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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VKFY
Facility ID: 00792

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245427**

2. STATE VENDOR OR MEDICAID NO. (L2) **516240800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA NH PLEASANTVIEW**
(L4) **901 SOUTHEAST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/10/2013** (L34)

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **123** (L18)

13. Total Certified Beds **123** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	123			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Karen Aldinger, HFE NE II 09/16/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 02/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/27/2013** (L33)

DETERMINATION APPROVAL

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

CCN: 24-5427

An extended survey was completed at Bethesda Nursing Home Pleasantview on May 8, 2013 and deficiencies were found, the most serious at a scope and severity level (S/S) level of L.

The health surveyors identified an immediate jeopardy (IJ) situation on May 3, 2013 involving deficiency F225 and F226. The IJ was abated on May 8, 2013. Also at the time of the survey, conditions were found in the facility that constituted Substandard Quality of Care (SQC) to resident health or safety at F225 (K) and F226 (L)

As a result of the survey findings, we imposed State Monitoring effective May 29, 2013 and we recommended enforcement remedies to CMS RO and CMS RO imposed the following remedies on their letter dated July 3, 2013:

- Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013
- Federal Civil Money Penalty of $200.00 per day beginning May 8, 2013
- Discretionary DOPNA effective July 22, 2013
- Mandatory DOPNA effective July 22, 2013

The facility was also subject to a two year loss of NATCEP, effective May 8, 2013 due to the extended survey.

A Health PCR was completed on July 24, 2013 and a LSC PCR was completed on July 12, 2013. The LSC PCR found all deficiencies corrected but the Health PCR found three deficiencies uncorrected at a S/S level of E and identified two new deficiencies at a S/S level of D.

As a result of the health PCR, state monitoring will remain in effect and we recommended to CMS RO the following and CMS RO concurred:

- Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 will remain in effect
- Federal Civil Money Penalty of $200.00 per day beginning May 8, 2013 will remain in effect
- Discretionary DOPNA effective July 22, 2013 will remain in effect
- Mandatory DOPNA effective July 22, 2013 will remain in effect

The facility was also subject to a two year loss of NATCEP, effective May 8, 2013 due to the extended survey.

A second health PCR was completed on September 10, 2013 and the facility was found in substantial compliance, effective August 30, 2013. As a result, we discontinued state monitoring effective August 30, 2013. We also recommended the following action to the CMS RO and CMS RO concurred:

- Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 will remain in effect
- Federal Civil Money Penalty of $200.00 per day beginning May 8, 2013 will remain in effect
- Discretionary DOPNA effective July 22, 2013 was discontinued effective August 30, 2013

See attached CMS-2567B from the September 10, 2013 revisit.

Protecting, Maintaining and Improving the Health of Minnesotans

CCN 24-5427 February 6, 2014

Ms. Michelle Haefner, Administrator
Bethesda Nh Pleasantview
901 Southeast Willmar Avenue
Willmar, Minnesota 56201

Dear Ms. Haefner:

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 August 30, 2013 the above facility is certified for:

123 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 123 skilled nursing facility beds located in rooms
You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

September 16, 2013

Ms. Norma Brendle, Administrator
Bethesda Nursing Home Pleasantview
901 Southeast Willmar Avenue
Willmar, Minnesota 56201

RE: Project Number S5427023

Dear Ms. Brendle:

On May 24, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 29, 2013. (42 CFR 488.422)

On July 3, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013

- Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013

Also, the CMS Region V Office notified you in their letter of July 3, 2013, 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 May 8, 2013.

This was based on the deficiencies cited by this Department for an extended survey completed on May 8, 2013 that included an investigation of complaint numberH5427017 and H527019 . The most serious deficiencies were found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

On July 24, 2013, 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 May 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28,m 2013. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on May 8, 2013. As a result of the revisit findings, we notified you that the

Category 1 remedy of state monitoring would remain in effect.

On August 9, 2012 , this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of July 3, 2013:

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 remain in effect

• Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 remain in effect

On September 10, 2013, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on July 24, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 24, 2013. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective August 30, 2013.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

• Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 be discontinued August 30, 2013

• Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013

The CMS Region V Office will notify you of their determination regarding the imposed remedies.

As we notified you in our letter of May 24, 2013, 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 May 8, 2013.

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

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

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245427	A. Building B. Wing	9/10/2013

Name of Facility	Street Address, City, State, Zip Code
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0225 Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - LSC	08/30/2013	ID Prefix F0226 Reg. # 483.13(c) LSC	08/30/2013	ID Prefix F0309 Reg. # 483.25 LSC	08/30/2013
ID Prefix F0329 Reg. # 483.25(l) LSC	08/30/2013	ID Prefix F0428 Reg. # 483.60(c) LSC	08/30/2013	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/sd	09/16/13	29245	09/10/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/8/2013

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VKFY
Facility ID: 00792

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245427**

2. STATE VENDOR OR MEDICAID NO. (L2) **516240800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA NH PLEASANTVIEW**
(L4) **901 SOUTHEAST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **07/24/2013** (L34)

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)
01 Hospital, 02 SNF/NF/Dual, 03 SNF/NF/Distinct, 04 SNF, 05 HHA, 06 PRTF, 07 X-Ray, 08 OPT/SP, 09 ESRD, 10 NF, 11 ICF/IID, 12 RHC, 13 PTIP, 14 CORF, 15 ASC, 16 HOSPICE, 22 CLIA

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12. Total Facility Beds **123** (L18)

13. Total Certified Beds **123** (L17)

10. THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	123			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 08/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 09/25/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **06/27/2013** (L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN: 24-5427

An extended survey was completed at Bethesda Nursing Home Pleasantview on May 8, 2013 and deficiencies were found, the most serious at a scope and severity level (S/S) level of L.

The health surveyors identified an immediate jeopardy (IJ) situation on May 3, 2013 involving deficiency F225 and F226. The IJ was abated on May 8, 2013. Also at the time of the survey, conditions were found in the facility that constituted Substandard Quality of Care (SQC) to resident health or safety at F225 (K) and F226 (L)

As a result of the survey findings, we imposed State Monitoring effective May 29, 2013 and we recommended enforcement remedies to CMS RO and CMS RO imposed the following remedies on their letter dated July 3, 2013:

- Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013
- Federal Civil Money Penalty of $200.00 per day beginning May 8, 2013
- Discretionary DOPNA effective July 22, 2013
- Mandatory DOPNA effective July 22, 2013

The facility was also subject to a two year loss of NATCEP, effective May 8, 2013 due to the extended survey.

A Health PCR was completed on July 24, 2013 and a LSC PCR was completed on July 12, 2013. The LSC PCR found all deficiencies corrected but the Health PCR found three deficiencies uncorrected at a S/S level of E and identified two new deficiencies at a S/S level of D.

As a result of the health PCR, state monitoring will remain in effect and we recommended to CMS RO the following and CMS RO concurred:

- Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 will remain in effect
- Federal Civil Money Penalty of $200.00 per day beginning May 8, 2013 will remain in effect
- Discretionary DOPNA effective July 22, 2013 will remain in effect
- Mandatory DOPNA effective July 22, 2013 will remain in effect

The facility was also subject to a two year loss of NATCEP, effective May 8, 2013 due to the extended survey.

See the CMS-2567B and CMS-2567 from these revisits.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5155

August 9, 2013

Mr. Douglas Dewane, Administrator
Bethesda Nursing Home Pleasantview
901 Southeast Willmar Avenue
Willmar, Minnesota 56201

RE: Project Number S5427023, H5427017, H5427019

Dear Mr. Dewane:

On May 24, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 29, 2013. (42 CFR 488.422)

On July 3, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013
- Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013
- Federal Civil Money Penalty of $200.00 per day beginning May 8, 2013

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on May 8, 2013 that included an investigation of complaint number H5427017 and H5427019. The most serious deficiencies were found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

On July 24, 2013, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2013. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on May 8, 2013. The deficiencies not corrected are as follows:

- **F0225 -- S/S: E -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals**
- **F0226 -- S/S: E -- 483.13(c) -- Develop/implement Abuse/neglect, Etc Policies**
- **F0309 -- S/S: E -- 483.25 -- Provide Care/services For Highest Well Being**

In addition, at the time of this revisit, we identified the following deficiencies:

- **F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs**
- **F0428 -- S/S: D -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On**

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of July 3, 2013:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 will remain in effect
- Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 will remain in effective
- Federal Civil Money Penalty of $200.00 per day beginning May 8, 2013 will remain in effect
- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 (42 CFR 488.417 (b))

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.

As we notified you in our letter of May 24, 2013, 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 May 8, 2013.

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

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

DEPARTMENT CONTACT

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

Brenda Fischer
Minnesota Department of Health
Midtown Square
3333 West Division, Suite #212
Saint Cloud, Minnesota 56301

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 November 8, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File 5427r1_13.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245427	A. Building B. Wing	7/24/2013

Name of Facility	Street Address, City, State, Zip Code
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0155 Reg. # 483.10(b)(4) LSC	06/28/2013	ID Prefix F0157 Reg. # 483.10(b)(11) LSC	06/28/2013	ID Prefix F0241 Reg. # 483.15(a) LSC	06/28/2013
ID Prefix F0242 Reg. # 483.15(b) LSC	06/28/2013	ID Prefix F0314 Reg. # 483.25(c) LSC	06/28/2013	ID Prefix F0323 Reg. # 483.25(h) LSC	06/28/2013
ID Prefix F0353 Reg. # 483.30(a) LSC	06/28/2013	ID Prefix F0371 Reg. # 483.35(i) LSC	06/28/2013	ID Prefix F0441 Reg. # 483.65 LSC	06/28/2013
ID Prefix F0496 Reg. # 483.75(e)(5)-(7) LSC	06/28/2013	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/BF	08/09/2013	29245	07/24/2031
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/8/2013

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245427	01 - MAIN BUILDING 01	7/12/2013

Name of Facility	Street Address, City, State, Zip Code
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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

(Y4) Item	(Y5) Date Correction Completed
ID Prefix / Reg. # NFPA 101 / LSC K0020	05/09/2013
ID Prefix / Reg. # NFPA 101 / LSC K0029	07/08/2013
ID Prefix / Reg. # NFPA 101 / LSC K0047	07/08/2013
ID Prefix / Reg. # NFPA 101 / LSC K0056	07/08/2013

Reviewed By State Agency	Reviewed By PS/sd	Date: 08/09/13	Signature of Surveyor: 27200	Date: 07/12/13
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/30/2013

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

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5155

August 9, 2013

Mr. Douglas Dewane, Administrator
Bethesda Nursing Home Pleasantview
901 Southeast Willmar Avenue
Willmar, Minnesota 56201

RE: Project Number S5427023, H5427017, H5427019

Dear Mr. Dewane:

On May 24, 2013, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 29, 2013. (42 CFR 488.422)

On July 3, 2013, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013
- Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013
- Federal Civil Money Penalty of $200.00 per day beginning May 8, 2013

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for an extended survey completed on May 8, 2013 that included an investigation of complaint number H5427017 and H5427019. The most serious deficiencies were found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

On July 24, 2013, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on May 8, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2013. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on May 8, 2013. The deficiencies not corrected are as follows:

- **F0225 -- S/S: E -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals**
- **F0226 -- S/S: E -- 483.13(c) -- Develop/implement Abuse/neglect, Etc Policies**
- **F0309 -- S/S: E -- 483.25 -- Provide Care/services For Highest Well Being**

In addition, at the time of this revisit, we identified the following deficiencies:

- **F0329 -- S/S: D -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs**
- **F0428 -- S/S: D -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On**

The most serious deficiencies in your facility were found to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of July 3, 2013:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 will remain in effect
- Federal Civil Money Penalty of $7,450.00 per day for five days beginning May 3, 2013 and continuing through May 7, 2013 will remain in effective
- Federal Civil Money Penalty of $200.00 per day beginning May 8, 2013 will remain in effect
- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 22, 2013 (42 CFR 488.417 (b))

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.

As we notified you in our letter of May 24, 2013, 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 May 8, 2013.

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

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

DEPARTMENT CONTACT

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

Brenda Fischer
Minnesota Department of Health
Midtown Square
3333 West Division, Suite #212
Saint Cloud, Minnesota 56301

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

PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility’s allegation of compliance; and,
- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 November 8, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Sincerely,

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File 5427r1_13.rtf

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

PRINTED: 08/09/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	R 07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite Post Certification Revisit was conducted on July 22, 23, and 24, 2013, for deficiencies issued as a result of the survey and complaint investigation of H5427017 and H5427019 on May 8, 2013. As a result of this post certification revisit survey deficiencies were reissued.	{F 000}	Received 8/20/13	
{F 225} SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	{F 225}	The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source are reported to the administrator immediately and to the state agency per policy. Residents R86, R69, R124, R118, and R129 have had bruises of unknown origin fully investigated and reported to the appropriate state agencies per policy. Residents R78, R40, R122, R99, and R3 had reports submitted to the state agency and have now had a thorough investigation completed. Policy and procedure for abuse prevention has been reviewed and is current. Management staff and professional nurses have been re-educated on conducting a full investigation when injuries of unknown origin are found. 8/27/13 [illegible]	8/30/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle [illegible] | TITLE: Administrator | (X6) DATE: 8-23-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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{F 225}	Continued From page 1 The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of abuse, mistreatment and bruises of unknown origin were thoroughly investigated and reported to the state agency for 5 of 5 residents (R86, R69, R124, R118, and R129) reviewed who had busies of unknown origin. In addition, the facility failed to ensure reports submitted to the state agency included a thorough investigation and/ or were reported immediately to the state agency for 5 of 9 reports made to the state agency for residents R78, R40, R122, R99, and R3. Findings include: R86 had a bruise of unknown origin identified by the facility which was not thoroughly investigated or reported to the state agency. R86 had diagnosis of senile dementia. The quarterly Minimum Data Set (MDS) dated 5/24/13, identified R86 had severe cognitive impairment and required extensive assistance with most activities of daily living (ADL's). R86's care plan dated July 2013, indicated, "staff	{F 225}	Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules – we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months. Assistant Administrator or designee will be responsible for auditing all files for administrator notification and completion of full investigation and reporting to OHFC per policy. All files will be audited x1 month, then random audits of 3 files will be conducted weekly x 3 months. Audit results will be reported to QA committee and action plans developed as needed. R86 - An incident report was completed and submitted on 8/6/2013. Staff members working in the Memory Care Unit where R86 resides were interviewed. Investigation report was completed and submitted on 8/13/2013. Resident does have a history of bruising;	

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{F 225}	Continued From page 2 will assist [R86] with sitting down in chair-frequently will hit his thigh and calf on arms of chair when sitting down." A facility resident injury/ incident report form dated 7/10/13 indicated R86 had "bruise on right calf" measuring 3 cm (centimeters) x 3 cm and 2 busies on his left thigh measuring 8 cm x 4cm and one measuring 3 cm x 2 cm and one on his left calf measuring 3 cm x 1 cm. The explanation was "Injuries are consistent with being pinched/ bumped on chair. Staff has seen him bump into a chair when he has come to sit for meals and from sitting down hard in chair." The report did not include any staff interviews or names of staff who had worked with R86 in the past several days to determine if the bruising came from. During interview on 7/23/13 at 10:00 a.m., registered nurse (RN)-A stated R86's bruising did not match the explanation regarding the resident sitting down in the chair "hard." She also verified the bruising of unknown origin for R86 was not thoroughly investigated and did meet the definition of a reportable bruise of unknown origin. RN-A stated this was not reported to the state agency. The administrator submitted an email as part of the investigation. On 7/10/13 at 1:50 p.m. the administrator sent an email to the nurse who filled out an incident report including, "I don't have enough information on this. Multiple bruising with one being quite large needs more investigation. Did we observe resident bump chair? If so, does that explain all bruising on both legs and thigh?..." The nurse response in the email on 7/10/13 at 1:56 p.m. indicated, "Yes staff has seen him bump into chairs when going to sit down for	{F 225}	he is ambulatory in the Merry Walker and has been observed by multiple staff members to bump his arms, hands, legs, etc. on objects while in the Merry Walker. New interventions were implemented including monitoring and documenting when staff members observe resident hit his arms, hands, legs, etc. on objects as well as monitoring and documenting whenever staff members observe resident being combative by noting how he is combative. A behavior assessment was done for resident on 8/12/2013 – the behavior assessment includes a list of interventions for staff to attempt to utilize when R86 becomes combative. Maintenance department was notified on 8/13/2013 to request for resident's bed to be evaluated.	

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{F 225}	Continued From page 3	{F 225}		

meals and yes it does explain all of them. He has bumped into a chair when he has went to sit and has come from both sides."

Although the facility identified R86 had multiple bruises of unknown origin, the facility did not complete a thoroughly investigation or report it to the state agency.

R69 had multiple bruises of unknown origin identified by the facility which was not thoroughly investigated or reported to the state agency.

R69 had diagnoses including dementia. The quarterly MDS dated 5/10/13 identified R69 had severe cognitive impairment and was independent with all activities of daily living.

R69's care plan dated July 2013, did not identify the resident had any physical aggression.

A Resident injury/ incident report form dated 7/10/13 indicated R69 "had a blue fading bruise 7 cm x 9 cm to left buttock, multiple (6) red/ purple bruises to right forearm (0.5 cm and 0.8 cm), scab to right knee measuring 1 cm x 0.8 cm." The explanation of how the injury occurred was "Bruise to left buttock occurred from fall on 7/5/13- see IPN (interdisciplinary progress notes). Scab to right knee and bruises to forearm are consistent with recent behaviors- hitting and kicking out at staff/ throwing walkers; see IPN notes 7/9/13." The investigation did not include any staff interviews nor did it include who was working with the resident when she was combative.

R69's IPN notes dated 7/5/13, indicated "At 1400 resident was found sitting on her buttocks at the

R69 - An incident report was completed and submitted on 8/15/2013. Investigation report is being completed. Direct care staff members who worked with Resident 69 in the days prior and day of incidents were interviewed by Assistant Administrator or interim DON. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules – we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months. Resident died at facility on 8/10/2013.

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{F 225}	Continued From page 4 foot of the recliner with her pressure alarm under her, she stated that she was trying to get from her recliner to wheelchair and slipped on the floor." R69's IPN notes dated 7/9/13 at 11:54 a.m. indicated "Resident was up in wheelchair at change of shift this morning. She was hitting out at staff saying 'you cant tell me what to do.' Resident was also kicking at housekeeper and yelling at her to get out of the housekeeping supply room..." Another Resident injury/ incident report form dated 7/15/13 for R69 indicated the resident had "on the left arm a few small bruises throughout forearm with a 1.5 cm x 1.5 cm mid forearm bruise which are consistent with recent behaviors, including hitting and kicking out at staff, throwing walkers and scooting along in her wheelchair and bumping into things. On her back side she continues with her large 10 cm x 7 cm on left buttock from her fall on 7/5/13 along with a 1 cm x 1 cm bruise above this one on her inner back of left thigh measuring 2 cm x 4 cm. Has one bruise on right hip/ thigh area measuring 4 cm x 2 cm. Consistent with her fall on 7/5/13 or from transferring self onto the toilet." The staff interviews indicated RN-C "feels these back side bruises are from her fall. This writer toileted resident and right hip/ thigh bruise is consistent with sitting on toilet and wheelchair too close and hitting the edge of it." During interview on 7/23/13 at 10:00 a.m. RN-A stated R69's bruises were not reported to the state agency. RN-A verified a resident being "combative" is not a explanation for bruising and this should have been reported.	{F 225}		

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{F 225}	Continued From page 5 During interview on 7/24/13 at 8:40 a.m. administrator stated R69 bruising was not reported because R69 stated she bumps into things all the time. She also stated she believed R69's bruises were explainable because of her being combative and a recent fall. The administrator was notified by email of this incident. Although R69 had multiple bruising which could not be explained, and the resident had severe cognitive impairment and was recently "combative" with cares, the facility did not thoroughly investigate or report the incidents to the state agency. R124 received bruising from being combative with cares and bruising of her wrists while being held down by staff. The facility did not complete a thorough investigation or report the injury to the state agency. R124 had diagnoses including Alzheimer's disease and psychosis. The significant change MDS dated 5/10/13 identified the resident had severe cognitive impairment and was an extensive assist with all ADL's. R124's care plan dated July 2013, indicated R124 had target behaviors of crying, weepiness, being angry at other residents, and refusing care and medications. However, the plan of care did not identify R124 had any behaviors of being combative. A Resident Injury/ Incident report form dated 7/6/13 indicated R124 had bruising on anterior of right wrist measuring 2 cm x 2 cm and a bruise on posterior of right hand measuring 7.5 cm x 4.5	{F 225}	R124 - An incident report was completed and submitted on 8/13/2013. Investigation report is being completed. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules -- we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months. Direct care staff members who worked with Resident 124 in the days prior and day of incident were interviewed by Assistant Administrator or interim DON.	

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{F 225}	Continued From page 6 cm. The description of the cause of the bruising was "Resident was being combative and resistive with cares on overnight with toileting. Staff holding residents wrists from hurting herself and staff." The investigation did not include any staff interviews or identify staff members who was working with R124 and was "holding the residents wrists." During interview on 7/23/13 at 10:00 a.m. RN-A stated she felt R124's bruising was explainable because R124 had been combative and staff had said they needed to hold her wrists to do cares. RN-A verified the investigation was not complete as it did not include any staff interviews nor did R124 being combative explain why she should have bruising. During interview on 7/24/13 at 8:40 a.m. the administrator stated staff should not be holding residents wrists to do cares, but, the facility felt like the bruising was explainable so they did not need to report it. The administrator received an email regarding the bruise of unknown origin on 7/6/13. Although the facility identified staff had to hold R124's wrists to do cares and she had bruising related to it; the facility did not thoroughly investigate or report it to the state agency. R118 had bruising of unknown origin which the facility did not thoroughly investigate or report to the state agency. R118 had diagnoses including dementia. The quarterly MDS dated 4/12/13 identified the resident had severe cognitive impairment and needed extensive assistance with all activities of	{F 225}	The two alleged perpetrators were interviewed and re-educated by Interim DON on 8/19/13 and 8/20/13 on Resident Rights, never holding residents down, and individualized interventions and care for dealing with difficult behaviors. A behavior assessment was done for resident on 8/19/13. R118 - An incident report was completed and submitted on 8/13/2013. Investigation report is being completed.	

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{F 225}	Continued From page 7 daily living. R118's care plan dated July 2013 indicated the resident has a history of skin tears to hands and arms and bruising. The facility provided two Resident Injury/Incident report forms for R118, both dated 7/15/13 with the same time of 8:30 p.m. One of the reports indicated the resident had purple bruising to right arm as follows: 8 cm x 4 cm on top of hand, 2 cm x 1 cm on wrist, 2 cm x 1 cm on forearm. Purple bruise to left shin 1 cm x 4 cm, and brown bruise to right shin 3 cm x 1.5 cm. The investigation was bruising to right forearm occurred from bumping arm on wheelchair. Bruising to left and right shin occurred from residents legs touching appropriate area during use of standing lift. An email sent to the administrator dated 7/17/13, 2 days after the incident report was filled out, indicated "transfer was observed and done correctly; resident legs do touch as they need to for correct use of lift..." The second Resident injury/incident report forms for R118 dated 7/15/13 at 8:30 p.m. indicated the resident had left arm skin tear and bruises. The incident occurred "left arm on lap and forearm was under arm rest and when she pulled arm out skin tear occurred due to bruise already there and fragile skin. The IPN note dated 7/15/13 indicated "while staff was getting resident ready for bed she found a skin tear on left upper forearm that measures 7 cm long that curves at the bottom towards the elbow. The area had fresh blood and arm had been on lap and forearm was under arm rest... There is a large bruise on upper forearm to elbow	{F 225}	Direct care staff members who worked with Resident 118 in the days prior and day of incident were interviewed by Assistant Administrator or Interim DON. No staff members reported witnessing any staff member being rough with resident. While bruising is still unknown, it is suspected by interviews that hand and arm bruising occurred from resident frequently placing hands and arms under the wheelchair arm rest. It appears R and L shin bruising occurred from using PAL lift. Transfer has been observed by RN. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules -- we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months. 20 random resident transfer audits consisting of any transfer using a transfer belt or mechanical lift including 8 day shift, 8 evening shift, and 4 night shift will be completed weekly by LPN or RN staff for 4 weeks. Results will be reviewed to the QA committee and additional action plans developed as needed.	

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{F 225}	Continued From page 8 that is irregular in shape and the inside edge is where the skin tear is. The bruise measures "10 cm x 5 cm. Multiple small .2 cm x .5 cm bruise surrounding larger bruise... Resident also has multiple bruising all purple in color on right arm: 8 cm x 4 cm top of hand, 2 cm x 1 cm wrist, 2 cm x 1 cm forearm. left shin 1 cm x 4 cm purple bruise. Right shin 3 cm x 1.5 cm brown bruise..." The investigation does not include any staff interviews nor does not identify on the second report why R118 had multiple small bruising which was not explained. During interview on 7/24/13 at 8:40 a.m. the administrator stated she felt this one "was pretty straight forward." She stated R118 had a history of having fragile skin and bruising is "expected" with R118. Although the facility identified R118 had multiple bruising which could not be explained, the facility failed to a complete a thorough investigation and the state agency was not notified. R129 had bruises of unknown origin identified by the facility which was not thoroughly investigated or reported to the state agency. R129 had diagnoses of Alzheimer's disease, psychosis and anxiety. The quarterly (MDS) dated 7/12/13 indicated she was cognitively impaired and needed extensive assistance with (ADL)'s.	{F 225}	R129 - An incident report was completed and submitted on 8/13/2013. Investigation report is being completed. Resident R129 is currently admitted to Meeker Memorial Hospital Behavioral Services due to severe behavioral concerns.	

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{F 225}	Continued From page 9 R129's current plan of care dated July 2013 indicated she had mood/behavior issues was on a secured memory care unit. The current plan of care also indicated that she curses, hits, kicks and pushes. R129's care plan further states she has skin impairment related to decreased mobility and weakness. R129 has poor vision, when up in her wheelchair she frequently bumps into tables, desks or residents wheelchairs causing bruises to lower arms. A facility resident injury/incident report form dated 7/5/13 indicated R29 had a 2.5 cm x 2 cm bruise on her right elbow, 3 cm x 2 cm bruise on left arm, 1 cm x 1 cm bruise on left hand, 2 cm x 1.5 cm bruise to top of right hand and 2 cm x 1 cm bruise on her right hand. the explanation for the bruise indicated "resident has poor vision. She does wander in her wheelchair and she runs and bumps herself and hands and arms on objects. She also has been combative hitting, scratching, destroying belongings." The intervention was "will reproach her with putting the dermafit (protective clothing) on arms and she does remove the dermafit and to wear long sleeves." The report indicated the administrator was notified but the state agency was not notified. Review of R129's progress note dated 7/4/13 indicated at supper resident became agitated. she was, "Yelling at staff and refused her medications stating she doesn't need that shit and to get away from her. She was also asking were the door was to get outside. She was going into other residents rooms. She stated she would smash the window to get out. After supper she was wondering the dining area running into wheelchairs and tables."... At 5:45 p.m. she was given Ativan (antianxiety medication) 1 mg	{F 225}	Per care plan, resident has poor vision, when up in wheelchair she frequently bumps into tables, desks, or residents' wheel chairs causing bruising to lower arms. Direct care staff members who worked with Resident 129 in the days prior and day of incident were interviewed. No staff members reported witnessing any staff member being rough with resident. Resident receives ASA daily which can increase the severity of bruising. When resident returns to facility, new interventions will include offering resident to wear long sleeves and/or Dermafit for protection of her arms. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules – we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months.	

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{F 225}	Continued From page 10 (milligram) intramuscularly (IM); writer had to hold her arms down while LPN (licensed practical nurse) gave the shot due to her swearing, hitting and scratching..." During interview 7/23/13 at 11:09 a.m., with the Nurse Consultant (NC)-A who stated that R129 does have behaviors and will hit the walls, arm of chair and strike out. The NC further stated the staff should not be holding the residents down. The NC verified as part of the investigation they did not look into the staff holding R129's hands down as the cause of the bruising. The NC further stated they should have investigated further. Although R129 had multiple bruises on her arms and hands noted after her hands were held down to receive Ativan IM, the facility failed to thoroughly investigate the cause of the bruising. R78 had an incident of staff neglect with transferring. The state agency was not notified immediately nor was a thorough investigation completed that included staff names. R78 had diagnoses including dementia and hip/joint pain. The quarterly MDS dated 5/3/13, identified the resident had severe cognitive impairment and needed extensive assistance with ADL's. R78's care plan dated July 2013, identified R78 required extensive assist of two staff with a gait belt or a PAL or hoyer lift, depending on the resident strength and pain level that day. The facility submitted an incident report to the the	{F 225}	R78 - Both NA-F and NA-H had been educated regarding Safe Patient Handling policy and were re-educated on following this policy as well as individualized resident care planning. Corrective actions were completed with both NAs on 7/21/13. R78 will be re-evaluated for transfer ability. 20 random resident transfer audits consisting of any transfer using a transfer belt or mechanical lift including 8 day shift, 8 evening shift, and 4 night shift will be completed weekly by LPN or RN staff for 4 weeks. Results will be reviewed to the QA committee and additional action plans developed as needed.	

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

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{F 225}	Continued From page 11 state agency dated 7/21/13 identifying on 7/20/13 "two staff members were assisting resident to transfer from her recliner to her wheelchair. Resident began to fall and was lowered to the floor by staff. Abrasion present to residents right side caused by rubbing against seat of wheelchair during fall. No transfer belt used during transfer." Although the incident occurred on 7/20/13, this was not reported to the state agency until 7/21/13, one day after the incident. The investigative report dated 7/21/13 submitted to the state agency regarding R78 indicated, ..."Care plan was not being followed, as no transfer belt was being used with transfer." The investigation did not identify who the staff member was but indicated "Corrective action included a verbal warning for both staff members present at the time of the fall.." During interview on 7/24/13 at 8:40a.m. the facility administrator stated she was unsure who the two staff members that were not transferring R78 according to the plan of care of 7/20/13. She verified this was not reported immediately to the state agency, it was reported the next day. During interview on 7/24/13 at 9:45 a.m. the administrator stated the staff who did not transfer R78 according to the plan of care on 7/20/13 was identified by (unknown) nurse as nursing assistant (NA)-F and NA-H. Education and corrective action was requested for NA-F and NA-H but was not provided by the facility. R40 was identified by the facility as experiencing	{F 225}		

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{F 225}	Continued From page 12 staff neglect at the facility on 7/3/13. Although the facility reported this to the state agency, the investigation was incomplete as there were no staff interviews or staff identified who had been working with R40. R40 had diagnoses including Alzheimer's disease. The quarterly MDS dated 4/12/13, identified the resident had severe cognitive impairment and needed extensive assistance with all ADL's. R40's care plan dated July 2013 indicated the resident was at risk for falls and the resident had a pressure alarm to bed and a body pillow and concave mattress while in bed. The initial report to the state agency dated 7/3/13 identified R40 "was found on floor by her bed at 8:40 a.m. 7/3/13. Resident was incontinent of bowel and bladder." There was no further information on the initial report. The investigative report submitted to the state agency on 7/9/13, 6 days after the initial report indicated, "Care plan stated TAB alarm and pressure alarm to be used while in bed. Care plan interventions were not being followed as the pressure alarm was found to be unplugged when [R40] was found on the floor by her bed... Staff was interviewed and information was inconclusive as to if the pressure alarm was plugged in the evening before or when it became unplugged. Evening staff did state they had the TAB alarm clipped to [R40] when she went to bed but not sure of the pressure alarm... Nursing staff from day shift interviewed and reported [R40] removes TAB alarm and that it also was not sounding when she fell nor was the pressure alarm. The	{F 225}	R40 - Staff members that were working with R40 at the time around the incident have been identified and were interviewed. CNA staff members were re-educated on TAB/pressure alarm use. Interim DON or designee will complete 10 random audits on TAB/pressure alarm checks per week x 3 weeks. Audit results will be reported to QA committee and action plans developed as needed.	

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{F 225}	Continued From page 13 TAB alarm was attached when night staff left at 6:30 a.m. but not sure of the pressure alarm... Staff on all shift will be re- educated." During interview on 7/24/13 at 8:40 a.m. the administrator stated there was no further investigation available related to which staff were interviewed or what staff were caring for R40 at the time of the neglect. The administrator verified the investigative report was submitted on 7/9/13, 6 days after the initial report. Education for staff regarding the 7/3/13 neglect incident with R40 was requested but not provided. The facility submitted three reports to the state agency regarding neglect and possible abuse by NA-E for residents R122, R99, and R3. However, the facility did not submit a thorough investigation regarding the past allegations and pattern of alleged mistreatment by NA-E. R122 quarterly MDS dated 5/31/13 identified the resident had moderate cognitive impairment and needed extensive assistance with all ADL's. A incident report was submitted to the state agency regarding R122 on 5/4/13. The incident details indicated the resident and wife stated that NA-E "is mean, he makes me lay in bed rather than sit in recliner, he wants to put me in my wheelchair when I want to sit in my recliner and he lies to me about the time." The date the incident occurred is "unknown." The investigative report submitted to the state agency regarding the incident with R122 and NA-E dated 5/10/13, 6 days after the initial report.	{F 225}	R122 - Tracking system has been implemented to identify name of caregiver that is involved in each resident incident in order to determine if a pattern with a certain caregiver is occurring with incidents. Resident was interviewed. NA-E did resign from the facility on 7/3/2013.	

