPN-A stated when R10 was awake and up in his wheelchair, he liked to talk to people and liked to talk about being a truck driver. LPN-A stated R10 liked to be talked to and got really excited when his family came to visit. R10 was very sociable when awake, but when he was not awake, he would look away from you if you attempted to talk to him.

On 11/30/17, at 11:28 a.m. NA-Q stated R10 was a tough one to get to activities, further stating R10 was not as interested in participating in the groups, but if you got him talking about hunting and fishing he would enjoy that.

On 11/30/17, at 1:09 p.m. activities aide (AA)-C stated R10 was very solitary, but liked being read

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to and liked to come have coffee and snacks. AA-C further stated R10 just liked visiting even if he was not responding, R10 liked being around people but was a quiet person and had the most reaction when his family visited. AA-C acknowledged R10 was on a one to one visit program and stated R10 was usually up in his wheelchair when he saw him and slept mostly in the afternoons, especially after lunch. AA-C stated the activities staff were in the facility from 8:30 a.m. to 4:30 p.m. and if R10 was in bed or sleeping, they did not disturb him.

On 11/30/17, at 1:16 p.m. the AD stated R10 loved music and snacks. The AD stated R10 liked talking about his old truck driving days and fishing, and sometimes liked to nap. R10 liked to sit in by the TV because another resident liked the same shows. The AD reported the activities staff were expected to document if R10 refused the activities or one to one visits and was unaware of the discrepancy between the activity assessment, which assessed R10 for two one to one visits, and the one to one schedule, which only had him scheduled for one visit. The AD stated she was not aware when it was switched or if it was a mistake. The AD stated it was her expectation for staff to check the one to one calendar daily and, if they could not complete all the scheduled one to one visits for that day, the staff were to provide them the next day. The AD stated her staff were visiting with R10 almost daily; however, since their conversations with R10 were less than five minutes, were not documenting the visits as one to one visits because they were short visits. The AD felt the visits still contained a meaningful interaction, and stated there was a documentation problem, as her staff didn't document those interactions since

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F 679	Continued From page 84 they were so short, and should have. The activity policy Residents with Special Needs, undated, indicated it was the policy of the facility to provide activity programs and modified interventions to promote the maintenance or enhancement of each residents quality of life and to promote physical, cognitive, and/or emotional health when practicable.	F 679		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R28) received necessary medical attention following the onset of an acute illness and the facility staff refused to transfer R28 to the hospital for treatment. R28 sustained actual harm as required hospitalization for treatment of pneumonia, sepsis and dehydration. In addition, the facility failed to comprehensively assess, monitor, and implement interventions for 1 of 1 resident (R58) who had non pressure related open areas to the lower legs and also had increase of edema (swelling) to legs. R58 sustained actual harm as the skin conditions worsened.	F 684	F684 Quality of Care R28 has been receiving medical attention as needed for new acute illnesses and transferred to the hospital for treatment when family has requested and when a charge nurse has noted changes in condition. R58 passed away on 12/01/17. All residents have been receiving medical attention and have been transferred to the hospital as needed for new acute illnesses.	1/14/18

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F 684	Continued From page 85 Findings include: R28's quarterly Minimum Data Set (MDS) dated 10/2/17, indicated R28 had diagnoses of Alzheimer's dementia, aphasia (inability to speak), and a stroke. R28 was not able to communicate or make decisions on her own. The assessment indicated R28 was totally dependent upon staff for all activities of daily living. On 11/29/17, at 12:50 p.m. family member (FM)-A and FM-B requested to speak to the State agency surveyor regarding a concern. FM-B stated FM-A and FM-B had been out of town in June 2017, and upon returning home, had stopped at the facility to see R28. When they arrived at the facility, they found R28 with a high fever, she was lethargic (a state of tiredness, weariness, fatigue, or lack of energy), and was unable to drink. They approached registered nurse (RN)-D, the charge nurse, and requested to have R28 seen in the emergency department, however, RN-D refused to assist the family with transportation to the hospital. FM-B stated RN-D told them that R28's primary physician had ordered an antibiotic earlier that day and R28 was not to go to the hospital. When requested again by the family, RN-D refused to contact the physician again or to assist in transferring R28 to the hospital. FM-A became tearful as FM-B stated an unidentified staff member obtained the phone number for the transportation company so that R28 could be transported to the hospital. FM-B contacted the transportation company and had R28 transferred to the emergency room without assistance from the facility. While at the hospital, R28 was diagnosed with sepsis (a life-threatening illness	F 684	Residents identified as having edema have been receiving ongoing monitoring. All residents with wounds have had a comprehensive assessment with ongoing monitoring and implementation of new interventions if indicated. The care plans for all residents with current open wounds (pressure & non-pressure related) have been reviewed and revised as needed to ensure they reflect the wounds and the care related to them. All resident care plans will be reviewed/revised to ensure they reflect edema monitoring prior to 1/14/18. Education will be provided to all charge nurses prior to 1/14/18 regarding the importance of updating family members and physicians with acute changes in condition whether related to skin or illness. The charge nurses will also be educated on the expectation of assisting residents/family members with requests of transfers to the clinic or ER. Education will be provided to charge nurses regarding comprehensively assessing (determine the cause of the wound and if it is avoidable or not), monitoring, and implementing new interventions for open areas and edema management. Education will be provided to all nurses on infection control practices during wound care.	

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F 684	Continued From page 86 caused by your body's response to an infection) and subsequently required a three day hospitalization for antibiotic intravenous therapy (IV). FM-B stated the emergency room physician informed the family that if R28 had not been started on IV therapy that day, she would have died by morning. FM-B stated she had reported the concern to the facility administrator, however, the administrator supported the actions of RN-D. Review of R28's Progress Notes revealed the following information: -On 6/20/17, at 3:35 p.m. indicated R28 had experienced an emesis prior to lunch, R28's temperature was noted to be 101.0 degrees Fahrenheit (F). R28 had another emesis at lunch and R28's temperature was "around 102" degrees F. After lunch, R28 was noted to have wheezes (whistling or rattling sound in the chest, as a result of obstruction in the air passages). R28's primary physician was called and an antibiotic was ordered for twice a day for ten days for possible aspiration (entry of material from the oropharynx or gastrointestinal tract into the larynx (voice box) and lower respiratory tract). -At 4:59 p.m. indicated R28's temperature at 2:20 p.m. was 100.9 degrees F. R28 was lethargic, skin was hot and moist to the touch, cheeks were red and R28 was only taking sips of fluids. Will continue to monitor. -At 5:01 p.m. indicated R28's temperature was 101.6 at 3:00 p.m. and was given Tylenol. R28 was seated in wheelchair, and received the first does of the antibiotic. FM-A and FM-B had requested R28 be evaluated in the emergency room. The charge nurse was informed of the	F 684	Education will be provided to all nursing staff regarding documentation of refusals. The Resident Incident/Change in Resident Health Status policy was reviewed revised on 12/11/17. The Skin Care Protocol Policy was reviewed on 12/30/17. The facility's policy titled Pressure Ulcers in Long Term Care will be reviewed and revised prior to 1/14/18. A RN wound round team lead will be selected prior to 1/14/18 to complete weekly reports to the Director of Nursing on wound progress. Audits will be completed three times weekly, for 90 days, on resident progress notes by the Director of Nursing or designee to ensure resident's physicians are notified of changes in condition. Audits will be completed on wound rounds by the Director of Nursing or designee 1 time weekly (all wounds each week), for 90 days, to ensure they are assessed, monitored, and to ensure new interventions are implemented if indicated. Audits will be completed three times weekly, for 90 days, by the Director of Nursing or designee on dressing changes to ensure infection control practices are followed. The results of these audits will be	

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F 684	Continued From page 87 request. -At 5:07 p.m. RN was called down R28's unit. "Husband looks angry" when RN walking towards him. FM-A and FM-B both requested to have R28 sent immediately to the hospital. FM-B had stated to the RN "just look at her." RN explained to FM-A and FM-B that R28's physician had ordered resident to stay at facility and had also ordered an antibiotic to be started for possible aspiration. FM-A stated he did not care what the physician had ordered or said. RN informed FM-A and FM-B that if they wanted R28 sent to the hospital that it was their choice and they had every right to do so but she would not be arranging rides or taking part of the situation due to having no doctor's order. The note further indicated the RN attempted to explain to FM-A and FM-B the reasoning for keeping R28 at the facility was due to the hospital or emergency room (ER) not doing anything more that what the facility was currently doing for R28 "here and now." FM-B had questioned R28's breathing and oxygen in which the RN indicated R28's oxygen level was 91% and that she would receive oxygen if her levels went below 90%. FM-A became angry, red in the face, pointing finger, and hollering at the RN. RN called the ER charge nurse to give a "little heads up" on the situation. The note lacked evidence an assessment of R28's condition was completed at the time of the family request and also lacked evidence of any attempts to contact R28's primary physician or an "on call" physician regarding the family's wishes. -6:01 p.m. R28 left facility via MediVan. RN notified the ED that the resident was on her way with family.	F 684	reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or designee is responsible for this deficiency. Corrective date: 1/14/18	

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-9:41 p.m. RN received call from the ER which informed the facility R28 was "really sick," was started on an intravenous antibiotic, had a nasogastric tube inserted, and R28 was septic therefore was admitted to the hospital.

Review of R28's Physician's Orders dated 6/20/17, included an order for Augmentin (antibiotic) 875-125 milligrams twice a day for ten days. The orders did not direct the staff to keep R28 at the facility and not to refrain from hospital transfers.

R28's Uniform Code Level Direction for Cardiopulmonary Resuscitation form dated 5/16/13, indicated the family had determined that no interventions were to be made in the event of a cardiac or respiratory arrest. Other conditions were to be treated as medically appropriate. The family had not restricted any other medical treatments in the event of an emergency. They had not refused further hospitalizations.

The Hospital Triage Chief Complaint documentation dated 6/20/17, indicated R28 arrived at the emergency room with the family and complaints of fatigue. Family reported when they arrived at the facility, R28 was observed hanging over the side of her chair with her tongue hanging out. R28 was not responding to family and her tongue was white and dry appearing. R28 had recently been treated for pneumonia and had been vomiting.

The Emergency Room note dated 6/20/17, indicated R28's white blood count was elevated to 29,400 (normal number of WBCs in the blood is 4,500 to 11,000 a high number indicates the body's reaction to fight infection). R28 was

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admitted to the hospital with a diagnosis of pneumonia.

The hospital Progress Note dated 6/22/17, indicated R28 had diagnoses of aspiration pneumonia and mild dehydration.

R28's Hospital Discharge Summary dated 6/23/17, indicated R28 required hospitalization for the provisional diagnosis of aspiration pneumonia with sepsis and clinical dehydration. R28 received IV fluids and antibiotics, her temperature had returned to normal, she was alert and was able to swallow food comfortably. R28 was to continue on oral antibiotics for a total of 10 additional days.

On 12/1/17, at 7:10 a.m. licensed practical nurse (LPN)-D stated if a family member requested a resident to go to the hospital, she would check on the resident, notify the charge nurse, and make arrangements to assist to transfer the resident to the hospital.

On 12/1/17, at 7:30 a.m. RN-A stated if a family member requested to send a resident to the hospital, the resident was to be assessed, a physician (either the resident's primary physician or the "on call" physician) was to be contacted and the facility staff were to assist with the transfer. RN-A stated she was aware of the concern on 6/20/17, when R28's family requested R28 be transferred to the hospital. RN-A stated ultimately R28 was seen in the hospital and admitted and verified it was the family's right to have the resident seen in the emergency room if they wished.

On 12/1/17, at 8:22 a.m. RN-B stated if a family

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member wished to have a resident seen in the emergency room, the staff were to complete an assessment, contact the primary physician or "on call" physician and obtain an order to transfer the resident to the hospital for further evaluation per the family request. RN-B stated R28 had a history of aspiration pneumonia and on 6/20/17, R28 was started on an oral antibiotic due to possible recurring aspiration. RN-B stated R28 had not been physically evaluated by the primary physician on 6/20/17, rather due to the physician knowing R28's history or aspiration pneumonia and previous treatments, and R28 having been recently treated with an antibiotic for aspiration pneumonia, R28's physician had instructed the facility to treat R28 at the facility, had ordered an antibiotic and requested to not send R28 to the emergency room. RN-B confirmed the instructions to refrain from hospital transfer/evaluation had not been written as a physician's order in R28's medical record. R28's primary physician and the family had discussed hospitalizations in the past and there was a verbal agreement to treat R28 at the facility versus in the acute hospital. RN-B stated she had attempted to contact R28's family on 6/20/17, to notify them of her deterioration however, she was unable to reach the family and did not document her attempts to contact the family in R28's record. Upon review of the 6/20/17 documentation, RN-B stated it would have been beneficial for RN-D to have completed an assessment of R28's condition, contact a physician and assist to transfer R28 to the emergency room per the family request.

-At 8:52 a.m. the director of nurses (DON) stated if a family member wished to have their loved one evaluated by the emergency room physician, the

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staff were to assess the resident, contact a physician and assist with making the arrangements for transfer to the hospital. The DON stated she would not expect the staff to refuse to transfer a resident when a family requested it.

-At 8:56 a.m. RN-C stated if a family member requested to have their loved one transferred to the hospital, she would complete a resident assessment, contact the primary physician or the on call physician, and make the arrangements to transfer to the hospital.

-At 9:03 a.m. the DON stated R28's primary physician was notified of R28's vomiting, fever and wheezes on 6/20/17, and had ordered R28 a new antibiotic. The DON stated R28's primary physician prefers the residents of the facility be treated in the facility and staff were to inform him of any changes. The DON confirmed R28's medical record did not contain a physician's order to refrain from hospitalizations and stated it was an understating between the primary physician and the facility to refrain from hospitalizations. The DON confirmed RN-D's documentation lacked an assessment of R28's condition on 6/20/17, and verified RN-D did not attempt to notify a physician of any potential changes in R28's condition. Upon review of the progress note dated 6/20/17, at 6:01 p.m. the DON stated she was unaware the documentation clearly indicated RN-D refused to assist FM-A and FM-B to transfer R28 to the emergency room for an evaluation and stated that was not the facility's normal practice. The DON stated she had talked to RN-D about the actions on 6/20/17, and directed RN-D and the rest of the staff to assist with transfers to the hospital per families' choice.

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However, the DON stated she had not documented the directive nor had she provided any type of formal training to the staff. The DON stated during shift to shift report, she had directed the staff to remind each other to follow family requests.

-At 9:21 a.m. the DON and State Agency surveyor attempted to contact RN-D without success.

-At 9:49 a.m. the facility administrator reviewed RN-D's documentation from 6/20/17, at 5:07 p.m. and stated he was unaware RN-D had not assessed R28 at the time of the family's request, or that RN-D had refused to contact a physician or assist the family in transferring R28 to the hospital. The administrator stated he felt RN-D's documentation showed frustration and it was his understanding that the family had not allowed RN-D time to assess R28 prior to them transferring R28 to the hospital. The administrator stated the DON had investigated the concern from the family however, confirmed there was no documentation related to the investigation nor indication additional staff training/coaching had been provided.

On 12/4/17, at 4:00 p.m. RN-D stated it was her understanding R28 had been started on a new antibiotic and she was not to be sent to the emergency room as they could not do anything differently than what was being done at the facility. RN-D confirmed R28's medical record did not contain a physician's order to refrain from hospital evaluation. RN-D stated on 6/20/17, when FM-A had requested R28 be sent to the emergency, FM-A was angry and threatening towards her so she had to walk away from the situation. RN-D stated she did not feel she had

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the time to assess R28 or to help with the transfer as the family had already made the arrangements and left with R28. RN-D stated she had called the emergency room regarding R28's family request however, she had not attempted to contact a physician.

The facility policy, Resident Incidents/Change in Resident Health Status dated 4/2015, directed staff to provide continued care for a resident when they become acutely ill. The policy directed the charge nurse to assess the illness, notify family and physician of any changes, assist with transfers to the hospital as needed and update the resident's care plan as needed.

R58's Care Center Diagnosis Sheet signed by the physician on 8/14/17, included diagnoses of history of stage one pressure ulcer (non-blanchable erythema of intact skin), chronic kidney disease stage 5 requiring dialysis, hypertension, history of deep vein thrombosis, and peripheral vascular disease.

R58's quarterly MDS dated 11/6/17, indicated R58 had moderate cognitive impairment, required extensive physical assist from one staff member for bed mobility and transfers.

A facility fax to R58's physician dated 4/4/17, revealed R28 was found to have small fluid filled blisters on her left leg which appeared to be due to lower extremity edema. Edema is only noted in the left leg. R58 to be set up with daily weights for one week. Will also wrap left with cast padding and an ace wrap. Will update physician with any concerns. R28 continues to receive scheduled dialysis. Facility assessment section indicated fluid filled blisters due to lower extremity

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edema, nothing additional requested for the resident. The physician response dated 4/5/17, indicated "agree with plan." No new orders given.

R58's physician visit progress form dated 10/9/17, indicated R58 had been stable since last visit and had contemplated discontinuing dialysis. The Review of Systems (ROS) section indicated skin was "negative."

R58's signed physician orders dated 11/17/17, included knee high Ted compression stockings to both lower extremities on in the morning and off at night (start date of 5/10/17).

R58's standing orders signed by the physician on 8/17/16, directed staff to apply Ted compression stockings or ace wraps, as needed.

R58's Physician Order Report dated 9/11/17-11/13/17, stamped "Nursing Orders Only" and signed as reviewed by the RN (no physician signature) on 11/15/17, revealed the following orders:
-Inspect skin on bath days for reddened or opened areas.
-11/11/17, Left lower extremity: Apply ABD (12 x 12 inch x one inch bandage) pads, wrap with roll gauze/Kerlix, and secure with tape, twice a day. Notify the charge nurse when weeping has subsided, or when healed or worsened. Twice a day.
-11/11/17, Right lower extremity: Wound cleanse, pat dry, apply non-adhesive dressing pad with a dab of Bacitracin, cover lower extremity with ABD pads due to weeping, roll with gauze/Kerlix, and secure with tape, twice a day. Notify charge nurse if worsening or when healed. When weeping subsides dressing can be changed daily instead

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of twice daily.

Review of R58's Treatments Administration Record (TAR) history dated 9/1/17-9/30/17, directed staff to cleanse the right shin wound, pat dry, apply a non-adherent pad with a dab of Bacitracin, roll with gauze, and secure with tape daily. The treatment was initiated on 9/17/17, with a discontinuation date of 10/6/17. Documentation revealed the treatment was provided daily, as directed.

Review of R58's TAR dated 10/1/17-10/31/17, directed staff to cleanse the right shin wound, pat dry, apply a non-adherent pad with a dab of Bacitracin, roll with gauze, and secure with tape, daily. The documentation revealed the the dressing was completed on 10/1/17, through 10/6/17.

Review of R58's TAR dated 11/1/17-11/20/17, directed staff to apply ABD pads to the left lower extremity, wrap with roll/gauze/Kerlix, and secure with tape twice a day. The TAR also directed staff to cleanse the right lower extremity wound, apply a non-adhesive pad with a dab of Bacitracin, cover extremity with ABD pads due to weeping, roll with gauze/Kerlix, and secure with tape twice a day. Both treatments were initiated on 11/11/17, with a discontinuation date of 12/1/17. The documentation revealed both treatments were completed twice daily from 11/12/17, through 11/30/17.

R58's care plan dated as last reviewed 11/8/17, indicated the following:
-Potential for alteration in skin integrity related to history of pressure ulcers. Chronic kidney disease (CKD) and valvular heart disease and directed

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staff to maintain adequate nutrition and hydration by providing dietary "decub" program.
-At risk for infection related to CKD and receives dialysis. Staff were directed to offer fluids on a regular basis with meals, medications, between meals and in the evening. Monitor for hydration, redness and breakdown. Be aware of changes in behavior, lethargy, confusion, agitation, assess changes and update physician as needed.
-Potential for fluid overload and alteration in circulation status with a goal R58 would not have excess fluid. Staff were directed to send to dialysis as ordered, medicate as ordered, in emergency staff would give Kayexalate as ordered if unable to attend dialysis, and to maintain adequate nutrition and hydration by providing dietary "decub" program.
R58's care plan failed to identify and address the actual non pressure related wound and edema and care directives.

R58's Checklist for Skin Risk Factors and Interventions form dated 5/2/17, indicated R58 had lower extremity concerns of signs and symptoms of arterial disease (PVD-peripheral vascular disease) such as cold extremity, thin and shiny skin and also arterial insufficiency concerns. The staff were directed to inspect skin daily, weekly skin assessment by licensed staff, moisturize dry skin, bathe with mild soap and gently dry, monitor pain and administer pain medications/treatments as ordered, involve/educate resident and/or family members, optimize blood flow to extremity, keep legs in neutral position, prevent trauma, proper fitting footwear, pressure reduction to heels, monitor weight/labs with a written note indicating dialysis would monitor labs, pad, protect and/or apply skin prep to fragile skin, encourage mobility and

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ambulation.

On 11/28/17, at 2:42 p.m. R58 was observed seated in her recliner with her legs in a dependent (down) position with white Ted compression stockings on bilaterally. Slight edema (swelling) was noted in both ankle areas. An ABD (a specific type of dressing) was visible on her right shin area. No dressing visible on the left leg.

On 11/29/17, at 12:00 p.m. R58 was observed seated in her recliner with legs down. R58's compression stockings were not on. Edema was noted in both lower extremities from ankle to mid calf area. R58's left leg had large scales of dry skin on the foot and ankle. The right mid shin had an ABD dressing on secured with gauze. The left shin area had a dime size superficial wound with clear, yellow tinged fluid running down R58's leg. R58 stated her leg had been weeping all morning.

On 11/29/17, at 6:09 p.m. R58 was observed in her recliner, both legs were noted to be edematous and weeping. RN-G entered the room and R58 reported to RN-G that her left leg had been weeping all day. RN-G proceeded to donne gloves and removed the right shin dressing. An approximate 2.0 inch by 0.5 inch with a depth of approximately 0.1 centimeter (cm) wound was noted on the right shin. The base of the wound was visible and a thin layer of yellow/green matter was observed in the lower area of the wound. RN-G sprayed cleanser on the wound and dried it with a clean 4x4 gauze. RN-G left the wound open, washed her hands and left the room to gather more supplies. Upon returning to the room, and without gloves on, RN-G applied a non adherent gauze directly on the wound and covered it with a ABD dressing

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and secured it with a gauze wrap. RN-G donned gloves, sprayed the left shin area with wound cleanser and dried it with a clean 4x4 gauze, removed her gloves and covered the shin area with an ABD dressing and secured it with gauze wrap.

On 11/29/17, at 6:17 p.m. RN-G stated R58's legs wept on and off, and at times, wept a lot. RN-G stated the dressings were nursing orders only and should be followed as written. RN-G stated R58's compression stockings should be applied according to the doctor's order.

R58's Activities of Daily Living Flowsheet directed staff to apply the compression stockings to both legs in the morning and take them off at night. The documentation revealed R58 had not utilized the compression stocking as ordered on six occasions in October 2017, and 24 days in November 2017. The record lacked documentation of rationale why stockings were not applied.

On 11/30/17, at 7:09 a.m. R58 was observed seated in the recliner with her legs down. The compression socks were not on. R58 stated staff did not put them on and did not offer to put them on. Both legs were noted to be edematous.

On 11/30/17, at 8:45 a.m. LPN-D was observed to complete R58's lower extremity wound care. LPN-D washed her hands, donned gloves, removed the right shin dressing, stated it looked better, and proceeded to spray wound cleanser on the wound, pat it dry, and applied an ABD dressing and gauze. LPN-D removed the left leg shin dressing and left it to remain open to air.

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R58's nursing progress note dated 11/11/17, indicated both lower extremities were swollen, weeping and R58 may have had a blood/fluid blister on her right lower extremity that had recently ruptured. Treatment for legs was set up for twice a day until swelling and weeping had subsided. Blood/fluid drainage was noted on dressing approximately 45 minutes after application. R58 was seated in her recliner with feet elevated. R58 was encouraged to elevate her legs as much as possible. The note did not include the size of the wound or indicate if R58's physician had been notified. In addition, no further documentation related to R58's edema or shin wound was noted in the medical record until 11/30/17.

R58's progress note dated 11/30/17, indicated R58 had intermittently refused dialysis and being resident continues to receive dialysis, hospice services were not indicated however, comfort cares could be started which included no further hospitalizations. A telephone physician order dated 11/30/17, indicated comfort care standing orders, weight loss expected due to terminal status. Even thought R58's current status had been identified as terminal, the facility failed to assess, monitor and document wound status and interventions/response to interventions at the onset of the wound and prior to the decline in her health status.

R58's medical record lacked evidence of physician notification of the right leg wound, the increase in leg edema, blister formation, or wound drainage. Additionally, the medical record lacked evidence of a wound assessment as well as ongoing wound documentation and monitoring including monitoring and management of the

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edema.

The E-Z Graph Wound Assessment dated 11/30/17, completed by RN-C indicated the right shin wound measured 5.0 cm by 1.0 cm, depth could not be determined because it was covered with slough (Slough is non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed). A progress note dated 11/30/17, at 3:29 p.m. indicated R58's physician was updated of the intermittent formation of blisters, the right leg wound, and edema. The cause of the wound was not identified on the assessment. R58's Physician Order's revealed a telephone order which indicated 1. Havenwood Care Center comfort care standing orders. 2. Weight loss expected due to terminal status. No order indicated related to changes in wound care/management.

On 11/30/17, at 12:10 p.m. RN-C stated R58 had a history of edema, weeping legs, and blisters. RN-C confirmed R58's medical record lacked monitoring of the condition of R58's legs and stated she was not aware of the wound to right leg and increased edema. RN-C stated if compression socks did not fit R58's legs due to the increased edema, nurses were to use ace wraps per the standing physician orders.