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{F 225}	Continued From page 14 The investigation indicated, NA-E stated "R122 prefers to stay in his recliner until after 5:00 p.m... when planning his time and attempting to meet all of his residents needs, there were times he had to assist [R122] to his wheelchair at 4:45 p.m... [NA-E] went on to tell writer, I would never hurt my residents... residents interviewed..." Multiple residents were interviewed and the response regarding NA-E was "He is quick to answer call light." "[NA-E] is careful with transfers." The report did not identify that NA-E had a pattern of allegations of mistreatment made by two other resident R99 and R3. R99 annual MDS dated 4/26/13 identified the resident had no cognitive impairment and needed extensive assistance with ADL's. A facility incident report dated 5/6/13 regarding R99 indicated the resident stated "that one aide throws me into bed and stated this happened in the day and evening..." The alleged perpetrator was identified as NA-E. The investigative report submitted on 5/9/13 regarding R99 indicated NA-E "work performance has been positive. residents interviewed..." Multiple residents were interviewed and the response regarding NA-E was "He is quick to answer call light." "[NA-E] is careful with transfers." There was nothing in the investigation regarding the other allegations of neglect and maltreatment made by R99 and R3. NA-E was interviewed and does not remember any incident as described by R99. There was nothing in the investigative report regarding the other allegations made by R122 and R3.	{F 225}	R99 - Tracking system has been implemented to identify name of caregiver that is involved in each resident incident in order to determine if a pattern with a certain caregiver is occurring with incidents. Resident was interviewed. NA-E did resign from the facility on 7/3/2013.	

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{F 225}	Continued From page 15 R3 quarterly MDS dated 6/7/13 identified the resident had no cognitive impairment and needed extensive assistance with ADL's. R3 reported allegations of staff maltreatment from NA-E and an investigative report was submitted to the state agency on 6/4/13. The incident details on the report to the state on 6/4/13 indicated "During survey, [R3] informed surveyor that a staff person was rough with her during cares. She also stated that she had reported this at her last care conference..." The survey was exited on 5/8/13 and this was not reported to the state agency until 6/4/13. The investigative report submitted to the state agency dated 6/7/13 indicated, R3 "informed a surveyor a staff person was rough with her... Writer interviewed [R3] on 6/4/13 and she does recall informing the surveyor that NA-E was rough... she stated he just does things fast...Multiple residents were interviewed and the response regarding NA-E was "He is quick to answer call light." "[NA-E] is careful with transfers." NA-E was interviewed and does not remember any incident as described by R99. There was nothing in the investigation regarding the pattern of allegations of neglect and maltreatment made by R99 and R3. Although the facility reported allegations of possible neglect and abuse regarding NA-E with residents R122, R99, and R3; the facility did not complete a thorough investigation regarding the history of abuse and neglect accusations for NA-E. NA-E resigned from the facility 7/3/13.	{F 225}	R3 - Tracking system has been implemented to identify name of caregiver that is involved in each resident incident in order to determine if a pattern with a certain caregiver is occurring with incidents. Resident was interviewed. NA-E did resign from the facility on 7/3/2013.	

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{F 226} SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the facility policy was followed regarding investigating and reporting allegations of abuse/mistreatment and bruising of unknown origin for 5 of 5 resident with bruises of unknown origin reviewed, R86, R69, R124, R118 and R129. In addition, the facility failed to ensure the abuse policy was followed regarding submitting reports to the state agency which included a thorough investigation and/ or reporting immediately to the state agency for 5 of 9 reports reviewed that were sent to the state agency for residents R78, R40, R122, R99, and R3. Findings include: The facility Abuse Prevention Policy/ Procedure dated 5/7/13 indicated "All alleged violations of mistreatment, neglect, abuse, injury of unknown origin, and misappropriation of resident property will be reported immediately to the Administrator, OHFC (state agency)... All alleged mistreatment, abuse, neglect, injuries of unknown origin... will be investigated by doing the following... Immediately report alleged incident to administrator. Complete a resident incident/ injury report form and submit report to state	{F 226}	The facility will develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Residents R86, R69, R124, R118, and R129 have had bruises of unknown origin fully investigated and reported to the appropriate state agencies per policy. Residents R78, R40, R122, R99, and R3 had reports submitted to the state agency and have now had a thorough investigation completed. Policy and procedure for abuse prevention has been reviewed and is current. Management staff and professional nurses have been re-educated on conducting a full investigation when injuries of unknown origin are found. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules – we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months.	8/30/13

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{F 226}	Continued From page 17 agency. Interview involved staff, co-workers of involved staff. Interview involved resident, other residents. Interview any witnesses...The facility will electronically submit a full investigative report of the findings to the state agency within five working days... The report shall include the following information as available: Name of vulnerable adult. Name and address of alleged perpetrator or staff responsible for incident, including job title, social security number, date of birth, length of employee, any prior incidents of maltreatment...". The definition of injury of unknown source on the policy was, "An injury should be classified as injury of unknown origin or source when both the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident and the injury is suspicious because of the extent of the injury or the location of injury (eg. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injuries over time... Physical abuse: Includes hitting, slapping, pinching, scratching, spitting, holding roughly, etc. It also includes controlling behavior through corporal punishment." R86 had a bruise of unknown origin identified by the facility which was not thoroughly investigated or reported to the state agency per facility policy. R86 had diagnoses of senile dementia. The quarterly minimum data set (MDS) dated 5/24/13 identified the resident had severe cognitive impairment and required extensive assistance with most activities of daily living (ADL's). R86's care plan dated July 2013, indicated "staff	{F 226}	Assistant Administrator or designee will be responsible for auditing all files for administrator notification and completion of full investigation and reporting to OHFC per policy. All files will be audited x1 month, then random audits of 3 files will be conducted weekly x 3 months. Audit results will be reported to QA committee and action plans developed as needed. R86 - An incident report was completed and submitted on 8/6/2013. Staff members working in the Memory Care Unit where R86 resides were interviewed. Investigation report was completed and submitted on 8/13/2013. Resident does have a history of bruising;	

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{F 226}	Continued From page 18 will assist [R86] with sitting down in chair-frequently will hit his thigh and calf on arms of chair when sitting down." A facility resident injury/ incident report form dated 7/10/13 indicated R86 had "bruise on right calf measuring 3 cm 3 cm and 2 busies on his left thigh measuring 8 cm x 4cm and one measuring 3 cm x 2 cm and one on his left calf measuring 3 cm x 1 cm. The explanation was "Injuries are consistent with being pinched/ bumped on chair. Staff has seen him bump into a chair when he has come to sit for meals and from sitting down hard in chair." The report did not include any staff interviews or names of staff who had worked with the resident in the past several days. During interview on 7/23/13 at 10:00 a.m. registered nurse (RN)-A stated R86's bruising did not match the explanation regarding the resident sitting down in the chair "hard." She also verified the bruising of unknown origin for R86 was not thoroughly investigated and did meet the definition of a reportable bruise of unknown origin. RN-A stated this was not reported to the state agency per facility policy. The administrator submitted an email as part of the investigation. On 7/10/13 at 1:50 p.m. the administrator sent an email to the nurse who filled out an incident report stating, "I don't have enough information on this. Multiple bruising with one being quite large needs more investigation. Did we observe resident bump chair? If so, does that explain all bruising on both legs and thigh?..." The nurse response in the email on 7/10/13 at 1:56 p.m. indicated, "Yes staff has seen him bump into chairs when going to sit down for meals and yes it does explain all of them. He has	{F 226}	he is ambulatory in the Merry Walker and has been observed by multiple staff members to bump his arms, hands, legs, etc. on objects while in the Merry Walker. New interventions were implemented including monitoring and documenting when staff members observe resident hit his arms, hands, legs, etc. on objects as well as monitoring and documenting whenever staff members observe resident being combative by noting how he is combative. A behavior assessment was done for resident on 8/12/2013 – the behavior assessment includes a list of interventions for staff to attempt to utilize when R86 becomes combative. Maintenance department was notified on 8/13/2013 to request for resident's bed to be evaluated.	

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{F 226}	Continued From page 19	{F 226}		

bumped into a chair when he has went to sit and has come from both sides."

Although the facility identified R86 had multiple bruises of unknown origin, the facility did not complete a thoroughly investigation or report it to . the state agency per facility policy.

R69 had multiple bruises of unknown origin identified by the facility which was not thoroughly investigated or reported to the state agency per facility policy.

R69 had diagnoses including dementia. The quarterly MDS dated 5/10/13 identified the resident had severe cognitive impairment and was independent with all activities of daily living.

R69's care plan dated July 2013, did not identify the resident had any physical aggression.

A Resident injury/ incident report form dated 7/10/13 indicated R69 "had a blue fading bruise 7 cm x 9 cm to left buttock, multiple (6) red/ purple bruises to right forearm (0.5 cm and 0.8 cm), scab to right knee measuring 1 cm x 0.8 cm." The explanation of how the injury occurred was "Bruise to left buttock occurred from fall on 7/5/13- see IPN (interdisciplinary notes). Scab to right knee and bruises to forearm are consistent with recent behaviors- hitting and kicking out at staff/ throwing walkers; see IPN notes 7/9/13." The investigation did not include any staff interviews nor did it include who was working with the resident when she was combative.

Another Resident injury/ incident report form dated 7/15/13 for R69 indicated the resident had "on the left arm a few small bruises throughout

R69 - An incident report was completed and submitted on 8/15/2013. Investigation report is being completed. Resident died at facility on 8/10/2013. Direct care staff members who worked with Resident 69 in the days prior and day of incidents were interviewed by Assistant Administrator or interim DON. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules – we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months.

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{F 226}	Continued From page 20 forearm with a 1.5 cm x 1.5 cm mid forearm bruise which are consistent with recent behaviors, including hitting and kicking out at staff, throwing walkers and scooting along in her wheelchair and bumping into things. On her back side she continues with her large 10 cm x 7 cm on left buttock from her fall on 7/5/13 along with a 1 cm x 1 cm bruise above this one on her inner back of left thigh measuring 2 cm x 4 cm. Has one bruise on right hip/ thigh area measuring 4 cm x 2 cm. Consistent with her fall on 7/5/13 or from transferring self onto the toilet." The staff interviews indicated RN-C "feels these back side bruises are from her fall. This writer toileted resident and right hip/ thigh bruise is consistent with sitting on toilet and wheelchair too close and hitting the edge of it." During interview on 7/23/13 at 10:00 a.m. RN-A stated R69's bruises were not reported to the state agency per facility policy. RN-A verified a resident being "combative" is not a explanation for bruising and this should have been reported and investigated. During interview on 7/24/13 at 8:40 a.m. administrator stated R69 bruising was not reported because the resident stated she bumps into things all the time. She also stated she believed R69's bruises were explainable because of her being combative and a recent fall. The administrator verified this was not reported to the state agency per facility policy. Although R69 had multiple bruising which could not be explained, and the resident had severe cognitive impairment and was recently "combative" with cares, the facility did not thoroughly investigate or report the incidents to	{F 226}		

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{F 226}	Continued From page 21 the state agency per facility policy. R124 received bruising from being combative with cares and staff was holding the residents wrists. The facility did not complete a thorough investigation or report it to the state agency per facility policy. R124 had diagnoses including Alzheimer's disease and psychosis. The significant change MDS dated 5/10/13 identified the resident had severe cognitive impairment and was an extensive assist with all ADL's. R124's care plan dated July 2013 indicated R124 had target behaviors of crying, weepiness, being angry at other residents, and refusing care and medications. However, the plan of care did not identify R124 had any behaviors of being combative. A Resident injury/ incident report form dated 7/6/13 indicated R124 had bruising on anterior of right wrist measuring 2 cm x 2 cm and a bruise on posterior of right hand measuring 7.5 cm x 4.5 cm. The description of the cause of the bruising was "Resident was being combative and resistive with cares on overnight with toileting. Staff holding residents wrists from hurting herself and staff." The investigation did not include any staff interviews or what staff was working with R124 who was "holding the residents wrists." During interview on 7/23/13 at 10:00 a.m. RN-A stated she felt R124's bruising was explainable because the resident had been combative and staff had said they needed to hold her wrists to do cares. RN-A verified the investigation was not complete as it did not include any staff interviews	{F 226}	R124 - An incident report was completed and submitted on 8/13/2013. Investigation report is being completed. All nursing staff will be educated on behavior management including appropriate, individualized interventions. Direct care staff members who worked with Resident 124 in the days prior and day of incident were interviewed by Assistant Administrator or interim DON. The two alleged perpetrators were interviewed and re-educated by Interim DON on 8/19/13 and 8/20/13 on Resident Rights, never holding residents down, and individualized interventions and care for dealing with difficult behaviors. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules – we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months.	

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{F 226}	Continued From page 22 nor did R124 being combative explain why she should have bruising. RN-A verified this should have been reported to the state agency and the investigation was not complete. During interview on 7/24/13 at 8:40 a.m. the administrator stated staff should not be holding residents wrists to do cares, but, the facility felt like the bruising was explainable so they did not need to report it. Although the facility identified staff had to hold R124's wrists to do cares and she had bruising related to it; the facility did not thoroughly investigate or report it to the state agency according to facility policy. R118 had bruising of unknown origin which the facility did not thoroughly investigate or report to the state agency per facility policy. R118 had diagnoses including dementia. The quarterly MDS dated 4/12/13 identified the resident had severe cognitive impairment and was an extensive assist with all activities of daily living. R118's care plan dated July 2013, indicated the resident has a history of skin tears to hands and arms and bruising. The facility provided two Resident injury/incident report forms for R118, both dated 7/15/13 with the same time of 8:30 p.m. One of the reports indicated the resident had purple bruising to right arm as follows: 8 cm x 4 cm on top of hand, 2 cm x 1 cm on wrist, 2 cm x 1 cm on forearm. Purple bruise to left shin 1 cm x 4 cm, and brown bruise to right shin 3 cm x 1.5 cm. The	{F 226}	R118 - An incident report was completed and submitted on 8/13/2013. Investigation report is being completed. Staff members working during the timeframe of the incident will be interviewed for further details.	

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{F 226}	Continued From page 23 investigation was bruising to right forearm occurred from bumping arm on wheelchair. Bruising to left and right shin occurred from residents legs touching appropriate area during use of standing lift. An email sent to the administrator dated 7/17/13, 2 days after the incident report was filled out, indicated "transfer was observed and done correctly; resident legs do touch as they need to for correct use of lift..." The second Resident injury/incident report forms for R118 dated 7/15/13 at 8:30 p.m. indicated the resident had left arm skin tear and bruises. The incident occurred "left arm on lap and forearm was under arm rest and when she pulled arm out skin tear occurred due to bruise already there and fragile skin. The IPN note dated 7/15/13 indicated "while staff was getting resident ready for bed she found a skin tear on left upper forearm that measures 7 cm long that curves at the bottom towards the elbow. The area had fresh blood and arm had been on lap and forearm was under arm rest... There is a large bruise on upper forearm to elbow that is irregular in shape and the inside edge is where the skin tear is. The bruise measures 10 cm x 5 cm. Multiple small .2 cm x .5 cm bruise surrounding larger bruise... Resident also has multiple bruising all purple in color on right arm: 8 cm x 4 cm top of hand, 2 cm x 1 cm wrist, 2 cm x 1 cm forearm. left shin 1 cm x 4 cm purple bruise. Right shin 3 cm x 1.5 cm brown bruise..." The investigation does not include any staff interviews nor does it include why on the second report the resident had multiple small bruising which was not explained. During interview on 7/24/13 at 8:40 a.m. the administrator stated she felt this one "was pretty straight forward." She stated R118 had a history	{F 226}	Direct care staff members who worked with Resident 118 in the days prior and day of incident were interviewed by Assistant Administrator or Interim DON. No staff members reported witnessing any staff member being rough with resident. While bruising is still unknown, it is suspected by interviews that hand and arm bruising occurred from resident frequently placing hands and arms under the wheelchair arm rest. It appears R and L shin bruising occurred from using PAL lift. Transfer has been observed by RN. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules – we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months.	

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{F 226}	Continued From page 24 of having fragile skin and bruising is "expected" with R118. Although the facility identified R118 had multiple bruising which could not be explained, the facility failed to ensure a complete investigation was completed or the state agency was notified per facility policy. R129 had bruises of unknown origin identified by the facility which was not thoroughly investigated or reported to the state agency per facility policy. R129 had diagnoses of Alzheimer's disease, psychosis and anxiety. The quarterly (MDS) dated 7/12/13 indicated she was cognitively impaired and needed extensive assistance with (ADL)'s. R129's current plan of care dated July 2013 indicated she had mood/behavior issues was on a secured memory care unit. The current plan of care also indicated that she curses, hits, kicks and pushes. R129's care plan further states she has skin impairment related to decreased mobility and weakness. R129 has poor vision, when up in her wheelchair she frequently bumps into tables, desks or residents wheelchairs causing bruises to lower arms. A facility resident injury/incident report form dated 7/5/13 indicated R29 had a 2.5 cm x 2 cm bruise on her right elbow, 3 cm x 2 cm bruise on left arm, 1 cm x 1 cm bruise on left hand, 2 cm x 1.5 cm bruise to top of right hand and 2 cm x 1 cm bruise on her right hand. the explanation for the bruise indicated "resident has poor vision. She does wander in her wheelchair and she runs and bumps herself and hands and arms on objects.	{F 226}	R129 - An incident report was completed and submitted on 8/13/2013. Investigation report is being completed. Resident R129 is currently admitted to Meeker Memorial Hospital Behavioral Services due to severe behavioral concerns. Per care plan, resident has poor vision, when up in wheelchair she frequently bumps into tables, desks, or residents' wheel chairs causing bruising to lower arms. Direct care staff members who worked with Resident 129 in the days prior and day of incident were interviewed. No staff members reported witnessing any staff member being rough with resident. Resident receives ASA daily which can increase the severity of bruising. When resident returns to facility, new interventions will include offering resident to wear long sleeves and/or Dermafit for protection of her arms. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13.	

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{F 226}	Continued From page 25 She also has been combative hitting, scratching, destroying belongings." The intervention was "will reproach her with putting the dermafit (protective clothing) on arms and she does remove the dermafit and to wear long sleeves. The report indicated the administrator was notified but the state agency was not notified. Review of R129's progress note dated 7/4/13 indicated at supper resident became agitated. she was yelling at staff and refused her med's stating she doesn't need that shit and to get away from her. She was also asking were the door was to get outside. She was going into other residents rooms. She stated she would smash the window to get out. After supper she was wondering the dining area running into wheelchairs and tables."... At 5:45 p.m. she was given Ativan (antianxiety medication) 1 mg (milligram) intramuscularly (IM); writer had to hold her arms down while LPN (licensed practical nurse) gave the shot due to her swearing, hitting and scratching."... During interview 7/23/13 at 11:09 a.m., with the Nurse Consultant (NC) who stated that R129 does have behaviors and will hit the walls, arm of chair and strike out. The NC further stated the staff should not be holding the residents down. The NC verified as part of the investigation they did not look into the staff holding the residents hands down as the cause of the bruising. The NC further stated they should have investigated further. Although R129 had multiple bruises on her arms and hands noted after her hands were held down to receive Ativan IM, the facility failed to thoroughly investigate the cause of the bruising or	{F 226}	CMS Dementia training consists of 6 modules – we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 26 report it to the state agency according to facility policy. The facility did not report staff neglect in transferring R78 to the state agency immediately or submit a thorough investigation which included the staff names according to facility policy. R78 had diagnoses including dementia and hip/joint pain. The quarterly MDS dated 5/3/13 identified the resident had severe cognitive impairment and needed extensive assistance with ADL's. R78's care plan dated July 2013, identified R78 required extensive assist of two staff with a gait belt or a PAL or hoyer lift, depending on the resident strength and pain level that day. The facility submitted an incident report to the the state agency dated 7/21/13 identifying on 7/20/13 "two staff members were assisting resident to transfer from her recliner to her wheelchair. Resident began to fall and was lowered to the floor by staff. Abrasion present to residents right side caused by rubbing against seat of wheelchair during fall. No transfer belt used during transfer." Although the incident occurred on 7/20/13, this was not reported until the next day, 7/21/13. The investigative report dated 7/21/13 submitted to the state agency regarding R78 indicated, ..."Care plan was not being followed, as no transfer belt was being used with transfer." The investigation did not identify who the staff was but indicated "Corrective action included a verbal warning for both staff members present at the time of the fall.."	{F 226}	R78 - Both NA-F and NA-H had been educated regarding Safe Patient Handling policy and were re-educated on following this policy as well as individualized resident care planning. Corrective actions were completed with both NAs on 7/21/13. R78 will be re-evaluated for transfer ability. 20 random resident transfer audits consisting of any transfer using a transfer belt or mechanical lift including 8 day shift, 8 evening shift, and 4 night shift will be completed weekly by LPN or RN staff for 4 weeks. Results will be reviewed to the QA committee and additional action plans developed as needed.	

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{F 226}	Continued From page 27 During interview on 7/24/13 at 8:40a.m. the facility administrator stated she was unsure who the two staff were not transferring R78 according to the plan of care of 7/20/13. She verified this was not reported immediately to the state agency, it was reported the next day. During interview on 7/24/13 at 9:45 a.m. the administrator stated the staff who did not transfer R78 according to the plan of care on 7/20/13 was identified by (unknown) nurse were NA-F and NA-H. Education and corrective action was requested for NA-F and NA-H but was not provided. R40 was identified by the facility as experiencing staff neglect at the facility on 7/3/13. Although the facility reported this to the state agency, the investigation was incomplete as there were no staff interviews or staff identified who had been working with the resident per facility policy. R40 had diagnoses including Alzheimer's disease. The quarterly MDS dated 4/12/13 identified the resident had severe cognitive impairment and needed extensive assistance with all ADL's. R40's care plan dated July 2013 indicated the resident was at risk for falls and the resident had a pressure alarm to bed and a body pillow and concave mattress while in bed. The initial report to the state agency dated 7/3/13 identified R40 "was found on floor by her bed at 8:40 a.m. 7/3/13. Resident was incontinent of bowel and bladder." There was no further	{F 226}	R40 - Staff members that were working with R40 at the time around the incident have been identified and were interviewed. CNA staff members were re-educated on TAB/pressure alarm use. Interim DON or designee will complete 10 random audits on TAB/pressure alarm checks per week x 3 weeks. Audit results will be reported to QA committee and action plans developed as needed.	

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{F 226}	Continued From page 28 information on the initial report. The investigative report submitted to the state agency on 7/9/13, 6 days after the initial report indicated, "Care plan stated TAB alarm and pressure alarm to be used while in bed. Care plan interventions were not being followed as the pressure alarm was found to be unplugged when [R40] was found on the floor by her bed... Staff was interviewed and information was inconclusive as to if the pressure alarm was plugged in the evening before or when it became unplugged. Evening staff did state they had the TAB alarm clipped to [R40] when she went to bed but not sure of the pressure alarm... Nursing staff from day shift interviewed and reported [R40] removes TAB alarm and that it also was not sounding when she fell nor was the pressure alarm. The TAB alarm was attached when night staff left at 6:30 a.m. but not sure of the pressure alarm... Staff on all shift will be re- educated." During interview on 7/24/13 at 8:40 a.m. the administrator stated there was no further investigation available related to which staff were interviewed or what staff was caring for R40 at the time of the neglect. The administrator verified the investigative report was submitted on 7/9/13, 6 days after the initial report. Education for staff regarding the 7/3/13 neglect incident with R40 was requested but not provided. The facility submitted three reports to the state agency regarding neglect and possible abuse by NA-E for residents R122, R99, and R3. However, the facility did not submit a thorough investigation regarding the past allegations of allegations of mistreatment by NA-E.	{F 226}		

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{F 226}	Continued From page 29	{F 226}		

R122 quarterly MDS identified the resident had moderate cognitive impairment and needed extensive assistance with all ADL's.

A incident report was submitted to the state agency regarding R122 on 5/4/13. The incident details indicated the resident and wife stated that NA-E "is mean, he makes me lay in bed rather than sit in recliner, he wants to put me in my wheelchair when I want to sit in my recliner and he lies to me about the time." The date the incident occurred is "unknown."

The investigative report submitted to the state agency regarding the incident with R122 and NA-E dated 5/10/13, 6 days after the initial report. The investigation indicated, NA-E stated "R122 prefers to stay in his recliner until after 5:00 p.m... when planning his time and attempting to meet all of his residents needs, there were times he had to assist [R122] to his wheelchair at 4:45 p.m... [NA-E] went on to tell writer, I would never hurt my residents... residents interviewed..." Multiple residents were interviewed and the response regarding NA-E was "He is quick to answer call light." "[NA-E] is careful with transfers." There was nothing in the investigation regarding the other allegations of neglect and maltreatment made by R99 and R3.

R99 annual MDS dated 4/26/13 identified the resident had no cognitive impairment and needed extensive assistance with ADL's.

A facility incident report dated 5/6/13 regarding R99 indicated the resident stated "that one aide throws me into bed and stated this happened in

Provider's Plan of Correction:

R122 - Tracking system has been implemented to identify name of caregiver that is involved in each resident incident in order to determine if a pattern with a certain caregiver is occurring with incidents. Resident was interviewed. NA-E did resign from the facility on 7/3/2013.

R99 - Tracking system has been implemented to identify name of caregiver that is involved in each resident incident in order to determine if a pattern with a certain caregiver is occurring with incidents. Resident was interviewed. NA-E did resign from the facility on 7/3/2013.

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{F 226}	Continued From page 30 the day and evening..." The alleged perpetrator was identified as NA-E. The investigative report submitted on 5/9/13 regarding R99 indicated NA-E "work performance has been positive. residents interviewed..." Multiple residents were interviewed and the response regarding NA-E was "He is quick to answer call light." "[NA-E] is careful with transfers." There was nothing in the investigation regarding the other allegations of neglect and maltreatment made by R99 and R3. NA-E was interviewed and does not remember any incident as described by R99. There was nothing in the investigative report regarding the other allegations made by R122 and R3. The facility policy indicated the report should include other allegations of alleged staff maltreatment with other residents. R3 quarterly MDS dated 6/7/13 identified the resident had no cognitive impairment and needed extensive assistance with ADL's. An investigative report submitted regarding allegations of staff maltreatment from NA-E for R3 was submitted to the state agency on 6/4/13. The incident details on the report to the state on 6/4/13 indicated "During survey, [R3] informed surveyor that a staff person was rough with her during cares. She also stated that she had reported this at her last care conference..." The survey was exited on 5/8/13 and this was not reported until 6/4/13. The investigative report submitted to the state agency dated 6/7/13 indicated, R3 "informed a surveyor a staff person was rough with her... Writer interviewed [R3] on 6/4/13 and she does recall informing the surveyor that NA-E was rough... she stated he just does things	{F 226}	R3 - Tracking system has been implemented to identify name of caregiver that is involved in each resident incident in order to determine if a pattern with a certain caregiver is occurring with incidents. Resident was interviewed. NA-E did resign from the facility on 7/3/2013.	

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{F 226}	Continued From page 31 fast...Multiple residents were interviewed and the response regarding NA-E was "He is quick to answer call light." "[NA-E] is careful with transfers." There was nothing in the investigation regarding the other allegations of neglect and maltreatment made by R99 and R3. NA-E was interviewed and does not remember any incident as described by R99. There was nothing in the investigative report regarding the other allegations made by R122 and R99. Although the facility reported allegations of possible neglect and abuse regarding NA-E with residents R122, R99, and R3; the facility did not complete a thorough investigation regarding the history of abuse and neglect accusations for NA-E. NA-E resigned from the facility 7/3/13.	{F 226}		
{F 309} SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess, monitor and provide appropriate interventions for 5 of 5 residents (R86, R124, R69, R129 and R115) reviewed, who resided on the memory care unit	{F 309}	All residents will receive necessary care and services to attain the highest practicable physical, mental and psychosocial well-being. Resident R129 is currently admitted to Meeker Memorial Hospital Behavioral Services due to severe behavioral concerns. Resident R86 did have had a behavior profile assessment and new care plan interventions added to care plan and NAR assignment sheet. Residents R124 and R115 will have a behavior profile assessment completed and new care plan interventions will be added to the care plan and NAR assignment sheet.	8/30/13

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{F 309}	Continued From page 32 and who displayed inappropriate behavior. Findings include: R86 displayed inappropriate behavior of hitting, kicking, and biting during routine cares, the facility failed to attempt to identify the cause of these behaviors, failed to attempt to determine what helps to de-escalate R86's behaviors, and failed to direct staff on how to care for him when he has these behaviors. R86's diagnosis included dementia with conduct disturbance. The quarterly Minimum Data Set dated 5/31/13, indicated R86 had severe cognitive impairment, showed inattention, disorganized thinking, had physical behaviors directed towards others, and rejected cares. R86 was frequently incontinent of bladder, and occasionally incontinent of bowel, and required extensive assistance from staff for toileting and hygiene. R86's behavioral symptoms care area assessment (CAA) dated 11/20/12 included, "Behavior impairment d/t [due to] progressive dementia with severe cognitive impairment with decisions poor/supervision required AEB [as evidenced by] wandering, agitation, and resisting cares." R86's care plan dated July 2013, included "Mood/Behavior impairment r/t dementia with severe cognitive impairment, communication impairment, dx [diagnosis] of disturbance of conduct. Target behaviors: yelling, wandering, belligerent with cares, refusing cares." A goal was listed as; "[R86] will feel safe and secure within the MCU [memory care unit]. Interventions included "Place in secured memory unit and review need for placement at quarterly care	{F 309}	R69 died at facility on 8/10/2013. A new behavior management process policy and procedure had been developed to include weekly behavior meetings to review behaviors and the effectiveness of new interventions. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules – we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months. Seven residents have been identified by the IDT as having behaviors that affect themselves or others such as yelling, hitting out, resisting cares; these seven residents have had behavior assessments completed and new, individualized interventions have been added to their care plan and NAR assignment sheets. If any other residents begin exhibiting behaviors that are harmful to themselves or others, the team will complete a behavior assessment. The IDT meets daily to discuss incidents, falls, and changes in behavior and this is how the team will identify the residents needing behavior assessments going forward.	

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{F 309}	Continued From page 33 conference. Administer Seroquel [an antipsychotic medication] and Ativan [an antianxiety medication] for target behaviors...Allow time for [R86] to verbalized his feelings and concerns. 1:1 [one on one] attention from staff as needed. Redirect when wandering, divert to activities if able.. When/if combative with any cares, leave alone (if safe) and re-approach later." R86's Behavior Occurrence Flow Sheet for July 1 though July 24, 2013 showed 26 occurrences of "resists/combative." All occurrences showed they were "upsetting/disruptive to others," the cause was listed as "unknown/unpredictable" or "direct care/provider." Interventions provided included "calm reassurance, structured activity/group, one on one's, leave (if res [resident] safe) re-approach when res calm, attempt w/different caregiver or to toilet. The effectiveness of these interventions included decreased in intensity/improved; or behavior continued. R86's June 2013 Behavior Occurrence Flow Sheet showed 32 episodes of being resistive/combative with similar interventions and outcomes. R86's May 2013 Behavior Occurrence Flow sheet showed 45 episodes of being resistive/combative also with similar interventions and outcomes. R86's IPN (Interdisciplinary progress notes) included the following: 6/5/13 "[R86] has a history of bruises to his lower arms. Frequently [R86] is resistive and combative with cares in the evening. Staff do need to hold his arms to protect themselves from	{F 309}	DON and DSS or designee will be responsible for auditing for behavior plans and follow-through on new interventions and completion of behavior flow sheets. Audits will be completed on 5 of these weekly for 4 weeks, then monthly for 3 months. Audit results will be reported to the QA committee and additional action plans developed as needed.	

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{F 309}	Continued From page 34	{F 309}		

getting hurt and also protect [R86] and get the cares done."

6/7/13 "Resident was resistive and combative with HS cares. Resident was attempting to hit, kick, bite and knock staff over when staff was getting him washed up for bed. 3 staff assist with cares. Staff was holding onto his wrists to keep him from hurting himself and staff. Resident did hit his left knuckles on the sliding bathroom door. Resident kicked out at staff when they laid him down in bed."

6/12/13 "Resident was combative and resistive with HS cares this evening. 3 assist to get resident washed up for bed. Staff held his wrist form getting punched and from hurting himself. Resident was kicking, stomping on staffs feet, attempting to push staff over, attempting to bite staff...Resident did hit his back on the back of the toilet."

6/18/13 "Resident became combative and resistive with his bath this evening. Resident was hitting and kicking out, attempting to arm wrestle and bite staff. Staff reported that he hit his Rt [right] hand on the side of the bathtub."
6/19/13 "CNA [certified nursing assistant] reported skin to be clear and intact at bath time this evening...[R86] was slightly combative right away and then was kicking and hitting-watch for bruising."

7/1/13 "Resident was combative and resistive with HS cares. He was hitting out, stomping on staff's feet, kicking out at staff, attempting to bite and knock staff over and digging nails into staff's wrists. Resident refused to let staff change is [sic] shirt for bed. When staff would attempt to

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remove his shirt he would straighten his arm. When staff got him over to bed, he continued to kick and hit out. Resident bumped his back on the back of his toilet a few times."

7/2/13 "Resident was combative and resistive with his shower this evening. Staff reported that resident was hitting, punching and kicking out at staff. Staff was holding his hands to keep him form [sic] hurting himself and staff. Will watch for bruising."

7/6/13 "Resident has been showing mores signs of repetitious self agitation, rubbing his arms, side of his head, and grinding of his teeth...Watch for bruising on his arms from him bumping them, also his hair on left temple has broken off due to him rubbing it."

7/7/13 "Resident was resistive with HS [bedtime] cares this evening. Resident was not letting staff put T-shirt on for bed. Staff was eventually able to get the shirt on."

7/10/13 "While getting resident ready the CNA (certified nurse aide) reported fining bruises on his R [right] calf measuring 3 cm [centimeters] X [by 3 cm, on 2 on his L [left] thigh one measuring 8 cc [sic] X 1 cm. Bruises are consistent with bumping his leg on the chair. RN was notified along with all other parties.

7/12/13 "Resident was resistive with am [morning] cares. Hitting, pushing, trying to bite staff, and was grabbing staff's fingers and trying to bend them backwards."