On 12/1/17, at 7:13 a.m. LPN-D stated R58's right shin wound was from a ruptured fluid filled blister which ruptured when R58's compression stockings were applied. LPN-D confirmed nursing had not been monitoring the amount of R58's edema and stated she did not know how long R58 had the blister before it ruptured.

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F 684	Continued From page 101 On 12/4/17, at 2:25 p.m. RN-D confirmed she had applied the first dressing to R58's right shin wound on 11/11/17, and verified she had not measured the wound or completed a wound assessment at that time. RN-D stated the approximate size of the wound on 11/11/17, was approximately 3.8 cm by 0.5 cm and was very superficial with no depth. RN-D confirmed she had not notified R58's physician regarding the presence of blisters or open wound. On 12/4/17, at 2:35 p.m. RN-C stated R58's right shin wound base was covered with slough so the extent of the wound could not be determined however, based on the measurements obtained on 11/30/17, the wound had gotten larger, and probably was worse than when the wound was first discovered. On 12/4/17, at 8:39 a.m. the DON stated R58's edema and the presence of the wound including management of the right shin wound should have been identified on the care plan. The DON stated the wound should have been assessed by a nurse and wound tracking initiated when the wound was first discovered. Additionally, the DON confirmed the nursing orders for the wound dressings and stated the Ted stockings directive should have been followed and the physician should have been notified of the changes to the skin integrity as soon as possible. The undated, Skin Care Protocol policy and procedure section titled, "with onset of all ulcers" directed staff to initiate wound flow sheet/EZ graph and to document on the following every week: -location	F 684		

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F 684	Continued From page 102 -size (length, width, depth, undermining or tunneling -color -odor -exudate -skin condition around wound -wound edges -wound bed appearance -only stage pressure related ulcers. Other ulcers are considered partial or full thickness. -assess for causative factor and implement intervention to prevent an injury from occurring again -initiate Braden's scale and do weekly unit healed. Once healed do Braden every week for four weeks. -wound rounds weekly -pain assessment -review chart and discuss with physician to determine type and etiology of ulcer. Venous ulcer described as shallow weeping lesions with irregular wound edges. Leg hyperpigmentation, edema and palpable pulses. -notify family and physician about change in skin condition and current treatment plan -obtain and review labs -assure resident receives multivitamin with zinc and vitamin C at least daily -notify registered dietician -document in nurses notes daily by LPN and weekly by the RN -if no improvement in two weeks, update physician and change plan of care. -start pressure relieving devices (wheelchair, recliner and bed) The undated Pressure Ulcers in Long Term Care policy section titled, "Other Skin Concerns" identified a Stasis Ulcer as a destruction of tissue	F 684		

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F 684	Continued From page 103 resulting from the stoppage or slowing of the normal blood flow to an area. This causes a back up in fluid causing congestion. The section titled, "Assessment Of Other Skin Concerns" directed the documented identification of the type of wound, the site, the size (width, length, depth, and condition of surrounding tissue) in centimeters, and if exudate. The policy Appendix described edema as a local or generalized condition in which the body tissues contain and excessive amount of tissue fluid. Exudate was described as fluid that leaks from injured tissue which may be oozing pus or serum. The policy went on to direct staff on how to measure for the extent of peripheral edema.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess pressure ulcer risk, reassess the efficacy of interventions, update the medical practitioner,	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer R58 passed away on 12/01/17.	1/14/18

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F 686	Continued From page 104 and/or consistently implement interventions to promote healing and prevent the development of new pressure ulcers for 3 of 3 residents (R58, R54, R50) who were reviewed for pressure ulcers. This failure resulted in actual harm to R58 and R54 due to the worsening of facility acquired pressure ulcers. In addition, R45 was identified at risk for pressure ulcers and the facility failed to provide turning and repositioning assistance as directed by the care plan. Findings include: R58's Care Center Diagnosis Sheet signed by the physician on 8/14/17, included diagnoses of history of stage one pressure ulcers, chronic kidney disease stage 5 requiring dialysis, hypertension, history of deep vein thrombosis, and peripheral vascular disease. R58's quarterly Minimum Data Set (MDS) dated 11/6/17, indicated R58 had moderate cognitive impairment, required extensive physical assist from one staff for bed mobility and transfers, was at risk for pressure ulcers and had an unstageable (extent of tissue damage could not be confirmed due to obscurity by slough or dead tissue) pressure ulcer which measured 1.5 centimeters (cm) by 1.3 cm with a depth of 0.2 cm and was covered by slough (Slough is non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed). R58's Pressure Ulcer Care Area Assessment (CAA) dated 3/2/17, indicated R58 had two stage two (Partial-thickness loss of skin with exposed	F 686	R54's wounds have been comprehensively assessed. The medical provider was updated on 11/23/17. Staff continue to offer repositioning according to R54's care plan. R54 at times refuses repositioning. R54 now has an alternating pressure mattress system. R50's wound has been comprehensively assessed. The medical provider was updated with wound progress. R50 has continued to refuse wearing Prevalon boots. He has been open to floating his heel on a pillow. R50's heel wound has been monitored on a weekly basis. R45 will receive turning and repositioning as directed by his plan of care. The facility will ensure all residents receive turning and repositioning as directed by their care plan. The nursing assistants will be educated prior to 1/14/18 on the importance of providing turning/repositioning as directed by the residents' plan of care and how to provide adequate tissue reperfusion during turning/repositioning. All charge nurses will be educated prior to 1/14/18 regarding the importance of comprehensively assessing the risk for pressure ulcers, reassessing the efficacy of interventions, updating the physician regarding wounds, and consistently implementing interventions to promote wound healing.	

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F 686	Continued From page 105 dermis, presenting as a shallow open ulcer) pressure ulcers on her bottom without signs/symptoms of infection, required extensive assistance with bed mobility, and was at risk for worsening pressure ulcers, development of new ulcers, infection, sepsis, weight loss, and discomfort. R58's Physician Order Report dated 9/11/17-11/13/17, and signed by the physician did not identify any orders regarding pressure related wounds. R58's Physician Order Report dated 9/11/17-11/13/17, stamped "Nursing Orders Only" and signed as reviewed by the RN (no physician signature) on 11/15/17, revealed the following orders: -apply barrier cream to coccyx with cares and toileting every shift. -Egg crate mattress to bed. -Inspect skin on bath days for reddened or opened areas. -Right buttock open area: cleanse and pat completely dry. Apply foam dressing. Change every three days and as needed until healed. R58's quarterly Tissue Tolerance Assessment (assessment used to determine the skin's ability to tolerate pressure over bony prominences over time) dated 11/15/17, indicated next to no change in skin condition section "still open." R58 was "weaker" and the assessment determined no change in care plan was required and to encourage R58 to turn every one hour. R58's quarterly Tissue Tolerance Assessment (TTA) dated 8/15/17, indicated R58's skin condition was improving and to encourage every one hour repositioning. The quarterly TTA dated 8/1/17,	F 686	All nurses will be educated prior to 1/14/18 regarding infection control practices during dressing changes. The Skin Care Protocol Policy was reviewed on 12/30/17. The facility's policy title Nursing Care Plans was reviewed on 12/12/17. The facility's Skin Care Management Policy will be reviewed and revised as needed prior to 1/14/18. A RN wound round team lead will be selected prior to 1/14/18 to complete weekly reports to the Director of Nursing on wound progress. Audits will be completed by the Director of Nursing or designee on all wounds each week, for 90 days, to ensure they are assessed, monitored, and to ensure new interventions are implemented if indicated. These audits will also be used to determine if physicians are updated with worsening of wounds (pressure and non-pressure related). An audit will also be completed on Braden Assessments to ensure they identify current open areas. Turning and repositioning audits will be completed seven times weekly, for 30 days, and then three times weekly, for 60 days on various shifts to ensure residents are receiving turning and repositioning as directed by their care plan.	

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F 686	Continued From page 106 indicated "reopened coccyx" and to continue to encourage every one hour repositioning, often refuses. R58's Braden Scale assessment (tool to identify pressure ulcer risk) located on the Observation Detail List Report completed on 11/29/17, with an observation date of 11/29/17, indicated R58 was chairfast, had slight limited ability to make frequent, through slight changes in body or extremity position independently, had adequate nutritional intake, had a potential friction and shearing problem and was at risk for the development of pressure related ulcers. The assessment did not identify any current open areas. R58's physician order dated 11/30/17, indicated comfort care standing orders and weight loss expected due to terminal status. This order was obtained during the survey, as R58's pressure ulcer services were being reviewed. R58's care plan last reviewed 11/8/17, indicated R58 had decreased mobility, and was nonambulatory and had a potential for alteration in skin integrity related to history of pressure ulcers, chronic kidney disease and valvular heart disease. R58 also had a potential for fluid overload and alteration in circulation related to kidney disease and dialysis treatments. The plan directed staff to provide the following: -Assist of one to transfer, sit up and lie down, get legs in/out of bed, was independent with turning and repositioning -Encourage to turn and reposition every one hour when in bed and wheelchair. -R58 frequently refused to reposition and staff to	F 686	Dressing change audits will be completed by the Director of Nursing or designee seven times weekly, for 30 days, and then three times weekly, for 60 days, to ensure infection control practices are followed. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or designee is responsible for this deficiency. Corrective date: 1/14/18	

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provide education on the importance of repositioning.
-Dialysis notified to have R58 sit on a cushion while there and to encourage every one hour repositioning.
-Monitor for persistent red areas and report to RN.
-Maintain adequate nutrition and hydration by providing dietary "decub" program
-Pressure relief cushion in wheelchair, however, at times R58 would put personal pillow over wheelchair cushion and has been educated that this would decrease efficiency of the cushion.
-egg crate mattress on bed
-R58 refused the alternating airflow mattress overlay
-R58 refuses "APP" mattress overlay
-Dialysis as ordered.
The care plan did not identify or address R58's current stage two pressure ulcer.

R58's Treatments Administration History (TAR) dated 8/1/17-8/31/17, directed staff to check R58's skin on bath days for reddened or open areas and to report to the RN. On 8/4, 8/11, 8/18, documentation indicated R58 had both reddened and open areas. Location not identified. On 8/25/17, documentation revealed R58 had an open area with no redness. Skin check directive was initiated on 4/27/17, with a discontinuation date of 12/1/17. The report further directed staff to cleanse, pat dry, and apply a foam dressing to the right buttock open area every three days and as needed, until healed. The treatment was initiated on 5/23/17, with a discontinuation dated of 12/1/17. R58's physician office visit form dated 8/8/17, section "ROS" Review of Systems read: "Skin: Negative."

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R58's TAR dated 9/1/17,- 9/30/17, directed staff to check R58's skin on bath days for reddened or open areas and to report to the RN. Weekly skin documentation revealed red and opened areas. Location not identified. The report further directed staff to cleanse, pat dry, and apply a foam dressing to the right buttock open area every three days and as needed, until healed. The treatment was initiated on 5/23/17, with a discontinuation dated of 12/1/17.

R58's TAR dated 10/1/17-10/31/17, weekly skin check documentation revealed red and open areas. On 10/6/17, "shins" was noted as red. The report further directed staff to cleanse, pat dry, and apply a foam dressing to the right buttock open area every three days and as needed, until healed. The treatment was initiated on 5/23/17, with a discontinuation dated of 12/1/17. R58's physician office visit form dated 10/9/17, section titled "ROS" Review of Systems read: "Skin: Negative."

R58's TAR dated 11/1/17-11/30/17, weekly skin check documentation revealed red and open areas, however on 11/8/17, no redness was present. location not noted. The report further directed staff to cleanse, pat dry, and apply a foam dressing to the right buttock open area every three days and as needed, until healed. The treatment was initiated on 5/23/17, with a discontinuation dated of 12/1/17.

On 11/29/17, during continuous observations from 1:47 p.m. until 7:15 p.m. the following was observed:

-At 1:47 p.m. R58 was seated in her recliner, on a flat firm pillow with her legs in the dependent

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position.
-At 2:38 p.m. an unidentified staff member delivered clean linen to R58's room and exited. The staff member did not offer or encourage R58 to reposition.
-At 2:41 p.m. R58 remained in the same position, sleeping. Nursing assistant (NA)-K entered the room and immediately exited.
-At 2:55 p.m. NA-K peeked her head into R58's room without verbalizing anything and exited.
-At 3:15 p.m. R58 remained in the same position and had not repositioned self. Trained medication assistant (TMA)-B entered the room and asked R58 if she wanted her eye drops. Following the administration of the eye drops, TMA-B exited the room without offering or encouraging R58 to reposition. R58 remained seated in her recliner, in the same position without repositioning until 4:49 p.m.
-At 4:49 p.m. NA-L entered the room, informed R58 it was dinnertime, applied a transfer belt around R58's waist and within seconds had transferred R58 into her wheelchair. R58 did not bear any weight during the transfer, and was not provided or encouraged to stand long enough to ensure adequate pressure relief or tissue re-perfusion occurred. R58 remained seated in her wheelchair until 5:39 p.m.
-At 5:39 p.m. NA-K and TMA-B applied the transfer belt and within less than five seconds, had R58 transferred and seated back into her reclining chair. Neither NA-K or TMA-B offered or encouraged R58 to stand or lay down in order to ensure adequate tissue re-perfusion/pressure relief was achieved.
-At 6:05 p.m. TMA-B entered the room and slightly elevated the recliner's footrest.
-At 7:08 p.m., RN-C stated in order for R58 to sustain tissue perfusion in the coccyx area, R58

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would have to be off of the coccyx for greater than one minute. RN-C confirmed R58 was not allowed enough time for tissue perfusion during the quick transfers.
-At 7:15 p.m. RN-C and RN-G transferred R58 to bed. R58's coccyx was covered with a foam dressing. RN-C removed the dressing which had a moderate amount of reddish/brown drainage and exposed a pressure ulcer on R58's coccyx. The wound had a very strong, foul odor and varying levels of depth, slight undermining (the tissue under the wound edges becomes eroded, resulting in a a pocket beneath the skin at the wound's edge) and a small area of white slough at the top of the wound. RN-C stated the wound was "way worse" than when she had previously observed it, and according to the 11/28/17, assessment documentation, the wound had worsened. R58 was not provided adequate pressure relief for five hours and 30 minutes.

On 11/30/17, at 7:09 a.m. R58 was observed seated in her recliner. R58 stated staff did not usually offered to reposition her, however, when they did, she would refuse if she was too tired. R58 confirmed she was not able to independently reposition and required staff assistance to do so. R58 also stated she did not request staff to assist her.

R58's Skin Condition Report (SCR) dated 9/12/17, indicated R58's coccyx wound was about the same with a brown scab and a pinpoint pen area. Continue foam dressing. Will try Nepro (protein, carb steady supplement for dialysis patients). Additional SCR revealed the following information:

-10/3/17, indicated scab no longer present,

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shallow crater. Reeducate R58 to turn and reposition, dialysis nurse reeducated, Nepro supplement and encourage daily vitamin.
-10/10/17, wound measured larger in circumference, but less depth. Encourage turning and repositioning due to resistiveness, reeducate dialysis to encourage and will see if resident will take more Nepro.
-10/18/17, indicated R58's wound had questionably worsened, the wound was smaller in size but was deeper with "whitish slough." The plan was to increase dialysis medication, daily vitamin, encourage hourly turning and repositioning, and to try to get R58 to use her "special" wheelchair cushion, and often uses her small blue pillow at dialysis per their staff.
-10/24/17, indicated R58's coccyx wound appeared smaller with no change and to continue foam dressing.
-10/31/17, indicated wound was "worse," physician was aware, continue foam dressing. R58's blue personal pillow she chooses to sit on is not as good as her pressure redistribution cushion but R58 insists on using her pillow.
-11/23/17, wound much improved, no longer a crater, just surface, forming light tab scab again. Continue all measures including foam dressing.
-11/28/17, indicated wound "worse" and to continue foam dressing. No further information was noted.

R58's E-Z Graph Wound Assessment Worksheets revealed the following information:

-9/12/17, the coccyx wound measured 0.1 centimeters (cm) by 0.1 cm with no depth indicated. The wound had scant amount of serous (serum like fluid) drainage and redness around the wound. No odor, eschar/slough,

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undermining or tunneling noted. May be open due to "dot" of drainage on dressing. Brown scab formation. Stage of wound not indicated. No further documentation of the wound until 10/3/17.
-10/3/17, stage two coccyx wound which measured 0.9 cm by 0.8 cm with a depth of 0.2 cm. Wound base yellow, scant serosanguinous (blood and serum) drainage with redness around the wound. No odor, eschar, undermining or tunneling noted. Foam dressing utilized.
-10/10/17, coccyx wound measured 1.4 cm by 0.9 cm by 0.1 cm depth. Scant serosanguinous drainage with redness around the wound. No odor, eschar/slough, undermining or tunneling noted. Stage of the wound not identified.
-10/17/17, stage two coccyx wound measured 0.6 cm by 1.0 cm by 0.1 cm depth. wound base yellow/white with small amount serosanguinous drainage. Redness around the wound. Slough noted with no odor, undermining or tunneling. Foam dressing utilized.
-10/24/17, stage two coccyx wound measured 0.7 cm by 0.8 cm by 0.1 cm depth. Wound base pink with scant serosanguinous drainage with redness around the wound. No odor, eschar/slough, undermining or tunneling noted.
-10/31/17, stage two wound measured 1.5 cm by 1.3 cm by 0.2 cm depth. Yellow wound base with small amount serosanguinous drainage and redness around the wound. Slough was present with no odor, undermining, or tunneling noted. No further wound graphic documentation noted until 11/23/17. Foam dressing utilized.
-11/23/17, stage two coccyx wound measured 1.7 cm by 1.3 cm by 0.1 cm depth. Wound base pink with scant amount bloody drainage with redness around wound. No odor, eschar/slough, undermining, or tunneling noted. "Starting to have tan scab over part of" wound.

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-11/28/17, stage two coccyx wound measured 3.5 cm by 1.5 cm with depth not recorded. Wound base yellow and white with odor and undescribed drainage. Odor and eschar/slough noted. No undermining or tunneling noted. Foam dressing utilized. R58's medical record lacked evidence R58's physician was notified or additional interventions implemented following the identification the pressure ulcer had worsened.

R58's Resident Progress Notes dated 10/31/17, indicated coccyx wound examined. Open area is larger and wound is covered with yellow slough. Moderate amount serosanguinous draining with slight foul odor. Encourage R58 to use her pressure relief cushion rather than her small blue pillow. Res stated she could sit on what she wanted. R58 educated and allowed to make this choice. Concern that resident has also refused her vitamin and Nepro. "Will continue to monitor." No further progress note documentation related to R58's pressure ulcer noted until 11/23/17.

R58's Resident Progress Notes dated 11/23/17, indicated the wound had shown improvement since last full assessment. "The writer had only been doing spot checks with PRN [as needed] dressing changes, for instance, when resident was being toileted and needed a clean one since last full assessment on 10/31/17, but there were no additional concerns in the interim; the area is not surface in nature, and no longer presents as a shallow crater; will continue all measures including the foam dressing; see wound notebook for measurements." No further progress note documentation related to R58's wound noted until 11/28/17.

R58's Resident Progress Note dated 11/28/17,

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indicated wound had a a significant odor with "some slough" with a yellow/dark drainage on previous dressing.

Although R58's progress notes revealed intermittent refusals for dialysis with a subsequent order for comfort cares, the documentation failed to identify if the development of the wound and it's deterioration was avoidable or unavoidable.

On 11/30/17, 12:10 p.m. RN-C verified R58's wound had gotten larger and deeper and stated R58's physician had not yet been notified of this change, but planned to do so today. RN-C confirmed R58's skin assessment from 11/28/17, was incomplete and verified weekly skin assessments were missing, and should have been performed. RN-C stated the type of wound care was left up to the nursing staff to determine which dressing would be most appropriate and felt the foam dressing was the most appropriate and had not attempted nor tried any other type of dressing or treatment. RN-C confirmed R58 often refused assistance with repositioning but stated staff had not consistently documented the refusals.

On 12/1/17, at 7:36 a.m. NA-M confirmed R58 required every one hour repositioning and stated when a resident was repositioned, they needed to stay off of the area for at least five minutes to ensure adequate pressure relief.

On 12/1/17, at 7:45 a.m. RN-A stated offloading (pressure relief) needed to occur for one to two minutes in order to ensure good blood flow back to the areas prone to pressure and skin breakdown. At 8:15 a.m. RN-C also confirmed offloading needed to occur for two to three

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F 686	Continued From page 115 minutes in order to adequate ensure tissue perfusion. On 12/4/17, at 8:39 a.m. the DON stated R58 required every one hour repositioning which meant she would be free from pressure for at least 2 minutes. The DON stated even though R58 often refused repositioning, the staff should have still offered and attempted to reposition her as directed by the care plan and not assume she would always refuse. DON stated staff were to document R58's refusals and then provide her education. The DON also stated resident wounds were to be monitored with each dressing change and comprehensively assessed weekly, and as needed. The wound assessment documentation should include: root cause, stage, measurements, if improved or worsened, evaluation of the effectiveness of interventions and treatments. The DON stated if the wound had worsened, the physician was to be notified as soon as possible for potential changes in treatment. In addition, the DON confirmed R58's care plan should have identified the presence of the actual pressure ulcer, with realistic goals, and interventions. R54's admission MDS dated 10/17/17, indicated R54 had diagnoses which included stroke, diabetes mellitus, hypertension and history of transient ischemic attacks. The MDS indicated R54 had severe cognitive impairment, required extensive assistance with bed mobility, transferring, ambulation, toileting and bathing. The MDS also indicated R54 had a two stage 2 pressure ulcers, one which was present on admission, and utilized a pressure reducing device in the bed (not chair), turning and positioning program, and received pressure ulcer care.	F 686		

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R54's Pressure Ulcer CAA dated 10/24/17, indicated R54 spent most time in the bed or wheelchair, required staff assist for bed mobility, was frequently incontinent of bowel and bladder and had two stage 2 pressure ulcers present upon admission. R54 was at risk for the worsening of the pressure sores, the development of additional pressure ulcers, discomfort and gangrene/sepsis and was complicated by R54's weakness/fatigue, dementia, diabetes, and incontinence. Staff directed to turn and reposition R54 hourly and to complete weekly rounds until ulcers were healed.

R54's care plan dated 10/25/17, indicated R54 had a potential for alteration in skin integrity related to history of a stroke, and inability to ambulate, transfer, turn and reposition, sit up or lie down and place legs into bed independently. Staff were directed to turn and reposition R54 every hour, utilize an alternating pressure mattress, and to monitor skin for red areas. The care plan did not address the presence of the two stage 2 pressure ulcers.

R54's temporary care plan identified a problem dated 10/11/17, which indicated R54 had open areas on right buttocks, coccyx/sacrum, and directed staff to provide a pressure relief mattress, Laniseptic (added 10/24), Mepilex dressing every 3rd day and as needed (PRN) (no date when added), Roho pressure redistribution cushion to wheelchair (added 11/22/17), and nutritional supplements to promote healing such as Vit C, Diabetshield, Thera-M, Glucerna and Promod.

R54's Braden Scale dated 10/14/17, indicated

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R54 was at risk for the development of pressure ulcers.

On 11/28/17, at 9:54 a.m. family member (FM)-E was visiting and stated R54 had sores on her bottom. At this time, R54 was observed in bed positioned partially on her right side, with a wedge pillow behind her.
-At 10:29 a.m. R54 was observed to remain in the same position.

On 11/28/17, at 2:21 p.m. R54 was observed in bed, asleep. A wedge pillow was positioned partially behind her on the left side. Both heels laid directly on mattress, unsupported.

On 11/29/17, at 12:50 p.m. R54 was observed in bed, asleep with the head of bed (HOB) elevated approximately 30 degrees. The wedge pillow was positioned behind her back, slightly on the right side. R54 rolled towards her back creating no pressure relief to the right buttocks and coccyx noted. Both heels rested directly on the mattress.
-At 1:10 p.m. R54 remained in the same position.
-At 2:16 p.m. R54 remain in bed, on her back. Cushions to the right of her but not under her. Heels directly on mattress.
- 2:45 p.m. same position.
- 3:00 p.m. Family here visiting. Position same.
- 3:30 p.m. Family has left. R54 asleep. Still on back and heels on mattress.
- 3:45 p.m. Observed NA-K and NA-L turn and reposition R54 onto her right side. Placed 2 wedge pillows behind her back. R54 came back so not positioned all way over to right side. R54 wanted HOB elevated some. Heels directly on mattress. Has indwelling urinary catheter. NAs stated R54 may not want to get up for supper as not unusual for her to stay in bed.

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F 686	Continued From page 118 - 4:15 p.m. R54 is positioned mostly on her back now. - 5:00 p.m. Position same. - 5:15 p.m. NA-L brought supper tray to her room. Positioned R54 onto back and elevated the HOB to approximately 45 degrees. Served cheese pizza, salad and peaches. Also small juice and milk. Feeding self. - 6:15 p.m. R54 ate 100%. HOB has been elevated since 5:15 pm. - 7:00 p.m. R54 was positioned on her right side with a wedge pillow behind her back, only slightly on the right side. Direct pressure to the right buttocks and coccyx. R54 was not positioned to relieve pressure to the right buttocks/coccyx pressure ulcers during observations. On 11/30/17, at 7:12 a.m. R54 was observed in bed positioned on her back and FM-E was visiting. - 7:20 a.m. R54 is awake. Position same. - 7:40 a.m. The DON and NA-J just coming out of R54's room. Stated they just got done repositioning R54 on her back for breakfast. HOB elevated. - 8:00 a.m. Position same. - 8:15 a.m. Position same. - 8:20 a.m. R54 was served breakfast. Feeding self. - 8:56 a.m. NA-J was observed to provide cares for R54. NA-J assisted with washing R54's back and axillae. R54 complained of pain with turning onto side, but once on her right side appeared less uncomfortable as no longer moaning. NA-J performed catheter cares then turned R54 onto her right side again. Incontinent of soft bowel movement. Observed large dressing to the	F 686		

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buttocks/coccyx area was almost off. NA-J summoned LPN-C to change dressing. LPN-C washed hands and removed the dressing and cleansed wound. Large pressure ulcer covering coccyx and right buttocks. The coccyx has approximately 3 x 2 inch area of black/brown eschar, and to the right of the coccyx the buttocks area is red and open with an area of slough between the coccyx and buttocks. LPN-C stated the pressure ulcer looks deeper. She applied a new Mepilex dressing that covered the entire area, and washed her hands. NA-J finished assisting with oral cares. NA-J stated that R54 prefers to lay on her back and tends to roll back once she is positioned on her side.
- 9:30 am R54 was observed on her left side and has wedge pillows behind her. However, she was not off coccyx area a was almost on back completely.
- 12:15 p.m. R54 was observed up in the w/c next to bed. Does have Roho cushion in chair. Denies pain to the bottom when up. Served nutritional supplement.
- 12:45 p.m. Still eating dinner.
- 1:15 p.m. Still up in wheelchair.

On 12/04/17, at 9:32 a.m. observed RN-C and NA-P provide cares. NA-P stated R54 does not stay over when positioned with the wedge pillow as likes to be on her back. RN-C and NA-P turned R54 far over on her left side to perform wound care. Sacral Mepilex dressing has large amount of exudate (light green, yellow). RN-C removed dressing and there was a sweet/foul odor to the drainage. RN-C stated the odor was new and thinks may be infected. RN-C washed hands then cleansed the wound with wound cleanser. R54 complained of some pain. RN-C touched the outside of the wound cleanser bottle

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with contaminated gloves and placed in window sill. RN-C stated the coccyx was deeper and pressure ulcer was worse. She measured the pressure ulcer. The black/brown eschar area to coccyx appeared larger and deeper since last observed by surveyor, in addition the area of yellow slough to the right of the black area is larger. RN-C applied skin prep and then the Mepilex dressing. R54 did not complain of pain while on left side during cares. RN-C stated the black/brown scabbed area measured 3 x 2 cm at coccyx and is 0.4 cm deep. RN-C washed her hands and had the contaminated wound cleanser bottle in her hand to return to the medication cart. Surveyor told RN-C the cleanser was contaminated and she left the bottle in the R54's room..
- 10:00 a.m. R54 was positioned on her left side, far over with pillows. No pressure to the coccyx area at this time.

Review of Skin Condition Reports from 10/13 - 12-4/17, indicated pressure ulcers present at admission that healed and then reopened on 11/10/17:

10/13/17: 1st documentation of pressure ulcer
Skin Condition Report - arrived from hospital with pressure ulcers to both buttocks. Continue Laniseptic barrier - foam dressing failed.
EZ Graph -1.2 cm x 0.8 and 1.5 cm x 1 cm "bottom."

10/17/17:
Skin Condition Report - areas much smaller - can see where the outline used to be - continue with Laniseptic and turn/repositioning.
EZ Graph - 0.4 x 0.2 x 0.1 deep (left buttock) 0.3 x 0.8 x 0/1 (right buttock)

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10/24/17:
Skin Condition Report - left buttock healed - right almost healed - will continue Laniseptic.
EZ Graph - left buttock healed - right scabbed.

10/31/17:
Skin Report - no longer open at all - still discolored reddish.

11/13/17:
Reopened
Skin Condition Report -reopened possibly from lying on back at ER (emergency room) on 11/10.
APP (alternating pressure mattress) applied - continue with diabetic shake - Glucerna - Promod - Mepilex instead of Laniseptic, MVI (multi-vitamin) and vitamin C.
EZ Graph - right coccyx and right buttocks - started Sacral Mepilex instead of Laniseptic - coded as DTI (deep tissue injury).
Area measures 7.5 cm x 5.5 cm with 2.5 cm purple pink color and 0.2 cm depth.
There was no physician (MD) notification of the newly developed pressure ulcer.

11/22/17:
Skin Condition Report - reinforced hourly turn and positioning - took off APP - got new Embrace mattress - Roho for w/c - has Foley now (urine retention) - MD faxed.
EZ Graph - 7.5 x 5.5 area - PU 3.1 x 2 x 0.2 eschar to right buttock.

11/28/17:
Skin Condition Report - the outer perimeter of the right buttocks is smaller - eschar unchanged - called MD due to no response from fax - continue with Mepilex dressing.

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F 686	Continued From page 122 EZ Graph - 2.5 x 2.5 eschar right buttocks - 7 cm area discolored. 12/4/17: Skin Condition Report - not yet documented at time of survey. EZ Graph - 3 x 2 cm scab - additional slough since last exam - undermining along edge of scabbed area. 0.4 cm depth. 6.5 c 7.5 area. Wound Round Documentation: 12/04/17: Wound note: "Assessed wound after resident finished her breakfast in conjunction with her turning schedule. The Mepilex had been changed yesterday according to the label of the dressing, and yet there was already a foul odor upon removal of resident's dressing, and the dressing was saturated throughout the bottom 1/2 with heavy purulent tan drainage. Cleansed the wound with dermaclenz and patted dry. The area covered with eschar is beginning to undermine on the proximal wound edge, with a depth of 0.4 cm. There is more adherent yellowish white slough below the area of eschar, which now measures 3 cm x 2 cm. The irregular area that is open and more surface in nature distal to the eschar on the right buttock is smaller in total area and still showing signs of improvement. Tried to call MD office for advice, but had to leave message. Tried to get resident in today to the wound clinic due to the decline, but there spaces were all full, and the MD that was there could not add a visit, he had another clinic to get to at lunch. Due to concern of the speed of decline in the wound along with the odor, felt that the wound should be seen by a provider today, so called back and was able to schedule an office visit for resident to be seen by Dr. [name] PA, [PA name], this afternoon at 1:40 PM. Medivan will pick her up between 1:10 and 1:20. Family is in agreement and son will	F 686		

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accompany. Son called resident's husband (his dad)on his own cell to update while this writer was present and he is OK with the transfer. Instructed the CNA about the appt., but to make sure she did not get her up too soon due to length of time she will be on the Roho cushion. Asked on the clinic form whether resident should have a wound culture or antibiotics and asked for advice on what dressing to use. Also notified them that she is still resistive to turning despite regular turning, she starts to roll herself toward her back. Asked if the indwelling cath should remain in place or not. Will send resident to the appt. and watch for new orders as a result of today's appt. Also mentioned that she continues to have intermittent abdominal discomfort. This morning she c/o [complained of] abdominal discomfort, but denied discomfort in the buttocks. Went back later to assess abdomen, and bowel sounds were active, and abdomen at that time was soft and non-tender; "it feels much better" and resident smiled. She had, however, already started to roll toward her back and assisted to reposition again." 11/28/17, Dietary note: "(skin issue update report) is noted res admitted with open are on bottom, left buttock healed, but now has an open area on sacrum. Res on Thera M, Vit C, Diabetishield 8oz BID [twice daily] , Glucerna 4oz [four times daily] QID, Promod 30 cc's BID. Note most recent Prealb completed on 10/23/17 at 15.0 this is low. Res offered decub as well. Will continue to review skin issue update report and labs as available prn. Continue nutr. intervention at this time." 11/28/17: Wound Rounds: "Assessed resident's sacral area and right buttock early yesterday morning with dressing change. The eschar found last week remains firmly fixed next to the right buttock crease. Actually, the perimeter of the rest of the open area that has no eschar has actually

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improved since last week with the switch to the Embrace mattress and Roho chair cushion. Will continue with the sacral mepilex because of this, but will reattempt to get wound clinic involved due to the presence of this eschar. Discussed this with resident's husband this morning due to his previous reluctance for her to attend appts, but he is willing to have her go to the wound clinic if we get the order. The fax that was sent Monday was returned to us with no response from the MD, so called to get this rectified. See wound notebook for measurements of area. Resident has been willing to eat better in the past few days. She seems to do better when her family visits."
11/23/17: RN note: "Writer did fax MD regarding resident's wound to sacral area. Writer informed MD what staff is currently doing to facilitate wound healing, and asked if he had any suggestions. Writer has asked MD if resident should see Wound care, and have a prealbumin lab completed."
11/22/17: Wound Rounds: "Assessed the area on resident's sacrum and right buttock again this week during Mepilex change with [name], DON. The sacralarea is now larger instead of smaller, and brown eschar is beginning to cover the area, which increased somewhat to 3.1 x 2 cm. The area that had been purplish, the surface skin separated and now some areas throughout are reddish pink surface, but mostly open. See wound notebook for all measurements. Additional measures needed to be taken. Was able to get a Roho cushion for this resident, which was placed in w/c and adjusted by [name], OT. The APP mattress will be removed, since the area had worsened. Had found that the first Embrace mattress was not the brand name "Embrace", but a substitute called "pressure relief"; maintenance now has received brand new in the package

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Embrace mattress which was placed on resident's bed. Hourly turns were reinforced to staff, although resident often rolls herself from side where staff has her positioned onto her back despite being propped with pillows when staff leaves the room. Resident has been insisting to eat in bed, but there are some shearing forces in play there with resident sliding down, so reeducated resident and staff that sitting on the roho cushion in w/c for meals is preferable, then returning to side in bed within the proper turning time frame is imperative. She is on diabetishield 1 box twice daily; promod; Glucerna 4x daily, thera-M and Vitamin C. Her most recent prealbumin in October was 15, which was below normal range, so these measures were instituted at that time. Will continue with the sacral Mepilex at that time and if still no improvement with all additional measures next week, will contact MD for suggestions."
11/13/17: Wound Rounds: "Due to reports of resident's skin breakdown, assessed resident's buttocks for the wound round book early this AM. Her left buttock remains intact. Her right buttock has worsened and has reopened since last Friday, 11/10, per [name], LPN, who visualized the area on Friday when assisting staff to toilet resident. The proximal margin is the top of the right buttock crease. There is a dark red area that had no drainage that appeared as a shallow ulcer with no drainage measuring 2.5 cm x1.5 cm x 0.2 cm. Extending from this is an additional area that is purplish in color but 5.5 x 6.5 in additional measurement of mostly intact skin. There was an abraded area within this purple area that measured 0.5 x 0.2 that had scant bloody drainage. Decision was made to remove resident's brief that had been in place; washed and dried the area and left the brief off, since

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resident has had a foley catheter in place since her visit to the ER on Friday night,to attempt to keep the area from becoming moist again from perspiration. A soaker was carefully placed under the resident. After about an hour, at the next repositioning, [name], LPN placed a sacral comfort foam border dressing over the entire area to prevent shearing forces. Will change this every 3 days and PRN. Will continue with the hourly turns. Resident is tolerating the APP mattress, and turning, in fact turned her to her left side and went back to check her and she was sound asleep and looked comfortable within 15 minutes. Resident denied stomach discomfort this AM and ate at least 1/2 of her breakfast; was able to feed herself. Concern for this worsening over the weekend; resident had spent Friday evening in the ER, not sure of her turning and repositioning at that time." (However, the MD was not notified of the development of pressure ulcer on 11/10/17, nor when the pressure ulcer worsened on 11/13/17.)
11/12/17: LPN note: "APP mattress was put on resident bed due to break down."
11/12/17: LPN note: "temp 100.1, writer gave PRN Tylenol at 7am, writer noted resident is tired but did say a few words to writer, noted residents wound to buttocks is worse and is open and bruising around it, Staff is repositioning resident from side to side every hr and applying barrier cream as needed."
10/24/17: Wound rounds: "Resident's left buttock is healed and the right buttock is mostly scabbed and just about healed. Will continue lantiseptic. See wound notebook. "
10/19/17: Dietary note: (update) "Noted per RN res has skin issues upon admission. Res was started on Diabetishield 1 box BID, Promod 30cc's BID, glucerna 4oz QID and is noted per

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poor appetite. Per discussion with RN r/t res skin issue also request for lab draw Total protein/Alb level. Is noted small open area on bottom in two area's. Pressure relieve mattress on bed and res is also hourly turned for re-positioning. Was noted res bs has not spiked too high r/t nutr. interventions that have been put into place. Writer will continue to monitor oral intakes, labs as available prn and skin issue update report document. Res started on decub plan."
10/14/17: RN note: "Writer had staff change resident's mattress from a Contour Mattress with a cutout to an Embrace Pressure Relieving Mattress d/t resident's bottom being currently open. Writer also put in an order for ProMod 30cc BID, and Arginaid Extra 1 box BID to help with wound healing."
10/14/17: RN note: "Resident has been changed to an every hour turn and reposition. Care plan and care sheet updated. Writer also put halo/grab bars on resident's bed to aid resident in turning and repositioning and transfers."
10/15/17: RN note: "Writer faxed MD regarding resident's open areas on her bottom, and informed him that staff has started Arginaid Extra and ProMod. Writer asked if MD would like to order Thera-M, and Vitamin C, along with an albumin/pre-albumin lab. Writer also asked MD if he suggested anything else to facilitate with resident's wound healing."
On 11/30/17 at 1:32 p.m. RN-C was interviewed regarding turning and positioning as R54 had been observed either lying in bed or chair with direct pressure to the right buttocks/coccyx area, and not repositioned every hour. She verified if the resident is not far over, there would not be pressure relief to the pressure ulcer. RN-C added that at about 9:45 a.m. that morning she and a NA turned and repositioned R54 onto her left side

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and she was far over. RN-C verified the pressure ulcer has worsened and believes that it re-developed when she was sent to the ER on 11/10 and was on gurney for long period of time. RN-C also verified the care plan did not include the open pressure ulcer, but were on the temporary care plan. She stated (with the DON present) that she thought that was going to be the practice, to add to the temporary care plan. The DON stated the wedge cushions may not be enough to keep her over, staff may need to try pillows.
On 12/04/17, at 9:02 a.m. RN-C verified the odor to the pressure ulcers and stated she contacted the MD to send to the clinic as the pressure ulcer may be infected and has worsened. RN-C added R54 has a referral to Wound Clinic on 12/7/17, but should be seen sooner. She also verified that there was not a fax or other notification to the MD when the pressure ulcer opened on 11/12 or when she assessed on 11/13/17. RN-C added she probably did this but did not document it, and she changed the order to Mepilex dressing without contacting the MD. RN-C also verified R54 needs to be far over to the right or left to get some pressure off of the pressure ulcer.
On 12/04/17, at 3:06 p.m. the DON verified if R54 is on on right side, back or in wheelchair, there would not be any pressure relief to the pressure ulcers.

R50's admission MDS dated 10/11/17, indicated diagnoses of bacteremia, diabetes mellitus, sleep apnea, spinal stenosis, chronic kidney disease requiring hemodialysis and radiculopathy of lumber region. MDS indicated intact cognition, required extensive assistance with bed mobility, transferring, toileting, and was non-ambulatory. The MDS also indicated the presence of an

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unstageable pressure ulcer, but did not identify the use of any pressure relief devices in bed or chair, and no turning and repositioning plan.

R50's Pressure Ulcer CAA dated 10/18/17, indicated the resident was in bed or wheelchair the majority of the time due to not being able to tolerate sitting up for very long and not able to walk. Resident requires staff assist for bed mobility. The CAA also indicate pressure ulcers were triggered due to needing extensive assistance with bed mobility. Incontinent of bowel and bladder. At risk for breakdown, pressure sores and discomfort. Complicated by muscle weakness, MRSA, and diabetes. The CAA did not address the pressure ulcer to the left heel at admission, therefore, lacked a comprehensive assessment of the pressure ulcer.

R50's care plan dated 10/18/17, indicated a potential for alteration in skin integrity related to suspected
deep tissue sore on left heel present upon admission, incontinence and need for staff assist with repositioning. Interventions included: turn and reposition every 2 hrs and PRN. Provide peri rectal care after each incontinent episode. Diabetic foot care bid with cares. Diabetic lower extremity
care 2 times month. Monitor for persistent red areas and report to RN. Maintain adequate nutrition and
hydration by providing dietary decub program. Wound care/dressing change as ordered. Keep skin
clean and dry. Therapeutic mattress. Blue pressure relieving boots on as ordered.

On 11/29/17 at 5:50 p.m. R50 was interviewed

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while lying in bed. R50 stated he had returned from dialysis short time ago. Observed a pressure reduction mattress to the bed, no heel boots. R50 stated he had a serious infection requiring hospitalization at University of MN. He was sent there for back fusion surgery and developed a methicillin-resistant staphylococcus aureus (MRSA) infection to his left shoulder which led to septicemia. R50 stated he did develop a sore to the left heel due to prolonged bed rest and proceeded to show surveyor his heel which had a small light brown scab. No redness or open areas were noted. R50 indicated the pressure ulcer was much larger but had decreased in size. He added that he turns himself in bed and refuses to wear the boots they provided to protect his sore. R50 stated he has had toes removed in the past from the right foot due to diabetes and sores. R50 demonstrated how he repositions in bed and added that he tries to elevate his left heel off the mattress by resting over his right lower leg. R50 did not like to use pillows to float the heels. Did not observe Prevalon boots (or other type) in his room.

On 11/30/17, at 10:59 am R50 was interviewed again. Stated was in bed for 6 weeks during hospitalization and developed sore to left heel at that time. Left heel was observed off the mattress at that time. Stated again that he refused to wear those ---- boots.
On 11/30/17, at 2:00 p.m. NA-L stated R50 does not require assistance with repositioning and he directs his own care. NA-L also stated R50 does not wear any boots to the heels.
Progress Notes from admission to 11/28/17:
11/28/17 Dietary note: "(skin issue update report) per note on 11/22/17 res admitted with purple area on left heel, is noted to have improved, but

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noted black scab. See orders r/t [related to] treatment and medication. At this time nutr. intervention remains to offer decub and res on nepro. Will continue to follow skin report and labs as available. At this time nutr. interventions remain appropriate."
10/18/17, Dietary note: "(skin issue) per skin issue update report 10/10/17 noted res admitted with purple area on left heel. Res has prevalon boot order, however is noted res refuses to wear. Res has been educated on behalf of the importance of wearing the boot and to have leg elevated. Per review of most current labs 10/11/17 Alb 2.1 low, Total protein 5.4 low. Res offered egg every bkfst and juice w/ meals note res is on dialysis and diet renal w/ note on fluid restrictions. Will request to start renal supplement 4oz BID. Writer will Leave message with RN charge in r/t request as noted above. Writer will continue to review skin issue update reports and labs as available prn.
10/11/17, RN Note: T98.7. No px noted. No emesis or SOB. Res got switched to a contour mattress with cutout today, res did not like the new bed and wanted his old flat mattress back d/t [due to] him feeling like he was trapped. Res then c/o [complained of] his bed being uncomfortable and couldn't lay in it. Writer found new mattress and switched it out, it is still a flat mattress."
10/06/2017, Recorded as late entry. RN NOTE: "Writer was informed by therapy staff that this resident had what appeared to be the "start" of a pressure ulcer on his left foot. Writer went to assess the area and noted an area about 2.5 cm in size on his left heel. The area was purple in color with some redness surrounding the purple area. Writer obtain a Prevalon boot and applied it to this resident's foot. Writer expressed concern about this area to the resident. Since he has

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decreased sensation in this foot he is at risk for this area to get worse. Writer expressed the importance of wearing the Prevalon boot to prevent pressure to this area. This resident verbalized understanding."
Review of Skin Condition Reports - since admit:
11/29/17: Skin Condition Report - pressure ulcer improved since admit despite resident refusing to wear blue boots or suspend heels on pillows. Will continue to educate resident on importance of position change, inspecting skin daily. EZ Graph - Pressure ulcer measures 0.6cm x 1/0 cm and is unstageable due to eschar
On 11/30/17, at 8:00 a.m. RN-C was interviewed regarding ongoing monitoring of the pressure ulcer. RN-C provided a copy from 11/29/17, and verified weekly wound rounds were not completed since admission. RN-C added she would look at the pressure ulcer when hanging intravenous antibiotics but did not document. RN-C added she was aware that R50 refuses to wear Prevalon boots, and he directs his own care which may not always be a good decision. RN-C stated the pressure ulcer was improving and did not require dressing changes as left open to air.
On 12/04/17, at 3:10 p.m. the DON verified staff should have been monitoring the pressure ulcer on a weekly basis.

R45's quarterly MDS dated 10/24/17, indicated R45 had diagnoses including Alzheimers dementia and chronic pulmonary obstructive disorder (COPD). The assessment indicated R45 displayed severe cognitive impairments, required extensive assistance with all bed mobility, transfers and ambulation. The assessment identified R45 at risk for the development of pressure ulcers.

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R45's Pressure Ulcer CAA dated 5/10/17, indicated R45 was at risk for the development of pressure ulcers due to needing extensive assistance with mobility and incontinent of bladder.

R45's care plan dated 10/31/17, directed the staff to assist R45 with repositioning every two hours.

R45's Checklist of Skin Risk Factors and Interventions dated 12/21/15, and updated on 11/28/17, indicated R45 had received a Braden Scale which indicated R45 was at risk for the development of pressure ulcers. The checklist directed the staff to assist with repositioning every two hours.

On 11/29/17, at 4:25 p.m. NA-E was observed to assist R45 to the restroom. From 4:34 p.m. to 7:46 p.m. R45 was continuously observed:.
-At 4:38 p.m. R45 was seated in a wheelchair next to the Walnut Grove nurse's station.
-At 5:19 p.m. R45 wheeled into the Walnut Grove dining room.
-At 5:47 p.m. NA-E assisted R45 with the meal.
-At 6:17 p.m. NA-E wheeled R45 out of the dining room and into the television lounge on Walnut Grove.
-At 7:45 p.m. RN-B wheeled R45 to his room.
-At 7:46 p.m. RN-B and NA-E assisted R45 to ambulate to the bathroom. R45's wheelchair was equipped with a pressure redistribution cushion and his skin was observed to be pink and intact. NA-E confirmed R45 had not been assisted with repositioning since 4:25 p.m. (a total of 3 hours and 20 minutes earlier).

On 11/30/17, at 12:37 p.m. RN-B confirmed R45 was at risk for the development of pressure

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ulcers and was to be assisted with repositioning every two hours as directed by the care plan.

Facility policy Skin Care Protocol last reviewed 1/2015, included the following:

Stage II pressure ulcer or partial thickness definition: partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open ruptured serum filled blister. Presents as a shiny or dried shallow ulcer without slough or bruising. Stage II treatments for abrasion or shallow crater: apply skin protective paste every shift. Light to moderate exudate: apply hydrocolloid dressing or Silvagel/Medihoney, change dressing every three to five days and as needed.
With onset of all ulcers: 1) initiate wound flow sheet/EZ graph, then document every week on: location, size, color, odor, exudate, skin condition around the wound, wound edges, wound bed appearance, ulcer stage (ulcers that have necrotic wound bed or covered with eschar are considered un-stageable and need to have a nurses note stating the ulcer is un-stageable, and assess ulcer for causative factors and implement interventions to prevent an injury from occurring again.
5) assess turning schedule
6) Review chart and discuss with MD to determine type and etiology of ulcer.
7) Notify family and MD about change in condition and current treatment plan.
11) Document in nurse's notes daily by licensed practical nurse (LPN) and weekly by Registered nurse.
13) If no improvement in 2 weeks, update MD

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F 686	Continued From page 135 and change plan of care. Facility Skin Care Management policy dated last reviewed 4/2015, included the following: -The physician/nurse practitioner must be notified of any pressure ulcer at stage III or greater on monthly rounds and as needed. If a pressure ulcer is not responding to treatment protocols, changes in treatment will be discussed with the physician or other members of the interdisciplinary team. -Observe skin conditions each shift. -Treatment protocols instructed to wash hands before and after each procedure, gloves are to be worn when in contact with body fluids or secretions is expected. -Documentation of Pressure Ulcers Policy directed staff to initiate a pressure ulcer assessment form for a stage II, III, or IV ulcer and document stage, site, size, exudate, shape. Policy also included, a temporary care plan must be initiated when the pressure ulcer assessment form is initiated, and the pressure ulcer would be reassessed on a weekly basis on the designated day. On a two week basis, the current therapy plan will be assessed for effectiveness.	F 686		
F 689 SS=K	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		1/14/18

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by:
Based on observation, interview, and document review, the facility failed to ensure proper working order of resident care equipment used to transfer residents to ensure safety and prevent accidents. Staff were observed to transfer a resident with a faulty mechanical lift utilizing an unsafe practice resulting in the lift almost tipping. The facility failed to operationalize a process for reporting unsafe use of the full body lifts while ensuring faulty lifts remained off the unit/out of use resulting in the risk of potential serious harm or injury to 1 of 2 residents (R66) who was observed to be transferred using the faulty full body lift. The facility's lack of assessment, reporting, and maintenance procedures, resulted in an Immediate Jeopardy (IJ), with the potential for serious harm, injury, or death, for 11 of 11 residents (R66, R28, R21, R10, R24, R59, R33, R43, R37, R19, R61) who resided on the Walnut Grove unit and required the use of the full body mechanical lift for transfers.

The immediate jeopardy began on 10/26/17, when the full body lift was fist noted to be faulty by maintenance staff and was again identified to be malfunctioning on 11/30/17, when the full body lift was observed to malfunction during a resident transfer and staff failed to report the malfunction to administration. The administrator and director of nursing (DON) were notified of the immediate jeopardy on 12/1/17, at 1:30 p.m. The immediate jeopardy was removed on 12/3/17, at 5:31 p.m., but non-compliance remained at the lower scope and severity of (E) pattern scope and severity with potential for more than minimal harm that is not Immediate Jeopardy.