7/13/13 "Resident was hitting, kicking, and trying to bite staff, took 4 staff to hold him while trying to

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{F 309}	Continued From page 36 change his dirty pad. Watch for bruising on hands and arms." 7/16/13 "Resident was resistive and combative with his bath. Resident was hitting and kicking at staff. Three staff assisted." 7/17/13 "Behaviors present that require MCU placement include: increased wandering, repetitive compulsive movements, active participation in specialized activity programming and resistive with cares requiring 3-4 staff to assist him." During interview on 7/23/13 at 1:20 p.m. nursing assistant (NA)-A stated R86 "can be very combative, we try to redirect him, talk to him, if that doesn't help we call in more staff, we have to hold him in order to get the cares done." When asked where they hold him at, NA-A stated on his hands/wrists, this is to keep us from "getting hit.". During interview on 7/23/13 at 2:00 p.m., the trained medication aide (TMA)-B stated R86 becomes combative with cares, so they usually have 3-4 staff take care of him, so that he doesn't hit staff or hurt himself, they have to hold his arms down, will hold him by the hands, R86 will pull hands back, twist them trying to get out of the grip so he can hit again. During interview on 7/23/13 at 2:08 p.m., NA-B stated R86 can become combative with cares, "we have to get more people if we can't get him to calm down, we have to hold onto his hands to keep from getting hit." NA-B stated holding onto him, does not calm him down, but the cares can be completed then.	{F 309}		

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During interview on 7/23/13, at 2:11 p.m., NA-C stated, R86 will start to hit and "you have to get more help to hold him so we can get the cares done." NA-C stated the cares are important and if resisting, "we do what we have to get them cared for." Having 3-4 staff member hold onto R86 for cares does not calm him down, but they can get the cares done for him.

During interview on 7/24/13, at 8:35 a.m. NA-D stated, "if staff are real patient with [R86], he will settle down, have to leave him in a safe place and re-approach later, and he will usually cooperate." NA-D stated it takes R86 a long time to process information, so need to tell him what you are going to do with him, give him time to "digest" the information. "He needs to be approached really calmly, he needs short commands, tone of voice makes a big difference." At 10:00 a.m. NA-D provided further information, stating the approach with R86 "needs to be cheerful, calm, giving him time to absorb what you are going to help him with, if his jaw tightens/twitches, he is getting agitated and you need to back off and come back later, maybe make his bed, just give him time, and then he will usually cooperate." NA-D indicated there have been times when R86 has had soiled pants and tries to walk around the unit with a soiled bottom and no pants, and have had to get 2 staff to hold him, while 2 more wash him up and get a pad and pants on him quickly. But typically, if staff approach him right, he won't have the behavior problems.

During interview on 7/24/13 at 9:37 a.m., NA-I stated a couple of weeks ago we were trying to toilet R86 we had to have several staff hold his arms so we could toilet him. He was trying to hit

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us he was holding and squeezing another staff members hands.

During interview with registered nurse (RN)-A on 7/24/13, at 9:45 a.m. RN-A stated she had been trying to work with staff just this week, on ensuring residents who are being combative are left alone, as long as they are safe, and re-approach later. Staff should not be holding down residents to care for them. For R86, staff should leave him in a safe place, re-approach, or try a different care giver. When asked why 3-4 caregivers would be providing care, RN-A stated she was not sure why that many caregivers would be necessary, as this may agitate him further. RN-A verified she had not consulted with direct care staff, or the Behavior Occurrence Flow Sheet(s) to determine what approaches work best to prevent R86 from becoming combative, or what approaches might calm him down. RN-A further stated R86 does have frequent bruising from his combative behaviors. RN-A stated the facility's pharmacy consultant had told her recently the care planned approaches for each resident needed to be individualized for what works with each resident, but she had not done that yet. RN-A agreed that staff had not been directed on how to manage R86's behaviors of hitting, kicking, biting, or how to prevent them, as this had not been determined, nor care planned for R86. Staff has regular training on how to manage combative behavior through Health Care Academy.

The dementia training summary provided by the facilities Consultant Nurse (CN) on 7/24/13, at 10:40 a.m. for the Health Care Academy training which all employees are required to complete,

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{F 309}	Continued From page 39 indicated on page 12, "If the client is combative or violent, stand to their side and out of their reach. You may need to get assistance from other staff. However, you should remember that too many people may be overwhelming in itself to the client." The program also gave tips on how to avoid a resident's "catastrophic reaction," and potential causes. During interview with the social service director (SSD) on 7/24/13, at 10:15 a.m. she stated R86 has multiple behaviors, combative with cares, compulsive things such as rubbing/scratching self; wandering and pacing. SSD agreed R86's assessment had not included potential causes of these behaviors and R86's care plan did not direct staff on how to prevent or deal with R86's behaviors, other than re-approach, which SSD agreed, staff should be leaving him alone, as long as he is safe and re-approach him, but sometimes it is necessary to get cares done and then it takes 3-4 staff to care for him. SSD stated one staff would hold each hand, and two would get his cares done. SSD was aware this was happening, but had not come up with any way to prevent R86 from having behavior problems, nor had she attempted to determine how to care for R86 when he did have behavior problems. SSD stated this was nursing's responsibility. Even though R86 had ongoing behavior problems, the facility failed to attempt any identification of causes, potential interventions to prevent behavior problems or how to handle them if they occurred. R86 was regularly cared for by 3-4 staff persons to hold onto him, so that cares could be perfomed, while he continued to resist, and R86 frequently sustained bruising during these episodes. NA-D, who regularly cared for	{F 309}		

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R86, had ideas on how to approach R86 to prevent escalation of behaviors, but NA-D had not been consulted so that these approaches could be used by all staff in caring for R86.

A facility policy on management of resident behavior issues was requested, but not provided by the facility.

R124 displayed inappropriate behaviors of being resistive and combative with care's and the facility failed to attempt to determine how to prevent the behaviors from occurring, or provide direction to staff on how to manage the behaviors when they did occur.

R124's diagnosis included Alzheimer's disease. The significant change MDS dated 5/1/13, identified R124 had severe cognitive impairment, showed inattention and disorganized thinking, was short tempered and easily annoyed. R124 had physical behaviors directed toward others which interfered with resident care. These behaviors had worsened since the previous assessment dated 2/21/13. R124 required extensive assistance with most activities of daily living (ADL's). The behavior CAA dated 5/17/13 included "Has needed more cues and reminders during ADL's and gets upset with staff when they try to redirect her during cares."

R124's care plan dated July 2013, included "Mood/Behavior impairment r/t Alzheimer's Disease with moderate cognitive impairment, slight communication impairment, new environment. Target Behaviors: crying, weepiness, being angry at other residents, refusing cares and meds." The goal for R124

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was listed as; "Resident will feel/secure within MCU [memory care unit]. Resident will continue to be easily re-directed during wandering." Interventions listed included; secured memory unit; allow time to verbalize needs, staff to chart on mood/behavior, if unable to redirect her, monitor/supervise whereabouts. Re-approach as needed. "Monitor behavior of playing in BM [bowel movement] and wandering...Update MD/CNP [physician or nurse practitioner] as necessary." The care plan failed to address R124 was combative with cares.

R124's Behavior Occurrence Flow Sheet for July 1 through July 24, 2013, indicated "combative/resistive w/ [with] cares occurred 28 times." The cause of the behavior was listed as unknown or direct care. Interventions included; calm reassurance, distraction/redirection, assist with talks,cueing, reorientation, or toileting. The results of the intervention were listed as either resumed behavior within 5 minutes, decreased intensity/improved, or behavior continued.

R124's June 2013 Behavior Occurrence Flow Sheet indicated 209 occupancies of this behavior on the night shift, interventions listed were the same, but they were never effective. Tracking for R124 being combative or resistive with cares did not begin until May 23, 2013 and had 48 occupancies all on the night shift for the rest of the month. Interventions had either decreased intensity or the behavior continued.

R124's IPN included the following:

5/15/13 "Four 1 cm purple bruises noted to residents right upper arm, medial side; consistent with extra assistance needed to get resident out

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{F 309}	Continued From page 42 of bathtub last evening following her bath. LPN reports that CNA needed assist to get resident out of the bathtub last evening, LPN assisted on right side. Bruising is consistent with the extra assistance needed." 5/23/13 "Resident was resistive and combative with toileting this shift. She was pushing staff, grabbing and pulling on staffs clothing and digging nails into staff skin." 5/24/13 "Resident was resistive and combative with cares, pushing at staff and digging her nails into staff skin." 6/2/13 "Resident was resistive and combative with toileting. She was hitting and pushing staff. Resident was unable to be redirected." 6/12/13 "[R124] was sitting at thee dinner table tonight waiting for her meal, when another resident came up to her and was talking and patting her on the arm. [R124] got upset and pushed herself away from the table and slapped the other resident on the L side of the face by the eye." 6/18/13 "Resident became resistive when staff was attempting to take vitals for her bath this evening. She had grabbed to the blood pressure cuff cord and started to pull on it. Staff re-approached her later and she started to push staff backwards, saying "No, No". She then reached over to the resident sitting next to her in the recliner and was pushing on her feet." 6/18/13. Bruise on L [left] wrist 3 x 1.75 cm and bruise on R upper arm 2 x 1.5 cm. [Resident name] has become very resistive with cares	{F 309}		

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during the night, has to be toileted d/t [due to] bed and clothing being soaked. Also is resistive with baths. She hits and pushes staff. [R124] is unable to talk and become angry at both staff and residents at times. She is kept at a distance from certain residents d/t [R124] striking out at them. Bruises are likely from combativeness with cares."

6/20/13 "[R124] has bruisers on both arms noted at bath time.."
6/22/13 "Resident was resistive with toileting, pushing at staff."

6/27/13, "Bruises that were charted on 6/20/13 were incorrect. [R124] had bruise on L upper arm and R wrist."

6/28/13 "[R124] does have behaviors-combative-resistive with care (daily-many times a day)."

7/6/13 "Resident was resistive and combative with toileting, hitting at staff."

7/6/13 "Staff reported that resident had bruises on there [sic] Rt hand. Resident was combative and resistive on over night cares. Resident was hitting out at staff. Staff was holding her wrists from her hurting herself and staff this morning. Bruise 1 is on the anterior of Rt wrist (thumb side). Measures 2 x 2 cm. Bruise 2 on posterior of Rt hand. Measures 7.5 x 4.5 cm."

7/14/13 "Husband did call back and he was informed of bruises and he states that he does grab her arms to help her stand up."

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7/14/13 "When [R124] husband was notified of bruises to her arms he stated he may have caused the bruises by holding her upper arm to help her get out of her chair."

7/17/13 "[R124] is resistive with cares."

During interview on 7/23/13, at 1:20 p.m. NA-A stated the afternoon shift has more trouble with R124 having behavior problems, R124 has been cooperative with cares on the day shift.

During interview on 7/23/13, at 1:50 p.m. TMA-A stated if R124 starts "making a fuss," TMA-A will leave her alone and try to approach later, this usually helps.

During interview on 7/23/13, at 2:08 p.m. NA-B stated if R124 gets combative, she will get additional help to hold her, so that cares can be completed.

During interview on 7/23/13, at 2:11 p.m. NA-C stated usually it helps to leave R124 alone if she gets combative and then re-approach later, sometimes if you have to get the cares done, NA-C will get more help to hold her so cares can be completed.

During interview on 7/24/13 at 11:30 a.m. RN-A stated she did not know the cause of R124's resistive/combative behavior, she had not consulted with the direct care staff on what precipitates R124's anger, or what works to calm R124. RN-A had noted R124 had been mostly combative on the night shift and had just in the last week started an overnight incontinent brief, so that staff would not need to interrupt R124 very often at night due to a wet bed. RN-A had not

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{F 309}	Continued From page 45 addressed when R124 becomes combative during other cares, or during a bath. In addition, staff had not instructed husband on proper transfer techniques, or supply him with a transfer belt to avoid bruising R124 when he transfers her, so that he does not need to pull on her arms. R69 exhibited physical behaviors towards staff and other residents, which the facility failed to assess for what precipitates behaviors, or direct staff on how to handle behaviors when they occur. R69's diagnosis included dementia without behavior disturbances. R69's quarterly MDS dated 5/16/13, indicated severe cognitive impairment, had no behavior problems and performed ADL's with only set up assistance from staff. The Behavioral Symptoms CAA dated 7/18/13 included "During the reference period, resident also had behaviors that including [sic] hitting/slapping at staff, self-transferring, yelling/screaming, wandering." R69's care plan dated July 2013, included "Potential for mood/behavior impairment /r/t history of anxious/worrisome behaviors i.e. worrying about laundry not being done & becoming upset about it, pacing, asking frequent questions, looking for lost newspapers, etc." R69's goal was listed as [R69] will be calm and comfortable within her surroundings." Interventions for staff included, to administer an antianxiety medication, redirect, and placement in secured unit. The care plan did not address any physical behaviors R69 displayed directed towards others. R69's Behavior Occurrences Sheet(s) indicated	{F 309}		

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tracking for "Resistive, Refusing ADL's" had started June 25, 2013 and recorded 60 episodes between June 25 and July 23, 2013. Interventions off the check list included calm reassurance, one to one, distraction/redirection, remove to quiet place, toilet, or off food/fluids. The results of the interventions were mainly ineffective.

R69's IPN included:

6/23/13 "Res [resident] started acting restless and agitated around supper time...setting off bed alarm multiple times, is getting up and down up and down. At 20:10 [9:10 p.m.] Staff go into room to talk to res to see what she needs but this just increases agitation and when staff try to approach res she yells at them and hits staff."

7/7/13 "She went out front door x 3 and not easily redirected. She swung at staff with her fist and hit her. She grabbed hold of the door and wouldn't let go."

7/8/13 "12:30 a.m. resident set off alarms trying to self-transfer. Toileted and started being combative when aide tried pulling clothes up and transfer back to bed. Upset with door open, alarms, wanting to go home and started screaming. Brought out to nurses station and west end dining area. Refused food, attempted Ativan [antianxiety medication] and resident spit it out. Possible bruising due to ramming her wheelchair and kicking and hitting staff and furniture."

7/9/13 "Resident was up in wheel chair at change of shift this a.m. She was hitting out at staff saying, "you can't tell me what to do."

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Resident was also kicking at housekeeper and yelling at her..."

7/10/13 "Resident was given a PRN [as needed] Ativan at 1:00 a.m. for wandering, self transferring, and pushing at staff while they were toileting her."

7/10/13 "...bruises to forearm are consistent with recent behaviors, including hitting and kicking out at staff and throwing walkers."

7/12/13 "Resident was very combative and agitated on the PM shift. Behavior has been escalating over the last month. Tonight at dinner resident was upset and hitting the NA and screaming out...She was given her PRN Ativan.

7/13/13 "...at 9;30 PM she started grabbing at another residents legs while siting by the bird sanctuary.

7/15/13 The note described multiple bruises on arms, hips, buttocks and thighs. "Scab and bruises are consistent with recent behaviors, including hitting and kicking out at staff and throwing walkers; see IPN dated 7/9/13 and from her fall on 7/5/13..."

7/16/13 The IPN indicated a move to the memory care unit. "She pulled hard on one of the kitchen staff shirt, trying to get her to take her out of here. She grabbed a staffs wrist, was pulling it down toward her and then twisted her wrist and finger, she ran into another staff with her wheelchair."

7/21/13 "Resident was kicking another resident foot before lunch."

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During interview with registered nurse (RN)-A on 7/24/13 at 9:45 a.m., RN-A had stated R69 was new to the memory care unit. R69 had been treated for a possible urinary tract infection, staff were going to see if that helped with her behaviors, but it did not. No other attempts were made to determine cause of the behaviors, or to determine what may work to prevent them. RN-A had not updated R69's care plan to include physical behaviors.

R129 had behaviors of hitting, kicking, pushing during routine cares, the facility failed to attempt to identify the cause of these behaviors, and failed to attempt to determine what helps to de-escalate R129's behaviors and failed to direct staff on how to care for her.

R129 diagnoses included Alzheimer's disease, psychosis, anxiety and dementia. The quarterly (MDS) dated 7/12/13, indicated she was cognitively impaired and needed extensive assistance with (ADL)'s. The MDS further indicated she had physical and behavioral symptoms, verbal symptoms and that she wandered daily. R129's behavioral symptoms CAA dated 4/12/13, included "...[R129] frequently wanders around the secured MCU and it does intrude on the privacy or activity of others. Target behaviors: disrobing, yelling, hitting, aimless wandering, tearing up incontinent pads, cursing, rudeness, bumping into other resident's, scratching staff and combativeness, with cares and rejection of cares...if unable to redirect behavior, ensure her safety and leave her alone, reproach [sic] at a later time."

R129's current physician orders dated July 1,

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2013, included Ativan 1 milligram (mg) oral or intramuscularly (IM) every twelve hours as needed for anxiety and agitation.

R129's care plan dated July 2013, indicated mood/behavioral issues due to Alzheimer's dementia with behavior disturbance. Requires placement on secured memory care unit. The care plan goal indicated R129 will adjust to nursing home placement. The interventions included to administer Trazadone (antidepressant), Buspar (treat anxiety) and Gabapentin (for anxiety). The care plan also indicated for staff to monitor target behaviors, crying, shredding, disrobing, negatism, hitting, kicking and pushing. The care plan further indicated to have staff inform her when she hears people in hall, television and talking with her that they are her neighbors, allow resident to sleep until 10:00 a.m. to 11:00 a.m., do not refer her as being in nursing home. The care plan did not address the use of Ativan.

During observation 7/24/13, at 9:00 a.m. R129 was observed to be on the memory care unit by the nurses desk no behaviors were observed.

R129's Behavior Occurrence Flow Sheet for May, June & July 2013 indicated the following:

May 2013: kicking, hitting, pushing, disrobing, and shredding did not occur.
Negative- occurred 20 times cause was listed as unknown and interventions calm reassurance, one to one and return to room. The results indicated decreased intensity/improved behavior.

June 2013:
Kicking- occurred 11 times, cause listed as

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{F 309}	Continued From page 50 unknown, interventions calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. The results of the interventions were not resistive. Hitting- occurred 10 times. cause unknown, interventions calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. The results of the interventions were behavior continued. Pushing- occurred 15 times. The cause is unknown. the interventions were calm reassurance, structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. Negative- occurred 46 times cause all listed as unknown. The interventions tried were calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. The results were resumed behavior with in 15 minutes to decreased intensity and improved. Disrobing and shredding did not occur. July 1st thru July 24th 2013: Kicking- occurred three times, cause listed as altered routing, visitor or other resident, the intervention indicated staff left resident alone and reproached when resident calm and attempt with different caregiver. The result behavior	{F 309}		

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{F 309}	Continued From page 51 continued. Hitting- occurred 18 times, cause listed a direct care or provider, interventions reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. Pushing- occurred 13 times cause listed as direct care provider interventions calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. Results were behavior continued. Negative- occurred 38 times. The cause was listed as unknown. The interventions calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. Results were behavior continued. Disrobing and shredding did not occur. R129's interdisciplinary progress notes included the following: 6/22/13- resident was wanting to go home, staff provided one to one. Ativan 1mg IM was given. 6/25/13- staff noted a bruise on R129's wrist and arms, resident wanders in her wheelchair and bumps her hands and arms on tables, chairs island , med cart and wall. 6/27/13- resident increasingly anxious as shift progressed, attempted to give as needed Ativan and resident refused. 6/28/13-Resident went to Center for Senior Behavioral Health- Meeker Memorial 11/28/12.	{F 309}		

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	246427	A. BUILDING ______ B. WING ______	R 07/24/2013

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{F 309}	Continued From page 52 Residents behaviors started increasing again. On 2/20/13 physican ordered Ativan 1 mg every 12hrs for severe agitation. Physican here and he also wrote order to give Ativan IM as needed. 6/30/13- resident up wandering, bumping into things. 7/1/13- resident bumping into things. 7/4/13 at 7:56 p.m. - resident becoming increasingly agitated, going into other residents rooms, trying to destroy belongings. Staff attempted to redirect all attempts failed. Writer gave Ativan IM . 7/4/13 at 8:39 p.m.- Resident was given Ativan IM at 5:45 p.m. had to hold her hands down while LPN gave the shot due to her swearing, hitting and scratching. 7/5/13- noted bruises on right hand and wrist and left hand. 7/9/13- resident was wandering in her wheelchair running and bumping into things hitting her legs, hands and arms on chairs, tables and island. 7/11/13- Attempted PRN Ativan X3 with no success. IM Ativan given at 5:30 p.m. behaviors were increasing she was wandering and bumping into many items. 7/13/13- resident was yelling and wanting to go home. Redirection was difficult as needed Ativan IM was given at 4:55 p.m.. Resident refused to eat supper. 7/14/13- Resident started yelling refused to let staff change her clothes. 7/15/13- Resident was upset and agitated this am Ativan 1mg given at 7:20 a.m.. 7/15/13 at 9:40 a.m.- Resident up wandering and she has been running into objects. 7/16/13- Resident started behaviors early afternoon with running into doors and other residents. Unable to redirect and wanting to go home. Resident was given Ativan at 4 p.m.	{F 309}		

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{F 309}	Continued From page 53 7/19/13- At 6"40 a.m., resident has been very agitated. She kept sitting up on the edge of her bed setting off her alarm. Difficult to redirect. Ativan 1mg IM was given also one to one staff intervention was used. 7/19/13 at 9:52 a.m.- Resident continues to be upset and yelling and swearing she ripped off the metal of the heat register in the bathroom and wanting to break the window so she can go home she has been throwing things at the window. Difficult to redirect. She did receive a 1.5 cm skin tear. Called certified Nurse Practitioner for new order for Ativan 1mg x 1 stat. Ativan IM was given per order. She continues to yell, swear, pound on the end of B-hall door and and was grabbing at the housekeeping cart, one to one staff interventions used. 7/21/13- Resident started escalating behaviors with unable to redirect. Ativan 1 mg given at 4 p.m. 7/22/13- noted bruise on left wrist, right arm and top right hand. 7/22/13- Resident yelling at staff attempted Ativan 1 mg x3 at 2 p.m. and refused so it was wasted, Ativan IM 1mg given at 2:30 p.m. and removed her from the area with others to settle her done. One on one done until 6 p.m. in her own bedroom 7/23/13- resident up in common area at the change of shift, she was restless, agitated and wanting to go home. Ativan 1 mg given at 11 p.m. During interview 7/24/13 at 9:37 a.m. with NA-I who stated when he notices behaviors he tries to sit with the residents, sometimes there behaviors are so bad we have to hold their hands down so they don't get hurt, I try to talk to them and explain to them where they are. "Last Friday [R129] was out of control and we had to hold her	{F 309}		

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{F 309}	Continued From page 54 hands down. On Monday this week she was yelling at us telling us to get her out of her house. Around 2:30 p.m., there was four staff in her room some were holding her hands and some trying to hold her still so we could give her a shot." During interview 7/29/13, at 9:00 a.m. the facility Pharmacy Consultant stated, that she was at the facility last week and specifically informed the nurse manager that they need to identify the cause and specific interventions for each residents behaviors and that it was not being done on the memory care unit. Although R129 had ongoing behavior problems, the facility failed to attempt any identification of causes, potential interventions to prevent behavior problems or how to handle them if they occurred. There was several times staff had to hold her hands down in attempt to her Ativan IM when R129 was agitated. R115 diagnosis included dementia. The annual MDS dated 6/14/13, identified the resident had severe cognitive impairment, was an extensive assist with all activities of daily living (ADL's), and had behaviors of rejection of care 1-3 days in the 7 day look back period. R115 behavioral CAA dated 6/14/13 indicated the resident had target behaviors of yelling, banging walker on walls and glass doors, hitting, combativeness, and refusing cares. R115 care plan dated July 2013, indicated the resident had behaviors of trying to leave without authorization, wandering, hitting and yelling. The care plan did not identify the resident was	{F 309}		

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{F 309}	Continued From page 55	{F 309}		

resistive with cares nor did it identify how to approach resident if resistive with cares.

During observation of R115 on 7/23/13, at 9:45 a.m. R115 was in a merri-walker walking around the memory care unit. No behaviors were observed.

Review of R115's facility interdisciplinary progress Notes (IPN) included:

6/16/13- "Staff reports that resident was resistive and combative with cares. He was hitting, grabbing and swearing with cares this a.m."
6/20/13-"Resident was yelling, swearing and grabbing at staff this morning."
6/23/13- "NA reported that resident was resistive and combative during cares this morning. NA was trying to wash residents peri area and resident started to swear, yell, and hit out at NA."
6/28/13- "Resident was combative with morning ADL's, swearing at staff."
6/29/13- "Staff reports that resident was swearing with cares this a.m."
7/6/13- "Resident was yelling and swearing at staff this morning when getting ready for the day. Resident told staff to get the hell out of here."
7/8/13- "Staff reports that resident was resistive with toileting this a.m."
7/11/13- "Staff reports that resident was resistive and combative with cares this a.m. He was yelling, swearing, telling staff he is going to kill them and was kicking at staff. After cares he was more cooperative.
7/15/13- "NA reports that resident was yelling, swearing, and attempting to hit at the NA during cares this a.m.
7/16/13- "Resident was combative with a.m. cares, yelling, swearing, and hitting out at staff.

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{F 309}	Continued From page 56 He wanted to stay in bed. Nursing assistant (NA) washed him up, got him dressed and then laid him down again." 7/20/13- "Resident was combative with a.m. cares today yelling, swearing, and hitting out at staff." 7/21/13- "Resident was resistive with a.m. cares, yelling, swearing, and calling staff names." 7/23/13- "Resident has been more sleepy this a.m. He ate no breakfast he was sleeping in his wheelchair at breakfast table." The most recent summary of R115's current psychotropic medications and behaviors dated 6/28/13 in the IPN notes indicated the following: "Currently [R115] receives the following psychotropic medications: Trazadone 50 mg every HS (hour of sleep). Seroquel 12.5 mg every HS. Target behaviors include: trying to leave without authorization, yelling/ screaming (2 days in June), hitting (2 days in June), cursing and swearing (9 days in June), and urinating in appropriate places (0 days in June). Staff administers Trazadone per MD (Doctor) orders and monitor for effectiveness..." During interview on 7/24/13, at 9:55 a.m. NA-F stated R115 can be combative with morning cares because "he doesn't like to get up in the morning" but NA-F stated "once you get him up he's pretty good." NA-F stated staff usually gets R115 up around 6:30 a.m., although sometimes the staff will leave him sleep until 8:30 a.m. and then it seems like R115 is "not as upset about getting up." NA-F was unsure why staff woke R115 up so early in the morning. During interview on 7/24/13, at 12:15 p.m. LPN-A	{F 309}		

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{F 309}	Continued From page 57 stated the NA's often report to her about R115 being combative with morning cares. LPN-A was not aware if staff was waking R115 up in the morning, but stated they should wait for him to wake up on his own before attempting cares. During interview on 7/24/13, at 12:20 p.m. NA-A stated she wakes R115 up around 7:00 a.m. NA-A stated R115 becomes combative "when he's not ready to get up in the morning." NA-A stated if R115 is not ready to get up in the morning staff will get him dressed and washed up and then put him back in bed under the covers to sleep a little longer. During interview on 7/24/13, at 12:25 p.m. RN-A stated she does monthly summaries of resident behaviors, although she did not look at specific times of day for R115. RN-A verified many of R115 behaviors are with morning cares, and this should be assessed to possibly decrease R115 behaviors. The facility did not provide any further information regarding policy's or assessments for R115 when asked.	{F 309}		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329	All residents drug regime will be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued;	8/30/13

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F 329	Continued From page 58 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to identify speficic parameters for giving oral or IM (intramuscularly) Ativan (antianxiety medication) for behaviors or provide non-pharmacological interventions for 1 of 1 residents (R129) reviewed who received IM Ativan for behaviors. Findings include: R129 diagnoses included Alzheimer's disease, psychosis, anxiety and dementia. The quarterly Minimum Data Set (MDS) dated 7/12/13, indicated severe cognitive impairment and needed extensive assistance with (ADL)'s. The MDS further indicated she had physical and behavioral symptoms, verbal symptoms and that she wandered daily. R129's behavioral symptoms CAA dated 4/12/13, included "... [R129] frequently wanders around the secured	F 329	or any combinations of the reasons above. Resident R129 is currently admitted to Meeker Memorial Hospital Behavioral Services due to severe behavioral concerns. A new behavior management process policy and procedure had been developed to include weekly behavior meetings to review behaviors and the effectiveness of new interventions including non-pharmacological interventions. Training regarding investigation when injuries of unknown origin are found as well as behavior management will be completed for nursing staff by 8/30/13. CMS Dementia training consists of 6 modules – we are currently training all nursing staff on module 1 and this training will be completed by 8/30/2013. The rest of the modules will be completed on a monthly schedule over the next 5 months. Seven residents have been identified by the IDT as having behaviors that affect themselves or others such as yelling, hitting out, resisting cares; these seven residents have had behavior assessments completed and new, individualized interventions have been added to their care plan and NAR assignment sheets.	

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F 329	Continued From page 59 MCU and it does intrude on the privacy or activity of others. Target behaviors: disrobing, yelling, hitting, aimless wandering, tearing up incontinent pads, cursing, rudeness, bumping into other resident's, scratching staff and combativeness, with cares and rejection of cares...if unable to redirect behavior, ensure her safety and leave her alone, reproach [sic] at a later time." R129's physician orders dated July 2013, included an order for Ativan (antianxiety) 1 milligram (mg) oral or intramuscularly (IM) every twelve hours as needed for anxiety and agitation with an origination date of 5/22/13. The order did not specify when to give orally versus IM Ativan. R129's progress notes dated 6/28/13, indicated R129 went to the Center for Senior Behavioral Health- Meeker Memorial on 11/28/12. Residents behaviors started increasing again. On 2/20/13 physican ordered Ativan 1 mg every 12 hrs for severe agitation, physican here and he also wrote order to give Ativan IM as needed in May 2013. The progress note did not give staff parameters of when to administer oral medication versus IM Ativan. Review of residents medication administration record (MAR) for June and July revealed the following: June 2013-R129 received oral Ativan three times and R129 received Ativan IM three times. July 2013- R129 received oral Ativan eight times, and Ativan IM six times. R129's Behavior Occurrence Flow Sheet for May, June & July 2013 indicated the following:	F 329	If any other residents begin exhibiting behaviors that are harmful to themselves or others, the team will complete a behavior assessment. The IDT meets daily to discuss incidents, falls, and changes in behavior and this is how the team will identify the residents needing behavior assessments going forward. DON and DSS or designee will be responsible for auditing for behavior plans and follow-through on new interventions and completion of behavior flow sheets. Audits will be completed on 5 of these weekly for 4 weeks, then monthly for 3 months. Audit results will be reported to the QA committee and additional action plans developed as needed.	

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F 329	Continued From page 60 May 2013: Kicking, hitting, pushing, disrobing, and shredding pad did not occur. Negative- occurred 20 times cause was listed as unknown and interventions calm reassurance, one to one and return to room. The results indicated the behavior had decreased, intensity improved behavior. June 2013: Kicking- occurred 11 times, cause listed as unknown, interventions calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. The results of the interventions were not resistive. Hitting- occurred 10 times. cause unknown, interventions calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. The results of the interventions were behavior continued. Pushing- occurred 15 times. The cause is unknown. the interventions were calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. Negative- occurred 46 times cause all listed as unknown. The interventions tried were calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks,.modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. And the results	F 329		

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F 329	Continued From page 61	F 329		

were resumed behavior with in 15 minutes to decreased intensity and improved.
Disrobing and shredding did not occur.

July 1st thru July 24th 2013:
Kicking- occurred three times, cause listed as altered routing, visitor or other resident, the intervention indicated staff left resident alone and reproached when resident calm and attempt with different caregiver. The result behavior continued.
Hitting- occurred 18 times, cause listed a direct care or provider, interventions reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold.
Pushing- occurred 13 times cause listed as direct care provider interventions calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. Results were behavior continued.
Negative- occurred 38 times. The cause was listed as unknown. The interventions calm reassurance , structured activity/group, one to one, distraction, remove to quite place, assist with tasks, modify environment, leave if safe reproach when resident calm, toilet, return to room offer food and fluid object to hold. Results were the behavior continued.
Disrobing and shredding did not occur in July.