Findings include:

F689 Free of Accidents Hazards/Supervision/Devices

On 12/1/17 R66 was screened for appropriate transfers by a physical therapist. She determined that a Hoyer lift was appropriate.

On 12/1/17 R28 was screened for appropriate transfers by a physical therapist. She determined that a Hoyer lift was appropriate.

All residents requiring use of a mechanical lift for transfers including R21, R10, R24, R59, R33, R43, R37, R19, and R61 were screened for appropriateness of transfer status by either a physical therapist or occupational therapist on 12/1/2017.

Hoyer lift #3 was pulled from service at 10:30 a.m. on 11/30/2017.

All mechanical lifts in the facility were inspected based on the manufacturer□s checklist to ensure proper working condition on 12/1/2017. Lifts include Hoyer lifts: #1, #2, #4; Pal lifts: #5, #6, #7; Ceiling Lifts: Room 28, Room 29, WG Shower Room. All lifts were found to be in proper working condition. Ceiling lift in room 29 required a replacement of the backup battery which was completed on 12/2/17.

The Director of Environmental Services or designee will inspect all lifts monthly to

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F 689	Continued From page 137 R66's current face sheet and diagnosis list signed 9/21/17, indicated R66 was diagnosed with spastic quadriplegia (paralysis or inability to move arms or legs) and cerebral palsy (developmental disability or brain damage affecting ability to move) with associated muscle atrophy (muscle wasting away). R66's admission Care Area Assessment (CAA) dated 2/16/17, indicated he had a communication impairment related to the inability to make self understood verbally/non verbally due to an anoxic brain injury at birth, noting his speech was slurred and difficult to understand. The CAA further indicated R66 received assistance with all activities of daily living (ADLs) and mobility needs. The CAA noted R66 was "unsteady with transfers and needing staff assist to steady him at times." R66's most recent quarterly Minimum Data Set (MDS) dated 10/24/17, identified no cognitive impairment, had functional limitations in all extremities, and continued to be totally dependent on staff for transfers. R66's current care plan, last reviewed 11/22/17, identified decreased physical mobility with the inability to transfer, turn, reposition, sit up, or lie down with out staff assistance. The care plan noted R66 could operate and control the electric wheelchair with set up. The care plan directed: "Provide total assist of 2 staff and hoyer [full body lift] to transfer." The care plan did not provide direction or instruct staff that is was safe to transfer R66 from the side or in a perpendicular way. During observation on 11/30/17, at 8:20 a.m. R66 was lying in bed and nursing assistant (NA)-D	F 689	ensure proper working condition according to manufacturer□s guidelines. Each type of mechanical lift has its own individual checklist which will be used to ensure proper working condition. If a mechanical issue is found the lift will be evaluated and a decision made as to whether it should be pulled from service until repairs can be made. The Director of Environmental Services or designee will audit monthly to ensure monthly lift inspections are completed and all lifts are in proper working condition. The Administrator will review audits monthly. The Mechanical Lift policy was reviewed on 12/1/2017. It was revised on 12/3/2017 to include: If staff members are completing a transfer and find the lift is not functioning correctly, the staff members will immediately stop the transfer, they will place the resident□s call light on and will have a nurse assess the resident/situation to determine the safest way to proceed with the transfer. In the event a mechanical lift is taken out of service the Director of Nursing or designee will assess the situation and determine the appropriate distribution of the remaining lifts in the facility. A Malfunctioning Equipment policy was created on 12/1/2017. An addendum to Malfunctioning Equipment policy was added on 12/3/2017 to include: If staff members are completing a transfer and find the lift is not functioning correctly, the	

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F 689	Continued From page 138 was completing R66's morning cares. NA-A knocked on R66's door, asked if NA-D needed assistance, left the room and returned with a full body sling for a mechanical lift. After completing cares and assisting R66 to dress, NA-D assisted R66 to roll from side to side in order to position the full body sling under him. After positioning the sling under R66, NA-A pushed a Joerns Hoyer Presence Lift (a type of full body mechanical lift) into R66's room, numbered "3" on it. R66's electric wheelchair was positioned in the middle of the room at the foot of the bed, approximately four feet from the bed. The electric wheelchair was facing the bed, which was against the right wall of the room. NA-D and NA-A positioned the lift over R66, double looping all four points of the sling, using the orange loops on the two top hooks and the two black loops on the bottom, to the lift. The lift had two long legs, one on either side of the lift, which were in the narrow position to fit under the bed. Using the lift's electronic controller, NA-D lifted R66 up off the bed in the sling, then maneuvered him to the left so he was suspended in the air while in the lift and positioned in the middle of the room. Neither NA-D nor NA-A tested the functioning of the lift's lower legs before use per manufacturer's instructions. At that time, NA-D attempted to push the lower left button of the remote, which would operate the legs of the lift, spreading them apart wider in order to fit around R66's electric wheelchair. NA-D noted the legs would not open when she pressed the control button, and she suggested to NA-A to lie R66 back down on the bed. NA-A directed NA-D to push the lift perpendicular to the electric wheelchair so R66 could be transferred from the side. With the legs of the lift in a narrow	F 689	staff members will immediately stop the transfer, they will place the resident□s call light on and will have a nurse assess the resident/situation to determine the safest way to proceed with the transfer. In the event a mechanical lift is taken out of service the Director of Nursing or designee will assess the situation and determine the appropriate distribution of the remaining lifts in the facility. All nursing staff will be educated on the proper use of mechanical lifts as well as the Malfunctioning Equipment policy on their prior to using a mechanical lift on their next scheduled shift. A competency evaluation will be completed on all nursing staff prior to using a mechanical lift on their next scheduled shift. An addendum to the education was added on 12/3/2017 to include: If staff members are completing a transfer and find the lift is not functioning correctly, the staff members will immediately stop the transfer, they will place the resident□s call light on and will have a nurse assess the resident/situation to determine the safest way to proceed with the transfer. In the event a mechanical lift is taken out of service the Director of Nursing or designee will assess the situation and determine the appropriate distribution of the remaining lifts in the facility. The Director of Nursing or designee will complete audits 7 times weekly, for 90 days, on varying shifts to ensure proper use and working condition of mechanical lifts.	

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F 689	Continued From page 139 position, NA-D pushed the lift forward, threading the left leg of the lift through the electric wheelchair's front two wheels, making a T shape with the chair and lift. NA-D and NA-A positioned R66 so his back was facing the electric wheelchair seat, and NA-D began to lower R66 into the wheelchair, while NA-A held onto the sling from the back to guide it down to the wheelchair. As NA-D was lowering R66 into the wheelchair, the lift's right leg began to rise off the floor (a couple of inches at that time). NA-A told NA-D to watch the lift "it's coming up," as NA-A went from the back of the wheelchair and positioned herself at R66's left side. Neither NA-D nor NA-A stopped the transfer to get a different lift. Instead, NA-D proceeded to lower R66 into the wheelchair using the controls and positioning herself in front of R66, with her left leg on the outside of R66's wheelchair and her right leg in between the legs of lift. The right leg of the lift continued to lift off the ground as R66 was lowered into his wheelchair, until the leg was approximately one and half feet off the ground and the boom of the lift (overhead metal beam that holds the sling) was resting in the back of NA-D's head. Once R66 was seated in the electric wheelchair, NA-D used the controls to lift the boom, while NA-D and NA-A unattached the sling from the hooks. The right leg of the lift was observed to hit the ground as the weight of R66 was removed from the lift. After transferring R66, NA-A was observed to push the lift outside R66's room, place it in the hallway just outside R66's door, and walked away. NA-D was observed to fix R66's bed and take out his garbage before proceeding into another resident's room. Neither NA-D nor NA-A notified other staff,	F 689	Results of these audits will be reported to the Quality Assurance Committee for review and recommendations. These audits will continue until the Quality Assurance Committee has determined that compliance has been achieved. The Director of Nursing is responsible for compliance with this requirement. Completion Date: 1/14/2018	

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administration, or maintenance of the faulty lift or of the incident.

The lift was continuously observed in the hallway outside of R66's room, available on the unit for potential use. The lift was observed in the hallway outside of R66's room on 11/30/17, until 10:16 a.m. when registered nurse (RN)-B and NA-P were observed bringing the same lift, containing the number "3," into R66's room to transfer him from his electric wheelchair into bed. At that time, the surveyor intervened, informing RN-B the lift's legs had not worked during the previous transfer that morning, and requested verification the lift worked before transferring R66. RN-B verified the lift was working by turning on the lift, releasing the red emergency stop button, and pressing the lower left button to expand the lower legs. R66 was not in the sling or attached to the lift at the time RN-B tested the lift, and at that time, the legs were observed to expand wide and work properly. RN-B proceeded to transfer R66 using the lift, this time positioning the lift parallel to the wheelchair, so the lift faced straight forward toward R66, with the legs spread wide in order to fit around R66's wheelchair. R66 was lifted in the sling, and after pulling the lift away from the wheelchair, RN-B used the control to narrow the legs in order to fit them under R66's bed. R66 was then lowered onto his bed, and RN-B pushed the lift out of R66's room, across the hallway, to be used to transfer R28.

During interview on 11/30/17, at 10:26 a.m. NA-D stated she rarely worked with R66 and had never transferred him from the side like that before. NA-D stated the lift was not working as the legs were not expanding or opening. NA-D stated the legs of the lift needed to expand or open when

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transferring R66 because otherwise the lift itself would not fit around his wheelchair. NA-D stated she would normally have sat R66 back down if the lift was not working, and had wanted to lay R66 back down on the bed that morning, but had proceeded with the transfer because NA-A told her to transfer him sideways. NA-D stated she was following NA-A's instruction. NA-D stated she should probably have used a different lift to transfer R66, noting that during the transfer she had moved herself in between the lift and R66, in order to keep the lift from tipping. When asked if the lift would have tipped if she had not been there, NA-D stated, "I don't know, probably," acknowledging the boom of the lift was resting on the back of her head. NA-D stated they probably would not have continued to transfer R66 if she had not been there to stop the lift from falling. NA-D further stated they would not normally continue to transfer a resident if the lift was coming up off the floor, however, she again stated she had continued with the transfer because NA-A was directing her to and R66 was already in the wheelchair. NA-D stated she had been taught to go straight forward with the lift when transferring a resident. NA-D further stated there was a specific trainer who taught her how to use the sit to stand mechanical lifts; however, during orientation the trainer had been unable to find a full body lift to train us with, so NA-D was trained on how to use the full body lift by another nursing assistant. NA-D stated, "I don't think we should have put [R66] up there [in the sling] when the lift wasn't working." NA-D stated she had reported the faulty lift to the charge nurse, licensed practical nurse (LPN)-A.

R28's quarterly MDS dated 10/2/17, indicated

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R28 had diagnoses of Alzheimer's dementia, aphasia (inability to speak), and status post stroke. The assessment indicated R28 was totally dependent upon staff for all activities of daily living. R28's care plan dated 10/4/17, directed the staff to assist R28 with transfers via two staff and a full body mechanical lift.

On 11/30/17, at 10:27 a.m. RN-B and NA-P were observed in R28's room with a full body mechanical lift. R28 was seated in her wheelchair as RN-B opened the legs of the mechanical lift, positioned the lift so the lift legs were on either side of the wheelchair as RN-B attached the lift to R28's body lift sling. RN-B utilized the lift controls to raise R28 out of the wheelchair. Once in the air, RN-B moved the lift backwards away from the wheelchair and attempted to close the legs of the lift. RN-B stated the lift was not functioning as the legs did not move upon command of the lift controller. RN-B stated she did not know what was wrong with the lift as it had just worked while transferring R66. RN-B pushed the lift control panel again to close the legs and the lift did not respond. With R28 still in the lift and suspended in the air, RN-B proceeded to physically push the lift approximately three feet from the wheelchair area to R28's bed. Once the lift was placed with the feet under the bed and the sling with R28 over the bed, RN-B again pushed the controller to direct the legs of the lift to close. The lift legs closed and R28 was lowered into the bed.

-At 10:32 a.m. RN-B directed NA-P to obtain a second mechanical lift and stated the current lift would need to be reported to the maintenance department to determine why it was not

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functioning properly. NA-P removed the lift from R28's room.
-At 10:32 a.m. NA-P returned to R28's room with a second full body mechanical lift.
-At 10:35 a.m. RN-B and NA-P transferred R28 from bed to a wheelchair without difficulties.

-At 12:21 p.m. RN-B stated the malfunctioning mechanical lift had been removed from the nursing unit and taken to the maintenance directors office. RN-B stated the lift could not be in use on the unit until it was functioning properly. RN-B stated she was unsure why the lift had worked correctly while transferring R66 however, it did not function properly while transferring R28 moments later.

During interview on 11/30/17, at 1:52 p.m. LPN-A stated she was not aware of any issues with the full body lifts that day, nor had any incidents been reported to her. LPN-A was surprised to hear the full body lift was back on the unit, stating it had malfunctioned a couple weeks ago and, "the girls came up and said the legs won't open." LPN-A verified the issue with the full body lift had also occurred approximately two weeks ago in that the legs would not open, therefore maintenance had taken it off the floor/removed from use, and wasn't aware the lift was back out on the floor to be used again.

During interview on 11/30/17, at 1:59 p.m. NA-A confirmed the legs on the full body lift had not worked that morning, and verified staff had the same issues with that lift before. NA-A stated the lift's legs would open and work when there wasn't a resident or any weight in the lift, but when there was weight, the legs would not work and would not open. NA-A stated the lift had been

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malfunctioning for the last couple of weeks and thought maintenance had fixed it, for awhile. NA-A wondered if it had something to do with weight being in the lift. During the interview, LPN-A walked by and confirmed she also was aware the lift would not work if there was weight in it, and wondered if maintenance had tested the lift with someone/weight in it. NA-A stated staff rarely transferred anyone sideways like they did that morning, and if they did, it would have been to a shower chair not a wheelchair. NA-A stated the transfer that morning was, "kind of scary, because [the lift] was tipping." When asked why the malfunctioning lift was used, NA-A replied, "You got a good point, we probably should have gone and gotten a different lift." NA-A stated she had been trained on the lifts by the manufacturer when they originally purchased the lifts. NA-A stated the process would be to let the charge nurse or maintenance know when equipment malfunctioned.

During interview on 12/1/17, at 7:17 a.m. NA-F verified she was aware of the lift not working the previous day, noting it was now torn apart and maintenance was waiting for a part to come in. NA-F stated the other day the lift was put back on the floor for use, and had heard it should not have been out on the floor to be used. NA-F further stated the unit had one bad lift which had been faulty for awhile and it had seemed that it malfunctioned depending on how much weight was in the lift. NA-F stated the facility had the full body lifts for a few years and they were used so much they "don't stay good." NA-F stated if the lift malfunctioned, she would have put the resident back down on the bed and got a different lift that worked. NA-F further stated the new nursing assistants were trained to use the lifts properly by

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the older nursing assistants, and had never received a refresher course on the lifts.

During interview on 12/1/17, at 7:40 a.m. RN-A stated that over the holiday weekend of 11/23 - 11/26/17, she was aware the facility had one malfunctioning mechanical lift from the Walnut Grove unit but was not sure if the lift had been repaired or if it was still in the maintenance department.

During interview on 12/1/17, at 8:07 a.m. NA-G stated in a situation where the lift's legs would not open, staff would take the lift and get it as close as possible to the wheelchair, attempting to get the legs underneath the wheelchair if possible, and would go straight on with the lift at first, but might need to turn the lift at an angle or thread the lift's legs through the wheelchair. NA-G stated she would then pull the resident down to the wheelchair making the transfer as safe as possible so the resident would not fall. NA-G stated there should never be a reason why any resident would fall from a lift, however, she would still want to make the transfer as "time efficient as possible" because the resident would not want to remain suspended up in the lift for long. NA-G stated, if the lift was starting to tip, and if she was in the front of the lift controlling it, she would put her foot down on the lift leg to stabilize it, and if she was on the other side of the transfer, she would hold onto the resident while the other staff person stabilized the lift. NA-G stated she was trained on how to use the mechanical lifts by another nursing assistant.

During interview on 12/1/17, at 8:27 a.m. the nurse scheduler stated nursing assistants watched a video on the use of mechanical lifts

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provided by Health Care Academy during orientation and once a year. The nurse scheduler further stated nursing assistants trained each other on the lifts during orientation, and the nursing assistant who was orienting new staff checked off the lifts on the orientation checklist indicating the staff person had been trained. Staff received further education if the facility purchased new lifts and if rehab had anything new to teach.

During interview on 12/1/17, at 8:50 a.m. RN-B stated she was not aware of, and confirmed no staff had informed her of, the mechanical lift's malfunctioning until the surveyor had brought it to her attention the day before. RN-B said had she been aware, she would have taken the lift off the floor and out of service. RN-B also stated she was not aware of any previous malfunctions of the lift. RN-B stated she was unaware of the lift almost tipping with a resident suspended in it, and no staff had reported the incident to her. RN-B stated she had seen that maneuver, of transferring a resident perpendicularly from the side work appropriately adding, "this maneuver doesn't scare me" but in the instance of R66's transfer, it "wasn't good," the lift was lifting up off the ground. RN-B stated clearly with R66's body type, the side maneuver transfer does not work and would have expected staff to tell someone about the incident. RN-B would have further expected staff to tell maintenance and find a functioning lift to use or tell her the lift was malfunctioning so she could alert maintenance and inform other staff not to use the lift. RN-B stated she would also expect staff to keep R66 as safe as possible during transfers, and could not state if the wheelchair or bed would have been the safest place for R66 at the point the lift was starting to tip. RN-B stated the older nursing

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assistants used to transfer residents from the side with the old lifts they had to use and wasn't aware if they had reverted back to that or not. RN-B stated for residents who utilized tilted wheelchairs, transferring that way could be safer, however, was not aware if R66 would be safe or not and stated, "our newer staff would not know that though." RN-B stated she was not sure that maneuver was used very often or only with residents who had tilted chairs, and verified it was "obviously" an unsafe transfer maneuver for R66. RN-B acknowledged nursing assistants trained new nursing assistants with the lifts during orientation and stated she herself did not go around individually telling the nursing assistants who was safe to transfer from the side or question if the every resident was assessed for safety with transferring techniques. RN-B stated she felt the nursing assistants would assess or problem solve enough to know if it was not safe to use that maneuver with every resident. RN-B stated having been an NA herself, she had used the side transfer maneuver appropriately in the past, therefore she would try it again. RN-B stated maintenance had taken the wheels off the lift, cleaned them for dust, and lubed the gears, however, was not aware of any other maintenance work and could not approximate how long ago it had taken place.

During interview on 12/1/17, at 9:21 a.m. NA-H stated she was aware of issues with the full body lift and confirmed the lift would stall when used. NA-H stated sometimes the lift would stall when lifting residents up and down and also when staff would attempt to close and open the lift's legs. NA-H stated she had worked with the lift twice and the legs had malfunctioned both times. NA-H further stated she had heard the lift was

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malfunctioning prior to her working there in October. NA-H stated when the lift malfunctioned, she would push the red emergency stop button in order to turn the lift off and start it back up again to get the legs to work. NA-H stated she had always transferred R66 from the front, going straight and head on was safer and due to the position R66 sat in the sling, it would be more difficult to transfer from the side, however, with some residents who sat tilted back in wheelchairs, it had worked better to transfer them from the side. NA-H stated she was trained by other NAs on how to use the mechanical lifts and she had only known how and who to transfer from the side because the nursing assistant who had trained her told her it would work better that way.

During interview on 12/1/17, at 9:38 a.m. the DON stated she was aware the lift had malfunctioned the previous day due to the legs not opening appropriately with weight on it and confirmed she knew the full body mechanical lift had been having issues already months previous. However, the DON stated the maintenance staff had looked at it and could not reproduce the issues when attempted. The DON stated she had been told the maintenance staff had previously looked at the functioning of the lift's legs because the legs would not open, but did not know the approximate timeframe as to when they looked at it. The DON stated she was not aware of the lift almost tipping with R66 in it and stated staff should have placed R66 back on the bed and obtained another lift. The DON also stated she would have expected staff to notify her of this incident and to also inform other staff as well as maintenance that the lift had malfunctioned. The DON stated side transfers had worked better for some residents for positioning purposes however,

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thought the nursing assistants would have received direction from the RN if the side transfers were safe to utilize or not. The DON stated if she had known about the incident, she would have started an investigation.

During interview on 12/1/17, at 1:31 p.m. the administrator stated he was not aware of the lift malfunctioning or that it had started tipping while a resident was suspended in it.

The Joerns Hoyer Presence Instruction Manual indicated the lift had legs with adjustable width which could be opened to, "enable access around armchairs or wheelchairs," noting the legs should be closed when negotiating narrow passages. The manual further instructed to always check, "The legs of the lift open and close satisfactorily," with the hand control before operating the lift. It further directed to, "Always plan your lifting operations before commencing."

The Facility's Lift Operation Procedure Policy, reviewed 4/15, directed step by step instructions for transferring residents with the lift from the bed to chair and from chair to lift. The procedure instructed to position the wheelchair under the resident in the lift. However, the procedure lacked direction on when to open the lift legs while transferring nor did it provide instructions on transferring from the side. In addition, the policy lacked direction for staff on procedures when the lift malfunctioned.

A copy of the Health Care Academy orientation video/education was requested but not provided.

MAINTENANCE OF EQUIPMENT

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Review of the preventative maintenance logs for the facility's seven Joerns Hoyer Presence lifts, from 2/17 to 11/17, identified the following:
- The logs included monthly preventative maintenance, which included checking the leg adjustment to, "Check the legs operate in both full extensions Inward/outward." No preventative maintenance to any of the lifts was completed or checked in November.
- The log for lift number "3," identified a notation on 10/26/17, which noted the leg adjustments did not work, reading, "Doesn't work with Resident suspended." The log noted the leg adjustments were not operational.

- A Purchase Order, dated 11/1/17, identified a Hoyer controller box had been ordered.
- A Purchase Order, dated 11/17/17, identified a actuator (motor) for the Joerns Hoyer lift had been ordered.

During interview on 12/1/17, at 7:26 a.m. maintenance staff (M)-A stated the lift had malfunctioned two weeks prior, and was brought down to the shop. M-A stated at that time there was a retaining pin which kept the motor for the legs in place had malfunctioned causing the motor to rotate back and forth and was slipping. M-A further stated at that time the motor had been replaced and the lift had been put back on the floor for use. However, M-A stated the lift had malfunctioned again yesterday so they had torn the lift apart and he had assisted in taking the same motor out. M-A stated this time they tested the legs by putting weight on the end of the lift which when demonstrated, the legs would not open. M-A thought staff was notified yesterday of the lift malfunctioning with weight and was not aware if the lift was tested with weight again

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before it was put back into use the first time as M-B had repaired the lift the first time if malfunctioned.

During interview on 12/1/17, at 7:30 p.m. M-B confirmed a short time ago the lift was malfunctioning which at that time he had ordered and replaced the lift's motor. M-B stated after replacing the motor, the lift was not tested with weight in it before it was put back out on the floor for use. M-B stated the lift had malfunctioned yesterday because there was a busted part causing the motor to slip. M-B stated the part had snapped when weight was put in the lift. M-B stated the lift worked just fine without weight; however, when there was weight in the lift, the motor would slip back and forth causing the legs to malfunction.

During interview on 12/1/17, at 7:40 a.m. the director of maintenance (DOM) stated the facility had performed monthly preventative maintenance (PM) checks on the lifts; however, the staff person that had previously completed the PM checks had quit and M-A would be doing the preventative maintenance. M-A stated he had started in that position that same day therefore, had not yet completed the preventative maintenance checks for the lifts. The DOM could not identify when the lift initially began to malfunction however, confirmed when the malfunctioning was originally identified, they had ordered a new control box for the lift. The DOM stated they had never installed the new controller box because they had identified the actual problem was with the actuator (a type of motor) in which a bracket had broken off which controlled the lift's legs opening and closing. The DOM stated actuator default was identified

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around November 13th, and around that time, he had tested the lift by putting weight on the end of it which resulted in the lift malfunctioning. The DOM stated the lift's motor was replaced but was not aware if the lift had been checked with weight in it prior to sending it back onto the floor for use, nor was he aware when the lift was pulled from the floor the second time it had been pulled from the floor or had malfunctioned. The DOM stated he did not keep maintenance records for when equipment was pulled from the floor or for the maintenance and tests done to faulty equipment. The DOM stated when they had torn the lift open, they could see it was a broken motor, had replaced it, and assumed it was fixed. The DOM stated yesterday the other motor (each motor operates one side of the legs) had busted and did not have a good explanation for why it was not working. The DOM stated he had tested the lift twenty five times with weight in it and was able to make it malfunction twice. The DOM verified he had not contacted the manufacturer, but was in contract with Pro Medical, the supplier who the facility bought the lifts from, in order to get replacement parts. The DOM acknowledged the order for the control box was placed on 11/1/17, and the order for the actuator was placed on 11/17/17, and stated the lift had been malfunctioning on and off, sporadically. The DOM stated the lift was not officially pulled off the floor until the motor was identified as the problem and verified it had been in use in between that time.

During interview on 12/5/17, at 3:39 p.m. the Joerns Hoyer Representative (JHR) stated the malfunction could have been from a faulty actuator and if the company had been notified, they would have requested a short video or picture from the facility showing the malfunction

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so they could attempt to diagnose the problem and attempt to reverse engineer the malfunction. The JHR stated the purpose of the lift's legs spreading was "purely common sense," further stating their lifts were meant to get around wider objects like recliners. The JHR stated the lifts could be used from the side but it depended upon the approach, further stating the training was to approach the wheelchair from the front, if you could. The JHR stated their lifts were designed not to tip even with the legs in the narrow position and in the event that the lift did tip, he would expect it to be taken very seriously and an investigation be conducted in order to see if there was operator error.

No further maintenance or equipment policies were provided.

The immediate jeopardy that began on 10/26/17, was removed on 12/3/17, at 5:31 p.m., when the facility took the following actions:
-removed the lift out of service.
-checked all mechanical lifts to ensure proper working order.
-assessed residents who utilize mechanical lifts for safe transfers with the lifts.
-updated policies and procedures for malfunctioning lifts.
-educated nursing staff on safe use of the lifts and updated policies, which included inspecting their current lifts to ensure proper functioning.
-implement preventive maintenance plan for all lifts.
The IJ was removed but the noncompliance remained at the lower scope and severity level of E - pattern scope and severity level, which indicated no actual harm with potential for more than minimal harm that is not immediate

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F 689	Continued From page 154 jeopardy.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		1/14/18

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	245397	A. BUILDING _____ B. WING _____	12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD CARE CENTER	1633 DELTON AVENUE BEMIDJI, MN 56601

(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 690	Continued From page 155 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with incontinence cares for 1 of 3 residents (R45) observe for incontinence cares. In addition, the facility failed to provide appropriate care and services for 1 of 1 resident (R53) who had a suprapubic catheter Findings include: R45's quarterly Minimum Data Set (MDS) dated 10/24/17, indicated R45 had diagnoses including Alzheimers dementia and chronic pulmonary obstructive disorder (COPD). The assessment indicated R45 displayed severe cognitive impairments, required extensive assistance with all activities of daily living and was frequently incontinent of bowel and bladder. R45's Urinary Incontinence Care Area Assessment (CAA) dated 5/10/17, indicated R45 required extensive assist from staff for incontinence cares and use of the toilet. R45's Bowel and Bladder Assessment dated 1/17/16, indicated R45 had functional incontinence due to decreased mobility and directed the staff to assist R45 to the toilet every two hours and provide assistance to change the incontinent products. R45's care plan dated 10/31/17, directed the staff to assist R45 with transfers on and off toilet and incontinence cares every two hours. On 11/29/17, at 4:25 p.m. nursing assistant	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI R45 has been receiving incontinent care as directed by his plan of care. R45's incontinent care plan was assessed and found to be appropriate. R53 was receiving appropriate care and services related to his suprapubic catheter. R53 passed away on 12/26/17. The facility will ensure residents receive incontinent care as directed by their care plan. One other resident was identified as having an indwelling catheter. He has been receiving catheter care per the facility's policy. Education will be provided on the importance of following resident care plans regarding incontinent care. Education will be provided to all nursing staff regarding catheter care and the importance of anchoring the catheter tubing prior to 1/14/18. The facility's policy on Catheter Care was reviewed and revised on 12/30/17 to include directions for storage of the urine collection bags. The facility's policy titled Nursing Care Plans was reviewed on 12/12/17.	

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F 690	Continued From page 156 (NA)-E was observed to assist R45 to the bathroom. From 4:34 p.m. to 7:46 p.m. thereafter, R45 was continuously observed: -At 4:38 p.m. R45 was observed seated in a wheelchair next to the Walnut Grove nurse's station. -At 5:19 p.m. R45 wheeled into the Walnut Grove dining room. -At 5:47 p.m. NA-E assisted R45 with the meal. An odor of diarrhea stool/bowel movement (BM) was noted near R45's table. -At 6:17 p.m. NA-E wheeled R45 out of the dining room and into the Walnut Grove television lounge. The BM odor continued to be present by R45. -At 7:45 p.m. registered nurse (RN)-B walked by R45 and confirmed an odor of BM. RN-B proceeded to wheel R45 to his room. While seated in the wheelchair, BM was observed on R45's sweat pants in the groin area. RN-B confirmed R45 was soiled. -At 7:46 p.m. R45 was assisted to ambulate to the bathroom by RN-B and NA-E. R45's pants and incontinent brief were saturated with loose BM and urine. NA-E stated she would assist R45 with a shower. NA-E confirmed R45 had not been assisted to the bathroom since 4:25 p.m. (a total of 3 hours and 20 minutes earlier). On 11/30/17, at 12:37 p.m. registered nurse (RN)-B confirmed R45 should have been assisted with incontinence cares every two hours as directed by the care plan. . R53's Physician Order Report provided by the facility on 12/4/17, included diagnoses of dementia without behavioral disturbance, confusion, and history of urinary tract infection,	F 690	Observational audits will be completed by the Director of Nursing or designee seven times weekly, for 30 days, and then three times weekly, for 60 days, on various shifts to ensure residents are receiving incontinent care as directed by their care plan. Audits will be completed seven times weekly, for 30 days, and then three times weekly, for 60 days, by the Director of Nursing or designee on catheter cares to ensure infection control practices are followed and proper anchoring of the catheter tubing. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or designee is responsible for this deficiency. Corrective date: 1/14/18	

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sepsis, and dehydration.

R53's quarterly MDS dated 11/8/17, indicated R53 had severe cognitive impairment, had an indwelling urinary catheter, was dependent on staff for hygiene, and required extensive assistant from two staff members for bed mobility, transfers, and toileting.

Prior to admission to the facility, R53 was admitted to the hospital on 7/31/17. Hospital discharge summary dated 8/9/17, indicated R53 was admitted to the hospital for urinary sepsis and urinary retention, was treated with antibiotics, and a suprapubic catheter was placed because of Phimosis (foreskin of the penis is too tight to be retracted to reveal the glans penis). The summary indicated R53 pulled out the catheter while hospitalized and it had to be replaced. The summary also indicated R53 would be discharged to Havenwood for ongoing care.

R53's progress notes from 9/1/17, through 12/1/17, indicated R53 was sent to the emergency room for reinsertion of the suprapubic catheter after it was pulled out four times.
-On 9/10/17, note indicated urine collection bag was connected to R53's wheelchair and was pulled out when R53 wheeled himself backwards in his wheelchair.
-On 9/16/17, note indicated R53's catheter was pulled out after tubing became entangled in the foot pedals of his wheelchair.
-On 10/3/17, note indicated R53 pulled out the catheter at the insertion site and ripped the tip of the catheter.
-On 10/21/17, note indicated R53 pulled out the catheter. A follow-up progress note related to the emergency room visit dated 10/22/17, included

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recommendations for securing the catheter tubing to the leg bag at all times with either ace wraps or Coban (elastic self-adherent wrap). R53's medical record did not reflect implementation of the recommendation.

R53's bowel and bladder care plan dated 8/23/17, indicated R53 had a suprapubic catheter. The interventions dated 11/10/17, directed staff to empty catheter drain bag every shift and as needed, and catheter care to be completed as ordered.

R53's physician orders provided by the facility on 12/4/17, advised staff to "please take care so that patient does not pull his suprapubic catheter out. Special instructions: (try to cover the dressing tubing by the brief, so that he forgets about it; notify nurse if he does pull it out, because he will need to be sent in to hospital or clinic to have it replaced)."

R53's nursing orders provided by the facility on 12/4/17, included: Leg bag for Foley Catheter to be put on for daytime hours and replace with drainage bag at night. Cleanse tubing connection site with alcohol swab, place bag in clean garbage bag and tie tight for next shift.

On 12/1/17, at 7:52 a.m. R53 was observed lying in bed with NA-M at bed side assisting R53 with his pants. The overnight urine collection bag hung from the side of the bed and the catheter tubing was not anchored or secured to R53's leg to prevent excessive tension. R53's catheter insertion site was covered with an abdominal binder. R53 became resistive during cares, NA-M lowered the bed and exited the room. While out of the room, R53 grabbed at catheter tubing that

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was along his right thigh, running it in between his fingers back and forth. NA-M returned to the room with NA-Q.
-At 8:00 a.m. NA-Q confirmed the overnight bag was not anchored to prevent excessive tension and was not secured with a catheter leg band holder, however, stated it was usually on. NA-M confirmed R53 had a history of pulling the catheter out, and that was why he had to where an abdominal binder.

On 12/1/17, at 9:52 a.m. RN-C explained R53 had a history of pulling his suprapubic catheter out, and has had to go to the emergency room several times. RN-C stated the catheter bag should be attached to the bed frame so it did not pull on the tubing at the insertion site and cause accidental removal, and the tubing should be secured by a leg bag holder in order to decrease tension and accidental removal. RN-C stated R53 used an abdominal binder so the insertion site was hidden to prevent R53 from pulling on it. RN-C was not aware of the recommendations for ace wraps or self-adhesive wrap to keep the leg bag tubing secure.

On 12/4/17, at 8:56 a.m. director of nursing (DON) stated the importance of having the collection bags secured was to prevent tension and accidental removal and R53's leg bag should have been secured by a catheter leg band.

Facility policy Catheter Care last reviewed 4/2015, included the directions, 5) Secure the tubing to the leg with catheter strap or tape. 6) Secure the drainage bag below the bed or under wheelchair. Keep it off the floor. The policy did not reflect storage of the urine collection bags.

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F 725	Continued From page 160	F 725		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to implement activity programs, and provide timely assistance with personal cares according to the residents' assessed need and as directed by the care plan. This practice had the potential to affect all 71	F 725	F725 Sufficient Nursing Staff R5 will receive oral hygiene as directed by her care plan. See plan of correction for F657 and F659. R58 passed away on 12/01/17. See plan	1/14/18

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F 725	Continued From page 161 residents who resided in the facility. Findings include: See 659 - care plan implementation: the facility failed to provide oral hygiene cares for 1 of 5 resident (R5) as directed by the care plan, and failed to provide repositioning, transfers, and application of compression stockings or ace wraps as directed by the care plan for 1 of 5 residents (R58) reviewed. See F677- Activities of daily living cares for dependent resident: the facility failed to provide oral hygiene services for 1 of 5 residents (R5) observed for oral hygiene and was dependent on staff for oral hygiene. See 679 - Activities: the facility failed to consistently provide activities according to the assessed need for 3 of 3 residents (R5, R46, R10) who had cognitive impairment and was observed not to be provided daily activities or one to one activity visits according to their assessed need. See F690 - Bowel/Bladder incontinence/catheter: the facility failed to provide timely assistance with incontinence cares for 1 of 3 residents (R45) observe for incontinence cares. RESIDENT CONCERNS: On 12/4/17, at 10:46 a.m. R61, an alert and oriented resident, stated she was aware the facility was short staffed, at times. R61 stated on those days it may take up to 40 minutes for the staff to answer a call light and she had	F 725	of correction for F659. R5, R46, and R10 will be provided with activities or one-to-one activity visits according to their assessed need. See plan of correction for F679. R45 will receive incontinent care as directed by his care plan. See plan of correction for F690. All other residents will receive oral hygiene as directed by their care plan. All other residents will receive repositioning, transfers, application of compression stocking/ace wraps as directed by their care plan. All other residents will be provided with activities or one-to-one activity visits according to their assessed need. All other residents will receive incontinent care as directed by their care plan. Staffing needs will be reevaluated for nursing and activities based on resident needs. A staffing Policy and Procedure will be developed and implemented prior to 1/14/18 to address resident needs and staffing per unit on a daily basis. This Staffing Policy and Procedure identifies solutions and shifting of staff when needed to meet resident needs. The facility will ensure sufficient staffing to provide incontinent care, oral hygiene, repositioning, transfers, application of	

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F 725	Continued From page 162 experienced incontinent episodes due to not being able to get to the restroom timely. -At 10:50 a.m. R37, an alert and oriented resident, stated there had not been enough staff members at the facility for the past 6-8 months. R37 stated she normally ate her breakfast in the dining room between 7:30 a.m. and 8:00 a.m. however, today (12/4/17) she had eaten in bed because they did not have enough staff to assist her with morning cares. R37 stated she was assisted out of bed at 10:00 a.m. R37 stated the concern was a nation wide problem, not just at the facility. FAMILY CONCERNS WITH LACK OF ADEQUATE STAFFING: On 11/28/17, at 11:51 a.m. family member (FM)-D stated having two staff working on the unit had really helped because staff were able to provide better cares, however, felt they really needed three staff. On 11/29/17, at 12:51 p.m. FM-A stated on 11/23/17, (Thanksgiving) the facility did not have enough staff to care for the residents on the Walnut Grove unit. FM-A stated the facility usually had three to four nursing assistants (NAs) working on the unit, however, on 11/23/17, there was only two NAs working. -At 1:05 p.m. FM-B stated the facility did not have enough staff. FM-B also stated when visiting the facility, FM-B had observed the residents not receiving assistance with care and assistance required during meals but, there were not enough staff to help them.	F 725	compression stockings/ace wraps as directed by their care plan. The facility will also ensure sufficient staffing to provide activities or one-to-one activity visits according to their assessed need. Audits will be completed 3 times weekly, for 90 days, on various shifts to ensure nursing assistants are following resident's individualized care plans for oral hygiene, application of TEDs socks/ace wraps, turning/repositioning, transfers and incontinent care. Audits will be completed by the Activities Director of resident activity attendance record sheets and one to one activity attendance logs for 20 residents weekly, for 90 days, to ensure residents are receiving activities and one to one activity visits according to their assessed need. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or designee and Activities Director are responsible for this deficiency. Corrective date: 1/14/18	

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F 725	Continued From page 163 STAFF CONCERNS: On 11/29/17, at 2:03 p.m. trained medication assistant (TMA)-C stated it was very difficult to get work done because the residents on the secured unit constantly wandered and required frequent direction. TMA-C stated when two staff were working on the unit, and those two staff were in a resident room providing care to a resident who required two staff assistance, that left no one on the floor to monitor and/or assist the other residents. TMA-C stated she/he tried to engage the residents in activities, however, they usually required one on one assistance in order to stay on task which was impossible to provide when also attempting to administer medications and assist with care needs. TMA-C also stated staff dished up and served the resident meals and when one staff was dishing up the meal, the second staff person was serving it, and at the same time, some residents would wander out of the dining room or need assistance with toileting which required one staff person to assist the resident and redirect the resident back into the dining room which disrupted and delayed the meal service. Some residents also required assistance with eating and cueing during meal service which were usually served last so staff could serve all the residents prior to assisting those that need help to eat. TMA-C stated it was very difficult to get your work done the way it should be done, and when it should be done. TMA-C stated staff call in everyday, therefore, staff that were working are mandated to work overtime which was very hard to do. TMA-C stated cares get missed, such as oral cares because staff are in a hurry trying to tend to all the residents' needs which leave no supervision in the hall monitor residents. TMA-C stated	F 725		

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he/she did not take breaks during the shift because there was too much to do. TMA-C stated he/she had talked to the staffing coordinator who stated only two staff were needed to work on the unit.

On 11/29/17, at 5:16 p.m. registered nurse (RN)-G stated the facility had one nurse and three trained medication assistants (TMA) in the facility for a few hours each day. Due to the shifts overlapping, from 4:30 to 5:00 p.m. each day she was the only nurse in the facility and from 9:00 p.m. to 10:00 p.m.. RN-G stated as a charge nurse, she assisted with finding staff members to work at the facility but there was never enough staff so they do the best they can and have to be more efficient.

On 11/29/17, at 6:32 p.m. nursing assistant (NA)-R stated the Walnut Grove unit usually had four NAs on the day and evening shift. NA-R stated there were usually three and if there were less than three, one of the staff member from the previous shift would be mandated to stay over.

On 11/29/17, at 7:00 p.m. NA-L stated the facility frequently works short of nursing assistants. She added that they try to get ambulation done on the evening shift right away, but if working short ambulation may not be provided.

-At 6:35 p.m. NA-E stated the facility was occasionally short of staff, but many staff were also willing to stay late to assist with the resident cares.

On 11/30/17, at 9:15 a.m. NA-Q stated she had been called in to work at 2:00 a.m. due to a lack of staffing. NA-Q reported she be working until

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2:00 p.m. to also work the day shift.

On 12/1/17, at 3:15 p.m. licensed practical nurse (LPN)-E stated the facility was short staffed everyday and was not able to "always" get work done. LPN-E stated the NAs were also not able to get everything done the way they should and confirmed the residents were not toileted timely. LPN-A stated staff attempt to engage the residents with some type of activity but the unit was extremely busy and it was hard for the staff to do activities with the residents. LPN-E stated she knew an activity staff person was to work on the unit from 1:00 p.m. to 8:00 p.m. every day which be a tremendous help, but that person did not come to the unit to work.

12/1/17, at 7:35 a.m. the administrator confirmed there were staff issues and challenges at the facility and their goal was to have three staff members on each wing, each shift, and they were working towards having four. The administrator also stated the facility was allocating money to make those changes to be able to have additional staff cover the time frames when the work load was heaviest. The staff schedule was reviewed with the administrator who verified the NA staff shortages noted below:

-12/4/17: one NA shift
-12/10/17: two NA shifts
-12/13/17: two NA shifts
-12/15/17: one NA shift
-12/18/17: one NA shift
-12/19/17: one NA shift.

On survey days 11/28-11/30/17, the schedule did not reflect staff shortages. However, during review of the schedule, the administrator stated

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the schedule did not reflect mandated staff working overtime to cover shifts.

On 12/1/17, at 8:10 a.m. RN-A stated staffing was very difficult, the facility was always short everyday. Staff would ask to volunteer to work over and some were mandated to work overtime which was very difficult for staff to stay motivated in this situation. RN-A stated the staff were stressed with the workload, with coworkers who did not show up for their shifts which had a direct affect on staff morale. RN-A what not sure what could be done to fix the problem. RN-A stated staff worked very hard but there are some residents who did not get assistance with toileting or meals as they should be. RN-A stated an activity staff person was supposed to be working on the unit from 1:00 p.m. to 8:00 p.m. daily which would help a lot but confirmed the activity staff person did not show up on the unit to work.

On 12/3/3/17, at 1:45 p.m. NA-S stated staffing was short today due to a staff person calling in, therefore, the night shift staff had stayed over to work. NA-S stated the facility was short of staff every weekend worked. NA-S stated when they do get a new staff person they do not want to stay because staff were always working short.

On 12/3/17, at 1:50 p.m. NA-T stated the facility worked short staffed all the time and staff did not want come in extra because they were so stressed with working short. NA-S stated the facility had more incontinent residents because staff just could not get all of the work done.

On 12/3/17, at 1:58 p.m. NA-D stated staff were working short most of the time, therefore, they could not get their work done which included

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toileting, on time.

On 12/4/17, at 10:33 a.m. RN-B stated the facility had difficulty with staffing due to lack of staff and lack of the staff's ability to show up for work. RN-B stated the staff worked together to cover the shifts either by volunteering for open shift, volunteering to stay at the facility for the next shift or by mandating a staff member to stay over to assist with resident cares. RN-B stated staffing was a concern every day, but the staff did the best they could to cover shifts.

On 12/4/17, at 10:41 a.m. the director of nursing stated the facility shoots for four NAs on the Walnut Grove unit, however, working with three NAs was doable on both the a.m. and p.m. shifts and one NA and one TMA/nurse on the night shift. The DON confirmed 28 residents resided on the Walnut Grove unit. The DON stated Willow Way unit would be staffed the same as Walnut Grove. Maple Lane unit, the secured unit's staffing goal was to have two NAs during the day and evening shift. The DON stated the facility had been going up and down with their NA staff and had lost quite a few NAs when school started. The DON confirmed they had staff call-ins everyday in which they do attempt to replace by asking for staff to volunteer to work or having to mandate staff to stay overtime. The DON stated the facility struggled with staffing and knew the staff verbalize their frustration with each other and were stressed and burnt out which was very difficult.

On 12/4/17, at 10:53 a.m. LPN-A stated the facility always had three NAs on the Walnut Grove unit which had 25 residents, however, 10 of those residents required assistance of two staff

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F 725	Continued From page 168 members for transfers and/or personal cares. LPN-A stated today, the cares on the Walnut Grove unit were a bit slow because even though they had three NAs, one of those NAs had been mandated to stay from the night shift, and the other two NAs were new employees and not as familiar with the residents as the more experienced NAs. LPN-A stated Walnut Grove ran much better when there were four NAs due to the fact the resident care demands were so heavy. On 12/4/17, at 2:30 p.m. the administrator was asked how the facility had determined the number of staff members required to provide care for the residents. The DON stated the staffing plan identified 9-11 licensed nurses, 15-23 nursing assistants and 1-3 administrative nurses daily. The DON confirmed the facility assessment did not identify the acuity of the residents, or their needs in relationship to the required number of staff members needed. The DON stated the facility assessment was only a rough draft of the needs of the facility. A policy related to sufficient staff was requested, however none was provided.	F 725		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care	F 726		1/14/18

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F 726	Continued From page 169 and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure licensed nursing staff demonstrated competency skills related to identifying changes in resident condition, timely notification of the physican when a change in condition was identified, quality of care related to the assessment and treatment of pressure and non pressure related skin wounds, actions to take when resident care equipment malfunctions, documentation required when injuries of unknown etiology are identified, and infection control practices related to adequate hand hygiene, glucometer disinfection, care of urinary catheter urine collection bags. This had the potential to affect all 71 residents residing in	F 726	F726 Competent Nursing Staff For R28, R58, and R54 see plan of corrective for F580. For R28 and R58 see plan of correction for F684. For R58, R54, R50, and R54 see plan of corrective for F686. For R66, R28, R21, R10, R24, R59, R33, R43, R37, R19, and R61 see plan of correction for R689.	

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F 726	Continued From page 170 the facility. Findings include: See 580 - Physician Notification: the facility failed to ensure a physican was notified of a change in condition for 1 of 1 resident (R28) who had developed, fever, vomiting and decreased lung sounds. The facility's failure to contact the physican resulted in actual harm for R28 who required hospitalization for pneumonia, sepsis and dehydration. In addition, the facility failed to notify the physican of the worsening of a stage two pressure ulcer and the increase in lower extremity edema with the development of a ruptured blister and weeping skin for 1 of 2 residents (R58), and failed to notify the physician when a pressure ulcer re-developed and worsened (R54). See 684 - Quality of Care: the facility failed to ensure 1 of 1 resident (R28) received necessary medical attention following the onset of an acute illness and the facility staff refused to transfer R28 to the hospital for treatment. R28 sustained actual harm as required hospitalization. The facility failed to comprehensively assess, monitor, and implement interventions for 1 of 1 resident (R58) who had non pressure related open areas to the lower legs and also had increase of edema (swelling) to legs. R58 sustained actual harm as the skin conditions worsened. See F686 - Pressure Ulcers: The facility also failed to comprehensively assess pressure ulcer risk, reassess the efficacy of interventions, update the medical practitioner, and/or consistently implement interventions to promote healing and prevent the development of new	F 726	For R28 see plan of correction for 842. For R21, R24, R58, R54, R5, R57, and R53 see plan of correction for F880. The facility will develop and complete competency evaluations for hand hygiene, what actions to take when equipment malfunctions, and care of urinary catheter urine collection bags with all nursing staff. Competency evaluations will be completed on all current nursing staff prior to 1/14/18. Competency training will be completed upon hire and annually from 1/14/18 forward. The facility will develop and complete competency evaluations with all charge nurses for identifying changes in resident condition, timely notification of the resident physician when a change in condition is identified, and assessment and treatment of pressure and non-pressure related skin wounds. Competency evaluations will be completed on all charge nurses prior to 1/14/18. Competency training will be completed upon hire and annually from 1/14/18 forward. The facility will develop and complete competency evaluations with all TMAs, LPNs, and RNs for the documentation required when injuries of unknown etiology are identified and glucometer disinfection. Competency evaluations will be completed on all current TMAs, LPNs and RNs prior to 1/14/18. Competency training will be completed upon hire and	

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F 726	Continued From page 171 pressure ulcers for 3 of 3 residents (R58, R54, R50) who were reviewed for pressure ulcers. This failure resulted in actual harm to R58 and R54 due to the worsening of facility acquired pressure ulcers. In addition, R45 was identified at risk for pressure ulcers and the facility failed to provide turning and repositioning assistance as directed by the care plan. See 689: Free of accident hazards: the facility failed to ensure proper working order of resident care equipment used to transfer residents to ensure safety and prevent accidents. Staff were observed to transfer a resident with a faulty mechanical lift utilizing an unsafe practice resulting in the lift almost tipping. The facility failed to operationalize a process for reporting unsafe use of the full body lifts while ensuring faulty lifts remained off the unit/out of use resulting in the risk of potential serious harm or injury to 1 of 2 residents (R66) who was observed to be transferred using the faulty full body lift. The facility's lack of assessment, reporting, and maintenance procedures, resulted in an Immediate Jeopardy (IJ), with the potential for serious harm, injury, or death, for 11 of 11 residents (R66, R28, R21, R10, R24, R59, R33, R43, R37, R19, R61) who resided on the Walnut Grove unit and required the use of the full body mechanical lift for transfers. See 842 - Accuracy of medical records: the facility failed to maintain accurate medical records for 1 of 1 residents (R28) reviewed related to bruises of unknown origin. See 880 - Infection control: the facility failed to ensure communal blood glucose machines were disinfected between resident use for 2 of 2	F 726	annually from 1/14/18 forward. The facility will utilize the facility assessment to identify competency needs. See F580 for corrective audit schedule. See F684 for corrective audit schedule. See F686 for corrective audit schedule. See F689 for corrective audit schedule. See F842 for corrective audit schedule. See F880 for corrective audit schedule. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or designee is responsible for this deficiency. Corrective date: 1/14/18	