During interview on 7/24/13, at 12:05 p.m., registered nurse (RN)-A on the memory care unit stated, "we try to give [R129] Ativan oral first, if

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F 329	Continued From page 62 she gets really destructive and wont take it, we give her Ativan IM. I talked to the nurse practitioner to do something different we tried everything. We currently don't have psych involved with her and behaviors have escalated since June. Her behaviors got so bad 7/19/13 we had to give her Ativan stat IM just a few hours after she received Ativan IM." RN-A then stated they do not have parameters when to give Ativan IM or oral. During interview on 7/24/13, at 1:00 p.m. the facility consultant nurse (CN) verified the orders do not indicate when to give Ativan oral or IM and should have. The CN stated the staff give the oral and assuming if the behaviors get out of control they probably give the medication in IM form. The CN further stated they should look into attempting to do something before her behaviors get so bad that they have to give the medication in the IM form and verified they have not looked into the cause of R129's behaviors and should have. During interview 7/29/13, at 9:00 a.m. the facility Pharmacy Consultant stated that she was at the facility last week and specifically informed the nurse manager that they need to identify the cause and specific interventions for each residents behaviors and that it was not being done on the memory care unit. The pharmacy consultant also stated the staff should not be holding the residents hands down to give Ativan IM and they should have parameters in giving oral or IM medications.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	Continued From page 63 The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview the consultant pharmacist failed to inform the facility they needed to identify specific parameters of when to administer Ativan IM (intramuscularly) or oral, further more the consultant pharmacist also failed to identify the facility need for identifying the cause of her behaviors for 1 of 1 residents (R129) who received IM Ativan. R129 had diagnoses of Alzheimer's disease, psychosis, anxiety and dementia. The quarterly (MDS) dated 7/12/13 indicated she was cognitively impaired and needed extensive assistance with (ADL)'s. The MDS further indicated she had physical and behavioral symptoms, verbal symptoms and that she wandered daily. R129's current physician orders indicates that she receives Ativan 1 milligram (mg) oral or intramuscularly (IM) every twelve hours as needed for anxiety and agitation dated 5/22/13. The order did not indicate if the medication should be given oral or IM or provide specific parameters as to which one to give.	F 428	The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. Resident R129 is currently admitted to Meeker Memorial Hospital Behavioral Services due to severe behavioral concerns. All other residents with orders for IM Ativan have had these orders discontinued and behavior plans are being implemented per assessment. If PRN psychotropic medications have not been used in the past 3 months, they have been discontinued by the medical provider. DON and Consultant Pharmacist have met and discussed need to review for unnecessary drugs, proper reasons for use, and parameters for use. All pharmacist recommendations will be followed up on by the DON or designee.	8/30/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	R 07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 64 Review of R129's progress notes dated 6/28/13 indicated R129 went to Center for Senior Behavioral Health- Meeker Memorial on 11/28/12. Residents behaviors started increasing again. On 2/20/13 Dr. Fuglestad ordered Ativan 1 mg every 12hrs for severe agitation. Dr. Fuglestad here and he also wrote order to give Ativan IM as needed in May 2013. The progress note did not indicate when to give the oral medication or IM. Review of residents medication administration record (MAR) for June and July revealed the following: June 2013-R129 received oral Ativan three times and R129 received Ativan IM three times. July 2013- R129 received oral Ativan eight times, and Ativan IM six times. Review of the consultant pharmacist reviews indicated R129's medications were reviewed 5/20/13, and 6/18/13, and indicated no potential problem or irregularity was identified and no medication regimen review report (MRR) was written. The pharmacist reviewed R129 medications on 7/23/13, and indicated no potential problem or irregularity was identified and no medication regimen review report (MRR) was written. The pharmacist did indicate Ativan increased and was used 12 times from 7/1 to 7/22/13. During interview 7/29/13 at 9:00 a.m., with the facility Consultant Pharmacist stated that she was at the facility last week and specifically informed the nurse manager that they need to identify the cause and specific interventions for each	F 428	Random audits of 5 residents currently on psychotropic medications will be completed monthly for 3 months. Audits will entail looking for parameters for use, appropriate diagnosis and appropriate target behaviors. Case managers or designee are responsible for completing these audits. Audit results will be brought to the QA committee and action plans developed as needed.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ B. WING ______	R 07/24/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 65 residents behaviors which was not being completed on the memory care unit (MCU). The pharmacy consultant also stated the staff should not be holding R129 hands down to give Ativan IM and they should have parameters in giving oral or IM medications. Although there was no parameters for giving Ativan oral or IM and the facility lacked identifying the cause of R129 behaviors the consultant pharmacist failed to address this concern.	F 428		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: VKFY
Facility ID: 00792

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245427**

2.STATE VENDOR OR MEDICAID NO. (L2) **516240800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHESDA NH PLEASANTVIEW**
(L4) **901 SOUTHEAST WILLMAR AVENUE**
(L5) **WILLMAR, MN** (L6) **56201**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/08/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **123** (L18)

13.Total Certified Beds **123** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With
Program Requirements
Compliance Based On:
____1. Acceptable POC

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	123			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jessica Sellner, HFE NEII 06/20/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 06/25/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **02/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

Posted 6/27/2013 ML

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

CCN: 24-5427
Page #2

An extended survey was completed at Bethesda Nursing Home Pleasantview on May 8, 2013 and deficiencies were found, the most serious at a scope and severity level (S/S) level of L.

The health surveyors identified an immediate jeopardy (IJ) situation on May 3, 2013 involving deficiency F225 and F226. The IJ was abated on May 8, 2013. Also at the time of the survey, conditions were found in the facility that constituted Substandard Quality of Care (SQC) to resident health or safety at F225 (K) and F226 (L)

As a result of the survey findings, we are imposing State Monitoring effective May 29, 2013 and we are recommending the following enforcement remedies to CMS RO:

- A Civil Money Penalty (CMP) effective May 8, 2013 for the deficiency cited at F225
- A CMP effective May 8, 2013 for the deficiency cited at F226
- Optional DOPNA effective July 8, 2013 (60 days rather than 90 days)
- Discretionary Termination of the provider agreement effective October 8, 2013 (Five months rather than 6 months)

Please note the facility is also subject to a two year loss of NATCEP, effective May 8, 2013 due to the extended survey.

Please refer to the CMS 2567 along with the facility's plan of correction.

Post Certification Revisit to follow.

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 2944

May 24, 2013

Ms. Michelle Haefner, Administrator
Bethesda Nursing Home Pleasantview
901 Southeast Willmar Avenue
Willmar, Minnesota 56201

RE: Project Number S5427023, H5427017 and H5427019

Dear Ms. Haefner:

On May 8, 2013, 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. In addition, at the time of the May 8, 2013 extended survey the Minnesota Department of Health completed an investigation of complaint number H5427017 and H5427019.

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 widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the May 8, 2013 extended survey the Minnesota Department of Health completed an investigation of two complaints number H5427019 and H5427017 that were found to be substantiated.

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;

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 May 8, 2013, 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:

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

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

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 May 29, 2013. (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 F225. (42 CFR 488.430 through 488.444)

  Civil money penalty for the deficiency cited at F226. (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, Bethesda Nursing Home Pleasantview is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective May 8, 2013. 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: Oliver Potts, Chief
330 Independence Avenue, SE
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.

PLAN OF CORRECTION (PoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SECOND OR FIFTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by **July 8, 2013 (two 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 optional denial of payment 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 optional denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by **October 8, 2013 (five months** after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Colleen Leach, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
PO Box 64900
Saint Paul, Minnesota 55164-0900

Telephone: (651)201-4117 Fax: (651)215-9697

Enclosure

cc: Licensing and Certification File

ADDENDUM TO PLAN OF CORRECTION

Provider Identification Number 245427

BETHESDA NH PLEASANT VIEW **901 Southeast Willmar Avenue**

Willmar, MN 56201

F 155 Page 1 addition:

Beginning the week of June 24, 2013, residents/family members will be assured at care conferences that they have a right to refuse any care and/or treatment they may wish to. If a resident refuses, it will be documented in the IPN, plan of care and the refusal will be honored. During the interview audit, one of the questions is, "Have you ever refused any care or treatment and if so what happened?" As of June 18, 2013 during the interviews no resident has identified that they have refused care or treatment or that they had wanted to.

F 157 Page 6 addition:

The DON will monitor the 24 hour boards daily, Monday through Friday and RN charge nurse will monitor them on weekends to assure that physicians/physician extenders and family members are notified per Bethesda Pleasant View policy and procedure.

F 225 Page 14 addition:

Incident/fall/unknown injury reports are reviewed by the falls team daily Monday through Friday. The administrator or designee reviews reports daily and is responsible for compliance with regulation requirements.

F 226 Page 74 addition:

R137: An incident report was completed and submitted on 5/30/2013. Investigation report was completed and submitted on 6/3/2013.

6/20/13 accepted

F353 Page 131 addition:

R133/74: On Bethesda's roster received from MDH, there is no R133 listed; according to Bethesda's roster, this resident is listed as R74. R133/74: An incident report was completed and submitted on 6/10/2013. Investigation report was completed and submitted on 6/13/2013.

F441 Page 148 addition:

Infection control is being monitored daily Monday through Friday for compliance and is currently being audited by DON/ADON at least weekly.

F496 Page 156 addition:

Nursing assistant registry was reviewed to ensure compliance.

Date of correction change to June 28, 2013.

Administrator Signature: Michelle Haefner Date: 6-20-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING ______ RECEIVED B. WING ______ JUN 07 2013	05/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201 St Cloud

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted that went into an extended survey, along with a complaint investigations were completed at the time of the survey. An investigation of complaint H5427017 and H5427019 were completed and both were substantiated during this survey. Deficiencys had been issued as a result of the substantiated findings at F225, F226, F353, F441.	F 000	Preparation, submission and implementation of this Plan of Correction does not constitute an admission of or agreement with the facts and conclusions set forth in the statement of deficiencies. All deficiencies listed on this 2567 are under appeal. This Plan of Correction is prepared and/or executed as a means to continuously improve the quality of care, to comply with all applicable state and federal regulatory requirements and constitutes the facility's allegation of compliance. All completion dates are 6/28/13	
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. 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 individual's	F 155 6/20/13 See addendum [initials]	BPV respects the rights of residents to refuse treatment. On admission residents are given a booklet entitled, Your Rights. Rights are also discussed with them. Each month, during resident council, one/two rights are reviewed with examples. Employees are oriented to resident rights at new employee general orientation and annually. Resident, R177, died in the hospital in November 2012. Staff will be re-educated June 3, 4, and 5, by the DON and ADON and 6th by the NHA about the residents' right to refuse care and/or treatment. For staff who are	7/8/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Staufner — TITLE: Administrator — (X6) DATE: 6-5-13

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

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	245427	A. BUILDING _____ B. WING _____	05/08/2013

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BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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F 155	Continued From page 1 option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This STANDARD is not met as evidenced by: Based on document review and interview, the facilities failed to ensure 1 of 1 resident's family (R177) had the right to refuse specific pharmacological interventions. Findings include: R177 was administered Ativan (a medication used to treat anxiety) after the family specifically told the facility they did not want this medication used as R177 had taken this medication in the past with adverse reactions. R177 had diagnosis that included dementia without behavioral disturbance, senile and pre-senile organic psychotic condition and adjustment disorder with depressed mood. The admission minimum data set (MDS), dated 10/8/12, identified R177 as severely cognitive impaired with episodes of verbal aggression, which put the resident as risk for injury and interfered with personal cares, involvement in activities and social interaction, she wanders using a wheelchair and needed extensive assistance of one facility staff for all her personal cares. According to nurse's progress notes, (on the day	F 155	attend an independent study tool will be utilized. Staff receiving specific information about a resident refusal are to report it to the nurse, who then makes sure the clinical manager is aware and documents as appropriate. An interview audit will be completed with 5 residents per week by social services staff for 8 weeks. Results will be reported to the QA committee for further direction with the NHA accountable for action items. The social services director will be responsible to monitor that residents will have the right to refuse. The NHA is responsible for compliance with resident rights.	

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of her admission), " family " was contacted regarding R177's agitation The documentation noted the family reported resident had received Ativan at the previous long term care facility and " this had the opposite affect on her ".

According to a progress note of 11/13/12, R177 was very upset and a physician was contacted. An order for lorazepam (Ativan) 1 mg every 8 hours, either orally or IM (intramuscular injection) thru 11/15/12 was received. R177 was given this medication on 5:00 p.m on this date.

On 5/2/13 at 3:41 p.m. during a telephone interview R177's family member (FM)-A stated the facility contacted a physician, obtained an order for Ativan, and administered this medication to R177 without consulting with any family members or honoring their request of no Ativan. FM-A stated they told the facility on the day of R177's admission that Ativan had been used at the prior long term care facility with opposite affects and they did not want it given to her mother.

During an interview on 5/6/13 at 2:55 p.m., registered nurse care manager (RN)-B stated she was unaware of the family request regarding the use of this medication. She reported that when a staff receive information like this from a family, a note should be placed in the front of the medical chart or on the medication administration record (MAR). RN-B indicated that during the admission process, staff did not document this family's request in either place. She further stated that if staff had documented this family's request, it would have been honored and the resident would not have received this medication.

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F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure that a physicians were	F 157	BPV staff do inform residents, family members and physicians when there has been an accident, a significant change in the resident's physical, mental or psychosocial status, and a need to alter treatment significantly. Nurse practitioner saw R122 on 5-10-13. She reduced metoprolol to 25 mg with orders to monitor and inform her of vital signs; upon review of the data she then reduced the dose to 12.5 mg on May 13, 2013. The physician visited 5-15-13 and made no further changes. No further episodes of syncope or fainting have occurred. Staff will be educated on when to contact the physician and/or physician extender on June 3, 4 and 5. The policy/procedure for when to notify the physician has been reviewed and revised. Vital signs are taken by NA's and LPN's and are to be reported to the RN if they are not within normal limits. Staff will be educated on 6-3, 4, and 5 by the DON and ADON and on 6-6-2013 by the NHA on these expectations. All other resident vital signs have been reviewed by the clinical managers and appropriate actions were taken: re-take the vital signs and/or contact the physician. The pressure ulcer protocol was reviewed and revised. Specific attention was paid to addressing the location, staging, size, exudates, pain, description of wound bed and wound edges, supplies to be utilized, and a	7/8/2013

F 157	Continued From page 4 notified of changes in a residents condition which included fainting spells during transfers, abnormal vital signs and development of a pressure ulcer for 1 of 1 residents (R122) who had a change in condition that needed physician intervention. Findings include: R122 since 12/07/2012, had experienced several episodes of passing out while using the standing mechanical (PAL) lift, had vital signs outside of the normal parameters, and developed a pressure ulcer on 3/29/13. R122 physician was never notified of these changes in R122 condition. R122 had diagnosis including hypertension and heart disease. R122's quarterly minimum data set (MDS) dated 3/1/13 identified the resident had moderate cognitive impairment, needed extensive assistance with all activities of daily living, was totally dependent on staff for all transfers, and did not have any skin concerns or pressure ulcers. R122's medical record, interdisciplinary progress notes (IPN) identified the following episodes of R122 "passing out" when using a mechanical (PAL) lift for transferring. 12/7/12- "Family is aware that he does have a spell and 'pass out' when in lift; PLEASE assist him to meet his toileting needs..." 1/21/13- "This afternoon staff had resident standing in standing PAL lift. They were changing his pad. He had a spell. His face got red and his body went faint. Staff put him down	F 157	specific protocol to follow. The DON is responsible for wound care management. The documentation for any/all other pressure ulcers has been addressed. Audits of the documentation for each resident with a pressure ulcer will occur weekly for 4 weeks. Policy/procedure reviewed and revised for outlier vital signs. The results will be reported to the QA committee for further direction on frequency and number of audits/week.	

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Continued From page 5

on toilet and he came to." No vital signs were documented on 1/21/13.
1/25/13- ..."Attempted to lift resident in standing PAL lift...resident went unresponsive while in the lift. Resident was transferred into recliner and became responsive." No vital signs were documented on 1/25/13.
3/6/13- "Family is aware that he does on occasion have a spell and pass out when in the lift."
3/26/13- "Resident had an unresponsive episode at 0700 while in PAL lift, he turned purple in color then went very pale and gray in color and his eyes were rolled back in his head. This writer sternum rubbed him for about one minute when he responded to his name, however, he would not open his eyes and look at staff that was in room with him at the time. Once he did start responding he was then lifted with the PAL again to get his incontinent product on him and he has been resting well since." No vital signs were documented on 3/26/13.
4/12/13- "Resident went unresponsive while staff had him in the PAL lift during cares, resident was sat down right away in his wheelchair and responded after one minute." Vital signs staff had taken were charted as pulse 43 and blood pressure 113/59.

During interview on 5/8/13 at 10:30 a.m., registered nurse clinical manager (RN)-A stated that neither the physician had not been notified of R122 "passing out" on the mechanical standing lift. RN-A stated she had called the nurse practitioner (NP) today to make her aware of R122 fainting spells and that the NP would be seeing R122 'tomorrow.' RN-A verified the physician should have been notified after every fainting spell.

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R122's also had various vital signs that were out of the normal range for individuals. The Mayo Clinic identifies a "normal blood pressure is 120/80" and "heart rate (pulse) can range from 60-100 beats per minute. If your pulse is consistently lower or higher and have symptoms of dizziness or lightheadedness you are to consult your physician." In review of R122's current physician orders, dated 4/2013, identified the following medications were ordered:

Metoprolol tartrate 50 mg twice a day for hypertension (high blood pressure).
Lisinopril/ HCTZ 10/12.5 mg everyday for hypertension.
Lasix 40 mg twice a day for edema (swelling).
Zaroxylin 2.5 mg daily for edema.

Upon review of R122's vital signs charted in Care Tracker under "Resident Vitals Chart" indicated the following:

2/26/13- Blood pressure (B/P) 95/57 pulse (P) 45. The B/P and pulse were not rechecked to ensure they were accurate or if the B/P and pulse improved.
3/5/13- P-49. There was no recheck of this reading.
3/12/13- B/P-55/96. P-41. There was no recheck of this reading.
3/15/13- B/P- 53/99. P-44. There was no recheck of this reading.
3/19/13- B/P- 97/55. P-46. There was no recheck of this reading.
3/26/13- P-45. There was no recheck of this reading.

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4/12/13- P43. There was no recheck of this reading.
4/16/13- B/P- 100/57. P-45. There was no recheck of this reading.
4/23/13- B/P- 76/38. P- 46. There was no recheck of this reading.
4/30/13- B/P- 92/54. P-49. There was no recheck of this reading.

During interview on 5/7/13 at 1:00 p.m., Nursing assistant (NA)-O stated that the nursing assistants do the vital signs and if they are out of range they are suppose to report them to the nurse in charge. NA-O was unaware of R122 having out of range vital signs (blood pressure 120/80, pulse 70-90).

During interview on 5/7/13 at 1:05 p.m. licensed practical nurse (LPN)-A stated if a blood pressure or pulse is "out of range" the NA's should be reporting the vital signs to the nurse so it can be closely monitored, and are to be reported to the physician. LPN-A stated the nurses do not check the vital signs the NA's do on the residents, but it is the it is responsibility of the NAs to report to the nurse if there are vital signs is an out of range. LPN-A acknowledged that R122's current medications can effect blood pressure and pulse, but was unaware of R122's past abnormal vital signs.

During interview on 5/7/13 at 1:15 p.m. RN-A reviewed the vital signs charted for R122 and stated the vital signs should have been rechecked, reported to the nurse, and R122's physician notified. RN-A stated when the physician or NP visits the resident, the vital sign review is completed from the most recent vital

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signs obtained. RN-A verified that R122's medical record lacked evidence that the abnormal vital signs were not followed up on or reported to the physician.

Upon review of R122's interdisciplinary progress notes (IPN) identified the following pressure ulcers:
3/29/13- "Coccyx is red. Applied as needed calmoseptine. Notified RN.
3/31/13- "Resident has red open area on his bottom. Calmoseptine cream applied. Will continue to monitor."
3/31/13- "Resident was repositioned every 2 hours and Calmoseptine was applied to his open area on his bottom..."
4/1/13- "Resident has two open areas on bottom. One on right upper buttocks and one on left upper buttocks. Stage one with no drainage. Staff have been applying Calmoseptine to area daily with cares, however, they have not minimized. Assisted staff with cleansing buttocks area. Applied skin barrier prep. Let dry. Applied Calmoseptine over both open areas. Applied Mepilex dressings, one to each open area."
4/11/13- "Per RN request leave residents bottom wound/ sore open to air dry. Please apply calmo. Will continue to monitor."
5/1/13- "Resident continues to have two open areas on bottom. One area on right buttocks close to butt crease is stage two with no drainage. It appears smaller in area than previously recorded... Left area of buttocks is healed and is a stage 1 with a pinpoint stage two present close to butt crease, no drainage."

Review of the Interdisciplinary Progress notes

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F 157	Continued From page 9 RN-A documented on the pressure ulcers on 5/3/13 indicate, "In April it was noticed he had a stage one/ stage two pressure areas on his bottom near his butt crease. The treatment followed out wound protocol... currently there is a stage one to the right buttocks that measures 4 centimeters (cm) x 3 cm with a stage two center near the crease that measures 0.3 cm x 0.3 cm. The left buttocks has a stage one near the crease that measures 3 cm x 3 cm and a stage two in the center which measures 0.2 cm x 0.2 cm. There is redness and purple colored skin noted on bottom..." During interview on 5/7/13 at 11:50 a.m. RN-A stated although staff were aware of R122's pressure ulcer at the end of April, the physician or nurse practitioner were not notified about the pressure ulcers until 5/3/13 (about one month after the facility identified R122 had a pressure ulcer). RN-A verified staff should have notified the physician immediately of any new open areas for residents. The facility policy titled Pressure Ulcer Treatment Policy and Procedure dated 2/23/04 instructed, "The physician or nurse practitioner will be notified of all new wounds, when there is a significant change in a wound, and when a wound is not healing... "	F 157		
F 225 SS=K	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225	BPV staff report alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriate of resident property immediately to the administrator. The alleged violations are thoroughly investigated, and further potential abuse	7/8/2013

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F 225	Continued From page 10 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure all allegations of abuse, neglect, and injuries of unknown origin were thoroughly investigated and immediately reported	F 225	is prevented. The results of the investigation are reported to the administrator or his designee and to other officials in accordance with state law. The vulnerable adult abuse policy and procedure was reviewed and revised. The investigative report form was revised. Staff was trained on May 8 and 9th, and on June3, 4, 5 by the DON and ADON and on June 6 by the NHA. The 'staff questionnaire' documents are the notes of staff being interviewed about abuse and neglect. Audits will be conducted by interviewing 10 staff per week for 8 weeks on reporting requirements of the Vulnerable Adult abuse act. DON and ADON will each conduct 5 interviews of staff on what to do in various situations weekly for four weeks. Auditing of 5 investigative reports each week will be done by the NHA and SSD for 4 weeks and then two per week for 4 weeks. This audit is for completeness and appropriate reporting. Audits of CNA tone of voice, appropriateness of conversation and location will occur by DON. Results will be reported to the QA committee. The DON is responsible to assure investigations are done, the NHA is responsible to assure that the investigations are complete and have been reported as required by state/federal laws.	

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F 225	Continued From page 11 to the administrator and State Agency (SA) as required, for 17 of 30 residents, (R122, R3, R43, R57, R55, R137, R128, R67, R10, R180, R5, R179, R39, R181, R59, R75, and R117) for whom allegations of abuse and/or neglect were reviewed; and failed to ensure injuries of unknown origin were thoroughly investigated and reported to the SA for 16 of 35 residents (R115, R19, R177, R8, R86, R109, R15, R51, R68, R98, R128, R10, R4, R37, R120 and R67) in the sample who were reviewed with injuries of unknown origin. The lack of identification, investigation, resident protection, and reporting constituted immediate jeopardy for R122, R3, R43, R57, R55, R137, R128, R67, R10, R5, R39, and R117 who currently reside in the facility. The administrator (A)-L, the director of nursing (DON), and the director of social work (LSW)-A were notified on 5/3/13 at 1:41 p.m., of the immediate jeopardy to the health and safety of the residents at a pattern level (K). The systemic failure of identification, investigation, resident protection, and reporting incidents of potential abuse/neglect, had the potential to affect most residents in the facility. The facility initiated an IJ removal plan which included revision of the abuse prevention plan and training provided to all staff, on each shift, prior to any direct resident contact. The facility also conducted training for residents in the facility including education on identification of resident neglect and abuse, who to report to, and a review of resident rights in the facility. In addition, direct care staff, licensed nursing staff, and unit	F 225	The results of each investigation will be found opposite the resident specifics in the statement of deficiencies.	

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F 225	Continued From page 12 managers were interviewed and were able to explain their responsibilities for identification of incidents of potential mistreatment; internal reporting; resident protection, investigation; and external reporting as defined in the facility's revised abuse prevention plan. The immediacy was removed on 5/8/13 at 3:20 p.m., and the scope and severity was reduced to no actual harm with a potential for no more than minimal harm, pattern. Findings include: R122 who was a current resident, told staff a nursing assistant (NA) was rough with him and he did not want that nursing assistant (NA) to take care of him. The facility did not investigate R122's allegation of the NA being rough with him, and the NA continued to provide care for the resident. R122's quarterly minimum data set (MDS) dated 3/14/13 indicated moderate cognitive impairment. During interview on 4/29/13 at 3:05 p.m., R122 stated a NA is "very rough" with him. R122 stated, "he swings me back and forth and pushes me around. I've got a swollen hip and it hurts me." R122 said he'd told the NA he hurt and it was too rough, and said the NA had responded, "just never mind, you are OK." R122 said he'd told the nurses he didn't want the nursing assistant to take care of him anymore and the nurse had told R122 they would take care of it. However, R122 stated the NA still takes care of him and the nurses "didn't do anything about it." R122 identified the NA who is rough with him as NA-A.	F 225	Training on the vulnerable adult abuse act, bill of rights and Elder Justice Act occurred in March of 2013 for all staff. Training occurred on May 8 and 9th on the revised vulnerable adult abuse act and the bill of rights. Residents 122, 3, 43, 57, 55, 137, 128, 67, 10, 180, 5, 179, 39, 181, 59, 75, and 117 each had a report and investigation completed. Any changes/recommendations to their plans of care are listed below: R122-Interviews of the resident, NA-A and other NA's were completed. NA-A is not assigned to this resident; however, may assist with two person transfers with the resident's permission. Care and transfer audits of 35 people at random occurred for 4 weeks; now it will continue at 25 per week for 4 weeks. Care and transfer audits were completed by nursing staff. Data is to be reported to the QA committee for	

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F 225	Continued From page 13 Review of R122's Facility Progress Notes indicated the following: 4/10/13- "Resident was very upset this early evening and wanted to talk to this writer. When this writer arrived in his room he stated that he did not want the male NA working with him tonight or in his room because 'he is a liar and I don't trust him, he lies about me.' This writer explain that someone else would be working with him and that this writer would take care of that for him...it was explained to both the resident and wife that this would be investigated and that the director of nursing (DON) and assistant director of nursing (ADON) would be notified." During another interview with R122 on 4/30/13 at 3:40 p.m., R122 stated he had put his call light on over an hour ago to go to the bathroom. R122 stated when NA-A came in to assist him to the bathroom R122 had told NA-A to "just forget it" because he did not want NA-A to take care of him. The resident stated he was going to try to wait to see if any other staff could help him. After an hour, he stated he was unable to wait to go to the bathroom any longer, so had turned on his call light again for assistance. R122 stated when NA-A came in again, he (the resident) asked isn't there "anyone else here who could help me?" R122 said NA-A had responded, "nope, I am the only one here." R122 said, "He hurts me he is so rough with me. He knows I don't want him to come in here, but he just keeps coming in." During interview on 4/30/13 at 3:55 p.m., NA-A stated he knew R122 did not want him to take care of him anymore, but stated they were short staffed and he had to care for him because it was	F 225	Further direction.	

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"his hall" of residents to care for. NA-A verified R122 had put his call light on earlier in the day and confirmed that when he'd answered the call light, the resident had told him to "just forget it." NA-A stated when he went back an hour later to respond to R122's call light, the resident had asked if there was anyone else to assist him to the bathroom. NA-A stated he'd told R122 there was no other staff available. NA-A stated he worked full-time and this was his usual hall of residents to care for. NA-A also confirmed he transferred "many residents" who were supposed to be a transfer of two, by himself. NA-A stated other staff did so as well because the facility is "short staffed and there is no one else to assist with transfers."

During interview on 4/29/13 at 6:06 p.m., licensed practical nurse (LPN)-B stated if there was reported abuse he would "talk to the resident first" to see if it was "valid." LPN-B stated he was aware R122 did not like NA-A, but really didn't know why. LPN-B stated he had not reported this to anyone because "everyone already knows it." He verified NA-A continues to care for R122.

During interview on 5/1/13 at 12:30 p.m., family member (FM)-G stated she had talked to a nurse and had asked that NA-A no longer provide cares for R122 as NA-A is "rough with him [R122]." FM-G stated the nurse had told her she would "take care of it" however, FM-G said NA-A continues to care for R122 "often."

During interview on 5/7/13 at 11:50 a.m., the DON stated she was aware R122 thought NA-A was "rough" with him. The DON also stated she'd reminded NA-A to provide R122 choices. The

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DON was unable to provide any documentation of any investigation into R122's concerns. There was no documentation that the DON had spoken to R122 more about his concerns, nor conversation with NA-A. In addition, the DON verified the resident's concern had not been reported to the administrator or SA.

Although the facility was aware R122 accused NA-A of being rough with him and did not want the NA to provide cares for him, the facility did not investigate his concerns, nor remove NA-A from providing R122's care.

R122 had also informed staff he was neglected at night because some staff refused to take him to the bathroom and told him to go to the bathroom in his brief instead.

Review of R122's facility Progress notes revealed the following:

4/10/13- Resident's wife stated, "Staff needs to get him up to the toilet or give him a urinal when he states he has to go and not tell him to 'wet yourself'."

During interview on 4/30/13 at 3:29 p.m., R122 stated, "If I ask to go to the bathroom at night they usually tell me to just poop or pee in my pants. They tell me to just go in my pants and they will clean it up later. I tell them I don't want to but they tell me it's ok, just go ahead." R122 stated it really made him feel bad and it hurts his "bottom" when he has to sit in a wet/soiled pad.

During interview on 5/7/13 at 11:50 a.m., the DON stated she was aware of the accusations

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F 225	Continued From page 16 R122 made regarding the night shift telling him to go to the bathroom in his pad instead of taking him to the bathroom. The DON verified she had not conducted any formal investigation nor documented such, but stated she "reminded night shift" to take residents to the bathroom upon request. The DON verified asking a resident to go to the bathroom in their pad and refusing to assist them to the bathroom would be considered neglect. The DON verified on 5/713 at 11:50 a.m., this allegation of potential neglect had not been reported to the SA or the administrator. R3 a current resident, reported a staff member had been rough with her which was not investigated or immediately reported to the administrator or the SA. R3's annual MDS dated 3/21/13 indicated she was cognitively intact. During interview on 5/3/13 at 2:00 p.m., R3 stated that there was a guy who works at the facility who could at times be rough with her during cares. R3 stated she had reported this at her last care conference to the care conference team, and does not know if anything has been done about it. R3 identified the staff member who was rough with her as NA-FF. R3 stated NA-FF still cares for her regularly. R3 also stated she was suppose to be transferred with assist of two, but often only one staff transferred her because of no other staff being available to assist. Review of the facility's interdisciplinary progress notes (IDP) dated 3/20/13 indicated a Care Conference was held on 3/13/13. The IDP note did not address that R3 had informed staff that NA-FF was rough with her. Review of the	F 225	R3 Report/investigation completed. NAR cares for resident very infrequently with resident permission. Staff training occurred May 8 and 9th. DON/ADON will hold nservices on June 3, 4, 5, and the NHA on June 6 to include resident rights, vulnerable adult abuse and transfers. Nursing staff have/will audit thirty-five residents care/transfers for 4 weeks, 25 residents will be audited for the next 4 weeks. Audits of staff (nursing staff do) knowing when/what to report will be done with 5 employees weekly for 8 weeks. Results will be reported at QA. QA will determine continued frequency and need.	

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F 225	Continued From page 17 facility's incident reports and Vulnerable Adult reports, did not address R3 concern regarding NA-FF being rough with her. R3's allegation of NA-FF being rough was never investigated, or reported to the administrator or SA as directed by the facility's policy. R43 a current resident, reported a nursing assistant had been rough with her. R43's quarterly MDS dated 2/1/13, indicated R43 was cognitively intact, had clear speech and was able to communicate her needs without any problems. The MDS indicated R43 had no specific behaviors or any symptoms of delirium, but required extensive assistance from one staff for all her personal cares. R43 was interviewed on 5/7/13, at 11:00 a.m., and reported several months ago a nursing assistant had been rough with her in preparation of a shower and during the shower. R43 reported the nursing assistant was rough taking off her clothes and that she'd asked the NA, "will you be nicer to me?" R43 indicated the nursing assistant seemed to get so upset that "she left me sitting in the shower room, by myself, without any clothing." R43 also reported this nursing assistant had showered her since the incident, but there had been no further rough treatment. R43 stated it made her nervous whenever this nursing assistant worked with her and she did not like it. She stated she had not told anyone about these feelings, as she didn't want the staff to get mad at her. A phone interview was completed with FM-AA on 5/7/13 at 11:03 a.m. FM-AA reported R43 had	F 225	R43. NA terminated. Plan of care reviewed and revised. Staff received training on the Vulnerable Adult Abuse act, resident rights, and the Elder Justice Act in March 2013. Staff were inserviced on respect and dignity on May 8 and 9th. Resident rights and vulnerable adult abuse act training will occur on June 3, 4, 5 for nursing staff the NHA will train all other staff on June 6th. Social services will interview 5 residents per week for 8 weeks with data reported to the QA committee for further direction. The NHA is responsible for compliance.	

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F 225	Continued From page 18 voiced concern regarding the rough treatment she was given by a nursing assistant when was being undressed in preparation for a shower, and also during the shower. FM-AA said she'd talked to the facility about this and as a result of the report, had been told the identified staff person would not bathe or provide other services to her mother. The initial report of this incident was reported to the State agency on 2/11/13 and the investigative report was filed with the state agency on the same day. The corrective action taken to prevent recurrence of this incident included the nursing assistant was not to bathe R43 alone; the nursing assistant was to have another nursing assistant in the room. The reported nursing assistant was identified as NA-J. The nurses' progress note dated 2/11/13, indicated FM-AA had been told the nursing assistant's behavior was "unacceptable" and the nursing assistant would be appropriately reprimanded. The progress note indicated FM-AA requested this nursing assistant never work with her mother (R43) again. A random review of nursing assistants who provided care to R43 was completed by reviewing the documentation in Care Tracker (an electronic system that allows staff to document services provided to residents). NA-J documented she had provided cares to R43 on 3/26/13, even though NA-J was not supposed to provide care for R43. An interview with registered nurse (RN)-A was completed on 5/7/13 at 11:34 a.m. RN-A reported she was not aware of FM-AA's request that NA-J not work with R43. In addition, RN-A reported she was unaware of any reported problems with NA-J or the corrective action,	F 225		

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which specified if NA-J showered R43, a second staff person was to be in the room. RN-A indicated she was unaware there were any restrictions with NA-J and which residents she worked with. RN-A reported NA-J continued to work with R43 as needed, which could include giving R43 a shower. RN-A verified she should have been made aware of this situation.
The facility had submitted a report to the SA on 3/12/13, (complaint number H5427019), regarding multiple allegations of abuse and neglect that had been observed by NA-K on the East side of the nursing home. These allegations were not thoroughly investigated or immediately reported to the SA and administrator as directed by the facility's policies.

The 3/12/13 complaint H5427019 report indicated the following:

"On 3/6/13 writer was made aware of allegations made by [NA-K] regarding mistreatment of residents... administrator (A)-E was informed... NA-K made the following accusations. She worked on the floor as a NA for 3-4 days, which was her training period... A NA said I am so f---ing sick of taking care of you to a resident. When a resident fell, a NA was told to allow the resident to remain on the floor until vitals could be done; the NA said I frickin don't have time to wait and picked the resident up and put her in bed. She [NA-K] also said NA's would sit at the nurses' desk and turn off the audible call light and would not take care of the resident with the light on. Also, a NA was trying to force a resident to eat by trying to push a spoon into her mouth, NA-K said it appeared to hurt the resident. NA-K also said that NA's would use one person transfers when

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they were suppose to use two staff. These residents were dropped into bed as a result... Related to these incidents, NA-K did not continue to work here."