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F 726	Continued From page 172 resident (R21, R24) observed to have blood sugar checks conducted without proper disinfection of the machine. This practice had the potential to affect 3 of 3 residents residing on the Walnut Grove unit who received routine blood sugar checks; failed to implement an infection control program utilizing process surveillance, such as hand hygiene audits, to reduce possible trends of infection which had the potential to affect all 71 residents who resided in the facility. Additionally, the facility failed to ensure proper hand hygiene was maintained during the provision of personal cares and/or wound treatments for 2 or 3 residents (R58, R54) observed during wound care and for 2 of 5 residents (R5, R57) observed during the provision of personal cares. Lastly, the facility failed to ensure urinary catheter bags were stored and cared for in a manner to prevent infections for 1 of 1 residents (R53) whose catheter bag was observed stored without a protective cap. On 12/4/17, at 3:10 p.m. the DON stated the facility had not conducted any staff competency testing in any areas.	F 726		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by:	F 730		1/14/18

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F 730	Continued From page 173 Based on interview, and document review, the facility failed to ensure 12 hours of annual inservice training was completed by 4 of 5 nursing assistants (NA-A, NA-B, NA-N , NA-O) whose personnel records were reviewed. Findings include: Nursing assistant (NA)-A was hired on 9/9/85. Her employee record indicated she had completed three of the 12 required training hours from 9/9/16 to 9/8/17. NA-B was hired on 11/29/15. Her employee record indicated she had completed six of the required 12 required training hours from 11/29/16 to 11/28/17. NA-N was hired on 11/15/11. Her employee record indicated she had completed five of the required training hours from 11/15/16 to 11/14/17. NA-O was hired on 3/17/16. Her employee record indicated she had completed 10 of the required training hours from 3/17/16 to 3/17/17. On 12/5/17, at 9:12 a.m. the administrator confirmed NA-A, NA-B, NA-N and NA-O had not completed the required hours of training. The facility Nursing Assistant job description dated 1/2015, directed job qualifications included must meet and maintain State/Federal requirements under OBRA [Omnibus Budget Reconciliation Act] 1987 for Nursing Assistants. The job description also indicated the individual would attend appropriate in-services, facility education programs and staff meetings.	F 730	F730 Nurse Aide Perform Review-12hrs/yr In-service NA-A, NA-B, NA-N, and NA-O will complete their 12 required in-service hours by 1/14/18. All other nursing assistants will complete their 12 hours of required in-service hours by 1/14/18. The Inservice Education Policy was reviewed and revised on 12/31/17. Audits will be completed on nursing assistant's in-service hours by the Director of Nursing or designee weekly, for 90 days. In-service hours will then be monitored monthly by the Director of Nursing or designee who will review in-service attendance records and identify staff needing to complete required training. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or designee is responsible for this deficiency. Corrective date: 1/14/18	

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F 730	Continued From page 174 The Inservice Education policy dated 12/2014, indicated in-service education was responsible for providing programs for the continuing education of all staff members in the physical, psychological, and spiritual aspects of the healing ministry. The policy did not address the 12 hour yearly training requirement for nursing assistants.	F 730		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in	F 756		1/14/18

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F 756	Continued From page 175 the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure the consulting pharmacist identified and reported medication irregularities related to the lack of a 14 day assessment following the initiation of as needed (PRN) psychotropic medications to the attending physician and the director of nursing to be acted upon for 4 of 4 residents (R57, R20, R42, R10) reviewed who received PRN psychotropic medications without the completion of a 14 day assessment. Findings include: R57 received as needed anti-anxiety medication without a 14 day review of the medication. This irregularity was not reported to the primary physican or director of nurses (DON) R57's significant Minimum Data Set (MDS) dated 11/2/17, indicated R57's diagnoses included end stage chronic obstructive pulmonary disease (COPD), atrial fibrillation and schizophrenia. The MDS indicated R57 required extensive assistance of one to two staff for all activities of daily living (ADL). The MDS indicated R57 had received one dose of an antianxiety medication during the	F 756	F756 Drug Regimen Review, report Irregular, Act On R57□s prn psychotropic medication was discontinued on 12/07/17. R20 passed away on 12/16/17. R42□s prn psychotropic medication was discontinued on 12/07/17. R10□s prn psychotropic medication was discontinued on 12/15/17. All other residents residing in this facility will be reviewed by the pharmacy consultant prior to 1/14/18 for the use of prn psychotropic medications to ensure the appropriate documentation has been completed or the medication has been discontinued. All charge nurses will be educated prior to 1/14/18 on the new requirement the 14 day face to face evaluation by the prescribing physician for the continued use of prn psychotropic medications.	

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F 756	Continued From page 176 assessment period. R57's Psychotropic Medication Use Care Area Assessment (CAA) dated 11/2/17, indicated R57 had received an antianxiety medication (Ativan) during the assessment period. The CAA indicated R57's primary physician reviewed R57's medications every 60 days and the consultant pharmacist reviewed R57's medications monthly. R57's Physican Orders dated 10/20/17, indicated R57 had been admitted to hopsice services for the treatment of end stage COPD and order Ativan 0.5 milligrams (mg) orally every four hours as needed for restlessness or shortness of breath. R57's care plan dated 11/8/17, indicated R57 required Hospice services for the care and treatment of end stage COPD. The plan directed staff to ensure R57 utilized oxygen, however, it did not address the use of the as needed Ativan or non pharmacological interventions to be attempted prior to the administration of the Ativan. R57's Electronic Medication Administration Record (EMAR) revealed R57 had received PRN Ativan on 10/20/17, at 10:15 p.m., 10/22/17, at 4:36 p.m. and 10/27/17, at 2:27 a.m. R57's Progress Notes from 10/20/17, through 12/4/17, did not include documentation of the efficacy of R57's Ativan usage. R57's medical record did not include an every 14 day face to face assessment completed by the primary physican for the efficacy and justification for the continued use of the PRN Ativan. R57 had not been evaluated by the primary physican	F 756	The facility□s Psychotropic policy was reviewed and revised on 12/29/17 to include the 14 day face to face evaluation by the prescribing physician for the continued use of prn psychotropic medications. Random audits will be completed three times weekly, for 90 days, on resident medication orders to ensure prn psychotropic medications have the appropriate face to face evaluation for continued use. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing or designee is responsible for this deficiency. Corrective date: 1/14/18	

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F 756	Continued From page 177	F 756		

since being discharged from the hospital on 10/20/17, the same day she was admitted to Hospice services.

The consultant pharmacist Summary Report dated 10/1/17, and 11/1/17, indicated R57 had "no irregularities identified."

On 12/4/17, at 8:44 a.m. licensed practical nurse (LPN)-A stated R57 utilized Ativan when she became extremely short of breath and displayed anxious behaviors. LPN-A reviewed R57's EMAR and confirmed R57 had not utilized the Ativan in the past 14 days.

On 12/4/17, at 9:00 a.m. R57 was observed seated in a wheelchair in the Walnut Grove dining room. R57 had oxygen running at four liters via nasal cannula. R57 was not observed to display air hunger or anxious behaviors.

On 12/4/17, at 9:40 a.m. the director of nurses (DON) confirmed R57 had an order for as needed Ativan through Hospice services. R57 had not utilized the medication in the past 14 days but had utilized it in the month of October. The DON stated she was aware of the requirement for an every fourteen day face to face meeting with the primary physican for the continued use of as needed psychotropic medications (including anti-anxiety medications), however, the facility had not established a system to ensure the physican evaluations could be completed. The DON confirmed R57 had not received a fourteen day evaluation for the continued use of Ativan PRN and she would have to discuss the concern with the consultant pharmacist.

On 12/4/17, at 1:15 p.m. the consultant

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pharmacist was interviewed via telephone. The pharmacist stated he had talked with the facility and directed them to have conversations with the physican's to establish a system as to how to become compliant with the every 14 day evaluation requirement for those residents receiving as needed psychotropic medication. The pharmacist stated he had left examples of policies with the facility to assist them in the process of compliance and had also left a review form with the DON during his last visit requesting R57's Ativan be evaluated by the primary physican. The pharmacist stated he would send a copy of the form to the DON.

On 12/4/17, at 4:18 p.m. the DON provided a copy of the Consultant Pharmacist Medication Review dated 12/4/17, in which he requested the primary physican to evaluate R57's PRN Ativan. The DON confirmed the medication review form had been completed on 12/4/17.

R20's was prescribed PRN anti-anxiety medication without a 14 day review of the medication. This irregularity was not reported to the primary physican or DON.

R20's annual MDS dated 9/18/17, indicated R20 had diagnsoses which included dementia with behavior disturbance, agitation, depression, anxiety and progressive Alzheimer's disease. The MDS indicated R20 required extensive assistance of one to two staff for all activities of daily living. The MDS indicated R20 had received antianxiety, antidepressant and antipsychotic medications daily during the assessment period.

R20's Physician Order Report reviewed 11/13/17, indicated orders to admit to secured unit Maple

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Lane due to Dementia with behavioral disturbances, Ativan 1.0 mg once an evening which was started on 12/7/15, with an open end date. Ativan 0.5 mg once a morning, with a start date of 12/8/15, and an open end date. In addition, an order for Ativan 1.0 mg as needed, with a start date of 2/4/16, and an open end date with with special instructions which read: in addition to scheduled doses/agitation.

R20's Psychotropic Medication Use CAA dated 9/18/17, indicated R20 psychotropic drug use included antipsychotic, antianxiety and antidepressant medications. R20's Behavioral symptoms CAA, dated 9/20/17, indicated wandering once in past 7 days, factors that could cause or exacerbate behaviors included sensory impairment, dementia, Alzheimer's disease and cerebrovascular accident.

R20's Care Plan reviewed 9/20/17, indicated R20 had an alteration in thought process with a potential for anxiety related to Dementia with Behavior Disturbance, anxiety and depression. Staff were directed to monitor, offer non-pharmacological interventions and medicate R20, as needed.

R20's Behavior/Mood Flow sheets dated 9/1/17, through 11/30/17, identified one episode of R20 refusing to go to bed or the bathroom on 11/13/17.

R20's PRN Medication administration History from 9/1/17, through 11/30/17, indicated PRN Ativan had not been administered. R20's medical record did not include an every 14 day face to face assessment completed by R20's primary physician to evaluate the medication efficacy and

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justification for the continued use of the PRN Ativan.

R20's Consultant Pharmacists Medication Review's dated 10/1/17, indicated no irregularities and 11/8/17, indicated irregularities-recommendation suggested tapering R20's Seroquel. R20's PRN Ativan was not addressed.

On 11/29/17, at 2:07 p.m. R20 was observed ambulating with Choice therapy, no behaviors were observed.
-At 2:28 R20 was observed in bed. No behaviors observed.

On 11/30/17, at 11:30 a.m. R20 was observed seated in his wheelchair in the dining room, no behaviors were observed.

On 12/1/17, at 9:30 a.m. Trained Medication Assistant (TMA)-C confirmed R20 took his medications very well, had not exhibited any behaviors and had not utilized the PRN Ativan for quite some time.

On 12/2/17, at 11:00 a.m. registered nurse (RN)-A confirmed R20 took his medications well and stated he had lost his wife a year ago and had exhibit behaviors when he was first admitted but his behaviors have since decreased. RN-A confirmed R20 had not utilized PRN Ativan and his medical record lacked a 14 day limitation/review date or indication/justification for ongoing/continued use for the PRN medication. RN-A stated the PRN medication could be discontinued.

On 12/4/17, at 1:30 p.m. the consultant

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pharmacist was interviewed via telephone. The pharmacist confirmed R20's medical record did not currently have recommendations related to the lack of the 14 day assessment and justification for continued use beyond the timeframe for PRN Ativan use. The consultant pharmacist stated he would address the issue on his next visit.

On 12/4/17, at 2:14 p.m. the DON confirmed R20's medical record lacked pharmacy recommendations related to a 14 day PRN medication evaluation and stated she would discuss these concerns with the pharmacist on his next visit.

R42 received as needed anti-anxiety and anti-psychotic medication without a 14 day review of the medication.

R42's significant change MDS dated 10/22/17, indicated R42's diagnoses included anxiety disorder, dementia and hypertension. The MDS indicated R42 required extensive assistance of one to two staff for all activities of daily living (ADL). The MDS also indicated R42 had received antipsychotic, antidepressant and antianxiety medication daily during the seven day assessment period.

R42's Psychotropic Medication Use CAA dated 10/22/17, indicated R22 had received Ativan, antipsychotic medication (Seroquel), antidepressant, (Remeron), and also had Ativan and Haldol prn if needed during the assessment period.

R42's Physician Orders dated 9/18/2017-11/20/17, indicated R42 was

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prescribed Remeron 45 mg daily, Lorazepam (anti-anxiety) 0.5 mg three times daily, Seroquel 50 mg every morning and 100 mg every evening, Haloperidol (antipsychotic) 1.0 mg every four hours PRN, and Ativan 0.5 mg every 4 hours PRN.

R42's care plan updated 11/11/17, indicated R42 required comfort cares following a recent discharge from hospice services for the care and treatment of a gastrointestinal bleed. The plan indicated R2 had alteration in thought process and directed staff to ensure R42's non pharmacological interventions were attempt prior to PRN medication use.

R42's EMAR revealed R42 had received the following PRN medications:

October 2017:
-Ativan on 10/5/17, at 3:02 p.m., . 10/13/17, at 4:30 p.m.
-Haloperidol on 10/09/17, at 3:49 p.m., 10/18/17, at 3:34 p.m. and 10/23/17, at 1:24 p.m.
November 2017:
-Ativan on 11/15/17 at 12:07 p.m., 11/26/17 at 5:51 p.m.
-Haloperidol was not administered.

R42's medical record did not include an every 14 day face to face assessment completed by the primary physician for the efficacy and justification for the continued use of the PRN Ativan and Haloperidol.

R42's Consultant Pharmacists Medication Review's dated 10/3/17, identified irregularities noted as Haloperidol 1.0 mg PRN medication, reassess use after 14 days per CMS guidelines

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or consider providing clinical recommendation for continued use, however R42's use of PRN Ativan was not addressed. R42's 11/1/17, review identified irregularities noted as 2nd request for Haloperidol recommendation from 10/17, however, the PRN Ativan was not addressed.

On 11/29/17, at 12:55 p.m. R42 was observed in the dining room, seated in a chair attempting to tie her shoe. No behaviors observed.
-At 1:23 p.m. R42 was observed participating in exercises with therapy. No behaviors observed. R42 was also observed ambulating the common hallway of the Maple Lane unit, with no behaviors observed.

On 12/1/17, at 8:10 a.m. RN-A stated R42 had previously been on hospice and during that time the PRN Haloperidol and PRN Ativan was implemented. RN-A confirmed R42 had improved in status, was removed from hospice and was started on comfort cares. RN-A verified R42's PRN Haldol and Ativan had not been evaluated for efficacy and continued use with a 14 day face to face physician assessment.

On 12/4/17, at 1:30 p.m. the consultant pharmacist was interviewed via telephone. The pharmacist confirmed the residents medical records did not currently have recommendations related to the 14 day justification for continued use beyond the timeframe for PRN Ativan. The consultant pharmacist stated he would address the issue on his next visit.

On 12/4/17, at 2:14 p.m. the DON confirmed R42's medical record lacked pharmacy recommendations related the use of the Ativan and also a response to the consulting

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pharmacists repeated recommendation for a 14 day medication evaluation related to the haloperidol use. The DON stated would discuss these concerns with the pharmacist on his next visit.
R10 received as needed anti-anxiety medication without a 14 day review of the medication.

R10's annual Behavioral and Psychotropic Medication Use CAA, dated 3/27/17, identified diagnoses of Alzheimer's dementia behavior dyscontrol, sleep behavior disturbance, and displayed behaviors during cares and with medication administration. The CAA identified R10 received antidepressant medication; however, did not capture any as needed psychotropics.

R10's quarterly MDS, date 9/10/17, indicated R10 had severe cognitive impairment and no observed behaviors during the assessment period.

R10's current physician orders, signed 10/20/17, identified order for Ativan to be given twice a day PRN. The order instructed to give Ativan for feeling anxious or behaviors of hollering, suicidal ideation, and verbal or physical aggression toward others.

A consultant pharmacist's medication review, dated 5/1/17, identified a tapering of the PRN Ativan had been requested due to lack of efficacy. The review further identified the request had been denied with the reason, "rare utilization but helpful when needed." The Ativan order was renewed on 5/11/17. There were no further requests for tapering or justification of continued use after 14 days.

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R10's current care plan, dated 9/12/17, indicated he had an alteration in thought processes with the potential for anxiety displayed in verbal abuse and physical aggression towards others and had suicidal ideation's. The care plan directed to use non-pharmacological behavioral interventions such as toileting, pain control, redirection with activities, and visiting about fishing/truck driving. The care plan further directed staff to "medicate as ordered," but did not address the PRN Ativan.

R10's medication administration record (MAR), reviewed from 6/17-11/17, identified the following:
- In June, R10 received PRN Ativan seven times.
- In July, R10 received PRN Ativan three times.
- In August, R10 received PRN four seven times.
- In September, R10 received PRN Ativan once.
- In October, R10 did not receive PRN Ativan.
- In November, R10 received PRN Ativan once.

R10's Behavior/Mood Flow Sheets, reviewed from 9/17, to 11/17, revealed one behavioral episode documented by the nursing assistants in the last three months.

R10's progress notes, reviewed from 9/1/17, to 11/26/17, identified the last documented behavior was in September. The notes indicated R10's psychiatrist had visited him on 11/20/17, and 10/27/17, noting the medications were reviewed and no changes made. Corresponding psychiatry note, dated 10/30/17, indicated R10 was clinically stable with no changes to current medication regimen. The psychiatry note from 11/20/17, was not provided.

R10's medical record lacked evidence of the efficacy and justification for the continued use of

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the PRN Ativan.

During interview on 12/4/17, at 10:05 a.m. RN-B reported she had noticed a decrease in R10's behaviors and stated psychotropic medications were reviewed with the pharmacist monthly for tapering, further stating psychiatry was in charge of R10 psychotropics, and they had recently talked about the potential for discontinuing the Ativan.

On 12/4/17, at 11:53 a.m. the DON stated herself, the pharmacist, and RN-B reviewed R10's medications monthly, looking at the behavioral interventions and tapering of psychotropics, however those conversations and meetings were not documented. The DON confirmed there were no irregularities on R10's consultant pharmacist summary report since May and stated they were planning on reviewing R10's PRN Ativan that week and actually were in the process of starting to review PRN psychotropics for the 14 day requirement.

On 12/4/17, at 1:15 p.m. the consultant pharmacist confirmed a medication review form had not been completed to alert R10's primary physician of the continued use of the as needed medication.

Havenwood Care Center Psychotropic policy and procedure updated on 7/23/17, indicated each residents' drug regimens would be free of unnecessary drugs. Every effort would be made to obtain the lowest dose possible for all psychotropic medications. The policy did not address the required 14 day face to face evaluation during resident use of PRN psychotropic medication.

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F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended	F 758		1/14/18

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F 758	Continued From page 188 beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents who received as needed (PRN) psychotropic medication received an every fourteen day (14) face to face evaluation by their primary physican, as required. This practice affected 4 of 4 residents (R57, R20, R42, R10,) who received PRN psychotropic medications. Finding include: R57 received as needed anti-anxiety medication without a 14 day review of the medication. R57's significant Minimum Data Set (MDS) dated 11/2/17, indicated R57's diagnoses included end stage chronic obstructive pulmonary disease (COPD), atrial fibrillation and schizophrenia. The MDS indicated R57 required extensive assistance of one to two staff members for all activities of daily living (ADL). The MDS indicated R57 had received one dose of an antianxiety medication during the assessment period. R57's Psychotropic Medication Use Care Area Assessment (CAA) dated 11/2/17, indicated R57 had received an antianxiety medication (Ativan) during the assessment period. The CAA	F 758	F758 Free from Unnec Psychotropic Meds/PRN Use R57□s prn psychotropic medication was discontinued on 12/07/17. R20 passed away on 12/16/17. R42□s prn psychotropic medication was discontinued on 12/07/17. R10□s prn psychotropic medication was discontinued on 12/15/17. All other residents residing in this facility will be reviewed by the pharmacy consultant prior to 1/14/18 for the use of prn psychotropic medications to ensure the appropriate documentation has been completed or the medication has been discontinued. All charge nurses will be educated prior to 1/14/18 on the new requirement the 14 day face to face evaluation by the prescribing physician for the continued use of prn psychotropic medications.	

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F 758	Continued From page 189 indicated R57's primary physician reviewed R57's medications every 60 days and the consultant pharmacist reviewed R57's medications monthly. R57's Physican Orders dated 10/20/17, indicated R57 had been admitted to hopsice services for the treatment of end stage COPD and was prescribed Ativan 0.5 milligrams (mg) orally every 4 hours as needed for restlessness or shortness of breath. R57's care plan dated 11/8/17, identified R57 required hospice services for the care and treatment of end stage COPD. The plan directed staff to ensure R57 utilized oxygen, however, it did not address the use of the as needed Ativan or non pharmacological interventions to be attempted prior to the administration of Ativan. R57's Electronic Medication Administration Record (EMAR) revealed R57 had received PRN Ativan on 10/20/17, at 10:15 p.m., 10/22/17, at 4:36 p.m. and 10/27/17, at 2:27 a.m. R57's Progress Notes from 10/20/17 - 12/4/17, did not include documentation of the efficacy of R57's Ativan usage. R57's clinical record did not include an every 14 day face to face assessment completed by the primary physican for the efficacy and justification for the continued use of the PRN Ativan. R57 had not been evaluated by the primary physican since being discharged from the hospital on 10/20/17, the same day she was admitted to hospice services. On 12/4/17, at 8:44 a.m. licensed practical nurse (LPN)-A stated R57 utilized Ativan when she	F 758	The facility□s Psychotropic policy was reviewed and revised on 12/29/17 to include the 14 day face to face evaluation by the prescribing physician for the continued use of prn psychotropic medications. Random audits will be completed 3 times weekly, for 90 days, on resident medication orders to ensure prn psychotropic medications have the appropriate face to face evaluation for continued use. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of nursing or designee is responsible for this deficiency. Corrective date: 1/14/18	

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became extremely short of breath and displayed anxious behaviors. LPN-A reviewed R57's EMAR and confirmed R57 had not utilized the Ativan in the past 14 days.
On 12/4/17, at 9:00 a.m. R57 was observed seated in a wheelchair in the Walnut Grove dining room. R57 had oxygen running at 4 liters via nasal cannula. R57 was not observed to be displaying air huger or anxious behaviors.
On 12/4/17, at 9:40 a.m. the director of nurses (DON) confirmed R57 had an order for as needed Ativan through hospice services. R57 had not utilized the medication in the past 14 days but had utilized it in the month of October. The DON stated she was aware of the requirement for an every fourteen day face to face meeting with the primary physican for the continued use of as needed psychotropic medications (including antianxiety medications), however, the facility had not established a system to ensure the physican evaluations could be completed. The DON confirmed R57 had not received a fourteen day evaluation for the continued use of Ativan PRN.

R20's was prescribed PRN anti-anxiety medication without a 14 day review of the medication.

R20's Diagnosis sheet undated, identified diagnosis of dementia with behavior disturbance, agitation, depression, anxiety and progressive Alzheimer's disease and hypertension. R2 was admitted on 11/4/15.

R20's Physician Order Report reviewed 11/13/17, indicated orders to admit to secured unit Maple Lane due to Dementia with behavioral disturbances, Ativan 1.0 mg once an evening with a start date of 12/7/15. Ativan 0.5 mg once a

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morning started on 12/8/15, as well as Ativan 1.0 mg as needed with a start date of 2/4/16, with special instruction this dose was in addition to scheduled doses / agitation.

R20's Psychotropic Medication Use CAA dated 9/18/17, indicated R20 psychotropic drug use included antipsychotic, antianxiety and antidepressant medications. R20's Behavioral symptoms CAA, dated 9/20/17, indicated wandering had occurred once in the seven day reference period, factors that could cause or exacerbate behaviors included sensory impairment, dementia, Alzheimer's disease and cerebrovascular accident.

R20's Care Plan reviewed 9/20/17 indicated R20 had an alteration in thought process with potential for anxiety related to Dementia with Behavior Disturbance, anxiety and depression. Staff were directed to monitor, offer non-pharmacological interventions and medicate as needed.

R20's Behavior/Mood Flow sheets dated 9/1/17, to 11/30/17, identified one episode of R20 refusing to go to bed or the bathroom on 11/13/17.

R20's PRN Medication administration History from 9/1/17, to 11/30/17, indicated PRN Ativan had not been administered/utilized. R20's clinical record did not include an every 14 day face to face assessment completed by the primary physician for the efficacy and justification for the continued use of the PRN Ativan.

On 11/29/17, at 2:07 p.m. R20 was observed ambulating with Choice therapy, no behaviors observed.

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-At 2:28 R20 was observed laying in his bed, no behaviors observed.

On 11/30/17, at 11:30 a.m. R20 was observed seated in his wheelchair in the dining room, no behaviors observed.

On 12/1/17, at 9:30 a.m. Trained Medication Assistant (TMA)-C confirmed R20 took his medications very well, spent time lying in bed, had not exhibited any behaviors and had not utilized PRN Ativan for quite some time.

On 12/2/17, at 11:00 a.m. RN-A stated R20 had lost his wife a year ago and exhibited behaviors when he was first admitted however, his behaviors have since decreased. RN-A confirmed R20 had not utilized the PRN Ativan. RN-A confirmed R20's medical record lacked a 14 day limitation/review date or indication/justification for ongoing/continued use for the PRN medication. RN-A stated the PRN medication could be discontinued.

On 12/2/17, 2:14 p.m. the DON verified R20 was prescribed PRN Ativan and confirmed 14 day parameters had not been identified or implemented related to its use and should have been. The DON confirmed R20's record lacked a pharmacy recommendations to evaluate R20's PRN Ativan and the record lacked a physician's recommendation related to efficacy and justification for continue use of R20's PRN Ativan. The DON stated this was an area they would work on.

R42 received as needed anti-anxiety and anti-psychotic medication without a 14 day review

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of the medication.

R42's significant MDS dated 10/22/17, indicated R42's diagnoses included anxiety disorder, dementia and hypertension. The MDS indicated R42 required extensive assistance of one to two staff members for all activities of daily living (ADL). The MDS indicated R42 had received antipsychotic, antidepressant and antianxiety medication daily during the seven day assessment period.

R42's Psychotropic Medication Use CAA dated 10/22/17, indicated R22 had received an antianxiety medication (Ativan), antipsychotic medication (Seroquel), antidepressant, (Remeron), in addition R42 also has Ativan and Haldol prn if needed during the assessment period.

R42's Physician Orders dated 9/18/2017-11/20/17, indicated R42 was prescribed Remeron (anti-depressant) 45 mg daily, Lorazepam (anti-anxiety) 0.5 mg three times daily, Seroquel 50 mg every am and 100 mg every evening, Haloperidol (antipsychotic) 1.0 mg every 4 hours PRN, and Ativan 0.5 mg every 4 hours PRN.

R42's care plan updated 11/11/17, identified R42 as requiring comfort cares-(recently discharge from hospice services for the care and treatment of gastrointestinal bleed. The plan indicated R2 had alteration in thought process and directed the staff to ensure R42's non pharmacological interventions were attempted prior to PRN medication uses.

R42's EMAR revealed R42 had received PRN

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Ativan on 10/5/17, at 3:02 p.m., 10/13/17, at 4:30 p.m. and Haloperidol 10/09/17, at 3:49 p.m., 10/18/17, at 3:34 p.m. and 10/23/17, at 1:24 p.m. R42 received PRN Ativan on 11/15/17 at 12:07 p.m., 11/26/17 at 5:51 p.m., and no utilization of PRN Haloperidol in 11/17.

R42's clinical record did not include an every 14 day face to face assessment completed by the primary physician for the efficacy and justification for the continued use of the PRN Ativan and Haloperidol.

On 11/29/17, at 12:55 p.m. R42 was observed seated in a chair in the dining room attempting to tie her shoe. No behaviors observed.
-At 1:23 p.m. R42 was observed participating in exercises with therapy, no behaviors observed. R42 observed ambulating the common hallway of the Maple Lane unit, no behaviors observed.

On 12/1/17, at 8:10 a.m. RN-A stated R42 had previously been on hospice during the time the PRN Haloperidol and PRN Ativan was implemented. However, RN-A stated R42 had improved in status, was removed from hospice services and was started on comfort cares. RN-A confirmed R42's PRN medications Haldol and Ativan had not been evaluated for efficacy and the need for continued use with a 14 day face to face physician assessment.

On 12/4/17, at 2:28 p.m. the DON confirmed R42 had not received a 14 day evaluation for PRN Ativan and Haldol and the clinical record lacked indication for continued use.
R10 received as needed anti-anxiety medication without a 14 day review of the medication.

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R10's annual Behavioral and Psychotropic Medication Use CAA, dated 3/27/17, identified diagnoses of Alzheimer's dementia behavior dyscontrol, sleep behavior disturbance, and displayed behaviors during cares and with medication administration. The CAA identified R10 received antidepressant medication; however, did not capture any as needed psychotropics.

R10's quarterly MDS, date 9/10/17, indicated a severe cognitive impairment and no observed behaviors during the assessment period.

R10's current physician orders, signed 10/20/17, identified order for Ativan to be given twice a day PRN. The order instructed to give Ativan for feeling anxious or behaviors of hollering, suicidal ideation, and verbal or physical aggression toward others.

A consultant pharmacist's medication review, dated 5/1/17, identified a tapering of the PRN Ativan had been requested due to lack of efficacy. The review further identified the request had been denied with the reason, "rare utilization but helpful when needed." The Ativan order was renewed on 5/11/17.

R10 care plan, dated 9/12/17, indicated he had an alteration in thought processes with the potential for anxiety displayed in verbal abuse and physical aggression towards others and had suicidal ideation's. The care plan directed to use non-pharmacological behaviors interventions such as toileting, pain control, redirection with activities, and visiting about fishing/truck driving. The care plan further directed to "medicate as ordered," but did not address the PRN Ativan.

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R10's medication administration record (MAR), reviewed from 6/17-11/17, identified the following:
- In June, R10 received PRN Ativan seven times.
- In July, R10 received PRN Ativan three times.
- In August, R10 received PRN four seven times.
- In September, R10 received PRN Ativan once.
- In October, R10 did not receive PRN Ativan.
- In November, R10 received PRN Ativan once.

R10's Behavior/Mood Flow Sheets, reviewed from 9/17, to 11/17, revealed one behavioral episode documented by the nursing assistants in the last three months.

R10's progress notes, reviewed from 9/1/17, to 11/26/17, identified the last documented behavior was in September. The notes further identified R10's psychiatrist had visited him on 11/20/17, and 10/27/17, noting the medications were reviewed and no changes made. Corresponding psychiatry note, dated 10/30/17, indicated R10 was clinically stable with no changes to current medication regimen. The psychiatry note from 11/20/17, was not provided.

R10's medical record lacked evidence of the efficacy and justification for the continued use of the PRN Ativan.

On 11/29/17, at 1:23 p.m. RN-B and NA-F were observed to transfer R10 from his wheelchair into the bed using the full body mechanical lift. R10 appeared sleepy and no behaviors were noted during the transfer.

On 11/29/17, at 5:50 p.m. R10 was observed sitting in the dining room and an unidentified nursing assistant was assisting him to eat. R10

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had his eyes closed and refused to take bites of food. R10 was later observed in bed sleeping and no behaviors had been noted.

On 11/30/17, at 8:13 a.m. R10 was awoken for breakfast and an unidentified nursing assistant assisted him to eat at the bedside. No behaviors were observed.

On 12/4/17, at 9:03 a.m. R10 was observed being assisted to eat breakfast by RN-B. No behaviors were observed.

On 12/4/17, at 10:05 a.m. RN-B stated the Ativan had been ordered for anxiety which had originally been started on 9/6/16. RN-B stated R10 had been admitted from a geriatric psych unit and had been on many psychotropic medications at that time. RN-B stated the Ativan had been used recently when R10 due to hollering out in the dining room, but had noticed a decrease in R10's behaviors. RN-B stated psychotropic medications were reviewed with the pharmacist monthly for tapering, further stating psychiatry was in charge of R10 psychotropics, and they had recently talked about the potential for discontinuing the Ativan.

On 12/4/17, at 11:53 a.m. the DON stated herself, the pharmacist, and RN-B reviewed R10's medications monthly, looking at the behavioral interventions and tapering of psychotropics. However, those conversations and meetings were not documented in R10's medical record. The DON stated they were planning on reviewing R10's PRN Ativan that week and were in the process of starting to review PRN psychotropics for the 14 day requirement.

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F 758	Continued From page 198 Havenwood Care Center Psychotropic policy and procedure updated on 7/23/17, indicated each residents' drug regimens would be free of unnecessary drugs. Every effort will be made to obtain the lowest dose possible for all psychotropic medications. The policy did not address the required 14 day face to face evaluation during resident use of PRN psychotropic medication.	F 758		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population;	F 838		1/14/18

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F 838	Continued From page 199 (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, that administrator failed to complete a comprehensive assessment of the facility needs to ensure an effective plan was in place to maintain the highest practicable care for all 71 residents residing at the	F 838	F838 Facility Assessment See plan of correction for F689. See plan of correction for F735.	

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F 838	Continued From page 200 facility. Findings include: Upon entrance to the facility on 11/28/17, at 8:00 a.m. when asked to provide a copy of the current facilty assessment, the administrator provided a copy of the Facility Assessment Tool dated 9/7/17. During the course of the recertification and extended survey conducted on 11/28/17, 11/29/17, 11/30/17, 12/1/17, 12/3/17, 12/4/17, and 12/5/17, significant quality of care concerns were identified regarding the following: -The prevention of accidents for residents who utilized mechanical lifts (See F689) -Sufficient nurse staffing (See F735) -Care of residents with pressure ulcers (see F686) -Notification of the primary physician regarding acute illness (See F578) -Care of a resident with acute illness (See F684) -Infection control practices (See F880) -The identification and facility practices related to resident neglect of care (See F600 and F607). -Staff competencies (See F726) On 12/4/17, at 2:20 p.m. the facilty assessment dated 9/7/17, was reviewed with the administrator and director of nurses (DON). The Facility Assessment Tool consisted of a 17 page document in which the administrator was to answer the template questions on how they would ensure the quality care for the residents within the facility. Pages nine thought 17 of the assessment which covered areas such as individual staff assignments, staff training/education and	F 838	See plan of correction for F686. See plan of correction for F578. See plan of correction for F684. See plan of correction for F880. See plan of correction for F600. See plan of correction for F607. See plan of correction for F726. The Facility Assessment will be completed prior to 1/14/18 to address the prevention of accidents for residents who utilize mechanical lifts, sufficient nurse staffing, care of residents with pressure ulcers, notification of the primary care physician regarding acute illnesses, care of a resident with acute illness, infection control practices, the identification and facility practices related to resident neglect of care, and staff competencies. The Facility Assessment will be completed in its entirety by 1/14/18. The facility will review the Facility Assessment at quarterly Quality Assurance committee meetings and will revise as needed. The Administrator is responsible for this deficiency. Corrective date: 1/14/18	

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competencies, policies and procedures for the provision of cares, working with medical practitioners, physical environment and building/plant needs, contracts with third parties, health information technology resources, infection prevention and control program, and the facility emergency preparedness plan were all incomplete. The administrator stated he and the DON were responsible for the completion of the Facility Assessment, however, up until a few weeks ago, they had not received training on how to complete the assessment therefore the assessment was incomplete. The administrator stated the document dated 9/7/17, was the facilities first good faith attempt of completing the assessment.

- At 2:29 p.m. the administrator was asked if the assessment addressed the use of mechanical lifts, such as how many lifts were required to provide care for the residents, or how they were to be maintained. The administrator confirmed mechanical lifts were not addressed.

- At 2:30 p.m. the administrator and DON was asked how the facility had determined the number of staff members were required to care for the residents. The DON stated the staffing plan identified 9-11 licensed nurses, 15-23 nursing assistants and 1-3 administrative nurses daily. The DON confirmed the assessment did not identify the acuity of the residents or their needs in relationship to the required number of staff members. The DON stated the assessment was a rough draft of the needs of the facility. In addition, the DON confirmed the facility infection control practices and the need for the use of mechanical lifts were not included in the assessment. The administrator confirmed the

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F 838	Continued From page 202 treatment of residents with acute illness was also not addressed in the assessment. At 2:38 p.m. the DON stated the plan identified the facility would care for residents with pressure ulcers and acute illness, however, the plan did not address how they were to complete this task. The DON also stated the assessment indicated the facility would prevent abuse and neglect, but confirmed the assessment did not identify how this was to be completed. - At 2:45 p.m. the administrator reiterated the Facility Assessment Tool dated 9/7/17, was a good faith attempt to complete the facility assessment, however, verified it was incomplete.	F 838		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 842		1/14/18

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HAVENWOOD CARE CENTER	1633 DELTON AVENUE BEMIDJI, MN 56601

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F 842	Continued From page 203 §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and	F 842		

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F 842	Continued From page 204 determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain accurate medical records for 1 of 1 residents (R28) reviewed related to bruises of unknown origin. Findings include: R28's quarterly Minimum Data Set (MDS) dated 10/2/17, indicated R28 had diagnoses of Alzheimer's dementia, aphasia (inability to speak), and status post stroke. The assessment indicated R28 was totally dependent upon staff for all activities of daily living. R28's care plan dated 10/4/17, directed the staff to complete all aspects of personal hygiene and to assist R28 with transfers via two staff members and a full body mechanical lift. On 11/29/17, at 12:51 p.m. family member (FM-A) reported when he had left the facility on the evening of 11/26/17, R28 did not have any type of marks on her face. However, upon returning to the facility on 11/27/17, FM-A found R28 with a reddened area on her forehead, a scratch along the left side of her nose and a swollen lip. FM-A stated he had reported the concern to registered nurse (RN)-A, however, RN-A had not gotten back to him. FM-A did not know how R28 had sustained the areas on her face.	F 842	F842 Resident Records □ Identifiable Information Late entry progress notes were made in R28□s medical record to reflect the injuries of unknown origin. Any other bruises of unknown origin will be documented in R28□s medical record. Accurate medical records will be maintained related to bruises of unknown origin for all residents. The facility□s policy on Resident Incident/Change in Resident Health Status policy was reviewed and revised on 12/31/17. Education will be provided to all TMAs, LPNs, and RNs prior to 1/14/18 to direct staff on how to document injuries of unknown origin. Audits will be completed 3 times weekly, for 90 days, by the Director of Nursing or designee on incident reports to ensure they are documented in the resident□s record. The results of these audits will be reported to the Quality Assurance	

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F 842	Continued From page 205 -At 1:05 p.m. R28's forehand was observed to be slightly red, there was a scabbed area approximately one half centimeter on the left side of her nose and the left side of the upper lip was slightly swollen. Review of R28's Progress Notes did not include any type of documentation related to the observed areas on R28's face. On 12/1/17, at 8:43 a.m. RN-B observed R28 resting in bed. RN-B confirmed R28 continued to have a slightly reddened area on her forehead, a scratch on her nose and slightly swollen lip. RN-B stated she was aware of the facial injuries/ bruises of unknown origin that were reported on 11/27/17. RN-B stated RN-A had called some of the staff and had filled out an incident report and the concern had been called into the State Agency as a bruise of unknown origin. RN-B reviewed R28's medical record and confirmed the medical record lacked documentation related to the identified areas. The Resident Incident Report dated 11/27/17, at 11:30 a.m. indicated FM-A had reported R28 had a bruise above her left eye brow, an abrasion on her nose and a swollen lip. The location of the where the incident had happened was identified as "unknown." The staff members were interviewed and RN-A was unable to pinpoint the origin of the injuries. RN-A indicated the analysis of the root cause of the injury as "possibly bumped with hoyer (full body mechanical lift) during transfer." The indicated report also indicated the incident appeared to constitute abuse or neglect of a vulnerable adult and was reported to the State Agency.	F 842	Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs. The Director of Nursing is responsible for this regulation. Corrective date: 1/14/18	

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F 842	Continued From page 206 Review of the State Agency report indicated the aforementioned incident had been reported to the State Agency on 11/27/17, at 11:30 a.m. -At 9:16 a.m. the director of nurses (DON) stated R28's facial injury had been reported to the State Agency, however, the investigation of the concern had not been completed. The DON confirmed the information related to the injury should have been documented in R28's medical record. The Resident Incident / Charge in Resident Health Status policy dated 4/2015, directed the staff how to care for a resident when and incident had been identified. The policy did not direct the staff to document the information in the clinical record. A policy related to the completion of the medical records was requested and none was provided.	F 842		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 865		1/14/18

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F 865	Continued From page 207 §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to conduct ongoing quality assessment (QA) and assurance activities and develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware of that had the potential to adversely affect all 71 residents residing in the facility. Findings include: The facility QA program lacked a process for in depth analysis, improvement activities, and action plans to address deficient practices for sufficient staffing, ensuring mechanical lifts functioned appropriately, pressure ulcer care, activities, care for clients with acute illness (prevention and treatment), catheter care and infection control. On 12/4/17, at 2:45 p.m. the administrator stated the QA committee currently had six formal quality improvement action plans. The plans monitored incidence of worsening or serous resident behavioral symptoms, prevalence of depressive symptoms, prevalence of resident who report moderate to severe pain, prevalence of antipsychotic medications without a diagnosis of psychosis, falls and prevalence of occasional to full bowel incontinence without a toileting plan. The administrator stated the six action plans were also part of the formal PIP project (performance based incentive program). The administrator also	F 865	F865 QAPI Plan The facility will ensure that the Quality Assessment and Assurance Program conducts quality assessment and assurance activities and develops and implements appropriate plans of action for sufficient staffing, ensuring mechanical lifts function appropriately, pressure ulcer care, activities, care for clients with acute illness (prevention and treatment), catheter care and infection control. These plans of action will include identified goals in each area. The facility's Quality Assurance Improvement Plan policy was reviewed on 12/30/17. Members of the QAPI committee will be educated on the need to conduct quality assessments and assurance activities and develop and implement appropriate plans of action to address opportunities for quality improvement. Audits will be completed monthly, for 90 days, by the Administrator or designee to ensure action plans are implemented for any care or quality related issues discussed at the QAPI meeting. The Administrator or designee will audit	

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F 865	Continued From page 208 stated the facility had identified concerns related to nurse staffing, pressure ulcers and infection control. However, they had prioritized the concerns and developed formal action plans only of the concerns related to the PIP program. He stated the QA team discussed the aforementioned concerns at every meeting, however, they had not established formal action plans. Review of the QA Meeting Minutes dated 11/22/17, 8/23/17, 7/19/17 and 5/17/17, indicated the QA committee identified concerns such as skin conditions, call light audits and each facility department head provided a report of concerns in their department. For example, the social service department reported how many admission and discharges had occurred since the last meeting. The notes did not address the identified PIP action plans or how the facility was working on accomplishing the identified goals. - At 3:35 p.m. the administrator stated the facility staff, residents and visitors were encouraged to bring concerns to the QA committee. The facility also reviewed past surveys and the quality indicator measures to identify potential concerns which could be reviewed at QA. He stated the QA committee was aware of the pressure ulcers and infection control concerns but had not discussed care of an acutely ill resident, mechanical lift functionality, activities, catheter care, or other areas identified during the current survey. The administrator stated action plans could be developed for those areas. The Qualify Assurance Improvement Plan policy dated 11/10/17, indicated the facility had a performance improvement program which	F 865	weekly reports from appropriate staff to ensure progress towards achieving identified goals. If issues are identified the Administrator will inquire on how we are addressing those issues and if there is a need to modify our plans of action. The Administrator is responsible for this deficiency. Corrective date: 1/14/18	

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F 865	Continued From page 209 systematically monitored, analyzed and improved the performance of the facility to improve the resident outcomes. The QA system was to monitor information from caregivers, residents, families and others along with information from adverse events, performance indicators, survey findings and complaints. The QA committee was to utilize a systematic analysis and systematic action program to monitor the identified concerns and develop improvement opportunities which would maintain effective compliance and enhance/ maintain the quality of life and care for the residents.	F 865		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		1/14/18

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F 880	Continued From page 210 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 211 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure communal blood glucose machines were disinfected between resident use for 2 of 2 resident (R21, R24) observed to have blood sugar checks conducted without proper disinfection of the machine. This practice had the potential to affect 3 of 3 residents residing on the Walnut Grove unit who received routine blood sugar checks; failed to implement an infection control program utilizing process surveillance, such as hand hygiene audits, to reduce possible trends of infection which had the potential to affect all 71 residents who resided in the facility. Additionally, the facility failed to ensure proper hand hygiene was maintained during the provision of personal cares and/or wound treatments for 2 or 3 residents (R58, R54) observed during wound care and for 2 of 5 residents (R5, R57) observed during the provision of personal cares. Lastly, the facility failed to ensure urinary catheter bags were stored and cared for in a manner to prevent infections for 1 of 1 residents (R53) whose catheter bag was observed stored without a protective cap. Findings Include: GLUCOMETERS: On 11/29/17, at 11:12 a.m. licensed practical nurse (LPN)-A was observed to enter R21's room with a lancet and cotton balls. LPN-A opened a closet in R21's room and removed a basket	F 880	F880 Infection Prevention and Control The facility will ensure proper disinfection of glucometers or the use of individual glucometers for R21 and R24. The facility will ensure all residents receiving glucose checks with a glucometer either have proper disinfection of glucometers between use or the use of individual glucometers. TMA-A received education regarding using the resident's individualized glucometers located in the tote in their closet. The facility will ensure proper hand hygiene is maintained during the provision of personal cares and/or wound treatments for R58 and R54. The facility will ensure proper hand hygiene is maintained during the provision of personal cares for R5 and R57. The facility will ensure proper hand hygiene is maintained during provision of personal cares and/or wound treatments for all other residents. On 12/1/17 both the resident's catheter bags were changed and the urologist was notified of the infection control concern.	

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F 880	Continued From page 212 containing a personal glucometer for R21. LPN-A completed the glucose monitoring test while utilizing the glucometer from the basket. LPN-A stated all of the residents who received blood glucose monitoring had a personal glucometer stored in their room. On 11/29/17, at 4:45 p.m. trained medication aide (TMA)-A was observed to obtain R21's blood sugar reading. TMA-A knocked on R21's door, entered with the CareSensN brand glucometer device, a new lancet, and a bottle of test strips from the medication cart, and set them on R21's bed side table. TMA-A donned gloves, cleaned R21's finger with an alcohol swab, poked the finger with the lancet, wiped away the first drop of blood, and obtained a blood sample on test strip. TMA-A inserted the test strip into the glucometer machine, and informed R21 her blood sugar reading. TMA-A removed the gloves, tossed them and the used test strip in the trash, took the used lancet, glucometer, and bottle of test strips and exited R21's room. TMA-A discarded the used lancet in the red sharps container located on the medication cart, placed the glucometer and bottle of test strips on the medication cart while she documented R21's blood sugar in the computer. After documenting, TMA-A used hand sanitizer and picked up a new lancet, the bottle of test strips, and the glucometer and proceeded to R24's room, where she knocked and entered, donned clean gloves, and inserted a new test strip into the same glucometer device which had not been disinfected prior to entering R24's room. TMA-A was about to poke R24's finger to obtain a blood sample, when the surveyor intervened and asked if the glucometer had been disinfected. At that time, TMA-A stated she usually did not disinfect the glucometer between residents, and	F 880	R53 passed away on 12/26/17. The facility will ensure urinary catheter bags will be stored and cared for in a manner to prevent infections for all other residents with urinary catheters. All nursing staff will be educated prior to 1/14/18 regarding hand hygiene both during personal care. All nursing staff will also be educated regarding how to store and care for a catheter bag. All TMAs, LPNs, and RNs will be re-educated regarding using the resident's individualized glucometer which is stored in their room. They will also be educated on disinfecting glucometers. All LPNs and RNs will be educated on appropriate hand hygiene during wound care. The facility's policy on Process Surveillance Policy will be reviewed and revised prior to 1/14/18 to include staff competencies for Process Surveillance of Hand Hygiene, Catheter Care, Sanitation of Blood Glucose Monitors and Hand Hygiene during wound care. Staff competencies will be completed on current staff by 1/14/18 and annually or upon hire in the future. The facility's policy on Disinfection of Blood Glucose Monitors was reviewed on 12/29/17. The facility's policy on Hand Hygiene was reviewed on 12/28/17. The facility's policy on Catheter Care was	

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F 880	Continued From page 213 proceeded to clean R24's finger with an alcohol swab and poke the finger with the lancet. TMA-A obtained a blood sample on the test strip and told R24 her blood sugar reading was. TMA-A removed her gloves, threw them and the used test strip in the trash, gathered the used lancet, bottle of test strips, and glucometer as she left R24's room. TMA-A tossed the used lancet in the red sharps container, set the bottle of test strips and the glucometer on top of the medication cart without disinfecting it. On 11/29/17, at 5:18 p.m. the glucometer was again observed on top of the medication cart. TMA-A stated there were two glucometer machines kept on the medication carts which were used for all residents on Walnut Grove. TMA-A confirmed the glucometers were used for three residents who received regular blood sugar checks as well as for random blood sugar checks. TMA-A stated she had never disinfected the glucometers between residents and was not aware of any regular disinfection performed on the glucometers. On 11/29/17, at 6:28 p.m. TMA-B stated each resident had their own glucometer in their rooms, and they only kept the ones on the medication carts for emergencies. On 12/4/17, at 9:13 a.m. registered nurse (RN)-B stated glucometers were kept in the individual residents' rooms along with cotton balls and alcohol wipes, and were disinfected once a week. RN-B stated there were glucometers on the cart as well, which were used for random or fasting blood sugar checks, and could also be used for regular blood sugar checks if staff wanted to use them. RN-B stated the glucometers on the	F 880	reviewed revised on 12/29/17. The facility's policy on Clean/Sterile Dressing changes was reviewed on 12/18/17. The Director of Nursing or designee will complete observational audits seven times per week on blood glucose checks to ensure proper disinfection of glucometers between use or the use of individual glucometers. The Director of Nursing or designee will complete observational audits seven times weekly, for 30 days, and then three times weekly, for 60 days on proper hand hygiene during the provision of cares. The Director of Nursing or designee will complete observational audits seven times weekly, for 30 days, and then three times weekly, for 60 days on proper hand hygiene during wound care. The Director of Nursing or designee will complete observational audits seven times weekly, for 30 days, and then three times weekly, for 60 days on urinary catheter bags are stored and cared for in a manner to prevent infections for residents with urinary catheters. The results of these audits will be reported to the Quality Assurance Committee for review and recommendation. The Quality Assurance Committee will determine further auditing needs.	