The Investigative report submitted to the State agency (OHFC -office of health facility investigations) on 3/12/13, (6 days after the original complaint) included:

"Potential issues were focused on the East end of the nursing home so current residents who resided on the East end were interviewed along with some West end residents, some of which previously resided on the East side... 35 current residents were interviewed, some of which do have dementia. No specific or substantiated reports from residents that they are being mistreated by staff. 30 staff members were interviewed, mostly current employees and some past employees. Some staff alleged that other staff were neglectful and mistreated some residents. It has not been substantiated that any resident was injured, their ability affected, or lifestyle altered. After our initial interview with current and former staff, many names were named as people of interest... DON and ADON met with primarily East end evening nursing staff on 3/8/13. Staff were given direction on appropriate resident care... Staff are informed of importance to report any suspected or witnessed abuse immediately. It was alarming to hear that staff are not reporting concerns immediately per their education..." The investigation submitted to the SA also identified staff were offered, and were to attend, a session on vulnerable adult reporting on 3/22/12, 3/27/12, or 3/28/12. In the investigation submitted to the SA dated 3/12/13,

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the facility did not identify any staff they had spoken to regarding other concerns, the resident who'd allegedly fallen was not identified, and there was no indication any further investigation had been conducted related to NA-K's allegations.

During interview on 5/1/13 at 11:15 a.m., the DON and LSW-A stated NA-K worked at the facility for only a short time and could not remember specific names of employees or staff. The DON and LSW-A stated they were unsure who had specifically investigated NA-K's allegations. They were also unable to provide documentation of any investigation regarding the resident who'd allegedly fallen and been picked up and put into bed by a (unknown) NA. LSW-A stated NA-K only worked for "a couple days" and the facility should have investigated to see which residents had fallen during NA-K's short employment to determine if the allegation was valid. The DON stated in regards to the allegations made by NA-K, the facility did a staff education for the East end nursing staff regarding resident care, as well as interviewed around 30 staff and residents on the East end of the building. The DON also verified the "4 sessions that were offered, and staff were to attend, on vulnerable adult reporting" had actually been conducted in 2012, not 2013; there was no mandatory retraining of staff to do these sessions again regarding the allegations and retraining of staff. The DON stated if staff had done this training in the last year, they would have been unable to do it again as the computer system where the education is completed only allows staff to do this once per year. The DON and LSW-A verified the staff and residents were not

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interviewed directly regarding the allegations of mistreatment made by NA-K or from further staff interviews alleging abuse, but rather were asked general questions such as "Have you ever noticed staff being verbally or physically abusive on the East end?" The DON and LSW-A stated their human resources staff (HR)-J, who mainly did the interviewing and corrective action write ups for employee files, was currently on leave from the facility and was not able to be interviewed during the duration of the survey. The DON stated she was not involved in the investigations, employee corrective actions, or any monitoring of employees because staff had expressed concern she may shown favoritism because she (the DON) had a family member working for the facility during that time period.

During interview on 5/2/13 at 10:55 a.m., A-E stated he'd spoken with NA-K regarding allegations of staff mistreatment to residents but verified he had not followed up or conducted any investigations. A-E stated the alleged incidents of staff mistreatment were related to "staff dynamics" and how the "staff works together." A-E stated it appeared their staff had a "mean girls" club and he continued to refer to the staff as "vipers," meaning he felt the staff were not getting along and were making accusations against each other regarding mistreatment and neglect.

SW-A provided her written conclusion dated 3/25/13, of the alleged incidents and the investigation of the allegations. "After NA-K and NA-LL reported their concerns we decided to interview East end staff and residents. From staff interviews many allegations were made by staff regarding care provided by other staff. Some of

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the accusations were reported to state agency and investigations were conducted... Given the perceived negative working environment by the East end staff, being unhappy and angry with many of their co-workers, it was difficult to determine whether all of the allegations were truthful. Residents were also interviewed in a effort to determine whether residents had been mistreated or felt fearful. The resident interviews were mostly positive. Some of staff allegations were followed up on with staff through disciplinary action process. Through these meetings it was determine that further reporting to MDH (Minnesota Department of Health) did not need to occur. Staff were educated and disciplined regarding allegations. Of the staff allegations regarding some of the named residents it was determined that no resident was actually injured, their abilities affected, or lifestyle altered. Again, much of what was shared points to a dysfunctional staff culture rather than any substantive resident abuse."

According to the report submitted to the SA on 3/6/13, regarding H5427019, the facility indicated they'd interviewed various residents and staff on the East end of the nursing home regarding allegations of abuse and neglect. The facility provided information from the interviews and investigations they'd completed as follows:

RESIDENT INTERVIEWS:

R57's a current resident's, quarterly MDS dated 3/14/13 indicated she had moderate cognitive impairment.

R57's- resident interview questions dated 3/2013

Provider's plan of correction: R57. Report and investigation completed. Staff interviewed. Resident calls out "owie" during cares no matter how gentle staff are. Resident responses are not related to situation, for example: says,

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F 225	Continued From page 24 questioned the resident, "Have you ever been treated roughly by staff." The resident answered, "Sometimes." There was no further interview done or investigation regarding this response from the resident. During interview on 5/1/13 at 11:40 a.m., SW-A stated she was not sure who completed this interview with R57 but verified there was no investigation or follow up for the resident's response. R55's a current resident's, quarterly MDS dated 3/1/13, indicated she had severe cognitive impairment. R55's resident interview questions dated 3/2013, asked the resident "Do you ever feel afraid because of the way you or some other resident is treated?" R55 responded, "Sometimes at night when I'm alone because I can't lock my door and keep it closed." There was no further interview or investigation regarding R55's response. During interview on 5/2/13 at 10:53 a.m., the DON stated this was talked about at care conference and R55 was not "afraid," she just wanted her door closed so she didn't have to worry about other residents coming into her room. The DON stated there was no documentation of this nor was there any further investigation. R137 current resident, had a quarterly MDS dated 4/4/13, indicated he was cognitively intact. R137's resident interview questions dated 3/2013, indicated when asked, "Have you ever been treated roughly by staff?" The resident	F 225	Get those darkies out of my room," in the midst of the interview. Behavior log started 5-30-13. Pain monitoring initiated. Tyelenol QID initiated. R55. Interviewed spouse. Resident has memory loss. BPV placement due to elopements at home. Resident wanted the door locked at home so she couldn't get out. Was on memory care unit and distressed with other residents wandering. She was moved to long term care, can and does close her door and has adjusted well. R137. Report/investigation completed. NAR no longer works here. Resident is not consistent in recall of events.	

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F 225	Continued From page 25 responded, "One moved too fast; shaken up a little." R137 was also asked, "Has staff yelled or been rude to you?" R137 responded, "One staff member a couple times when getting up." There was no further interview or investigation regarding R55's responses. During interview on 5/2/13 at 10:53 a.m., SW-A stated she had not heard of the accusation R137 made regarding a staff member who had yelled at him and "shaken him up." SW-A stated SW-B must have completed this investigation and not followed up on it. SW-A verified there was no investigation nor was there any further clarification from the resident regarding the accusations of staff yelling at him or moving too fast with him. R128 a current resident, had a quarterly MDS dated 2/14/13 indicated he was cognitively intact. R128's resident interview questions dated 3/2013, identified when asked, "has staff yelled or been rude to you?" The resident responded, "May have happened; 'questioned why I did what I did and I didn't feel that was appropriate." There were no follow up questions asked of R128, and there was no investigation. R128, who was considered to be cogitatively intact per the quarterly MDS dated 2/14/13, was interviewed on 5/3/13 at 2:30 p.m. R128 reported at times, the night nursing staff are very abrupt and rude when they wake him up at 3:00 a.m. or 4:00 a.m. to check for continence. R128 stated at times he feels they are harsher than they need to be.	F 225	R128. Report/investigation completed. Interviewed other residents on same unit. No abuse suspected. Social services staff to interview 5 residents each week for 8 weeks about resident rights with data reported to the QA committee for further direction.	

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During interview on 5/2/13 at 10:53 a.m., LSW-A stated she had not heard of the accusation R128 made regarding night shift being rude to him. LSW-A verified there was no investigation nor was there any further clarification from the resident regarding the accusations of staff behaviors of being abrupt, rude or harsh.

STAFF INTERVIEWS:

A staff questionnaire completed by an unknown NA dated 3/11/13 included, "Have you witnessed any verbal or physical abuse to any resident on the East end?" The unknown NA had responded, "Your [residents] going to have to wait until next shift comes; between 6- 6:30 a.m. during report; if BM (bowel movement) feel they have to wait until next shift and then forget to tell next shift." There was no further interview or investigation of this allegation of resident neglect.

During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated they had not followed up with any staff or residents regarding the alleged incident.

A staff questionnaire completed by NA-D dated 3/7/13 indicated, "Have you witnessed any verbal or physical abuse to any resident on the East end?" NA-D had responded a resident "needed a hoyer [lift], the resident said they wanted to walk so a NA put the walker in front of them and told them to walk. The resident said 'I can't walk.' Per NA-D the (unknown) NA was taken off that day." There was no further interview or investigation of this allegation of resident neglect; nor was the alleged NA perpetrator identified in this questionnaire.

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	During interview on 5/2/13 at 11:15 a.m., the DON stated the supervisor had "checked into this incident" and spoken to NA-D. The DON stated the administrator was not notified of the incident, nor was the state agency contacted regarding the above incident. The DON verified she believed the resident was R67, however, stated she had not spoken to the resident or the alleged staff, NA-B (identified by DON), regarding this allegation of neglect and had no written investigation of the alleged incident. R67's was a current resident and their quarterly MDS indicated she had moderate cognitive impairment.		R67. Report/investigation completed. Staff interviewed and validated NA-B account. Resident is cognitively impaired.	
	A staff questionnaire done by TMA-A dated 3/11/13, indicated she had reported to the nursing department a situation that had occurred between R67 and NA-B, "told R67 to 'walk then' since she insisted she could. Really needs hoyer... informed ADON and she talked to NA-B." There was no further investigation of this incident nor any interviews with the resident.			
	During interview on 5/2/13 at 11:15 a.m., the DON confirmed there had been no investigation, and stated the administrator had not been notified of the incident, nor was the State agency contacted.			
	A staff questionnaire done by NA-A dated 3/8/13, indicated he "Knows there's issues on East end; didn't say specifics but said 'waters a little thicker over there'." There was no further interview or investigation regarding this statement.			
	During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated they had not followed up			

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with NA-A regarding the statement he made and they did not know what it meant.

A staff questionnaire completed by the ADON dated 3/8/13 indicated, "Have any of your coworkers talked about any verbal or physical abuse they or anyone else may have done to a resident?" The ADON had responded, "Yes...Verbal... behind resident's back. Resident 'shit themselves'." There was no further interview or investigation of the statement, and the resident nor employee were identified in the above alleged incident.

During interview on 5/2/13 at 11:15 a.m., the DON stated she was not aware of the above alleged incident.

A staff questionnaire done by RN-A dated 3/11/13 indicated, "Have any of your coworkers talked about any verbal or physical abuse they or anyone else may have done to a resident?" RN-A had responded, "NA's talking loudly and becoming more frustrated." RN-A also indicated a resident had told her she was left in the shower by staff, and it had been reported to OHFC; she stated the ADON investigated. RN-A also had multiple complaints of staff using cell phones and observing a employee texting while sitting on a resident bed while the resident was using the bathroom. There was no further interview or investigation of these statements.

During interview on 5/2/13 at 11:15 a.m., the DON stated she had not spoken to RN-A regarding her interview or the complaints described in the staff questionnaire.

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F 225	Continued From page 29 A staff questionnaire completed by RN-B dated 3/7/13 asked, "Have you witnessed any verbal or physical abuse to any resident on the East end?" RN-B had responded, "Sometimes get after girls for not doing proper care; brush teeth, washing face." There was no further interview or investigation of this statement and neither the residents, nor employee were identified. During interview on 5/2/13 at 11:15 a.m., LSW-A and the DON stated the questionnaire completed by RN-B was not followed up on and there was no other information available regarding any of allegations. A staff questionnaire completed by NA-GG on 3/11/13 indicated, "R10 fell during a transfer with NA-C; NA-C came back to desk to eat and then laughed as she told the nurse [resident's name] fell; didn't find nurse right away." R10 who is a current resident, their quarterly MDS dated 4/1/13, indicated she had severe cognitive impairment. During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated R10 had fallen and verified the incident had not been reported to the State agency as the facility had determined there was no neglect or mistreatment which occurred. The facility provided an interdisciplinary progress (IDP) note (which the facility identified as their investigation of the fall) for R10 dated 12/20/12, regarding the fall which happened when NA-C was caring for the resident. The note identified the following: Resident slid out of shower chair at 6:50 p.m.	F 225	R10. Fall was reported by former employee and allegedly occurred months ago. Interview/investigation completed. Staff training on transfer compliance. Care/Transfer audits on 35 residents for 4 weeks and 25 residents for 4 weeks being done. Side rails removed from bed as she needs 1-2 persons to assist with bed mobility on 12/18/12. Staff to utilize lift sheet, allegro pad and the resident to reposition. Brakes are to be on during transfers and re-positioning. Staff directed to be more careful and move slower when dressing, transferring, turning in bed, try not to surprise her to help prevent bruising.	

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F 225	Continued From page 30 Staff was unhooking straps to lift sling when resident leaned forward and grabbed the lift bar and pulled herself forward. Resident started to slip to the floor; staff assisted resident to the ground...Resident does have a 2 cm (centimeter) long abrasion to the left side of her head... Bruising may happen to her coccyx area and the posterior side of legs bilaterally due to hitting the floor and legs of the lift... Resident proceeded to have bed bath..." After review of the IDP, during interview with the DON on 5/2/13 at 11:15 a.m., the DON verified the 12/20/12 progress note indicated R10 was being transferred with only one staff; although the resident is suppose to be transferred with two staff. There was also nothing documented regarding the allegation of NA-C not notifying the nurse right away of the fall. The DON stated this incident should have been investigated and reported to the SA and the administrator, which it was not. The DON also provided an Employee Corrective Action Notice dated 3/20/13 for NA-C which indicated, "Resident [R10] fell during a transfer and you went to the nurses' station to eat. You failed to find a nurse right away. When you were telling the nurse about the resident fall, you were laughing." The DON stated an employee corrective action is done for all employees, even if the allegation is not substantiated. A staff questionnaire (undated and unsigned) indicated that R179 had complained about NA-D because she would turn off the call light and walk out; then come back with an attitude...crying resident [unknown]- burns on hands- crying	F 225	R179. Resident was not burned. During investigation another resident was noted to have gauze bandaging on both hands and up her arms due to multiple skin tears from falls at home. She was admitted with	

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F 225	Continued From page 31 because of NA-D; not sure why." The resident who was crying was unnamed, and there was no follow up to the reference of the burns on hands. During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated they were unaware of this statement regarding a resident with "burns on hands" and could not provide the name of a resident who had burnt themselves in the facility. The DON indicated R179 had been talked to regarding the allegations of NA-D turning off her call light, however the DON had no documented investigation of the incident, and it had not been reported to the administrator. The DON stated HR-J had issued an Employee Corrective Action to NA-D. The Employee Corrective Action form dated 3/14/13 included, "You have been witnessed being frustrated with a resident. You turned off the resident light and walked out and then went back into room with an attitude." The DON was unable to clarify what "an attitude" referred to and stated they'd felt there was no resident neglect or mistreatment occurring so this incident had not been reported to the SA. The DON verified there was not a thorough investigation including employee and/or resident interviews regarding the allegation. R179 did not have an MDS available to identify cognition. A staff questionnaire completed by NA-E on 3/7/13 indicated, NA-HH and NA-II "changed R5 and hit her on the bum." R5's who was a current resident, quarterly MDS dated 1/24/13, indicated the resident had severe cognitive impairment. The facility submitted a report to the state agency regarding R5 (above) on 3/13/13, 6 days after they were made aware of the allegation. The	F 225	the gauze bandaging and the NA mixed up the residents. The report and investigation were completed. Resident discharged 11-27-12. NA denied turning off the call light. Staff training about vulnerable adult abuse, resident rights, and the Elder Justice Act occurred in March 2013.; May 8 and 9 and again June 3, 4, 5 and 6th. Call light audits will occur 15 times per week for 4 weeks by the NHA and pager/cell phone audits by the DON will occur 10 times per week for 4 weeks. Date will be reported to QA committee for further direction. R5. Interviewed. Resident made various scattered comments which had nothing to do with the alleged incident. Unable to determine if the "hit to the bum" occurred Social services to interview and ask about a	

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F 225	Continued From page 32 facility investigative report submitted on 3/13/13, indicated the following: "HR-J completed staff interview with NA-E on 3/7/13 "... During interview NA-E stated that she heard resident R5 had said that 'blonde girls hit her.'.. and changed her and hit on the bum..." The facility indicated as part of their investigation they spoke with R5 regarding the incident but she did not have any complaints about staff mistreatment and made remarks which did not make sense. The facility indicated "DON, ADON met with primary East end evening nursing staff on 3/8/13- staff were given direction on appropriate resident care." On 3/25/13 the state agency requested additional information from the facility regarding the report on R5. The state agency requested, "Were other residents interviewed as part of your investigation? Did other residents voice any concerns regarding their care? Was other staff interviewed? Did staff indicated they had witnessed any mistreatment by other staff?" The ADON replied on 3/25/13, "35 current residents were interviewed, some which do have dementia. No specific or substantiated reports were received from residents that they are/ were being mistreated by staff. 30 staff members were interviewed, mostly current employees and some past employees. Some staff alleged that other staff were neglectful and mistreated some residents but this was not reported to have been witnessed, just that they had heard about it. All allegations received through these interviews were filed with [state agency]." The facility interview with R5 on 3/14/13, did not ask R5 about the alleged incident of 'blonde girls being mean' or 'changing and hit on the bum';' The resident was asked generic questions about	F 225	Interview 5 residents per week for 8 weeks. Data to be reported to QA for further direction.	

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F 225	Continued From page 33 care in general at the facility. Although the facility submitted a report to the state agency, they did not complete an investigation which included interviewing other staff and residents about R5's allegations. In addition, the further information submitted to the state agency upon request did not include specific allegations which were made by staff and observed which the facility policy directed the facility to complete. A staff questionnaire completed by NA-E on 3/7/13 indicated, They "Heard [NA-F] hit R180; Resident grabbed her and she punched his arm...staff joked around about catheter equipment witnessed backflow...would silence [residents] alarms and not answer theirs or anyone else's call lights...Reported abuse to nurse on staff..." R180 did not have an MDS available to identify cognition. The facility submitted an OHFC report regarding the allegation of R180 being hit in the arm by NA-F. The facility investigative report submitted to the SA indicated, "After our initial interview with current and former staff, many names were named as people of interest. Due to short time period of employment, together with the passage of time (May 2012), one of the complainants (NA-K) could not recall the alleged perpetrators names but stated she would know them if she saw them again. We have just completed out investigation and are still sorting through our notes to determine whether any individuals stand out as abusive perpetrators. In the investigative process it was identified that an employee heard a resident may have been hit by a NA. The named resident died in March of 2012. There was one incident report of named resident having	R180. Investigation/report completed. Resident died 3-19-13. East side staff provided with training on Vulnerable Adult Act, resident rights and care expectations by DON and ADON. In addition to the above, all staff completed Vulnerable Adult Abuse Act, Resident Rights and Elder Justice Act training in the Health Care Academy in March 2013. Vulnerable adult abuse act and resident right training occurred May 8 and 9. Nursing staff will have training June 3, 4, 5 and all other staff on June 6th by the NHA on resident rights, and vulnerable adult abuse. Social services staff will interview 5 residents weekly for 8 weeks. Data will be reported to the QA committee for further direction.	

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F 225	Continued From page 34 a bruise to his hands during this time period, it was determined hands were bumped while in wheelchair causing bruise to appear. No other reports of injury/ bruising to resident." Although the facility submitted a report to the SA regarding the allegation, the investigation did not identify the alleged perpetrator, although the employee was initially identified as NA-F. The facility did not complete any further staff interviews regarding the alleged accusation of R180 being hit on the arm. Although the facility stated "many names were named as people of interest," there were no names submitted nor was there any investigation the facility could provide regarding this statement. A staff questionnaire completed by NA-JJ dated 3/8/13, indicated, "snippy comments made to R57; 'here's your drink and I got to go; staff approach to resident." There was no further investigation of this statement nor was the staff person identified who made these remarks to R57. During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A verified these allegations were made but there had been no investigation completed. R57's quarterly MDS dated 3/14/13, indicated the resident had moderate cognitive impairment. A staff questionnaire completed by NA-G dated 3/11/13 indicated, "[NA-R] verbally inappropriate to R39; she's not the only person to take care of and quit turning on lights...staff would talk dirty in from of R181 to get him to talk dirty." The facility had submitted a report to OHFC regarding this	F 225	R57. Report and investigation completed. Resident calls out "owie" during cares, no matter how gentle the care giver is. Resident intersview responses and comments do not fit the situation, for example: says, "get those darkies out of my room" in the midst of the interview. Behavior log initiated. Tyelenol QID with a pain log has been initiated. R39. Report/investigation completed.	

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F 225	Continued From page 35 accusation on 3/13/13, regarding R181, 2 days after the facility was aware of the incident. The Investigative report submitted to OHFC indicated the following: "Throughout the course of our internal investigation, a number of occurrences of alleged abuse have surfaced... It has not been substantiated any resident was actually injured, their abilities affected, or lifestyle altered. Indeed, much of what we discovered points in the direction of a dysfunctional employment culture rather than any substantive resident abuse issues... Human resources (HR)-J completed staff interview with NA-G on 3/11/13... During the interview, NA-G stated 'staff would talk dirty in front of him [R181] to get him to talk dirty. This supposed allegation would have occurred sometime before 7/4/12 when R181 died. Due to these supposed allegation, DON and ADON met with East end evening nursing staff on 3/8/13- staff were given direction on appropriate resident care..." Although the facility submitted the alleged verbal abuse to the SA regarding R181, the facility had not completed, or submitted, a thorough investigation including interviews done with staff members, nor was it clear whether NA-G had been interview to provide names regarding staff who had been talking dirty to R181. R181 did not have an MDS available. During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated there had been no follow up or investigation regarding the allegation of NA-R being verbally inappropriate to R39. Although R39's was a current resident and her	F 225	R39 (continued) Resident interviewed with no complaints. Interviewed other residents about NA-R with no complaints. NA-R resigned. R181. Report/investigation completed. Deceased 7-4-12. DON and ADON met with evening staff on unit. They addressed Vulnerable adult abuse act, resident rights and care expectation. All staff completed Health Care Academy programs on Vulnerable adult abuse, residents rights and Elder Justice Act in March 2013. Training in vulnerable adult abuse act and resident rights occurred May 8 and 9. Nursing staff will be re-educated on vulnerable adult abuse, resident rights and care expectations on June 3, 4, 5 and the NHA will educate all other staff on June 6th.	

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quarterly MDS dated 4/4/13 indicated she was cognitively intact, the DON verified she had not spoken to R39 or NA-R regarding the allegations of verbal abuse towards R39; nor had she reported the allegation to the administrator or SA as indicated by facility policy.

A staff questionnaire completed by RN-B dated 3/8/13, indicated another resident "said a couple of (unknown) NA's complain about R10 always having to pee...R10 daughter said she'd overheard NA's complain they have 13 residents and they just can't do it anymore." The questionnaire asked if CM-B had ever gone to the nursing department to report abuse. CM-B had answered, "Yes; emailed DON regarding the complaint above." When asked if she was aware if the report was investigated or if she received a response from the nursing department she responded, "Never answered or responded with her follow up; do you think she reads her emails!"

During interview on 5/2/13 at 11:00 a.m. DON stated she remembers "hearing" about this complaint but believed the "talk" was coming from another resident who roomed next to R10; so the 'other resident' (unknown) was complaining about how often R10 was complaining, not the staff. However, there was no documented investigation, interviews, or follow up regarding this allegation. R10's quarterly MDS dated 4/1/13 indicated she had severe cognitive impairment.

A staff questionnaire completed by LPN-G dated 3/8/13, indicated "Don't appreciate verbal communication to residents; baby talk; short staffed; short lipped." LPN-G indicated she'd had concerns a few months ago; "resident with a

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F 225	Continued From page 37 bloody nose; picked up tissue don't have time." This is all the questionnaire indicated. There was no resident named nor was there any follow up of what LPN-G was referring to. During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A verified there had been no follow up or investigation regarding the allegations made by LPN-G, and there had been no follow up interview with LPN-G. A staff questionnaire completed by NA-F dated 3/8/13, indicated an unknown NA, "Would argue with [R180]; would scream at each other... heard 'one girl' was walking a resident while texting and resident almost fell.." NA-F indicated she had reported resident abuse to the nursing department and "was blown off. I couldn't take seeing my residents not cared for..." There is no further investigation of the above incidents. R180 did not have an MDS available for review. Although this questionnaire was dated 3/8/13, during interview with the DON and LSW-A on 5/2/13 at 11:15 a.m., they stated they were unaware of this allegation. They verified there had been no investigation conducted, the administrator had not been notified, and there had been no report made to the SA, regarding NA-F's allegations. A staff questionnaire completed by NA-KK dated 3/11/13, indicated she had witnessed neglect, "doing the bare minimum not positioning/ checking/ changing...call lights not in reach; don't put on toilet, just meant to change rather then put on toilet; turned off call light without doing cares; don't do peri care; hide in resident's room, texting	F 225	R180. Resident died on 3/19/12.	

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F 225	Continued From page 38 while feeding residents...I'm quitting because my ethical standards are very high and I can't stand to see what's happening..." Although there are several staff names written on the side of the questionnaire, there was no investigation or follow up regarding these accusations, nor was there any follow up staff interviews conducted regarding the staff identified. During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated there had been no investigation, nor additional interviews conducted regarding NA-KK's accusations of resident neglect. The DON and LSW-A verified they had not spoken to NA-KK regarding the allegations. An undated staff questionnaire completed by NA-LL, indicated the NA had gone to the DON about staff mistreatment to residents but "[DON] got bent out of shape and told to go to nurse (LPN or RN supervisor); never comfortable going back to DON..." Witnessed abuse; "R59...NA-B screaming at him because resident keeping her late; R59 also talked to nurse; R59 scared...NA-B throws people into bed and yells at them while getting ready..." R59's quarterly MDS dated 1/4/13, indicated he was cognitively intact. R59 no longer resides in the facility. During interview on 5/2/13 at 11:15 a.m., the DON stated she believed the allegation was referring to a situation which had occurred between NA-B and R59 'months ago.' The DON stated she had no formal investigation, nor had there been a report made to the SA, but the DON stated NA-B had told her "she would never do this" to R59. The DON stated she had spoken to R59 and felt R59 "would have told me" if there	F 225	DON recalls numerous conversations in which she re-directed staff to talk to the nurse or case manager on their unit. She instructed them that those persons could take care of the issue the staff raised and if they didn't follow through staff should come back to her. Some staff did not like being re-directed. R59. Report/investigation completed. Removed NA-B from schedule while investigation was being conducted. Corrective action taken with NA-B. May 3 and 4 before staff began work they received training on the revised Vulnerable Adult Abuse act, counseling on teamwork, positive staff interaction, taking time with residents, empathy and considering each residents cognitive ability when providing care. Nursing staff Inservices held June 3, 4, 5 and for all other staff on June 6 by the	

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F 225	Continued From page 39 were any concerns of abuse. However, the DON was unable to provide any documentation of an investigation of this incident. LSW-A verified this allegation should have been reported to the SA immediately, then investigated. During interview on 5/2/13 at 11:15 a.m., A-E stated he was not aware of any of the allegations of staff mistreatment and abuse which came from the staff and/ or resident interviews from March 2013. The facility provided several other submitted allegations of resident mistreatment which had been submitted to the state agency. The reports indicated the following: R75 had allegations of neglect. R75's quarterly MDS dated 1/1/13, indicated he was cognitively intact. The facility submitted a report to the state agency for R75 dated 11/8/12, with incident details including, "Staff reported that resident has a blister on his inner thigh. Resident reported that staff applied warm pack to resident's left leg that was too hot. Resident now has a blister/ redness on his left inner thigh." No "alleged perpetrator" was known. The facility's investigative report submitted to the SA on 11/15/12 (7 days after the incident) indicated, "On 11/7/13 resident was noted to have redness and a blister within the red area on his left inner thigh. Blister was thought to have been caused by a warm pack that was applied to resident's left thigh per his request to help with pain control. Care plan interventions were being	F 225	NHA. R75. Report/Investigation completed. Nursing department training on facility policy regarding warm packs on June 3, 4, and 5th. Nursing staff are conducting/conducted Care/transfer audits for 35 residents per week for 4 weeks and then 25 residents per week for 4 weeks will be done. Data will be reported to QA for further direction.	

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F 225	Continued From page 40	F 225		

followed when the incident occurred. Internal investigation revealed that resident and his daughter felt that the warm pack was the cause of the blister. In talking with staff, they report the resident does request warm packs. Staff also reported that resident has requested that staff make the warm pack hotter. This information was obtained from nursing assistants that work with resident and they are considered a credible source. As stated prior, the resident sustained a blister on his left inner thigh which has not affected his abilities or lifestyle. An alleged perpetrator has not been identified. All staff have been instructed on facility policy regarding warm packs to attempt to prevent recurrence of the incident."

The facility also provided the Resident Incident/ Injury Report Form dated 11/7/13, which the facility had not sent to the SA as part of their investigation. An attached note from the nurse, which appears to have been addressed to A-L and the DON dated 11/7/12 at 9:32 p.m., indicated R75 "Family noted a 3 cm long blister on his left thigh this evening that came from warm packs the resident has been requesting recently."

Although the facility submitted a report of the incident regarding R75's blister to the SA, the report was made 11/8/12 (the next day), and the facility did not submit complete results of the investigation including names of staff who were interviewed, whether the resident had used a warm pack in the previous days, whether a resident interview had been completed regarding when and who placed the warm packs, or identification of how staff was warming up and using the warm packs.

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F 225	Continued From page 41 During interview on 5/1/13 at 10:15 a.m. the DON and LSW-A verified the investigation results submitted to the SA were not complete. The DON also verified she was not aware of whether there had been any staff training regarding the proper use of warm packs following this incident. SW-A stated R75 was no longer in the facility but had no cognitive problems while a resident. R117, a current resident, had experienced a fall related to alleged neglect of care. R117's annual MDS dated 1/17/13 indicated he was cognitively intact. The facility submitted an incident report to the SA regarding R117 dated 12/14/12, "R117 was being transferred from the toilet to his wheelchair when he fell- he was being transferred with one staff, but his care plan is to use two staff with assist. " The facility's investigative report submitted on 12/17/12, indicated "On 12/14/12, [R117] was being toileted and was finished, so [NA-I] was going to transfer him from the toilet back to his wheelchair when... his leg buckled and he fell- she was transferring him by herself and did not have a second person to assist, therefore care plan interventions were not being followed when the incident occurred. R117 sustained no injuries during this fall...NA-I is aware of care plan, and was again made aware of the care plan as well as signed a corrective action." During interview on 5/1/13 at 10:15 a.m., the DON and LSW-A stated they were not aware of the above incident which had been submitted to the SA. However, the facility provided an Employee Corrective Action Notice for NA-I dated	F 225	R117. Report/Investigation completed. NA terminated. Training on the plan of care and following the plan and transfers. Transfer/care audits are to be done on 35 residents for 4 weeks and then 25 residents for 4 weeks. Data to be reported to the QA committee meeting for further action.	

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F 225	Continued From page 42 12/14/12 indicating, "Transferred resident by herself he is a two person assist with transfers. He fell to the floor in his bathroom." The corrective action form was completed by HR-A. The DON and SW-A were unable to identify whether NA-I had received any additional education as identified in the investigative report submitted to the SA 12/17/12, which indicated that NA-I had been re-educated to the resident's plan of care. The DON stated that if NA-I had been educated, the education should have been kept in NA-I's file which would have been completed by nursing and not by HR-A. Although the facility reported the alleged neglect of health care to the SA, there were discrepancies in the investigation report regarding the employee's re-education following the incident. R57 made allegations of neglect. R57's quarterly MDS dated 3/14/13 indicated she had moderate cognitive impairment. The facility submitted an incident report to the state agency dated 10/11/12 indicating R57 "Reported that staff moved her call light out of reach while she was in bed. She was told to stop yelling and then staff told her if she needed to use the bathroom she'd have to do it where she was because she wasn't getting up. She said she felt closed in with the room door shut and no way to get up and out of the room." The facility investigative report dated 10/16/12 submitted to the state agency indicated..."Staff believes R57 had to wait about 6 minutes for two staff people to return to assist with her request. Staff reports that R57 did become upset when she had to wait for them... The following day, 10/11/12, writer was asked by R57's son to come to her room. He told	F 225	R57. Report and investigation completed. Resident was not interviewable. Her responses were unrelated to the discussion, for example, she would say,"Get that darkie out of my room". There were no persons of color in the room. Frequently calls out 'owie'. Behavior log initiated. Tyelenol QID initiated with a pain log initiated.	

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F 225	Continued From page 43 writer she was very upset about care she had received. This writer spoke with her... The alleged perpetrator is a NA (un-named)... When R57 reported this incident to writer...R57 had reported another incident with this NA... This AP (alleged perpetrator) will not be scheduled to work with R57 and encouraged not to enter her room without a co-worker." On 10-16-12 the state agency requested more information from the facility asking to provide the AP's name and asked if any other residents interviewed or asked if they had concerns regarding the AP's cares? The facility response identified the NA as NA-MM...."No other residents were interviewed. Staff working with NA-MM were interviewed and reported R57's call light was answered by the AP who informed the resident she needed assistance to reposition her...The other staff person reported she believed R57 waited between 5 and 7 minutes for two staff people to return to her room. Neither the AP nor the other staff person made mention of R57 yelling out or that her room door was closed." During interview on 5/3/13 at 11:15 a.m., the DON stated she was not involved in the investigation of the alleged incident with R57 and NA-MM. She stated it appeared the investigation was not "complete" as none of the staff who were reported to be interviewed were named, nor was there any record of which staff was interviewed. There was also no interview with NA-MM. The DON stated NA-MM was still working at the facility and was not being monitored to ensure she no longer worked with R57. Although the facility reported the allegation to the SA, a thorough investigation was not completed and did they ensure NA-MM did not work with R57, even	F 225		

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F 225	Continued From page 44 though R57 was upset by NA-MM actions. During interview on 5/2/13 at 11:15 a.m., A-E stated back in January 2013, NA-LL had made "accusations" of resident mistreatment by staff. A-E stated nothing was done at that time, or reported, because of the "staff dynamics." A-E said he'd felt the accusations were all part of the "mean girls club" with staff accusing other staff of resident mistreatment to get them in trouble. There was no documentation of these allegations made by NA-LL in January. Then the facility received allegations of abuse and neglect from NA-K in March 2013. Many of the allegations that NA-K identified were "the same" as the concerns identified by NA-LL, so at that time A-E decided it would be best to look into some of the allegations. Although the facility was aware of multiple allegations of resident abuse and neglect. The facility failed to thoroughly investigate and/or report these allegations to the administrator and SA as indicated in their policy. Also, the investigations which the facility did submit to the SA, were not comprehensive to ensure the SA had all the information to make a determination whether resident abuse and/or neglect had occurred, or whether further investigation needed to be completed by the SA. The facility had no system in place to ensure staff knew who to report allegations of resident abuse and neglect to, and the facility was unable to verify who was responsible to ensure all allegations were completed and that staff accused of resident mistreatment would be monitored.	F 225		

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F 225	Continued From page 45 The Bethesda Homes Resident Incident/Injury Report Form Evaluations, identified the following injuries of unknown origin which were not thoroughly investigated, and/or reported to the administrator and state agency immediately: R115's quarterly MDS dated 3/28/13 indicated severe cognitive impairment and required extensive assistance from staff with most activities of daily living (ADLs) R115 incident/injury report noted a bruise on 12/10/12, measuring 8 centimeters (cm) X 6 cm on the top left hand, 4 cm X 2 cm between the third and fourth finger of the left hand, 4 cm X 4 cm on right arm and a 6 cm X 4 cm bruise on the left buttock. The incident report indicated the staff were unsure when the bruises occurred, did not determine the source of injury, no staff were interviewed, and there was no observation of cares to determine if the bruises could have been a result of care received. R115 incident/injury report noted to have bruises on 2/20/13, measuring 2 cm X 2 cm on left forearm, 5 cm X 2.5 cm on right outer elbow and 2 cm X 2 cm on the back of the right elbow. The incident report indicated the staff were unsure when the bruise occurred, did not determine the source of the injury, no observation of cares to determine if bruises could have been a result of care received nor were the resident or staff interviewed. Although the facility was aware of R115's injury of unknown origin the facility did not thoroughly investigate or immediately notify the SA.	F 225	Incident reports were completed for each resident with bruising. Incident reports are reviewed at the daily Falls meeting. Training on May 8 and 9 on the vulnerable adult abuse act included bruises of unknown origin. Nursing staff training on June 3, 4, 5 and for all other staff on June 6th by the NHA will include Vulnerable adult abuse act and bill of rights. March 2013 all staff completed vulnerable adult abuse, resident rights and Elder Justice Act training via Health Care Academy. Random audits by the nursing staff for cares and transfers of 35 residents each week for four weeks and 25 residents each week for four weeks will occur. Results will be reported to the QA committee who will determine continued auditing needs. R115. Resident utilizes a Merry Walker for ambulation. Frequently bumps into walls, chairs anything. Receives aspirin therapy. Sleeve protection in place.	

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F 225	Continued From page 46 R19's quarterly MDS dated 2/21/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R19 incident/injury report noted bruises on 4/28/13 measuring 7 cm X 6.5 cm to right hand and 3 cm X 1.3 cm to right forearm and 5 cm X 3.5 cm to left forearm. The incident report indicated R19 was unable to answer questions on how it happened or if she had bruises. Furthermore, the report indicated staff was unsure when the bruises occurred, did not determine the source of the injury, no observation of cares to determine if bruises could have been a result of care received, and no staff interviews were completed. R19 incident/injury report noted a bruise on 3/13/13 measuring 6 cm X 10 cm on her left upper arm. The incident report indicated the staff were unsure when the bruise occurred but that the bruise was consistent with R19 leaning towards the left in her wheelchair against the arm rest. The report did not determine the source of the injury, no observation of cares were conducted to determine if the bruise could have been a result of care received, nor was the resident or staff interviewed. R19 incident/injury report noted multiple bruises on 3/1/13 measuring 3 cm X 2 cm and 2.5 cm X 3 cm on right forearm, two bruises measuring 0.5 cm X 0.5 cm on the left forearm, two more measuring 1.5 cm X 2 cm and 1.5 cm X 1.5 cm further up the same left arm, 2.5 cm X 4 cm bruise on top of left hand. The incident report indicated the staff were unsure when the bruises occurred, that the resident rolls self in bed and	F 225	R19.Wheel chair armrest padding applied May 29, 2013. Resident moves about in bed a great deal. Side rail assessment done on 5/30/2013 and removed the same date. 5/30/13 sleeve type arm protection in place. Audits of staff reporting of Vulnerable adult abuse issues will be conducted on 10 employees weekly for 8 weeks. Staff training on vulnerable adult abuse, resident rights, and Elder Justice Act occurred on Health Care Academy in March 2013. Vulnerable adult abuse and resident right training occurred on May 8 and 9. Nursing staff will be trained on June 3, 4, 5, and all other staff on June 6 by the NHA on vulnerable adult abuse and resident rights.	

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has bilateral side rails which she hits on occasions and indicated the resident denied any staff being rough. No staff interviews were completed.

R19 incident/injury report noted a bruise on 2/17/13 measuring 2.1 cm X 7 cm on her lower back. The incident report indicated staff were unsure when the bruise occurred, did not determine the source of the injury, but through staff interviews note that when staff do not use portable lift (PAL), R19 "quickly" tries to transfer into wheelchair, hitting the arm rest with her hips or back. The resident was marked as not interviewable.

R19 incident/injury report noted a bruise on 1/14/13 measuring 3.5 cm X 2.0 cm on her right breast. The incident report indicated the staff were unsure when the bruise occurred but that it is consistent with when staff laid her down in bed and resident rolled and hit her chest on the middle bar of the side rail. No resident or staff interviews were completed.

R19 incident/injury report noted bruises on 1/4/13 measuring 2.5 cm X 1.5 cm on right forearm, 4.0 cm X 2.0 cm and 5.0 cm X 3.0 cm bruises on left side of back and abdomen area. The incident report indicated staff were unsure when the bruise occurred, that the bruises are consistent with R19 not sitting up straight in the wheelchair and hitting her side on the arm rest and that R19 denied staff or family being rough with her. No observation of cares were conducted to determine if the bruise could have been a result of care received and no staff interviews were completed.

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R19 incident/injury report noted a bruise on 11/18/12 measuring 5 cm X 6.5 cm on left upper thigh. The incident report indicated staff were unsure when the bruise occurred. Staff was interviewed "thought it is possible resident bumped her thigh when she was transferring", and that although the R19 was not able to be interviewed, the report indicates "she does not recall anyone being rough with her, does not recall bumping, pinching, scratching herself". No observation of cares were conducted to determine if the bruise could have been a result of care received and no further investigation was completed.

R19 incident/injury report noted multiple bruises on 11/12/12 measuring 2 cm X 0.5 cm on left shoulder, 2 cm X 1 cm on left hand below her wrist and 5.5 cm X 2 cm on left arm above wrist. The incident report indicated staff were unsure when the bruise occurred, but that the bruises on her wrist were consistent with resident hitting arm on bedside table and side rail on bed. It further indicated staff did not determine the source of the shoulder injury and that that the resident stated "I scratch my arms or shoulder every now and then" and denied staff or family were being rough with her. No observation of cares were conducted to determine if the bruise could have been a result of care received and no staff interviews were completed.

Although the facility was aware of R19's multiple instances of bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA.

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F 225	Continued From page 49 R177's admission MDS dated 10/15/12 indicated moderate cognitive impairment and required extensive assistance from staff with most ADLs. R177 incident/injury report noted a scratch and bruises on 11/26/12, measuring 12 cm (scratch) and 3 cm X 1 cm bruise on left buttock, 1 cm X 1 cm and 2.5 cm X 2 cm to right buttock, and a light bruise to back of left thigh. The incident report indicated staff was unsure when the bruises/scratch occurred and the bruise on the left thigh was from her cushion in her wheelchair and the others were consistent from transfers from staff. No observation of cares were conducted to determine if the bruise could have been a result of care received and no staff interviews were completed. Although the facility was aware of R177's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R8's significant change MDS dated 1/25/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R8 incident/injury report noted bruises on 1/11/13, measuring 2 cm X 1 cm on upper outside of left arm, 1.5 cm X 1 cm on upper inside of left arm and 2.5 cm X 2 cm on right shin. The incident report indicated that although staff was unsure when the bruises occurred they stated arm bruises were from hitting her side rails while in bed and shin bruise was from hitting her leg on her wheelchair. R8 was deemed non interviewable, no staff was interviewed.	F 225	R177. Deceased, hospitalize 11-28-12 and died there. R8. Side rail assessment completed 5-30-13. Use is appropriate and continues.	

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F 225	Continued From page 50 Although the facility was aware of R8's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R86's quarterly MDS dated 2/28/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R86 incident/injury report noted a bruise on 11/20/12. The incident report indicated "a large yellow/purple bruise" on the outside of the right arm but had no measurements of size, the staff were unsure when the bruises occurred and that R86 was often resistive to cares and attempted to wrestle staff member "1-2 weeks ago". No observation of cares were conducted to determine if the bruise could have been a result of care received nor was the resident or staff interviewed. R86 incident/injury report noted a bruise on 4/16/13, measuring 5.5 cm X 4 cm on the left arm. The incident report indicated the staff were unsure when the bruises occurred and that R86 was often combative with cares. No observation of cares were conducted to determine if the bruise could have been a result of care received nor was the resident or staff interviewed. Although the facility was aware of R86's bruise of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R109's quarterly MDS dated 3/14/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R109 incident/injury report noted a bruise on	F 225	R86. Resistive to cares routinely, bruising believed to occur during cares. Sleeve protection applied, resident will not keep them on. Nurses are conducting Care/transfer audits on 35 residents for 4 weeks, and for 25 residents for 4 weeks. Data reported to QA committee for further action needed. R109. Forcefully seats self in chairs, on	

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F 225	Continued From page 51 10/30/12, measuring 12 cm X 3 cm on her back. The incident report indicated the staff were unsure when the bruises occurred, but assumed source of injury to be when an aide reported R109 sat down hard and hit her back on the top of toilet. R109 was not interviewable, there were no additional staff interviews. Although the facility was aware of R109's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R15's quarterly MDS dated 12/7/12 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R15 incident/injury report noted bruises on 11/23/12, measuring 3 cm X 2.5 cm and 3.5 cm X 4.0 cm on left hand, 2.3 cm X 2.3 cm on left wrist and 3.4 cm X 3.2 cm on right hand. The incident report indicated the staff were unsure when the bruises occurred, and did not determine the source of injury but that R15 was combative prior to 11/23/12. No observation of cares were conducted to determine if the bruise could have been a result of care received nor was staff interviewed. Although the facility was aware of R15's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R51's quarterly MDS dated 1/17/13 indicated severe cognitive impairment and was totally dependent on staff with all ADLs. R51 incident/injury report noted a skin tear and bruise on 12/28/12, measuring 6 cm X 2.9 cm	F 225	R15. Resident had history of punching, and hitting staff. He was resistive to measuring bruising. He died 1-16-13. R51. Deceased 3-22-13.	

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F 225	Continued From page 52 skin tear on left forearm and a 7.1 cm X 5.4 cm bruise surrounding the area. The incident report determined the source of injury was from staff boosting resident up in the chair and sliding the lift sheet up. No resident or additional staff interviews were completed. Although the facility was aware of R51's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R68's quarterly MDS dated 2/7/13 indicated severe cognitive impairment and required extensive assistance from staff with ADLs. R68 incident/injury report noted a bruise on 4/22/13, yellow in color on the right frontal mid thigh. The incident report indicated staff were unsure when the bruise occurred, no measurements for the bruise and that it was consistent with "resistiveness with cares" during a shower. No observation of cares were conducted to determine if the bruise could have been a result of care received. No staff or resident interviews were completed. Although the facility was aware of R68s bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R98's quarterly MDS dated 2/21/13 indicated severe cognitive impairment and required extensive assistance from staff with ADLs. R98 incident/injury report noted to have a bruise on 11/28/12, measuring 1.5 cm X 1.0 cm on right inner thigh. The incident report indicated the staff were unsure when the bruises occurred but	F 225	R68. Resident is resistive to cares. This bruising incident occurred while resisting a shower. The time of his shower will be changed to mornings and re- evaluated. Nursing staff conducting Care/transfer audits on 35 residents for 4 weeks and 25 residents for 4 weeks. Data reported to QA committee for further action. R98. Bruising believed to be caused by the Merry Walker strap. Now, only occasionally uses Merry Walker.	

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F 225	Continued From page 53	F 225		
	presumed the bruise was consistent where her incontinent pad is at times. No observation of cares were conducted to determine if the bruise could have been a result of care received. The resident and staff were not interviewed.			
	Although the facility was aware of R98s bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA.			
	R128's quarterly MDS dated 2/14/13 indicated he was cognitively intact and required extensive assistance from staff with most ADLs.		R128. Side rail assessment completed on 5/2/2013. Appropriate and continues to use them. Ambulates with a wheel chair, and bumps into objects routinely. Has sleeve type arm protection.	
	R128 incident/injury report noted to have a bruise on 9/8/12, measuring 1.6 cm X 2.4 cm slightly to the right of buttock crease. The incident report indicated the staff were unsure when the bruises occurred but noted the bruise was a result from bumping into the siderails on his bed during a transfer with a PAL lift. No additional interviews with staff were completed.			
	Although the facility was aware of R128's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA.			
	R128 incident/injury report noted to have multiple bruises on 10/30/12, measuring 2.3 cm X 2.3 cm and 1.5 cm X 1.6 cm to lower right arm, 2.2 cm X 2.0 cm and 1.5 cm X 2 cm to lower left arm and "large bruise" to top of left hand. The incident report indicated staff was unaware when the bruises occurred, did not determine the source of injury and did not interview the resident or staff.			

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F 225	Continued From page 54 Although the facility was aware of R128s bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R10's who was a current resident's quarterly MDS dated 4/1/13 indicated severe cognitive impairment and was totally dependent on staff with most ADLs. R10 incident/injury report noted six bruises on both arms on 11/29/12, measuring 1.0 cm X 2.5 cm and 2.0 cm X 2.0 cm on upper right arm, 1.0 cm X 2.5 cm bruise by left elbow, 2.0 cm X 3.0 cm below left elbow, 1.5 cm X 2.0 cm on left forearm and 3.0 cm X 1.0 cm bruise on lower left forearm. The incident report indicated the staff were unsure when the bruises occurred and that bruising is consistent with where the lift sheet lies with transfers. Staff was reminded to be careful with transfers, however no staff interviews were completed. Although the facility was aware of R10's multiple bruises of unknown origin the facility failed to conduct a thorough investigation or immediately notify the SA. R10 incident/injury report noted bruises on 1/13/13, measuring 4 cm on top of right hand, 2 cm X 3 cm by right thumb, 2 cm circle from left thumb to top of left hand. The incident report indicated a family member brought the bruises to the attention of staff because they were unfamiliar to her and she had not been notified. The report also indicated staff were unsure when the bruises occurred and stated that bruises were "consistent	F 225	R10. Re-arranged room. Side rails removed 12/18/2012. Recliner removed from room. Tried sleeve arm protection, did not work due to arm swelling. Padded wall by bed with a fall mat. Nursing staff are conducting Care/transfer audits on 35 residents for 4 weeks and 25 residents for 4 weeks. Data to be reported to QA committee for further direction.	

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F 225	Continued From page 55 with where table is in dining room or where bedside table is". No observation of cares were conducted to determine if the bruise could have been a result of care received. The resident and staff were not interviewed. Although the facility was aware of R10's multiple bruises of unknown origin the facility failed to conduct a thorough investigation or immediately notify the SA.	F 225		
	R4's quarterly MDS dated 1/17/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R4 incident/injury report noted bruises on 8/3/12, measuring 3 cm X 1.5 cm and 1.5 cm X 2 cm on right hand and a 2.5 cm X 1.5 cm bruise on the right hand and wrist. The incident report indicated the resident was combative during his shower hitting his hands against a wall, however there was no investigation nor staff interviews completed. Although the facility was aware of R4's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA.		R4. Deceased 2-12-13. Was combative with cares as well as resistive. Hit wall with his hand.	
	R37's quarterly MDS dated 2/14/13 indicated severe cognitive impairment and required extensive assistance from staff with all ADLs. R37 incident/injury report noted bruises on 8/3/12 measuring 1 cm X 1 cm on upper right wrist and a 0.5 cm X 0.5 cm on left inner wrist. The incident report indicated that she was resistive with cares on 7/30/12 during her shower. R8 was unable to		R37. Resists cares and showers. Won't keep sleeve type arm protection on.	

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F 225	Continued From page 56 respond when questioned. No staff was interviewed. Although the facility was aware of R37's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R120's quarterly MDS dated 3/21/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R120 incident/injury report noted to have bruises on 8/19/12, measuring 3.5 cm X 5.0 cm on chest and a 9 cm X 13 cm on her right hand. The incident report indicated the staff was unsure when the bruises occurred, the source of the injury and no staff was interviewed. Although the facility was aware of R120's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA. R67's was a current resident and their quarterly MDS dated 1/24/13 indicated moderate cognitive impairment and required extensive assistance from staff with most ADLs. R67 incident/injury report noted to have a bruise on 1/8/13, measuring 8.8 cm X 3.3 cm on left side of abdomen. The incident report indicated the staff were unsure when the bruises occurred, but that the source of injury was a result of getting skin pinched in PAL belt. No further staff interviews were completed.	F 225	R120. Receives aspirin daily. Was ambulating at that time with a walker, when she sat the walker was in front of her and she may have hit her chest on it. Deceased 5-16-13.	

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R67 incident/injury report noted to have multiple bruises on 8/2/12, measuring 0.9 cm X 1.1 cm on left forearm, 0.5 cm X 0.8 cm on top of right hand, 1.0 cm X 0.8 cm on right elbow, 0.9 cm X 0.9 cm on right deltoid, 0.6 cm X 1.0 cm on left buttocks. The incident report indicated the staff were unsure when the bruises occurred, did not determine the source of injury, did not observe cares to determine if the bruise could have been a result of care received. No staff was interviewed.

Although the facility was aware of R67's bruises of unknown origin, the facility did not thoroughly investigate or immediately notify the SA.

During interview on 5/1/13 at 11:15 a.m. SW-A and DON stated all the above reports were complete; the facility had no further investigation of the injuries of unknown origin. SW-A stated the "nurses" bring all bruising investigations to a staff Monday meeting and the facility reviews the bruising reports. SW-A and DON could not remember specifically reviewing the above injuries of unknown origin, but did verify the investigations were not complete and they did meet the definition of injury of unknown origin and should have been reported to the SA.

The facility's Abuse Prevention Policy/Procedure dated 3/26/12, included the following:

"The facility will report all alleged incidents of neglect, abuse, or exploitation according to state and federal regulations. The DON, ADON, case managers, and/ or social services will do a thorough investigation of the possible neglect or abuse cases, taking the appropriate action

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F 225	Continued From page 58 providing protective and/ or counseling services as needed (prevention mechanism)...The facility will report all alleged incidents of neglect, abuse, or exploitation according to state and federal regulations. All staff in all departments are required to report to nursing immediately any suspected abuse, injuries and/ or other incidents. Nursing will evaluate any suspected abuse or physical injury that cannot be explained in accordance with state and federal regulations and will report immediately to the administrator, MDH (SA), ..."	F 225		
F 226 SS=L	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement an abuse prohibition policy which required and instructed staff to complete a thorough investigation of any alleged abuse, neglect and/ or injuries of unknown origin. This directly affected 17 of 30 residents, (R122, R3, R43, R57, R55, R137, R128, R67, R10, R180, R5, R179, R39, R181, R59, R75, and R117) who had allegations of abuse, and neglect reviewed. In addition, the facility failed to ensure bruises of unknown origin were thoroughly investigated and reported to the administrator and State Agency (SA) for 16 of 35 residents (R115, R19, R177, R8, R86, R109,	F 226	BPV has developed and written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The policies and procedures were revised. Staff were inserviced on May 8 and 9 about vulnerable adult and resident rights. June 3, 4, 5 and 6th staff will receive training on vulnerable adult abuse and resident rights. The DON is responsible for the investigation of unknown injuries as well as other potential abuse situations. DON/ADON will audit/interview 10 staff weekly on reporting requirement of the vulnerable adults abuse act. Social services staff will interview 5 residents a week for 8 weeks and report data to the QA committee for further direction.	

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R15, R51, R68, R98, R128, R10, R4, R37, R120 and R67) in the sample who were reviewed with bruises of unknown origin.

The failure to develop and/or implement an abuse prevention plan which instructed staff on how to protect residents in the facility against potential abuse and neglect, constituted an immediate jeopardy for R122, R3, R43, R57, R55, R137, R128, R67, R10, R5, R39, and R117 who currently resided in the building. The systemic failure to report and thoroughly investigate incidents of potential abuse/ neglect, employees' lack of knowledge on how to report allegations of mistreatment and neglect, the undeveloped abuse prevention policy, and the systemic breakdown of the facility's inability to identify who was in charge of investigating and/or reporting allegations of resident mistreatment and or neglect, had the potential to effect all 118 residents currently residing in the facility.

The administrator (A)-E, the director of nursing (DON), and the director of social services (LSW) -A were notified on 5/3/13 at 1:41 p.m., of the immediate jeopardy to the health and safety of the residents at a widespread level (L). The facility initiated an IJ removal plan which included review and revision of the abuse prevention plan and training to all staff on each shift prior to any direct resident contact. The facility also provided education to residents in the facility about abuse, neglect, who to report to, and resident rights in the facility. Direct care staff, licensed nursing staff, and unit managers were interviewed and were able to explain their responsibility for identification of incidents of potential mistreatment; internal reporting; resident

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protection, investigation and external reporting. The immediacy was removed on 5/8/13 at 3:20 p.m., and the scope and severity was reduced to no actual harm with a potential for no more than minimal harm, widespread.

Findings include:

The facility's Abuse Prevention Policy/Procedure dated 3/26/12, included the following:

"The facility will report all alleged incidents of neglect, abuse, or exploitation according to state and federal regulations. The DON, ADON, case managers, and/ or social services will do a thorough investigation of the possible neglect or abuse cases, taking the appropriate action providing protective and/ or counseling services as needed (prevention mechanism)...The facility will report all alleged incidents of neglect, abuse, or exploitation according to state and federal regulations. All staff in all departments are required to report to nursing immediately any suspected abuse, injuries and/ or other incidents. Nursing will evaluate any suspected abuse or physical injury that cannot be explained in accordance with state and federal regulations and will report immediately to the administrator, MDH, and CEP... The DON, ADON and SS will met to review reported incidents as needed. An investigation form will be completed and a report submitted within five working days...The facility will electronically submit a full investigative report of the findings to the Minnesota department of health within five working days... The report shall include the following information as available: Name of vulnerable adult. Name and address of alleged perpetrators... any prior incidents of

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F 226	Continued From page 61 maltreatment. Cause of reported injury. Details of facility investigation... Action taken to prevent recurrence of incident... Protection of vulnerable adult: All attempts will be made by [facility] to prevent further abuse/ neglect of residents by implementing the following actions...Staff to resident abuse: In the event of a witnessed episode of abuse or an allegation of abuse that seems likely to have occurred, the staff person involved will be immediately suspended from his/ her job assignment until the investigation is complete...If appropriate, employees of this facility who have been accused of resident abuse may be reassigned to non-resident care duties until the result of the investigation have been reviewed by the administrator...All employees of facility are mandated reporters of any suspected abuse or neglect of a vulnerable adult. A complaint/ concern may be filed by any facility employee, resident, or family member... All staff are required to report to a charge nurse immediately and nursing will immediately notify administrator...." The policy did not indicate who was responsible to ensure all allegations of resident abuse/ neglect were reported, and investigated. The policy also indicated "Nursing will evaluate any suspected abuse or physical injury that cannot be explained in accordance with state and federal regulations and will report immediately to the administrator, MDH, and CEP... " The policy did not define injuries of unknown origin; nor did it instruct staff on what to do if an injury of unknown origin was discovered. The policy also lacked staff direction on what to do if they suspected maltreatment of residents, as well as who it should be reported to and who was	F 226		

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F 226	Continued From page 62 responsible for investigation. R122 a current resident, reported nursing assistant (NA)-A was rough with him and he did not want that NA-A taking care of him. The facility did not investigate R122's allegation of NA-A being rough, and did not report the allegation to the administrator or SA as directed by the facility's policy. NA-A continued to care for R122 despite R122 complaints. R122's quarterly minimum data set (MDS) dated 3/14/13 indicated moderate cognitive impairment. During interview on 4/29/13 at 3:05 p.m. R122 stated a NA-A is "very rough" with him. R122 stated, "he swings me back and forth and pushes me around. I've got a swollen hip and it hurts me." R122 said he'd told the NA he hurt and it was too rough, and said the NA had responded, "just never mind, you are OK." R122 stated he told the nurses that he did not want NA-A to take care of him anymore and they told R122 they would "take care of it." However, R122 stated NA-A still takes care of him and the nurses "didn't do anything about it." Review of R122 Facility Progress Notes indicated the following notes: 4/10/13- "Resident was very upset this early evening and wanted to talk to this writer. When this writer arrived in his room he stated that he did not want the male NA [NA-A] working with him tonight or in his room because 'he is a liar and I don't trust him, he lies about me.' This writer explain that someone else would be working with him and that this writer would take care of that for	F 226	Training on the vulnerable adult abuse act, bill of rights and Elder Justice Act occurred in March of 2013 for all staff. Training occurred on May 8 and 9th on the revised vulnerable adult abuse act and the bill of rights. Residents 122, 3, 43, 57, 55, 137, 128, 67, 10, 180, 5, 179, 39, 181, 59, 75, and 117 each had a report and investigation completed. Any changes/recommendations to their plans of care are listed below: R122-Interviews of the resident, NA-A and other NA's were completed. NA-A is not assigned to this resident; however, may assist with two person transfers with the resident's permission. Nursing will audit Care and transfer audit of 35 people at random occurred for 4 weeks; now it will continue at 25 per week for 4 weeks. Data is to be reported to the QA committee for further direction.	

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him...it was explained to both the resident and wife that this would be investigated and that the director of nursing (DON) and assistant director of nursing (ADON) would be notified."

During another interview with R122 on 4/30/13 at 3:40 p.m., R122 stated he had put his call light on over an hour ago to go to the bathroom. R122 stated when NA-A came in to assist him to the bathroom R122 had told NA-A to "just forget it" because he did not want NA-A to take care of him. The resident stated he was going to try to wait to see if any other staff could help him. After an hour, he stated he was unable to wait to go to the bathroom any longer, so had turned on his call light again for assistance. R122 stated when NA-A came in again, he (the resident) asked isn't there "anyone else here who could help me?" R122 said NA-A had responded, "nope, I am the only one here." R122 said, "He hurts me he is so rough with me. He knows I don't want him to come in here, but he just keeps coming in."

During interview on 5/1/13 at 12:30 p.m., family member (FM)-G stated she had talked to a nurse and had asked that NA-A no longer provide cares for R122 as NA-A is "rough with him [R122]." FM-G stated the nurse had told her she would "take care of it" however, FM-G said NA-A continues to care for R122 "often."

During interview on 5/7/13 at 11:50 a.m., the DON stated she was aware R122 thought NA-A was "rough" with him. The DON also stated she'd reminded NA-A to provide R122 choices. The DON was unable to provide any documentation of any investigation into R122's concerns. There was no documentation that the DON had spoken

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to R122 more about his concerns, nor conversation with NA-A. The DON verified NA-A continued to care for R122, and stated NA-A was not being monitored to ensure he was not treating other residents roughly. In addition, the DON verified the resident's concern had not been reported to the administrator or SA.

R122 also told staff he was neglected at night as staff would not take him to the bathroom; they just told him to go to the bathroom in his brief.

Review of R122's facility Progress notes revealed the following:

4/10/13- Residents wife stated, "Staff needs to get him up to the toilet or give him a urinal when he states he has to go and not tell him to 'wet yourself'."

During interview on 4/30/13 at 3:29 p.m., R122 stated, "If I ask to go to the bathroom at night they usually tell me to just poop or pee in my pants. They tell me to just go in my pants and they will clean it up later. I tell them I don't want to but they tell me it's ok, just go ahead." R122 stated it really made him feel bad and it hurts his "bottom" when he has to sit in a wet/soiled pad.

During interview on 5/7/13 at 11:50 a.m., the DON stated she was aware of the accusations R122 made regarding the night shift telling him to go to the bathroom in his pad instead of taking him to the bathroom. The DON verified she had not conducted any formal investigation nor documented such, but stated she "reminded night shift" to take residents to the bathroom upon request. The DON verified asking a resident to go

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F 226	Continued From page 65 to the bathroom in their pad and refusing to assist them to the bathroom would be considered neglect. The DON verified during interview on 5/713 at 11:50 a.m., that this allegation of potential neglect had not been investigated thoroughly, reported to the administrator, or reported to the SA in accordance with the facility's policy. R3 a current resident, reported a staff member had been rough with her and the facility had not investigated or immediately reported to the administrator or SA as directed by the facility policy. R3's annual MDS dated 3/21/13 indicated she was cognitively intact. During interview on 5/3/13 at 2:00 p.m., R3 stated there is a male nursing assistant (NA)-FF at times can be rough during cares. R3 stated she reported this at her last care conference to the care conference team and does not think anything had been done regarding her accusation. R3 stated NA-FF still provided cares for her even though she reported NA-FF of being rough. Review of the facility's interdisciplinary progress notes (IDP) dated 3/20/13 indicated a Care Conference was held on 3/13/13. The IDP note did not address R3 had informed staff that NA-FF was rough with her. Review of the facility's incident reports and Vulnerable Adult reports, did not address R3's concerns regarding NA-FF being rough with her. R3's allegation of NA-FF being rough was never investigated, or reported to the administrator or SA as directed by the facility's policy.	F 226	R3 Staff training occurred May 8 and 9th. Inservices on June 3, 4, 5, and 6 included resident rights, vulnerable adult abuse and transfers. Thirty-five residents care/transfers have been audited for 4 weeks, 35 residents care/transfers will be audited for the next 4 weeks and 25 residents will be audited for the next 4 weeks. Results will be reported at QA. QA will determine continued frequency and need.	

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F 226	Continued From page 66 R43 a current resident, alleged a nursing assistant was rough with her. This allegation was not thoroughly investigated or reported to the administrator or state agency as directed by the facility policy. R43's quarterly MDS dated 2/1/13, indicated R43 was cognitively intact, had clear speech and was able to communicate her needs without any problems. The MDS indicated R43 had no specific behaviors or any symptoms of delirium, but required extensive assistance from one staff for all her personal cares. R43 was interviewed on 5/7/13 at 11:00 a.m. and reported an incident that occurred several months ago, when a nursing assistant had been rough with her in preparation of a shower and during the shower. R43 reported the nursing assistant was rough taking off her clothes and that she'd asked the NA, "will you be nicer to me?" R43 indicated the nursing assistant seemed to get so upset that "she left me sitting in the shower room, by myself, without any clothing." R43 also reported this nursing assistant had showered her since the incident, but there had been no further rough treatment. R43 stated it made her nervous whenever this nursing assistant worked with her and she did not like it. She stated she had not told anyone about these feelings, as she didn't want the staff to get mad at her. A phone interview was completed with FM-AA on 5/7/13 at 11:03 a.m. FM-AA reported R43 had voiced concern regarding the rough treatment she was given by a nursing assistant when was	F 226	R43. NA terminated. Plan of care reviewed and revised. Staff received training on the Vulnerable Adult Abuse act, resident rights, and the Elder Justice Act in March 2013. Staff were inserviced on respect and dignity on May 8 and 9th. Resident rights and vulnerable adult abuse act training will occur on June 3, 4, 5 for nursing staff and on June 6th for all other staff by the NHA. Social services will interview 5 residents per week for 8 weeks with data reported to the QA committee for further direction.	

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F 226	Continued From page 67 being undressed in preparation for a shower, and also during the shower. FM-AA said she'd talked to the facility about this and as a result of the report, had been told the identified staff person would not bathe or provide other services to her mother. The nurses' progress note dated 2/11/13, indicated FM-AA had been told the nursing assistant's behavior was "unacceptable" and the nursing assistant would be appropriately reprimanded. The progress note indicated FM-AA requested this nursing assistant never work with her mother (R43) again. The facility's initial report of this incident was reported to the SA on 2/11/13, and the investigative report was filed with the SA on the same day. The corrective action taken to prevent recurrence of this incident indicated the nursing assistant was not to bathe R43 alone, and the nursing assistant was to have another nursing assistant in the room. The reported perpetrator was identified as NA-J. A random review of nursing assistants who provided care to R43 was completed by reviewing the documentation in Care Tracker (an electronic system that allows staff to document services provided to residents). NA-J documented she had provided cares to R43 on 3/26/13, even though NA-J was not supposed to provide care for R43. An interview with registered nurse (RN)-A was completed on 5/7/13 at 11:34 a.m. RN-A reported she was not aware of FM-AA's request that NA-J not work with R43. In addition, RN-A reported she was unaware of any reported problems with NA-J or the corrective action,	F 226		

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which specified if NA-J showered R43, a second staff person was to be in the room. RN-A indicated she was unaware there were any restrictions with NA-J and which residents she worked with. RN-A reported NA-J continued to work with R43 as needed, which could include giving R43 a shower. RN-A verified she should have been made aware of this situation.

The facility submitted a report to the state agency on 3/12/13 identified as complaint number H5427019, regarding multiple allegations of abuse and neglect that were observed by NA-K on the east side of the nursing home. These allegations were not thoroughly investigated or immediately reported to the state agency and administrator as directed by the facility policy.