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F 880	Continued From page 214 medication cart should be cleaned with Clorox brand hydrogen peroxide disinfectant wipes, which were locked in the medication room behind the nurses station. RN-B verified the TMA's received training on the glucometers during orientation with the licensed practical nurses (LPN) and know they should have been disinfected as needed, after use. RN-B stated she had not performed audits on the glucometer disinfection protocol. On 12/4/17, at 11:45 a.m. the director of nursing (DON) stated the glucometer should have been disinfected between resident use. The CareSensN Blood Glucose Monitoring System Owner's Manuel instructed the exterior of the glucometer could be cleaned using alcohol. The manual further directed organic solvents like benzene or acetone as well some household and industrial cleaners could damage the glucometer. A facility policy entitled Disinfection of Blood Glucose Monitors, undated, directed to clean the glucometer after use with the appropriate manufacturer recommended disinfectant wipes, wiping down all surfaces of the glucometer, and allowing the glucometer to air dry before next use. INFECTION CONTROL PROGRAM: The facility's Infection Tracking Logs, reviewed from 3/25/17, to 12/1/17, revealed weekly tracking of infections in order to identify trends. The logs contained boxes for each infection tracked such as UTI (urinary tract infections), respiratory, GI (gastrointestinal), skin, eye, and other. Next to each type of infection were boxes	F 880	The Director of Nursing is responsible for this deficiency. Corrective date: 1/14/18	

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in which tallies were marked to represent the number of cases of each infection type for the week. Below the columns of boxes, hand writing denoted if a trend was identified. The logs revealed the following:

- March: two UTIs.
- April: one UTI.
- May: two UTIs.
- June: four UTIs.
- July: twelve UTIs. Five of the UTIs occurred during the week of 7/8/17, to 7/14/17, and a notation read "increased UTIs this week monitor." The following week, a notation read the UTI were better, questioned if education was needed, and noted "A lot of testing done in July for UTIs."
- August: eight UTIs. Four of the UTIs occurred during the week of 8/19/17, to 8/25/17, and a notation read "UTI's up again." The following week, a notation read, "UTI's still up monitor."
- September: six UTIs.
- October: three UTIs.
- November: four UTIs.

The logs lacked analysis of the increased number of UTIs between July 2017, through September 2017.

The facility's Infection Worksheets were reviewed from June 2017, through October 2017. The worksheets were filled out at the end of each month and tracked the date of infection, site, symptoms, cultures, and treatment for antibiotic treated infections. The worksheets revealed the following:

- In June:
Walnut Grove: three UTIs were treated with antibiotics. All were labeled as nosocomial (facility acquired), all had symptoms, and all were

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cultured with different organisms. Two UTI's occurred on the same day.
-In July:
Walnut Grove: five UTIs were treated with antibiotics. All were labeled as nosocomial and all had symptoms. One case was sent to the hospital for a respiratory infection, while at the hospital tested positive for UTI. Four of the UTIs were cultured with different organisms. Two UTI's occurred on the same day.
Willow Way: five UTIs were treated with antibiotics. Four of the UTIs had symptoms and all were labeled as nosocomial. Five of the UTIs were cultured and positive. Three of the UTIs tested positive for E. Coli (Escherichia Coli). One UTI had a catheter, which had been changed a week prior to the onset of infection.
- In August:
Willow Way: three UTIs were treated with antibiotics. All were labeled nosocomial and two had symptoms. All UTIs were cultured and two grew E. Coli.

On 12/4/17, at 9:13 a.m. RN-B stated each unit had an infection log and new infections were written down daily by the nurses. RN-B stated the logs were discussed in their morning meetings, and she checked the logs at the end of the week, writing down new infections on the Infection Tracking Logs while doing a weekly assessment for trends. RN-B stated she had noticed an increase in UTIs in July but did not do any education or audits, instead chose to monitor the number of UTIs and noted the number of UTIs had trended downward and attributed the increase in UTIs to more testing being done at clinic appointments, in the emergency room, and with hospitalizations, as well as more antibiotics prescribed. RN-B stated there was no common

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room or bug correlated to the increased number of UTI's. She further stated once a month she pulled a list of residents who were treated with antibiotics to complete the Infection Worksheets, writing the positive and negative cultures and noted some residents who had cultures done may not have been started on antibiotics due to the result of the culture. RN-B stated she typically completed those at the beginning of the next month, and that was then she she would've been doing November's log. RN-B reviewed the symptoms, the length of the infection, and if a UTI was positive when looking for trends. She further stated there wasn't a specific number she looked at when classifying something as a trend, adding it wasn't uncommon to have four UTIs on a unit and five or under wasn't a terrible number of infections to have. When looking at the UTIs, RN-B stated there were potentially three to four that were from the facility in July and two actual UTIs in August. RN-B acknowledged July was not a good month for the UTIs and stated audits on hand washing, peri care, and catheter care were not routinely performed, rather only performed if she noticed a problem and she would educate the staff right then and there. RN-B stated she didn't perform audits because when they had been cited in the past for infection control and had performed audits, there wasn't a difference in the number of UTIs. RN-B stated about a year prior she had conducted extra monitoring and additional education with not significant change in the number of infections. RN-B stated she had not looked to see if the UTIs with positive cultures were true growth or colonized.

On 12/4/17, at 11:45 a.m. the DON stated the facility was not currently doing any audits of hand hygiene or peri care rather were just observing

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staff for hand hygiene, and had seen staff using the hand sanitizer and washing their hands in the sinks. The DON stated peri care audits were not done unless there was a problem and verified none had been done recently, other than the last audit done about six months prior. The DON stated she developed the policies for the infection control program while RN-B performed more data collection for the program. The DON was aware of the increase in UTIs between July and August, stating they had discussed it in the QA (quality assurance) meetings. The DON thought RN-B had performed peri care education at the time, stating if RN-B saw concerns she would would have been educating the staff. The DON stated they would only do audits if the number of infections was above their baseline and increase form the norm.

A facility policy entitled Process Surveillance, undated, instructed, "process surveillance will be completed using audit forms." The policy further directed process surveillance would be completed on the following areas: hand washing, use of hand sanitizer, medication administration, catheter insertion, dressing changes, sanitization of glucometer machines, and gloves use, in a frequency determined by the Infection Control Coordinator, "by infection occurrences in the facility," and for staff competency.
Hand Hygiene:

R5's care plan dated 11/21/1, indicated R5 had diagnoses of Alzheimer's Dementia, was at risk for infection, incontinent of bowel and bladder, required complete assist with personal hygiene and perirectal cares.

On 11/30/17, at 8:47 a.m. nursing assistant

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(NA-C) and NA-M were observed to assist R5 to a standing position and ambulate to the Maple Lane common bathroom, utilizing a four wheeled walker. Once in the bathroom, NA-C directed R5 to pivot and sit down on the toilet. NA-C proceeded to pull R5's hip protector briefs down, bent down and proceeded to release the incontinent pad adhesive tabs from each side of the pad. NA-C stated "I guess I should wash my hands." NA-C washed her hands, donned gloves and continued to remove R5's urine soaked pad. NA-C confirmed R5's brief was wet with urine. Without removing her gloves, or washing her hands, NA-C stood up and obtained a washcloth from the washbasin, wrung excessive water out and handed the washcloth to R5 and directed her to wash her face. NA-C used a black hair pick to comb R5's hair. NA-C bumped R5's toothbrush causing it to fall into the soap and water filled washbasin. NA-C removed the toothbrush from the basin and placed it into a plastic bag. NA-M assisted R5 to wash and dry the front side of her body, applied Nystatin antifungal powder under R5's breasts and proceeded to assist R5 to don a shirt, incontinent brief and black pants.

-At 9:05 a.m. with the same gloved hands, NA-C and NA-M assisted R5 to a standing position. R5 had a bowel movement. NA-C proceeded to cleanse R5's perineal area with a wet wipe. NA-C was handed a washcloth and towel to wash and dry R5's backside. NA-M provided barrier cream to NA-C who dispensed the barrier cream onto the same gloved hand and applied to R5's buttock area. NA-C removed her gloves and assisted NA-M with adjusting R5's clothing and transfer R5 back into a wheelchair. NA-C proceeded to pick up the soiled clothing and put into a clothing bag, put the soiled brief and wipes

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into a garbage bag, picked up the Nystatin powder and exited the bathroom and handed the barrier cream to TMA-D who placed the barrier cream into the medication cart. NA-C disposed of trash and soiled linen into the dirty linen room, removed her gloves and washed her hands.

-At 9:25 a.m. NA-C confirmed she had not appropriately donned gloves and washed her hands. NA-C stated she should have washed her hands and applied gloves prior to touching R5's soiled incontinent brief and again after removing the brief and prior to/after providing personal cares. NA-C stated she had recently completed handwashing and gloving training.

On 11/30/17, at 11:59 a.m. the DON confirmed staff should have appropriately washed their hands and donned gloves as directed during the recent training related to gloving and handwashing.

On 11/20/17, at 7:41 a.m. NA-D was observed to enter R57's room and begin to assist R57 with morning cares. NA-D donned gloves, washed R57's face, upper body and perineal area. R57 was noted to have been incontinent of urine. Following the completion of perineal cares, NA-D removed her gloves and without washing her hands, NA-D proceeded to assist R57 to fully dress. Once dressed, NA-D informed R57 she needed to find assistance to transfer her into the wheelchair and she would return momentarily with help. R57 was then assisted to lay back down in bed again.

-At 7:56 a.m. NA-D had returned and emptied R57's wash basin, picked up the garbage and dirty laundry, and returned the bathing supplies to R57's cupboards and exited the room. NA-D did not wash her hands. NA-D immediately went

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R33's room, knocked on the door, entered and began talking with NA-A. NA-D was asked if she had washed her hands prior to entering R33's room and stated she had not washed her hands since the completion of R57's perineal cares. NA-D shut the door and proceeded to assist NA-A with R33.
-At 8:03 a.m. NA-D exited R33's room, walked to the Walnut Grove nurses station hand washing sink and washed her hands.
-At 8:05 a.m. NA-D confirmed the first time she had washed her hands since completing R57's perineal cares was done at the handwashing station by the Walnut Grove nurses station.
NA-D and NA-A then returned to R57's room and assisted her into the wheelchair.

On 12/4/17, at 9:57 a.m. the DON stated the staff were to wash their hands after removing gloves and the completion of the personal cares. The DON stated NA-D should have washed her hands after perineal cares and prior to leaving R57's room.

R53 utilized a suprapubic catheter and staff failed to maintain appropriate infection control practices.

On 12/1/17, at 7:52 a.m. R53 was observed lying in bed while NA-M was assisting R53 with his pants. R53's bed was elevated to just below waist level of the NA. The overnight urine collection bag was dangling off the side of the bed with the bottom part of the bag touching the floor. R53 became resistive during cares, NA-M lowered the bed,which caused the collection bag to rest completely on the floor. NA-M removed her gloves and left the room without performing hand hygiene. NA-M returned to the room with NA-Q, and without washing their hands, both NAs

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donned gloves. NA-M removed the leg urine collection bag from a garbage bag. The leg collection bag did not have a cap over the connection port which connect into the catheter that would ensure a closed system to help prevent bacterial contamination.
-At 8:00 a.m. NA-Q stated the leg bag cap had been gone for a long time, if it had come with one to begin with. NA-M was not aware if there was supposed to be a cap on or not.

-At 9:52 a.m. RN-C stated the leg collection bags were changed once a month and more often if needed. RN-C stated R53's was last changed at his appointment on 11/3. In addition, RN-C stated the urine collection bag should not be on the floor and should have a cap on it when it is stored.

-At 11:00 a.m. RN-C stated both bags were changed and stated she had called R53's urologist to report the bags had been changed due to an infection control concern.

On 12/4/17, at 8:56 a.m. the DON stated there should have been a cap on the urine collection bag, and the overnight collection bag should not have been on the floor, and hand hygiene should be completed before and after resident care.

Facility policy Catheter Care last reviewed 4/2015, included the directions, 5) Secure the tubing to the leg with catheter strap or tape. 6) Secure the drainage bag below the bed or under wheelchair. Keep it off the floor. The policy did not reflect storage of the urine collection bags.

On 11/29/17, at 6:09 p.m. RN-G was observed providing wound care to R58's legs. RN-G walked

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over to the other side of the room, picked up the garbage can, touched the inside of the can liner, and placed the garbage on the floor below the dressing change supplies. RN-G obtained and donned a pair of gloves without first washing her hands. RN-G cut the dressing off the right leg and peeled back the dressing and through it away. With the same gloved hands, RN-G sprayed the wound with wound cleanser, patted the wound dry, removed her gloves, washed her hands and announced she had to go get some Telfa (non-adherent dressing). RN-G returned to the room and without washing her hands or donning gloves, proceeded to apply the Telfa dressing, an ABD dressing (12 inch x 12 inch x 1 inch dressing), and rolled gauze to R58's right leg wound. RN-G donned new gloves, sprayed the left leg with wound cleanser, patted the leg dry, removed gloves, and applied an ABD dressing and gauze. When asked, RN-G stated she should have washed her hands prior to donning gloves, should have worn gloves when applying the dressings and also should have washed her hands between the wound dressings.

On 11/30/17, at At 8:45 a.m. LPN-D was observed providing wound care to R58's legs. LPN-D washed her hands, donned gloves, cut off the right leg dressing, stated the wound looked better, sprayed wound cleanser on the wound, patted it dry, and applied an ABD dressing and gauze. With the same gloved hands, LPN-D proceeded to remove the left leg dressing and did not reapply a new dressing. LPN-D had not changed her gloves or performed hand hygiene throughout the observation.

On 12/1/17, at 7:13 a.m LPN-D confirmed she had not performed appropriate hand hygiene and

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stated she should have washed her hands inbetween the dressings and donned new gloves.

On 12/4/17, at 8:56 a.m. DON stated LPN-D should have removed her gloves after cleansing the wound, washed her hands and reapplied new gloves and again in between dressing changes.

On 11/30/17, at 8:56 a.m. NA-J was observed providing R54 personal cares. NA-J assisted with washing R54's face/axillae and back. R54's brief was removed and revealed R54 had been incontinent of a moderate soft bowel movement. NA-J proceeded to provide peri care and noticed R54's pressure ulcer dressing was coming off so she summoned the LPN to assist. LPN-C entered the room and NA-J finished performing peri cares and removing the BM. LPN-C asked if NA-J could go and get a clean pad, so NA-J removed her soiled gloves and left the room to retrieve a clean pad from the linen closet without washing her hands.
-At 9:20 a.m. NA-J stated she should have washed her hands before she left the room.

On 12/4/17, at 9:32 a.m. RN-C and NA-P were to provide R54 pressure ulcer care. RN-C washed her hands, donned gloves and removed the soiled sacral mepilex dressing from the coccyx/buttocks area. The dressing had a large amount of exudate (light green, yellow) which had a sweet/foul odor. RN-C washed her hands again, donned gloves, and proceeded to cleanse the pressure ulcer and surrounding skin with a bottle of wound cleanser. RN-C had touched the outside of the wound cleanser bottle with her gloved hands, contaminating it, and proceeded to set the bottle in the window sill when she was done using it. After reapplying a new dressing,

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F 880	Continued From page 225 RN-C washed her hands and was going to leave R54's room with the contaminated bottle of wound cleanser and place in the med cart. Surveyor intervened and informed RN-C the wound cleanser bottle was contaminated. RN-C stated she would leave the bottle in R54's room for her use only. A hand hygiene policy and procedure was requested, however received a handwashing procedure which outline how to wash hands, but not when to wash them during the provision of cares	F 880		

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 11/28, through 12/5/17, during a recertification survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	E 007	E007 Program Patient Population	1/14/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/01/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245397	A. BUILDING _____ B. WING _____	12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAVENWOOD CARE CENTER	1633 DELTON AVENUE BEMIDJI, MN 56601

(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
E 007	Continued From page 1 facility failed to address patient/client population, including, but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in in their emergency preparedness plan. This had the potential to affect all 71 residents residing at the facility. Findings include: On 12/1/17, at 3:00 p.m. the administrator and director of maintenance (DOM) were interviewed regarding the facility's emergency plan. The administrator and DOM stated that the facility had conducted a risk assessment as part of their emergency plan on 11/8/17, but had not yet completed all of the required components for the emergency preparedness (EP) requirements. The risk assessment did address the attached assisted living facilities and ability to use those in case of emergency. The administrator and DOM verified the facility did not have an emergency plan that included: persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.	E 007	The facility will develop and maintain an emergency preparedness plan that will include how the facility will address the patient/client population, including but not limited to, persons at-risk; the type of services the facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. The facility will educate each staff member on their role in the event of an emergency at the facility and the location of the Emergency Preparedness binder prior to 1/14/18. The facility will review the Emergency Preparedness Plan at quarterly Quality Assurance committee meetings and will revise as needed. The Administrator is responsible for this deficiency. Corrective date: 1/14/18	
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and	E 009		1/14/18

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E 009	Continued From page 2 Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in their emergency plan. This had the potential to affect all 71 residents residing at the facility. Findings include:	E 009	E009 Local, State, Tribal Collaboration Process The facility will develop and maintain an emergency preparedness plan that includes a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials□ effects to maintain an integrated response during a disaster or emergency situation, including documentation of the facility□s efforts to contact such officials, and, when applicable, of its participation in collaborative and cooperative planning	

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E 009	Continued From page 3 On 12/1/17, at 3:00 p.m. the administrator and director of maintenance (DOM) were interviewed regarding the facility's emergency plan. The administrator and DOM stated that the facility had a list and contact information for the local, state, and federal emergency officials, but had not yet made contact with them as part of their emergency plan.	E 009	efforts. The facility will educate each staff member on their role in the event of an emergency at the facility and the location of the Emergency Preparedness binder prior to 1/14/18. The facility will review the Emergency Preparedness Plan at quarterly Quality Assurance committee meetings and will revise as needed. The Administrator is responsible for this deficiency. Corrective date: 1/14/18	
E 013 SS=F	Development of EP Policies and Procedures CFR(s): 483.73(b) (b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. *Additional Requirements for PACE and ESRD Facilities: *[For PACE at §460.84(b):] Policies and procedures. The PACE organization must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section,	E 013		1/14/18

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E 013	Continued From page 4 and the communication plan at paragraph (c) of this section. The policies and procedures must address management of medical and nonmedical emergencies, including, but not limited to: Fire; equipment, power, or water failure; care-related emergencies; and natural disasters likely to threaten the health or safety of the participants, staff, or the public. The policies and procedures must be reviewed and updated at least annually. *[For ESRD Facilities at §494.62(b):] Policies and procedures. The dialysis facility must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. These emergencies include, but are not limited to, fire, equipment or power failures, care-related emergencies, water supply interruption, and natural disasters likely to occur in the facility's geographic area. This REQUIREMENT is not met as evidenced by: Based on interview and document, the facility failed to ensure their emergency preparedness policies and procedures were based on the facility's emergency plan, risk assessment and communication plan utilizing an all hazards approach. This had the potential to affect 71 residents residing in the facility. Finding include: On 12/1/17, at 3:00 p.m. the administrator and	E 013	E013 Develop of EP Policies and Procedures The facility will develop and implement emergency preparedness policies and procedures based on the facility□s emergency plan, risk assessment, and communication plan utilizing an all hazards approach. This plan will include policies and procedures for the following areas: subsistent needs for staff and patients, procedures for tracking staff and patients, policies and procedures include	

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E 013	Continued From page 5 director of maintenance (DOM) were interviewed regarding the facility's emergency preparedness program. The administrator and DOM stated that the facility had conducted a risk assessment as part of their emergency plan on 11/8/17, but had not yet completed all of the required components for the emergency preparedness (EP) requirements. The administrator and DOM verified they had not yet developed policies and procedures for the following areas: Subsistent needs for Staff and Patients - food, water, medical and pharmaceutical supplies; - temperatures to protect health and safety and for the safe and sanitary storage of provisions; - emergency lighting; - fire detection, extinguishing, and alarm systems; - sewage and waste disposal. Procedure for Tracking Staff and Patients - system to track the location of on-duty staff and sheltered residents in the facility's care during an emergency; - if on-duty staff and sheltered residents are relocated during emergency, the facility must document the specific name and location the receiving facility or other location. Policies and Procedures including Evacuation - safe evacuation from the facility,which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external resources of assistance. Policies and Procedures for Sheltering	E 013	evacuation, policies and procedures for sheltering, policies and procedures for medical documentation, policies and procedures for volunteers, policies and procedures for arrangements with other facilities, and policies and procedures for roles under a waiver declared by the secretary. The facility will educate each staff member on their role in the event of an emergency at the facility and the location of the Emergency Preparedness binder prior to 1/14/18. The facility will review the Emergency Preparedness Plan at quarterly Quality Assurance committee meetings and will revise as needed. The Administrator is responsible for this deficiency. Corrective date: 1/14/18	

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E 013	Continued From page 6 - a means to shelter in place for residents, staff, and volunteers who remain at the facility. Policies and procedures for Medical Documentation - a system of medical documentation that preserves resident information, protects confidentiality of resident information, and secures and maintains availability of records. Policies and Procedures for Volunteers - the use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of state and federally designated health care professionals to address surge needs during an emergency. Policies and Procedures for Arrangements with other Facilities - the development of arrangements with other long term care facilities and other providers to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. Policies and Procedures for Roles under a Waiver Declared by the Secretary - the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	E 013		
E 029 SS=F	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws	E 029		1/14/18

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E 029	Continued From page 7 and must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a written emergency communication plan that contained a description of how the facility will coordinate patient care within the facility, across healthcare providers, and with state and local public health departments in order to protect the health and safety of their patients/residents. This had the potential to affect 71 residents residing in the facility. Findings include: On 12/1/17, at 3:00 p.m. the administrator and director of maintenance (DOM) were interviewed regarding the facility's emergency plan. The administrator and DOM stated that the facility had conducted a risk assessment as part of their emergency plan on 11/8/17, but had not yet completed all of the required components for the emergency preparedness (EP) requirements. The administrator and DOM verified the facility had not developed a communication plan which includes the following: Development of a communication plan - develop and maintain an emergency preparedness communication plan that complies with federal, state and local laws. Names and Contact Information - the communication plan includes; names and	E 029	E029 Development of Communication Plan The facility will develop and maintain an emergency preparedness communication plan that contains a description of how the facility will coordinate patients care within the facility, across healthcare providers, and with state and local public health departments in order to protect the health and safety of their patients/residents. The plan will include the development of a communication plan, names and contact information, primary/alternate means of communication, methods for sharing information, sharing information on occupancy and needs, and family notification. The facility will educate each staff member on their role in the event of an emergency at the facility and the location of the Emergency Preparedness binder prior to 1/14/18. The facility will review the Emergency Preparedness Plan at quarterly Quality Assurance committee meetings and will revise as needed. The Administrator is responsible for this deficiency. Corrective date: 1/14/18	

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E 029	Continued From page 8 contact information for staff, resident's physicians, other long term care facilities and volunteers. Primary/Alternate Means of Communication - primary and alternate means for communicating with facility staff, and federal, state, tribal, regional, and local emergency management agencies. Methods for Sharing Information - a method for sharing information and medical documentation for residents under the facility's care, as necessary, with other health providers to maintain the continuity of care. Sharing Information on Occupancy and Needs - a means of providing information about the facility's occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. Family Notification - a method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents and their families or representatives.	E 029		
E 036 SS=F	EP Training and Testing CFR(s): 483.73(d) (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and	E 036		1/14/18

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E 036	Continued From page 9 procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and maintain an emergency preparedness training and testing program that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan.	E 036	E036 EP Training and Testing The facility will develop and maintain an emergency preparedness training and testing program that is based on the emergency plan, risk assessment,	

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E 036	Continued From page 10 Findings include: On 12/1/17, at 3:00 p.m. the administrator and director of maintenance (DOM) were interviewed regarding the facility's emergency preparedness plan. The administrator and DOM stated that the facility had conducted a risk assessment as part of their emergency plan on 11/8/17, but had not yet completed all of the required components for the emergency preparedness (EP) requirements. The administrator and DOM verified the facility did not developed an emergency preparedness program that included all of the required components, therefore, have not conducted any training/testing of staff. The administrator did share that the facility was involved in a full-scale exercise that was community based on 10/26/17, and a table top exercise. The DOM added that the facility does train staff annually on fire, severe weather, active shooter and missing resident, but training/testing has not occurred on the facility's emergency plan polices/procedures as they have not yet been developed. Emergency Preparation Training and Testing - the facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan , risk assessment, policies/procedures, and communication plan. Emergency Preparedness Training Program - provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services	E 036	policies and procedures, and the communication plan. The facility will educate each staff member on their role in the event of an emergency at the facility and the location of the Emergency Preparedness binder prior to 1/14/18. The facility will review the Emergency Preparedness Plan at quarterly Quality Assurance committee meetings and will revise as needed. The Administrator is responsible for this deficiency. Corrective date: 1/14/18	

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E 036	Continued From page 11 under arrangement, and volunteers, consistent with their expected role; - provide emergency preparedness training at least annually; - maintain documentation of all emergency preparedness training; - demonstrated staff knowledge of emergency procedures. Emergency Preparation Testing Requirements During interview on 11/30/17, at 8:30 a.m. the administrator stated that the they did not complete a full-scale exercise that was community based or facility based but that they did meet this past year to discuss emergency response to cold weather related emergencies. In review of the emergency manual, the facility lacked documentation of a full scale exercise or documentation of an additional exercise or an analysis of the facilities response and revision to the emergency plan based on an emergency testing exercise.	E 036		

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	245397	A. BUILDING **01 - NURSING HOME** B. WING _____	**11/28/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on November 28, 2017. At the time of this survey Havenwood Care Center 01 Main Building was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. Havenwood Care Center was built in 4 stages. The 1968 original building is 1- story, without a basement and was determined to be Type II (111) construction. In 1971 an addition to the south of the original building was built, is 1-story with a partial basement and was determined to be of a Type II (222) construction. The 1974 addition was built to the south of the 1971 addition, is 1-story without a basement and was determined to be of Type II (111) construction. In 1992 additions were built to the west of the 1968 building and east of the 1971 building. They are separated with 2-hour fire barriers and determined to be Type II(111) construction. The building is completely protected with an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas, installed in accordance with NFPA 72 "The	K 000		

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

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K 000	Continued From page 1 National Fire Alarm Code" 1999 edition. The fire alarm system has automatic notification of the local fire department. The facility has a capacity of 90 beds and had a census of 70 at the time of the survey. Because the original building and its additions meet the construction type allowed for existing buildings, this facility was surveyed as a single building. The requirement at 42 CR, Subpart 483.70(a) is MET.	K 000		