The 3/12/13 complaint H5427019 report indicated the following:

"On 3/6/13 writer was made aware of allegations made by [NA-K] regarding mistreatment of residents... administrator (A)-E was informed... NA-K made the following accusations. She worked on the floor as a NA for 3-4 days, which was her training period... A NA said I am so f--ing sick of taking care of you to a resident. When a resident fell, a NA was told to allow the resident to remain on the floor until vitals could be done; the NA said I frickin don't have time to wait and picked the resident up and put her in bed. She [NA-K] also said NA's would sit at the nurses' desk and turn off the audible call light and would not take care of the resident with the light on. Also, a NA was trying to force a resident to eat by trying to push a spoon into her mouth, NA-K said it appeared to hurt the resident. NA-K also said

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that NA's would use one person transfers when they were suppose to use two staff. These residents were dropped into bed as a result... Related to these incidents, NA-K did not continue to work here."

The Investigative report submitted to the SA (OHFC -office of health facility investigations) on 3/12/13, (6 days after the original complaint) included:

"Potential issues were focused on the East end of the nursing home so current residents who resided on the East end were interviewed along with some West end residents, some of which previously resided on the East side... 35 current residents were interviewed, some of which do have dementia. No specific or substantiated reports from residents that they are being mistreated by staff. 30 staff members were interviewed, mostly current employees and some past employees. Some staff alleged that other staff were neglectful and mistreated some residents. It has not been substantiated that any resident was injured, their ability affected, or lifestyle altered. After our initial interview with current and former staff, many names were named as people of interest... DON and ADON met with primarily East end evening nursing staff on 3/8/13. Staff were given direction on appropriate resident care... Staff are informed of importance to report any suspected or witnessed abuse immediately. It was alarming to hear that staff are not reporting concerns immediately per their education..." The investigation submitted to the SA also identified staff were offered, and were to attend, a session on vulnerable adult reporting on 3/22/12, 3/27/12, or 3/28/12.

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F 226	Continued From page 70 In the investigation submitted to the SA dated 3/12/13, the facility did not identify any staff they had spoken to regarding other concerns, the resident who'd allegedly fallen was not identified, and there was no indication any further investigation had been conducted related to NA-K's allegations. During interview on 5/1/13 at 11:15 a.m., the DON and LSW-A stated NA-K worked at the facility for only a short time and could not remember specific names of employees or staff. The DON and LSW-A stated they were unsure who had specifically investigated NA-K's allegations. They were also unable to provide documentation of any investigation regarding the resident who'd allegedly fallen and been picked up and put into bed by a (unknown) NA. LSW-A stated NA-K only worked for "a couple days" and the facility should have investigated to see which residents had fallen during NA-K's short employment to determine if the allegation was valid. The DON stated in regards to the allegations made by NA-K, the facility did a staff education for the East end nursing staff regarding resident care, as well as interviewed around 30 staff and residents on the East end of the building. The DON also verified the "4 sessions that were offered, and staff were to attend, on vulnerable adult reporting" had actually been conducted in 2012, not 2013; there was no mandatory retraining of staff to do these sessions again regarding the allegations and retraining of staff. The DON stated if staff had done this training in the last year, they would have been unable to do it again as the computer system where the education is completed only allows	F 226		

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F 226	Continued From page 71 staff to do this once per year. The DON and LSW-A verified the staff and residents were not interviewed directly regarding the allegations of mistreatment made by NA-K or from further staff interviews alleging abuse, but rather were asked general questions such as "Have you ever noticed staff being verbally or physically abusive on the East end?" The DON and LSW-A stated their human resources staff (HR)-J, who mainly did the interviewing and corrective action write ups for employee files, was currently on leave from the facility and was not able to be interviewed during the duration of the survey. The DON stated she was not involved in the investigations, employee corrective actions, or any monitoring of employees because staff had expressed concern she may shown favoritism because she (the DON) had a family member working for the facility during that time period. During interview on 5/2/13 at 10:55 a.m., A-E stated he'd spoken with NA-K regarding allegations of staff mistreatment to residents but verified he had not followed up or conducted any investigations. A-E stated the alleged incidents of staff mistreatment were related to "staff dynamics" and how the "staff works together." A-E stated it appeared their staff had a "mean girls" club and he continued to refer to the staff as "vipers," meaning he felt the staff were not getting along and were making accusations against each other regarding mistreatment and neglect. According to the report submitted to the SA on 3/6/13, regarding H5427019, the facility indicated they'd interviewed various residents and staff on the East end of the nursing home regarding allegations of abuse and neglect. The facility	F 226		

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F 226	Continued From page 72 provided information from the interviews and investigations they'd completed as follows: RESIDENT INTERVIEWS: R57's a current resident's, quarterly MDS dated 3/14/13 indicated she had moderate cognitive impairment. R57's- resident interview questions dated 3/2013 questioned the resident, "Have you ever been treated roughly by staff." The resident answered, "Sometimes." There was no further interview done or investigation regarding this response from the resident. During interview on 5/1/13 at 11:40 a.m., SW-A stated she was not sure who completed this interview with R57 but verified there was no investigation or follow up for the resident's response. R55's a current resident's, quarterly MDS dated 3/1/13, indicated she had severe cognitive impairment. R55's resident interview questions dated 3/2013, asked the resident "Do you ever feel afraid because of the way you or some other resident is treated?" R55 responded, "Sometimes at night when I'm alone because I can't lock my door and keep it closed." There was no further interview or investigation regarding R55's response. During interview on 5/2/13 at 10:53 a.m., the DON stated this was talked about at care conference and R55 was not "afraid," she just wanted her door closed so she didn't have to	F 226	R57. Staff interviewed. Resident calls out "owie" during cares no matter how gentle staff are. Says, "get those darkies out of my room". Pain is medicated with Cymbalta and QID Tylenol for one week. Pain log initiated June 3, 2013. Behavior log started 5-30-13. R55. Interviewed spouse. Resident has memory loss. BPV placement due to elopements at home. Resident wanted the door locked at home so she couldn't get out. Was on memory care unit and distressed with other residents wandering. She was moved to long term care, can and does close her door and has adjusted well.	

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F 226	Continued From page 73 worry about other residents coming into her room. The DON stated there was no documentation of this nor was there any further investigation. R137's a current resident, quarterly MDS dated 4/4/13, indicated he was cognitively intact. R137's resident interview questions dated 3/2013, indicated when asked, "Have you ever been treated roughly by staff?" The resident responded, "One moved too fast; shaken up a little." R137 was also asked, "Has staff yelled or been rude to you?" R137 responded, "One staff member a couple times when getting up." There was no further interview or investigation regarding R55's responses. During interview on 5/2/13 at 10:53 a.m., SW-A stated she had not heard of the accusation R137 made regarding a staff member who had yelled at him and "shaken him up." SW-A stated SW-B must have completed this investigation and not followed up on it. SW-A verified there was no investigation nor was there any further clarification from the resident regarding the accusations of staff yelling at him or moving too fast with him. R128 a current resident's, quarterly MDS dated 2/14/13 indicated he was cognitively intact. R128's resident interview questions dated 3/2013, identified when asked, "has staff yelled or been rude to you?" The resident responded, "May have happened; 'questioned why I did what I did and I didn't feel that was appropriate." There were no follow up questions asked of R128, and there was no investigation.	F 226	R128. Report/investigation completed. Interviewed other residents on same unit. No abuse suspected. Social services staff to interview 5 residents each week for 8 weeks about resident rights with data reported to the QA committee for further direction.	

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R128, was interviewed on 5/3/13 at 2:30 p.m. R128 reported at times, the night nursing staff are very abrupt and rude when they wake him up at 3:00 a.m. or 4:00 a.m. to check for continence. R128 stated at times he feels they are harsher than they need to be.

During interview on 5/2/13 at 10:53 a.m., LSW-A stated she had not heard of the accusation R128 made regarding night shift being rude to him. LSW-A verified there was no investigation nor was there any further clarification from the resident regarding the accusations of staff behaviors of being abrupt, rude or harsh.

STAFF INTERVIEWS:

A staff questionnaire completed by an unknown NA dated 3/11/13 included, "Have you witnessed any verbal or physical abuse to any resident on the East end?" The unknown NA had responded, "Your [residents] going to have to wait until next shift comes; between 6- 6:30 a.m. during report; if BM (bowel movement) feel they have to wait until next shift and then forget to tell next shift." There was no further interview or investigation of this allegation of resident neglect.

During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated they had not followed up with any staff or residents regarding the alleged incident.

A staff questionnaire completed by NA-D dated 3/7/13 indicated, "Have you witnessed any verbal or physical abuse to any resident on the East end?" NA-D had responded a resident "needed a

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F 226	Continued From page 75 hoyer [lift], the resident said they wanted to walk so a NA put the walker in front of them and told them to walk. The resident said 'I can't walk.' Per NA-D the (unknown) NA was taken off that day." There was no further interview or investigation of this allegation of resident neglect; nor was the alleged NA perpetrator identified in this questionnaire.	F 226		
	During interview on 5/2/13 at 11:15 a.m., the DON stated the supervisor had "checked into this incident" and spoken to NA-D. The DON stated the administrator was not notified of the incident, nor was the SA contacted regarding the above incident. The DON verified she believed the resident was R67, however, stated she had not spoken to the resident or the alleged staff, NA-B (identified by DON), regarding this allegation of neglect and had no written investigation of the alleged incident. R67's quarterly MDS indicated she had moderate cognitive impairment.		R67. Report/investigation completed. Staff interviewed and validated NA-B account. Resident is cognitively impaired.	
	A staff questionnaire done by TMA-A dated 3/11/13, indicated she had reported to the nursing department a situation that had occurred between R67 and NA-B, "told R67 to 'walk then' since she insisted she could. Really needs hoyer... informed ADON and she talked to NA-B." There was no further investigation of this incident nor any interviews with the resident. R67's was a current resident, and their quarterly MDS indicated she had moderate cognitive impairment.			
	During interview on 5/2/13 at 11:15 a.m., the DON confirmed there had been no investigation, the administrator had not been notified of the incident, nor was the State agency contacted.			

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F 226	Continued From page 76 A staff questionnaire done by NA-A dated 3/8/13, indicated he "Knows there's issues on East end; didn't say specifics but said 'waters a little thicker over there'." There was no further interview or investigation regarding this statement. During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated they had not followed up with NA-A regarding the statement he made and they did not know what it meant. A staff questionnaire completed by the ADON dated 3/8/13 indicated, "Have any of your coworkers talked about any verbal or physical abuse they or anyone else may have done to a resident?" The ADON had responded, "Yes...Verbal... behind resident's back. Resident 'shit themselves'." There was no further interview or investigation of the statement, and the resident nor employee were identified in the above alleged incident. During interview on 5/2/13 at 11:15 a.m. the DON stated she was not aware of the above alleged incident nor was this reported to the administrator or state agency. A staff questionnaire done by RN-A dated 3/11/13 indicated, "Have any of your coworkers talked about any verbal or physical abuse they or anyone else may have done to a resident?" RN-A had responded, "NA's talking loudly and becoming more frustrated." RN-A also indicated a resident had told her she was left in the shower by staff, and it had been reported to OHFC; she stated the ADON investigated. RN-A also had multiple complaints of staff using cell phones and	F 226		

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F 226	Continued From page 77 observing a employee texting while sitting on a resident bed while the resident was using the bathroom. There was no further interview or investigation of these statements. A staff questionnaire completed by RN-B dated 3/7/13 asked, "Have you witnessed any verbal or physical abuse to any resident on the East end?" RN-B had responded, "Sometimes get after girls for not doing proper care; brush teeth, washing face." There was no further interview or investigation of this statement and neither the residents, nor employee were identified. During interview on 5/2/13 at 11:15 a.m., LSW-A and the DON stated the questionnaires completed by RN-A and RN-B were not followed up on, and there was no other information available regarding any of allegations. A staff questionnaire completed by NA-GG on 3/11/13 indicated, "R10 fell during a transfer with NA-C; NA-C came back to desk to eat and then laughed as she told the nurse [resident's name] fell; didn't find nurse right away." R10 was a current resident and their quarterly MDS dated 4/1/13, indicated she had severe cognitive impairment. During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated R10 had fallen and verified the incident had not been reported to the State agency as the facility had determined there was no neglect or mistreatment which occurred. The facility provided an interdisciplinary progress (IDP) note (which the facility identified as their investigation of the fall) for R10 dated 12/20/12,	F 226	R10. Fall was reported by former employee and allegedly occurred months sago. Interview/investigation completed. Staff training on transfer compliance. Nursing staff will/are conducting Care/Transfer audits on 35 residents for 4 weeks and 25 residents for 4 weeks. Side rails removed from bed as she needs 1-2 persons to assist with bed mobility on 12/18/12. Staff to utilize lift sheet, allegro pad and the resident to reposition. Brakes are to be on during transfers and re-positioning. Staff directed to be more careful and move slower when dressing, transferring, turning in bed, try not to surprise her to help prevent bruising.	

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F 226	Continued From page 78 regarding the fall which happened when NA-C was caring for the resident. The note identified the following: "Resident slid out of shower chair at 6:50 p.m. Staff was unhooking straps to lift sling when resident leaned forward and grabbed the lift bar and pulled herself forward. Resident started to slip to the floor; staff assisted resident to the ground...Resident does have a 2 cm (centimeter) long abrasion to the left side of her head... Bruising may happen to her coccyx area and the posterior side of legs bilaterally due to hitting the floor and legs of the lift... Resident proceeded to have bed bath..." After review of the IDP, during interview with the DON on 5/2/13 at 11:15 a.m., the DON verified the 12/20/12 progress note indicated R10 was being transferred with only one staff; although the resident is suppose to be transferred with two staff. DON stated this incident should have been investigated and reported to the SA and the administrator, which it was not. A staff questionnaire (undated and unsigned) indicated that R179 had complained about NA-D because she would turn off the call light and walk out; then come back with an attitude...crying resident [unknown]- burns on hands- crying because of NA-D; not sure why." The resident who was crying was unnamed, and there was no follow up to the reference of the burns on hands. During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated they were unaware of this statement regarding a resident with "burns on hands" and could not provide the name of a	F 226	R179. Resident was not burned. During investigation another resident was noted to have gauze bandaging on both hands and up her arms due to multiple skin tears from falls at home. She was admitted with the gauze bandaging and the NA mixed up the residents. The report and investigation were completed. Resident discharged 11-27-12. NA denied turning off the call light. Staff training about vulnerable adult abuse, resident rights, and the Elder Justice Act occurred in March 2013.; May 8 and 9 and	

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F 226	Continued From page 79 resident who had burnt themselves in the facility. The DON indicated R179 had been talked to regarding the allegations of NA-D turning off her call light, however the DON had no documented investigation of the incident, and it had not been reported to the administrator. The DON stated HR-J had issued an Employee Corrective Action to NA-D. The Employee Corrective Action form dated 3/14/13 included, "You have been witnessed being frustrated with a resident. You turned off the resident light and walked out and then went back into room with an attitude." The DON was unable to clarify what "an attitude" referred to and stated they'd felt there was no resident neglect or mistreatment occurring so this incident had not been reported to the SA. The DON verified there was not a thorough investigation including employee and/or resident interviews regarding the allegation. R179 did not have an MDS available to identify cognition. A staff questionnaire completed by NA-E on 3/7/13 indicated, NA-HH and NA-II "changed R5 and hit her on the bum." R5 was a current resident and their quarterly MDS dated 1/24/13, indicated the resident had severe cognitive impairment. The facility submitted a report to the state agency regarding R5 (above) on 3/13/13, 6 days after they were made aware of the allegation. The facility investigative report submitted on 3/13/13, indicated the following: "HR-J completed staff interview with NA-E on 3/7/13 "... During interview NA-E stated that she heard resident R5 had said that 'blonde girls hit her.'.. and changed her and hit on the bum..." The facility indicated as part of their investigation they spoke with R5 regarding	F 226	again by the DON and ADON June 3, 4, 5 and June6 by the NHA. Call light audits by the NHA will occur 15 times per week for 4 weeks and pager/cell phone audits will occur 10 times per week for 4 weeks. Data will be reported to QA committee for further direction. R5. Interviewed. Resident made various scattered comments which had nothing to do with the alleged incident. Unable to determine if the "hit to the bum" occurred. Social services to interview and ask about a "hit to the bum". Social services to interview 5 residents per week for 8 weeks. Data to be reported to QA for further direction.	

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the incident but she did not have any complaints about staff mistreatment and made remarks which did not make sense. The facility indicated "DON, ADON met with primary East end evening nursing staff on 3/8/13- staff were given direction on appropriate resident care." On 3/25/13 the state agency requested additional information from the facility regarding the report on R5. The state agency requested, "Were other residents interviewed as part of your investigation? Did other residents voice any concerns regarding their care? Was other staff interviewed? Did staff indicated they had witnessed any mistreatment by other staff?" The ADON replied on 3/25/13, "35 current residents were interviewed, some which do have dementia. No specific or substantiated reports were received from residents that they are/ were being mistreated by staff. 30 staff members were interviewed, mostly current employees and some past employees. Some staff alleged that other staff were neglectful and mistreated some residents but this was not reported to have been witnessed, just that they had heard about it. All allegations received through these interviews were filed with [state agency]."

The facility interview with R5 on 3/14/13, did not ask R5 about the alleged incident of 'blonde girls being mean' or 'changing and hit on the bum';' The resident was asked generic questions about care in general at the facility. Although the facility submitted a report to the state agency, they did not complete an investigation which included interviewing other staff and residents about R5's allegations. In addition, the further information submitted to the SA upon request did not include specific allegations which were made by staff and

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F 226	Continued From page 81 observed which the facility policy directed the facility to complete. A staff questionnaire completed by NA-E on 3/7/13 indicated, They "Heard [NA-F] hit R180; Resident grabbed her and she punched his arm...staff joked around about catheter equipment witnessed backflow...would silence [residents] alarms and not answer theirs or anyone else's call lights...Reported abuse to nurse on staff..." R180 did not have an MDS available to identify cognition. The facility submitted an OHFC report regarding the allegation of R180 being hit in the arm by NA-F. The facility investigative report submitted to the SA indicated, "After our initial interview with current and former staff, many names were named as people of interest. Due to short time period of employment, together with the passage of time (May 2012), one of the complainants (NA-K) could not recall the alleged perpetrators names but stated she would know them if she saw them again. We have just completed out investigation and are still sorting through our notes to determine whether any individuals stand out as abusive perpetrators. In the investigative process it was identified that an employee heard a resident may have been hit by a NA. The named resident died in March of 2012. There was one incident report of named resident having a bruise to his hands during this time period, it was determined hands were bumped while in wheelchair causing bruise to appear. No other reports of injury/ bruising to resident." Although the facility submitted a report to the SA regarding the allegation, the investigation did not	F 226	R180. Investigation/report completed. Resident died 3-19-13. East side staff provided with training on Vulnerable Adult Act, resident rights and care expectations by DON and ADON. In addition to the above, all staff completed Vulnerable Adult Abuse Act, Resident Rights and Elder Justice Act training in the Health Care Academy in March 2013. Vulnerable adult abuse act and resident right training occurred May 8 and 9. Nursing staff will have training June3, 4, 5 and all other staff on June 6 by the NHA on resident rights, and vulnerable adult abuse. Social services staff will interview 5 residents weekly for 8 weeks. Data will be reported to the QA committee for further direction.	

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F 226	Continued From page 82 identify the alleged perpetrator, although the employee was initially identified as NA-F. The facility did not complete any further staff interviews regarding the alleged accusation of R180 being hit on the arm. In addition, although the facility stated "many names were named as people of interest," there were no names submitted nor was there any investigation the facility could provide regarding this statement.	F 226		
	A staff questionnaire completed by NA-JJ dated 3/8/13, indicated, "snippy comments made to R57; 'here's your drink and I got to go; staff approach to resident." There was no further investigation of this statement nor was the staff person identified who made these remarks to R57.		R57Investigation and report completed. Resident calls out "owie" during cares, no matter how gentle the care giver is. During the interview, R57 responses have nothing to do with the discussion, for example, says, "get those darkies out of my room". Tylenol QID initiated along with behavior and pain logs.	
	During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A verified these allegations were made but there had been no investigation completed, also these allegations were not reported to the state agency or administrator as directed by the facility policy. R57 was a current resident and their quarterly MDS dated 3/14/13, indicated the resident had moderate cognitive impairment.			
	A staff questionnaire completed by NA-G dated 3/11/13 indicated, "[NA-R] verbally inappropriate to R39; she's not the only person to take care of and quit turning on lights...staff would talk dirty in from of R181 to get him to talk dirty." The facility had submitted a report to the SA's OHFC regarding this accusation on 3/13/13, regarding R181, 2 days after the facility was aware of the incident. The Investigative report submitted to OHFC indicated the following:		R39. Report/investigation completed. Resident interviewed with no complaints. Interviewed other residents about NA-R with no complaints. NA-R resigned.	

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"Throughout the course of our internal investigation, a number of occurrences of alleged abuse have surfaced... It has not been substantiated any resident was actually injured, their abilities affected, or lifestyle altered. Indeed, much of what we discovered points in the direction of a dysfunctional employment culture rather than any substantive resident abuse issues... Human resources (HR)-J completed staff interview with NA-G on 3/11/13... During the interview, NA-G stated 'staff would talk dirty in front of him [R181] to get him to talk dirty. This supposed allegation would have occurred sometime before 7/4/12 when R181 died. Due to these supposed allegation, DON and ADON met with East end evening nursing staff on 3/8/13-staff were given direction on appropriate resident care..."

Although the facility submitted the alleged verbal abuse to the SA regarding R181, the facility had not completed, or submitted, a thorough investigation including interviews done with staff members, nor was it clear whether NA-G had been interviewed to provide names regarding staff who had been talking dirty to R181. R181 did not have an MDS available.

During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated there had been no follow up or investigation regarding the allegation of NA-R being verbally inappropriate to R39. R39's was a current resident and their quarterly MDS dated 4/4/13 indicated she was cognitively intact, the DON verified she had not spoken to R39 or NA-R regarding the allegations of verbal abuse towards R39; nor had she reported the allegation

F 226

R181. Report/investigation completed. Deceased 7-4-12. DON and ADON met with evening staff on unit. They addressed Vulnerable adult abuse act, resident rights and care expectation. All staff completed Health Care Academy programs on Vulnerable adult abuse, residents rights and Elder Justice Act in March 2013. Training in vulnerable adult abuse act and resident rights occurred May 8 and 9. Nursing staff will be re-educated on vulnerable adult abuse, resident rights and care expectations by the DON and ADON on June 3, 4, 5 and all other staff by the NHA on June 6.

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to the administrator or SA as indicated by facility policy.

A staff questionnaire completed by registered nurse (RN)-B dated 3/8/13, indicated another resident "said a couple of (unknown) NA's complain about R10 always having to pee...R10 daughter said she'd overheard NA's complain they have 13 residents and they just can't do it anymore." The questionnaire asked if CM-B had ever gone to the nursing department to report abuse. CM-B had answered, "Yes; emailed DON regarding the complaint above." When asked if she was aware if the report was investigated or if she received a response from the nursing department she responded, "Never answered or responded with her follow up; do you think she reads her emails!" R10's quarterly MDS dated 4/1/13 indicated she had severe cognitive impairment.

During interview on 5/2/13 at 11:00 a.m. DON stated she remembers "hearing" about this complaint but believed the "talk" was coming from another resident who roomed next to R10; so the 'other resident' (unknown) was complaining about how often R10 was complaining, not the staff. However, there was no documented investigation, interviews, or follow up regarding this allegation. This allegation had not been reported to the administrator or SA in accordance with facility policy.

A staff questionnaire completed by LPN-G dated 3/8/13, indicated "Don't appreciate verbal communication to residents; baby talk; short staffed; short lipped." LPN-G indicated she'd had concerns a few months ago; "resident with a

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bloody nose; picked up tissue don't have time." This is all the questionnaire indicated. There was no resident named nor was there any follow up of what LPN-G was referring to.

During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A verified there had been no follow up or investigation regarding the allegations made by LPN-G, and there had been no follow up interview with LPN-G. In addition, they verified this allegation had not been reported to the administrator or SA as directed by facility policy.

A staff questionnaire completed by NA-F dated 3/8/13, indicated an unknown NA, "Would argue with [R180]; would scream at each other... heard 'one girl' was walking a resident while texting and resident almost fell.." NA-F indicated she had reported resident abuse to the nursing department and "was blown off. I couldn't take seeing my residents not cared for..." There is no further investigation of the above incidents. R180 did not have an MDS available for review.

Although this questionnaire was dated 3/8/13, during interview with the DON and LSW-A on 5/2/13 at 11:15 a.m., they stated they were unaware of this allegation. They verified there had been no investigation conducted, the administrator had not been notified, and there had been no report made to the SA, regarding NA-F's allegations.

A staff questionnaire completed by NA-KK dated 3/11/13, indicated she had witnessed neglect, "doing the bare minimum not positioning/ checking/ changing...call lights not in reach; don't

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F 226	Continued From page 86 put on toilet, just meant to change rather then put on toilet; turned off call light without doing cares; don't do peri care; hide in resident's room, texting while feeding residents...I'm quitting because my ethical standards are very high and I can't stand to see what's happening..." Although there are several staff names written on the side of the questionnaire, there was no investigation or follow up regarding these accusations, nor was there any follow up staff interviews conducted regarding the staff identified. During interview on 5/2/13 at 11:15 a.m., the DON and LSW-A stated there had been no investigation, nor additional interviews conducted regarding NA-KK's accusations of resident neglect. The DON and LSW-A verified they had not spoken to NA-KK regarding the allegations, the administrator had not been notified, and no report to the SA had been made. An undated staff questionnaire completed by NA-LL, indicated the NA had gone to the DON about staff mistreatment to residents but "[DON] got bent out of shape and told to go to nurse (LPN or RN supervisor); never comfortable going back to DON..." Witnessed abuse; "R59...NA-B screaming at him because resident keeping her late; R59 also talked to nurse; R59 scared...NA-B throws people into bed and yells at them while getting ready..." R59's quarterly MDS dated 1/4/13, indicated he was cognitively intact. R59 no longer resides in the facility. During interview on 5/2/13 at 11:15 a.m., the DON stated she believed the allegation was referring to a situation which had occurred between NA-B and R59 'months ago.' The DON	F 226	R59. Report/investigation completed. Removed NA-B from schedule while investigation was being conducted. Corrective action with NA-B. May 3 and 4 before staff began work they received training on the revised Vulnerable Adult Abuse act, counseling on teamwork, positive staff interaction, taking time with residents, empathy and considering each residents cognitive ability when providing care. Inservices by DON and ADON June 3, 4, 5 and the NHA on June 6 on vulnerable adult abuse and resident rights. Social services will interview 5 residents weekly about resident rights, the data will be	

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F 226	Continued From page 87 stated she had no formal investigation, nor had there been a report made to the SA, but the DON stated NA-B had told her "she would never do this" to R59. The DON stated she had spoken to R59 and felt R59 "would have told me" if there were any concerns of abuse. However, the DON was unable to provide any documentation of an investigation of this incident. LSW-A verified this allegation should have been reported to the SA immediately, then investigated. The DON verified the administrator was not aware of this accusation. During interview on 5/2/13 at 11:15 a.m., A-E stated he was not aware of any of the allegations of staff mistreatment and abuse which came from the staff and/ or resident interviews from March 2013. The facility provided several other submitted allegations of resident mistreatment which had been submitted to the state agency. The reports indicated the following: R75 had allegations of neglect. R75's quarterly MDS dated 1/1/13, indicated he was cognitively intact. The facility submitted a report to the state agency for R75 dated 11/8/12, with incident details including, "Staff reported that resident has a blister on his inner thigh. Resident reported that staff applied warm pack to resident's left leg that was too hot. Resident now has a blister/ redness on his left inner thigh." No "alleged perpetrator" was known. The facility's investigative report submitted to the	F 226	for further direction/action needed. R75. Report/Investigation completed. Training on facility policy regarding warm packs by DON and ADON on June 3, 4, and 5th. Nursing staff conducted/conducting Care/transfer audits for 35 residents per week for 4 weeks and then 25 residents per week for 4 weeks. Data will be reported to QA for further direction.	

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F 226	Continued From page 88 SA on 11/15/12 (7 days after the incident) indicated, "On 11/7/13 resident was noted to have redness and a blister within the red area on his left inner thigh. Blister was thought to have been caused by a warm pack that was applied to resident's left thigh per his request to help with pain control. Care plan interventions were being followed when the incident occurred. Internal investigation revealed that resident and his daughter felt that the warm pack was the cause of the blister. In talking with staff, they report the resident does request warm packs. Staff also reported that resident has requested that staff make the warm pack hotter. This information was obtained from nursing assistants that work with resident and they are considered a credible source. As stated prior, the resident sustained a blister on his left inner thigh which has not affected his abilities or lifestyle. An alleged perpetrator has not been identified. All staff have been instructed on facility policy regarding warm packs to attempt to prevent recurrence of the incident." The facility also provided the Resident Incident/ Injury Report Form dated 11/7/13, which the facility had not sent to the SA as part of their investigation. An attached note from the nurse, which appears to have been addressed to A-L and the DON dated 11/7/12 at 9:32 p.m., indicated R75 "Family noted a 3 cm long blister on his left thigh this evening that came from warm packs the resident has been requesting recently." Although the facility submitted a report of the incident regarding R75's blister to the SA, the report was made 11/8/12 (the next day), and the facility did not submit complete results of the	F 226		

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F 226	Continued From page 89 investigation including names of staff who were interviewed, whether the resident had used a warm pack in the previous days, whether a resident interview had been completed regarding when and who placed the warm packs, or identification of how staff was warming up and using the warm packs. During interview on 5/1/13 at 10:15 a.m., the DON and LSW-A verified the investigation results submitted to the SA were not complete. The DON also verified she was not aware of whether there had been any staff training regarding the proper use of warm packs following this incident. SW-A stated R75 was no longer in the facility but had no cognitive problems while a resident. R117, a current resident, had experienced a fall related to alleged neglect of care. R117's annual MDS dated 1/17/13 indicated he was cognitively intact. The facility submitted an incident report to the SA regarding R117 dated 12/14/12, "R117 was being transferred from the toilet to his wheelchair when he fell- he was being transferred with one staff, but his care plan is to use two staff with assist. " The facility's investigative report submitted on 12/17/12, indicated "On 12/14/12, [R117] was being toileted and was finished, so [NA-I] was going to transfer him from the toilet back to his wheelchair when... his leg buckled and he fell- she was transferring him by herself and did not have a second person to assist, therefore care plan interventions were not being followed when the incident occurred. R117 sustained no injuries during this fall...NA-I is aware of care plan, and was again made aware of the care plan as well	F 226	R117. Report/Investigation completed. NA terminated. Training on the plan of care and following the plan and transfers. Nursing staff conducting or are conducting transfer/care audits 35 residents for 4 weeks and then 25 residents for 4 weeks. Data to be reported to the QA committee meeting for further action.	

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F 226	Continued From page 90 as signed a corrective action." During interview on 5/1/13 at 10:15 a.m., the DON and LSW-A stated they were not aware of the above incident which had been submitted to the SA. However, the facility provided an Employee Corrective Action Notice for NA-I dated 12/14/12 indicating, "Transferred resident by herself he is a two person assist with transfers. He fell to the floor in his bathroom." The corrective action form was completed by HR-A. The DON and SW-A were unable to identify whether NA-I had received any additional education as identified in the investigative report submitted to the SA 12/17/12, which indicated that NA-I had been re-educated to the resident's plan of care. The DON stated that if NA-I had been educated, the education should have been kept in NA-I's file which would have been completed by nursing and not by HR-A. Although the facility reported the alleged neglect of health care to the SA, there were discrepancies in the investigation report regarding the employee's re-education following the incident. R57 a current resident, made allegations of neglect. R57's quarterly MDS dated 3/14/13 indicated she had moderate cognitive impairment. The facility submitted an incident report to the SA dated 10/11/12 indicating R57 "Reported that staff moved her call light out of reach while she was in bed. She was told to stop yelling and then staff told her if she needed to use the bathroom she'd have to do it where she was because she wasn't getting up. She said she felt closed in with the room door shut and no way to get up and out	F 226	R57. Report and investigation completed. Nursing staff training on May 8 and 9 included call light placement. That training also included appropriate responses to residents. Nursing training on June 3, 4, and 5 included responding to call lights. NHA administrator will audit 15 call lights each week for 4 weeks. Resident is not reliable during interviews. Her responses have unrelated comments interspersed with the topic of the conversation. Data will be reported to QA for further action.	

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F 226	Continued From page 91 of the room." The facility investigative report dated 10/16/12, submitted to the SA indicated..."Staff believes R57 had to wait about 6 minutes for two staff people to return to assist with her request. Staff reports that R57 did become upset when she had to wait for them... The following day, 10/11/12, writer was asked by R57's son to come to her room. He told writer she was very upset about care she had received. This writer spoke with her... The alleged perpetrator is a NA (un-named)... When R57 reported this incident to writer...R57 had reported another incident with this NA... This AP (alleged perpetrator) will not be scheduled to work with R57 and encouraged not to enter her room without a co-worker." On 10/1612, the SA had requested more information from the facility asking to provide the AP's (alleged perpetrator) name and asked if any other residents interviewed or asked if they had concerns regarding the AP's cares? The facility response identified the NA as NA-MM and included...."No other residents were interviewed. Staff working with NA-MM were interviewed and reported R57's call light was answered by the AP who informed the resident she needed assistance to reposition her...The other staff person reported she believed R57 waited between 5 and 7 minutes for two staff people to return to her room. Neither the AP nor the other staff person made mention of R57 yelling out or that her room door was closed." During interview on 5/3/13 at 11:15 a.m., the DON stated she was not involved in the investigation of the alleged incident with R57 and NA-MM. She stated it appeared the investigation	F 226		

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was not "complete" as none of the staff who were reported to be interviewed were named, nor was there any record of which staff was interviewed. There was also no interview with NA-MM. The DON stated NA-MM was still working at the facility and was not being monitored to ensure she no longer worked with R57. Although the facility reported the allegation to the SA, a thorough investigation was not completed and did they ensure NA-MM did not work with R57, even though R57 was upset by NA-MM actions.

During interview on 5/2/13 at 11:15 a.m., A-E stated back in January 2013, NA-LL had made "accusations" of resident mistreatment by staff. A-E stated nothing was done at that time, or reported, because of the "staff dynamics." A-E said he'd felt the accusations were all part of the "mean girls club" with staff accusing other staff of resident mistreatment to get them in trouble. There was no documentation of these allegations made by NA-LL in January. Then the facility received allegations of abuse and neglect from NA-K in March 2013. Many of the allegations that NA-K identified were "the same" as the concerns identified by NA-LL, so at that time A-E decided it would be best to look into some of the allegations.

The facility failed to ensure injuries of unknown origin were thoroughly investigated and reported to the State Agency (SA) and administrator.

The facility abuse policy dated 3/26/12, did not define injures of unknown origin; nor did it instruct staff on what to do if a injury of unknown origin was discovered.

Incident reports were completed for each resident with bruising. Incident reports are reviewed at the daily Falls meeting. Training on May 8 and 9 on the vulnerable adult abuse act included bruises of unknown origin. Training by the DON and ADON June 3, 4, 5 and by the NHA for all other staff on June 6th will include Vulnerable adult abuse act and bill of

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F 226	Continued From page 93 Review of the Bethesda Homes Resident Incident/Injury Report Form Evaluations, from August 2012 thru May 2013 were reviewed and the following was noted: R115's quarterly MDS dated 3/28/13 indicated severe cognitive impairment and required extensive assistance from staff with most activities of daily living (ADLs) R115 incident report noted bruises on 12/10/12, measuring 8 centimeters (cm) X 6 cm on the top left hand, 4 cm X 2 cm between the third and fourth finger of the left hand, 4 cm X 4 cm on right arm and a 6 cm X 4 cm bruise on the left buttock. The incident report indicated the staff were unsure when the bruises occurred, did not determine the source of injury, there were no observation of cares to determine if the bruises could have been a result of care received and no staff were interviewed. Although the administrator and DON were notified on 12/10/12, it was not reported immediately to the state agency (SA) as directed by the facility's policy. The facility investigation indicated resident "has been resistive and combative with cares", "bumps into things when up in Merry Walker", and bruise on buttock was explained "? from sitting down hard or bumping his buttock". There was no further investigation of the incident. R115 incident report noted bruises on 2/20/13, measuring 2 cm X 2 cm on left forearm, 5 cm X 2.5 cm on right outer elbow and 2 cm X 2 cm on the back of the right elbow. The incident report indicated the staff were unsure when the bruise occurred, did not determine the source of the injury, no observation of cares were completed to	F 226	rights and Elder Justice Act training via Health Care Academy. Nursing staff will/have conducted audits for cares/ transfers of 35 residents each week for four weeks and 25 residents each week for four weeks will occur. Results will be reported to the QA committee who will determine continued auditing needs. R115. Walks in Merry Walker. Frequently bumps into walls, chairs anything. Receives aspirin therapy. Sleeve protection in place. Audits of sleeve protection use will occur by DON three times a week for four weeks. Results will be reported to	

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F 226	Continued From page 94 determine if bruises could have been a result of care received nor were the resident or any staff interviewed about the injury. Although the administrator and DON were notified on 2/20/13, it was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated the resident is known to run into tables, counter tips and chairs when up walking in Merry Walker. There was no further investigation of the incident. R19's quarterly MDS dated 2/21/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R19 incident report noted a bruises on 4/28/13 measuring 7 cm X 6.5 cm to right hand and 3 cm X 1.3 cm to right forearm and 5 cm X 3.5 cm to left forearm. The incident report indicated R19 was unable to answer questions on how it happened or if she had bruises. Although the administrator and DON were notified on 4/28/13, it was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated "there is no IPN notes, 24 hour notes or behavior charting mentioning any bruising or a possible cause of the bruises". No staff interviews or further investigation of the incident was completed. R19 incident report noted a bruise on 3/13/13 measuring 6 cm X 10 cm on her left upper arm. The incident report indicated the staff were unsure when the bruise occurred, did not determine the source of the injury, no observation of cares were conducted to determine if the bruise could have been a result of care received,	F 226	the QA committee for further action. R19.Wheel chair armrest padding applied May 29, 2013. Resident moves about in bed a great deal. Side rail assessment completed 5/30/2013, side rails removed same date. 5-30-13 sleeve type arm protection in place. Staff training on vulnerable adult abuse, resident rights, and Elder Justice Act occurred on Health Care Academy in March 2013. Vulnerable adult abuse and resident right training occurred on May 8 and 9. Nursing staff training on June 3, 4, 5, by DON /ADON and by the NHA on June 6, 2013, for all other staff on vulnerable adult abuse and resident rights. DON will conduct abuse/neglect interview audits three times per week with nursing staff. Audits of wheel chair arm padding will occur three times a week for four weeks by the DON. Audit results will be reported to the QA committee for further action.	

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nor was the resident or staff interviewed. Although the administrator and DON were notified on 3/13/13, it was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated the bruise was "consistent with leaning towards the left in her wheelchair and leaning against the arm rest". There was no further investigation of the incident.

R19 incident report noted multiple bruises on 3/1/13 measuring 3 cm X 2 cm and 2.5 cm X 3 cm on right forearm, two bruises measuring 0.5 cm X 0.5 cm on the left forearm, two more measuring 1.5 cm X 2 cm and 1.5 cm X 1.5 cm further up the same left arm, 2.5 cm X 4 cm bruise on top of left hand. The incident report indicated the staff were unsure when the bruises occurred, no staff interviews were completed. The form identified the administrator and DON were notified on 3/2/13, one day after the bruise of unknown origin was discovered, the incident was not reported immediately to the SA and while the bruise on the top of the resident's hand was explained to be from a blood draw 2/26/13, the report indicated resident "is active and is capable of bumping her arms on her wheelchair, siderails and grab bars in the bathroom". There was no further investigation of the incident completed.

R19 incident report noted a bruise on 2/17/13 measuring 2.1 cm X 7 cm on her lower back. The incident report indicated staff were unsure when the bruise occurred, and the resident was marked as not interviewable. Although the administrator and DON were notified on 2/17/13, it was not reported immediately to the SA as directed by the facility's policy. The facility

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investigation indicated the resident sometimes "quickly" tries to transfer into the wheelchair, hitting the arm rest with her hips or back. There was no further investigation of the incident completed.

R19 incident report noted a bruise on 1/14/13 measuring 3.5 cm X 2.0 cm on her right breast. Although the administrator and DON were notified on 1/14/13, it was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated "when staff laid her down in bed, resident rolled and hit her chest on middle bar of the side rail". No staff or resident interviews were completed, or further investigation of the bruising even though the bruising was located on her breast.

R19 incident report noted bruises on 1/4/13 measuring 2.5 cm X 1.5 cm on right forearm, 4.0 cm X 2.0 cm and 5.0 cm X 3.0 cm bruises on left side of back and abdomen area. The incident report indicated staff were unsure when the bruise occurred, no observation of cares were conducted to determine if the bruise could have been a result of care received. Although the administrator and DON were notified on 1/4/13, it was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated the bruises are "consistent with resident hitting arms on bedside table and not sitting up straight in the wheelchair and hitting her side on the arm rest". No staff interviews were completed, or further investigation was completed to determine possible cause.

R19 incident report noted a bruise on 11/18/12 measuring 5 cm X 6.5 cm on left upper thigh. The

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F 226	Continued From page 97 incident report indicated staff were unsure when the bruise occurred. Staff was interviewed "thought it is possible resident bumped her thigh when she was transferring", and that although the R19 was not able to be interviewed, the report indicates "she does not recall anyone being rough with her, does not recall bumping, pinching, scratching herself". No observation of cares were conducted to determine if the bruise could have been a result of care received. Although the administrator and DON were notified on 11/18/12, it was not reported immediately to the SA as directed by the facility's policy. No further investigation of the incident was completed. R19 incident report noted multiple bruises on 11/12/12 measuring 2 cm X 0.5 cm on left shoulder, 2 cm X 1 cm on left hand below her wrist and 5.5 cm X 2 cm on left arm above wrist. The incident report indicated staff were unsure when the bruise occurred, no observation of cares were conducted to determine if the bruise could have been a result of care received and no staff interviews were completed. Although the administrator and DON were notified on 11/12/12, it was not reported immediately to the SA as directed by the facility's policy. The facility incident report indicated the bruises on her wrist were consistent with resident hitting arm on bedside table and side rail on bed and further indicated staff did not determine the source of the shoulder injury. No further investigation of the incident was completed. R177's admission MDS dated 10/15/12 indicated moderate cognitive impairment and required extensive assistance from staff with most ADLs.	F 226	R177. Deceased, hospitalize 11-28-12 and died there.	

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F 226	Continued From page 98 R177 incident report noted a scratch and bruises on 11/26/12, measuring 12 cm (scratch) and 3 cm X 1 cm bruise on left buttock, 1 cm X 1 cm and 2.5 cm X 2 cm to right buttock, a light bruise to back of left thigh. No observation of cares were conducted to determine if the bruise could have been a result of care received. Although the administrator and DON were notified on 11/26/12, it was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated that although staff was unsure when the bruises/scratch occurred, the bruise on left thigh was from her cushion in her wheelchair and the others were consistent from transfers from staff. No staff interviews and further investigation of the incident was completed. R8's significant change MDS dated 1/25/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R8 incident report noted bruises on 1/11/13, measuring 2 cm X 1 cm on upper outside of left arm, 1.5 cm X 1 cm on upper inside of left arm and 2.5 cm X 2 cm on right shin. Although the administrator and DON were notified on 1/11/12, it was not reported immediately to the SA as directed by the facility's policy. The facility incident report indicated that although staff was unsure when the bruises occurred, the arm bruises were from "hitting her side rails while in bed" and shin bruise was from "hitting her leg on her wheelchair". No staff interviews and further investigation of the incident was completed.	F 226	R8. Side rail assessment completed 5-30-13. Side rail use appropriate. Resident still using them.	

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F 226	Continued From page 99 R86's quarterly MDS dated 2/28/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R86 incident report noted a bruise on 11/20/12. The incident report indicated "a large yellow/purple bruise" on the outside of the right arm but had no measurements of size. No observation of cares were conducted to determine if the bruise could have been a result of care received nor was the resident. Although the administrator and DON were notified on 11/20/12, it was not reported immediately to the SA as directed by the facility's policy. The facility incident report indicated that although staff was unsure when the bruises occurred, the resident was often resistive to cares and attempted to wrestle staff member "1-2 weeks ago". No staff or resident interviews or further investigation was completed. R86 incident report noted a bruise on 4/16/13, measuring 5.5 cm X 4 cm on the left arm. Although the administrator and DON were notified on 4/16/12, it was not reported immediately to the SA as directed by the facility's policy. The incident report indicated the staff were unsure when the bruises occurred, but noted it was from "being combative with HS cares". No staff or resident interviews were completed, or further investigation of the incident was conducted. R109's quarterly MDS dated 3/14/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R109 incident report noted a bruise on 10/30/12, measuring 12 cm X 3 cm on her back.Although	F 226	R86. Resistive to cares routinely, bruising believed to occur during cares. Sleeve protection applied. Nursing staff are conducting/conducted Care/transfer audits on 35 residents for 4 weeks, and for 25 residents for 4 weeks. Data reported to QA committee for further action needed. R109. Forcefully seats self in chairs, on	

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F 226	Continued From page 100 the administrator and DON were notified on 10/30/12, it was not reported immediately to the SA as directed by the facility's policy. The incident report indicated the staff were unsure when the bruises occurred, but "assumed" the source of injury to be when an aide reported the resident sat down hard and hit her back on the top of toilet. No additional staff interviews or further investigation of the incident was completed.	F 226		
	R15's quarterly MDS dated 12/7/12 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs.		R15. Resident had history of punching, and hitting staff. He was resistive to measuring bruising. He died 1-16-13.	
	R15 incident report noted bruises on 11/23/12, measuring 3 cm X 2.5 cm and 3.5 cm X 4.0 cm on left hand, 2.3 cm X 2.3 cm on left wrist and 3.4 cm X 3.2 cm on right hand. Although the administrator and DON were notified on 11/23/12, it was not reported immediately to the SA as directed by the facility's policy. The incident report indicated the staff were unsure when the bruises occurred, and did not determine the source of injury but that the resident was combative prior to 11/23/12. No additional staff interviews or further investigation of the incident was completed.			
	R51's quarterly MDS dated 1/17/13 indicated severe cognitive impairment and was totally dependent on staff with all ADLs.		R51. Deceased 3-22-13.	
	R51 incident report noted a skin tear and bruise on 12/28/12, measuring 6 cm X 2.9 cm skin tear on left forearm and a 7.1 cm X 5.4 cm bruise			

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F 226	Continued From page 101 surrounding the area. Although the administrator and DON were notified on 12/28/12, it was not reported immediately to the SA as directed by the facility's policy. The incident report determined the source of injury was from staff boosting resident up in the chair and sliding the lift sheet up. No further staff interviews, observations of care or further investigation of the incident was completed. R68's quarterly MDS dated 2/7/13 indicated severe cognitive impairment and required extensive assistance from staff with ADLs. R68 incident report noted a bruise on 4/22/13, yellow in color on the right frontal mid thigh. No observation of cares were conducted to determine if the bruise could have been a result of care received. Although the administrator and DON were notified on 4/22/13, it was not reported immediately to the SA as directed by the facility's policy. The incident report indicated the bruise was consistent with "resistiveness with cares" during a shower. No staff or resident interviews were completed, or further investigation was completed. R98's quarterly MDS dated 2/21/13 indicated severe cognitive impairment and required extensive assistance from staff with ADLs. R98 incident report noted a bruise on 11/28/12, measuring 1.5 cm X 1.0 cm on right inner thigh. No observation of cares were conducted to	F 226	R68. Resident is resistive to cares. This bruising incident occurred while resisting a shower. Showers will be changed to mornings and re-evaluated. Nursing staff are conducting/conducted Care/transfer audits on 35 residents for 4 weeks and 25 residents for 4 weeks. Data reported to QA committee for further action. R98. Bruising believed to be caused by the Merry Walker strap. Now, only occasionally uses Merry Walker.	

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F 226	Continued From page 102 determine if the bruise could have been a result of care received. Although the administrator and DON were notified on 11/28/13, it was not reported immediately to the SA as directed by the facility's policy. The incident report indicated the staff were unsure when the bruises occurred but presumed the bruise was consistent where her incontinent pad is at times. No staff interviews or further investigation was completed. R128's who was a current resident, quarterly MDS dated 2/14/13 indicated he was cognitively intact and required extensive assistance from staff with most ADLs. R128 incident report noted a bruise on 9/8/12, measuring 1.6 cm X 2.4 cm slightly to the right of buttock crease. Although the administrator and DON were notified on 9/8/13, it was not reported immediately to the SA as directed by the facility's policy. The incident report indicated the date and time of injury was unknown, but was "a result from bumping into the siderails on his bed" during a transfer with a PAL lift. No additional interviews with staff, or further investigation was completed. R128 incident report noted multiple bruises on 10/30/12, measuring 2.3 cm X 2.3 cm and 1.5 cm X 1.6 cm to lower right arm, 2.2 cm X 2.0 cm and 1.5 cm X 2 cm to lower left arm and "large bruise" to top of left hand. The incident report indicated staff was unaware when the bruises occurred, did not determine the source of injury. Although the administrator and DON were notified on 10/30/12, it was not reported immediately to the SA as	F 226	R128. Side rail assessment completed. Use is appropriate and he continues to use them. Ambulates with a wheel chair, and bumps into objects routinely. Has sleeve type arm protection on. Nursing do Sleeve protection audit three times a week for 4 weeks. Data reported to QA committee for further action.	

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F 226	Continued From page 103 directed by the facility's policy. The facility investigation noted "bumps his arms on the table and other objects frequently". No interviews with staff or further investigation was completed. R10's quarterly MDS dated 4/1/13 indicated severe cognitive impairment and was totally dependent on staff with most ADLs. R10 incident report noted six bruises on both arms on 11/29/12, measuring 1.0 cm X 2.5 cm and 2.0 cm X 2.0 cm on upper right arm, 1.0 cm X 2.5 cm bruise by left elbow, 2.0 cm X 3.0 cm below left elbow, 1.5 cm X 2.0 cm on left forearm and 3.0 cm X 1.0 cm bruise on lower left forearm. Although the administrator and DON were notified on 11/29/12, it was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated resident "has a history of bruising to her arms and hands from bumping them on the bedside table, side rails, from lift sheet during transfers". No staff interviews or further investigation was completed. R10 incident report noted bruises on 1/13/13, measuring 4 cm on top of right hand, 2 cm X 3 cm by right thumb, 2 cm circle from left thumb to top of left hand. No observation of cares were conducted to determine if the bruise could have been a result of care received. The form identified the administrator and DON were notified on 1/14/13, one day after the bruise of unknown origin was discovered by a family member, the incident was not reported immediately to the SA,	F 226	R10. Re-arranged room. Side rails removed 12/18/2012. Recliner removed from room. Tried sleeve arm protection, did not work due to arm swelling. Padded wall by bed with a fall mat. Nursing staff conducted/conducting Care/transfer audits on 35 residents for 4 weeks and 25 residents for 4 weeks. Data to be reported to QA committee for further direction.	

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F 226	Continued From page 104 and facility investigation indicated the bruises were "consistent with where table is in dining room or where bedside table is", there were no staff interviews or further investigation completed.	F 226		
	R4's quarterly MDS dated 1/17/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs.		R4. Deceased 2-12-13. Was combative with cares as well as resistive. Hit wall with his hand.	
	R4 incident report noted bruises on 8/3/12, measuring 3 cm X 1.5 cm and 1.5 cm X 2 cm on right hand and a 2.5 cm X 1.5 cm bruise on the right hand and wrist. Although the administrator and DON were notified on 8/3/12, it was not reported immediately to the SA as directed by the facility's policy. The facility incident report indicated the resident was combative during his shower hitting his hands against a wall, however there was no staff interviews or further investigation completed about the incident.			
	R37's quarterly MDS dated 2/14/13 indicated severe cognitive impairment and required extensive assistance from staff with all ADLs.		R37. Resists cares and showers. Tried sleeve type arm protection; will not keep them on.	
	R37 incident report noted bruises on 8/3/12 measuring 1 cm X 1 cm on upper right wrist and a 0.5 cm X 0.5 cm on left inner wrist. The incident report indicated that she was resistive with cares on 7/30/12 during her shower. R8 was unable to respond when questioned. Although the administrator and DON were notified on 8/3/12, it			

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F 226	Continued From page 105 was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated resident was resistive with cares on 7/30/12 during her shower. There were no staff was interviewed or further investigation of the incident. R120's quarterly MDS dated 3/21/13 indicated severe cognitive impairment and required extensive assistance from staff with most ADLs. R120 incident report noted bruises on 8/19/12, measuring 3.5 cm X 5.0 cm on chest and a 9 cm X 13 cm on her right hand. The incident report indicated the staff was unsure when the bruises occurred or the source of the injury. Although the DON was notified on 8/19/12, it was not reported immediately to the administrator or to the SA as directed by the facility's policy. The facility investigation indicated "resident has been wandering the halls and throughout the unit this shift". There were no staff interviews or further investigation completed. R67's who was a current resident, quarterly MDS dated 1/24/13 indicated moderate cognitive impairment and required extensive assistance from staff with most ADLs. R67 incident report noted a bruise on 1/8/13, measuring 8.8 cm X 3.3 cm on left side of abdomen. Although the administrator and DON were notified on 1/8/13, it was not reported	F 226	R120. Receives aspirin daily. Was ambulating at that time with a walker, when she sat the walker was in front of her and she may have hit her chest on it. Deceased 5-16-13.	

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F 226	Continued From page 106 immediately to the SA as directed by the facility's policy. The facility investigation indicated resident skin was pinched in PAL belt. There were no staff interviews or further investigation completed about the bruising. R67 incident report noted multiple bruises on 8/2/12, measuring 0.9 cm X 1.1 cm on left forearm, 0.5 cm X 0.8 cm on top of right hand, 1.0 cm X 0.8 cm on right elbow, 0.9 cm X 0.9 cm on right deltoid, 0.6 cm X 1.0 cm on left buttocks. Although the administrator and DON were notified on 8/2/12, it was not reported immediately to the SA as directed by the facility's policy. The facility investigation indicated the resident bumps her arms all the time. There were no staff was interviewed nor further investigation of the incident as directed by the facility's policy. During interview on 5/1/13 at 11:15 a.m., the DON and SW-A stated all the above reports and investigations of bruising were complete and there was no further investigation conducted. The SW-A stated the "nurses" bring all bruising investigations to a Monday staffing meeting, and the staff review the bruising reports. However, the DON and SW-A could not remember having reviewed the above bruises of unknown origin. Following review of the investigations, they verified the investigations were not complete, and that these bruising of unknown origin should have been reported to the administrator and SA according to facility policy.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241	BPV promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The case manager	

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F 241	Continued From page 107 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to provide care for 1 of 1 resident (R43) in a dignified and respectful manner with regards to the resident's personal preference. Findings include: R43 reported she is being left in the dining room, alone at least once per week and she did not like this. She reported it is lonely and it makes her feel sad to be left there by herself. The resident was admitted to the facility on 9/12 with diagnoses of osteoarthritis (chronic arthritis, unspecific arthropathies (disease of the joints), congenital anomalies of the heart with congenital mitral insufficiency and adult failure to thrive. A quarterly minimum data set (MDS) was completed on 2/1/13 noted R43 was cognitively intact. The MDS indicated she wore a hearing aid and glasses, had clear speech and was able to communicate her needs without any problems. She had no specific behaviors or any symptoms of delirium. She needed extensive assistance from one staff for all her personal cares and her primary means of transportation was the wheelchair or walker. She was totally dependent on one staff for all her locomotion. A phone interview was completed with a family member (FM)-AA on 5/7/13 at 11:03 a.m. FM-AA	F 241	responsible for a plan to assure that R43 is not left in the dining room alone. The clinical manager and evening supervisor will audit the dining room 5 times per week for 4 weeks to assure the plan is being followed. Results will be reported to the QA committee. DON and ADON will conduct training on dignity June 3, 4, 5, and the NHA will be responsible for training on June 6th. Case manager is responsible to assure R43 is not left alone in the dining room. Social services will interview R43 weekly for four weeks about her dining experience. Results will be discussed with case manager weekly and changes made as needed. Data reported to QA committee for further action. The NHA is responsible for compliance with resident rights.	7-8-2013

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F 241	Continued From page 108 reported she came to see R43 at about 6:45 p.m. on a Sunday night, approximately 5 or 6 months previous. She found R43, sitting in the dining room, by herself and she was crying. FM-AA indicated R43 told her, she had been left all alone and that she could not get any help to get back to her room. FM-AA indicated that a dietary aid was in the dining room at the time but R43 reported the dietary aid did not pay attention to her. FM-AA indicated she talked to some nursing assistants who were working that evening and they admitted to her they had forgotten R43 in the dining room. R43 was interviewed on 5/7/13 at 11:00 a.m. and reported she had been left alone in the dining room by staff several times. She indicated this occurs on a regular basis about once a week. She stated she felt lonely and sad when this happened and was unsure why but told staff how she felt when this happened. An interview with nursing assistant (NA)-CC and NA-EE at 11:20 a.m. on 5/7/13 was completed. Both NA's reported they were aware that R43 did not like to be the last resident in the dining room as the resident had talked to them about this. An interview with registered nurse care manager (RN-A) was completed on 5/7/13 at 11:34 am. RN-A reported she was not aware of R43's request, nor was she aware of the reported incident. RN-A indicated she should have been told about this by the nursing assistants and a plan for ensuring R43 was not left alone in the dining room should be part of her plan of care. She indicated it was currently not in her care plan.	F 241		
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES	F 242	Please see top of page 110 for the plan of correction. Thank you.	

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F 242	Continued From page 109 The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 2 residents reviewed for choices, (R122), was allowed to sleep where he chose according to previous life routines. Findings include: R122 quarterly minimum data set (MDS) dated 3/1/13 indicated the resident had moderate cognitive impairment and was an extensive assist with all activities of daily living (ADL's). During observation on 5/1/13 at 8:00 a.m. R122 was observed laying in his bed sleeping. R122's current plan of care dated April 2013 identified R122 "sleeps in recliner often, refuses to lay in bed." R122's current nursing assistant care sheets dated 5/1/13 instructed staff resident "allowed to be in recliner as much as he wants; patient to be offered option of change of position every 2 hours." R122's current physician orders dated May 2013	F 242	BPV assures that the resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Data about choice is collected on admission, annually and with significant change. The data is utilized in the development of the resident's plan of care. R122 is asked where he prefers sleep. Any such requests will be honored, communicated on the 24 hour report, documented in the chart, noted on resident's plan of care and the NA care assignment sheet as done for R122. All staff were trained via Health Care Academy on Vulnerable Adult Abuse, Resident rights and the Elder Justice Act. Staff were trained May 8 and 9 on Vulnerable Adult abuse and resident rights. Nursing staff were trained on June 3, 4, 5 all other staff on June 6 by the NHA about vulnerable adult abuse and resident rights. All staff are trained on the bill of rights in new employee general orientation and annually. Quarterly nursing department meetings will have a standing agenda item of resident rights. The NHA is responsible for compliance with resident rights policies and procedures. Staff will continue to collect data on resident choices and	7-8-13

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F 242	Continued From page 110 instructed "Patient to be allowed to be in recliner as much as he wants; Patient need to be offered option of change of position every 2 hours..." This order has an original order date of 1/27/12. During interview on 4/30/13 at 3:40 p.m. R122 stated the evening staff does not let him sleep in his recliner at night. The resident stated he had "always" slept in his recliner as it is more comfortable, but the staff tells him he needs to get off his bottom so they make him lay down in bed at night. R122 stated he tells the staff he does not want to lay in bed, but they make him lay down. During interview on 4/30/13 at 3:55 p.m. nursing assistant (NA)-A stated R122 often wants to sleep in his recliner, but NA-A stated he tells the resident he needs to lay in bed to get pressure off his "bottom." During interview on 5/1/13 at 8:00 a.m. registered nurse clinical manager (RN)-A stated R122 does have a physician order which instructs staff the resident can be up in the recliner as much as he chooses. RN-A stated staff should be offering the resident the choice to lay in bed; but not making him lay in bed. During interview on 5/1/13 at 12:30 p.m. family member (FM)-G stated she had told staff "many times" R122 can sleep in the recliner if he chooses; they had even obtained a physician order to allow the resident to sleep in the recliner, but staff still lays him in bed at night even when R122 tells them not to. Although R122, a family member, and a physician	F 242	staff will interview 5 random residents each week for 8 weeks about resident rights. Data will be reported to QA committee for further direction. NHA is responsible for compliance with resident rights.	

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F 242	Continued From page 111 order made staff aware of the residents wishes to sleep in the recliner in the evening; the facility failed to allow R122 a choice regarding where he wished to sleep.	F 242		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to ensure a physician was notified of changes in a residents condition which included fainting spells during transfers and abnormal vital signs for 1 of 1 residents (R122) who had a change in condition. Findings include: R122 since 12/07/2012, had experienced several episodes of passing out while using the standing mechanical (PAL) lift, had vital signs outside of the normal parameters, and developed a pressure ulcer on 3/29/13. R122 physician was never notified of these changes in R122 condition. R122 had diagnosis including hypertension and heart disease. R122's quarterly minimum data set (MDS) dated 3/1/13 identified the resident had	F 309	BPV provides the necessary care and services to attain and maintain the highest practicable physical, mental and psycho-social well-being, in accordance with the comprehensive assessment and the plan of care for each resident. R122 was seen by the NP on May 10, 2013, metoprolol orders decreased from 50 mg to 25 mg with orders to monitor vital signs and inform NP. Subsequently, the dose was reduced to 12.5 mg on May 13, 2013. May 15, 2013, the resident's physician saw him and made no further changes. There have been no further episodes of lightheadedness. The policy and procedure for notifying families and physicians has been reviewed and revised. The policy and procedure for vital sign outlier's has been reviewed and revised. Staff training will occur June 3, 4, and 5th about vital sign monitoring and expectations of reporting to the clinical manager, notifying physicians/physician extenders, families about changes in condition. The 24 hour report tool has had MD notification and family notification added to it. Consulting pharmacist will be given access to care tracker in order to monitor vital signs as needed. Case manager to review all residents vital signs.	7-8-13

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F 309	Continued From page 112 moderate cognitive impairment, needed extensive assistance with all activities of daily living, was totally dependent on staff for all transfers, and did not have any skin concerns or pressure ulcers. During interview on 5/1/13 at 12:30 p.m. family member (FM)-G stated she was aware R122 had passed out in the lift before and thought it could be happening because only one person is transferring the resident in the lift, and the resident had to spend more time being "held" up by the lift and he "loses his breath and faints." FM-G stated she had not spoken to the physician or nurses why R122 was passing out while using the lift. During observation on 5/8/13 at 11:07 a.m. R122 was being transferred by the PAL mechanical lift with nursing assistant (NA)-M and NA-N. When R122 was raised up during the transfer, his arms were shaking while holding onto the handles, and his toes were just touching the platform of the standing lift. His feet were swaying, not applying any weight while in the mechanical lift. NA-M and NA-N verified R122 was not 'standing', his feet were just touching the platform of the lift. Both NA's stated R122 has "passed out" on the lift when lifting him, which NA-N stated R122 would "...lose his breathe." During interview on 5/8/13 at 1:35 p.m., R122 stated he believed he passes out when on the standing lift because the staff raise him so high and he is just "hanging there." He indicated when he passes out it happens more often when there is only one staff transferring him with the standing lift because it takes longer and he had to "hang"	F 309		

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F 309	Continued From page 113 longer in the lift. R122's medical record, interdisciplinary progress notes (IPN) identified the following episodes of R122 "passing out" when using a mechanical (PAL) lift for transferring. 12/7/12- "Family is aware that he does have a spell and 'pass out' when in lift; PLEASE assist him to meet his toileting needs..." 1/21/13- "This afternoon staff had resident standing in standing PAL lift. They were changing his pad. He had a spell. His face got red and his body went faint. Staff put him down on toilet and he came to." No vital signs were documented on 1/21/13. 1/25/13- ..."Attempted to lift resident in standing PAL lift...resident went unresponsive while in the lift. Resident was transferred into recliner and became responsive." No vital signs were documented on 1/25/13. 3/6/13- "Family is aware that he does on occasion have a spell and pass out when in the lift." 3/26/13- "Resident had an unresponsive episode at 0700 while in PAL lift, he turned purple in color then went very pale and gray in color and his eyes were rolled back in his head. This writer sternum rubbed him for about one minute when he responded to his name, however, he would not open his eyes and look at staff that was in room with him at the time. Once he did start responding he was then lifted with the PAL again to get his incontinent product on him and he has been resting well since." No vital signs were documented on 3/26/13. 4/12/13- "Resident went unresponsive while staff had him in the PAL lift during cares, resident was sat down right away in his wheelchair and	F 309		

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F 309	Continued From page 114	F 309		

responded after one minute." Vital signs staff had taken were charted as pulse 43 and blood pressure 113/59.

During interview on 5/8/13 at 10:30 a.m. registered nurse clinical manager (RN)-A stated the physician or nurse practitioner (NP) had not been aware of R122 passing out on the standing lift. She stated she had called the NP today to make her aware of R122 passing out spells on the lift and she was going to see R122 'tomorrow.' RN-A verified there had been no assessment to ensure R122 was safe to use the standing PAL lift since admission in 2011. In addition, RN-A was unable to locate any orthostatic blood pressures done on R122 since admission in 2011 and verified it was 'facility policy' every resident should be getting orthostatic blood pressures checked monthly. RN-A stated with R122 passing out on the standing lift, orthostatic blood pressures should have been checked as well as vital signs should have been monitored when the resident passed out on the lift; however, she was unable to provide vital sign readings from when the resident had passed out on the standing lift.

R122's also had various vital signs that were out of the normal range for individuals. The Mayo Clinic identifies a "normal blood pressure is 120/80" and your "heart rate (pulse) can range from 60-100 beats per minute. If your pulse is consistently lower or higher than this and have symptoms of dizziness or lightheadedness you are to consult your physician." In review of R122's current physician orders, dated 4/2013, identified the following medications were ordered:

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F 309	Continued From page 115 Metoprolol tartrate 50 mg twice a day for hypertension (high blood pressure). Lisinopril/ HCTZ 10/12.5 mg everyday for hypertension. Lasix 40 mg twice a day for edema (swelling). Zaroxylin 2.5 mg daily for edema. Upon review of R122's vital signs charted in Care Tracker under "Resident Vitals Chart" indicated the following: 2/26/13- Blood pressure (B/P) 95/57 pulse (P) 45. The B/P and pulse were not rechecked to ensure they were accurate or if the B/P and pulse improved. 3/5/13- P-49. There was no recheck of this reading. 3/12/13- B/P-55/96. P-41. There was no recheck of this reading. 3/15/13- B/P- 53/99. P-44. There was no recheck of this reading. 3/19/13- B/P- 97/55. P-46. There was no recheck of this reading. 3/26/13- P-45. There was no recheck of this reading. 4/12/13- P43. There was no recheck of this reading. 4/16/13- B/P- 100/57. P-45. There was no recheck of this reading. 4/23/13- B/P- 76/38. P- 46. There was no recheck of this reading. 4/30/13- B/P- 92/54. P-49. There was no recheck of this reading. During interview on 5/7/13 at 1:00 p.m., Nursing assistant (NA)-O stated the nursing assistants do the vital signs and if they are out of range they are suppose to report them to the nurse in	F 309		

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F 309	Continued From page 116 charge. NA-O was unaware of R122 having out of range vital signs. During interview on 5/7/13 at 1:05 p.m. licensed practical nurse (LPN)-A stated if a blood pressure or pulse is "out of range" the NA's should be reporting the vital signs to the nurse so it can be closely monitored, and are to be reported to the physician. LPN-A stated the nurses do not check the vital signs the NA's do on the residents, but it is the it is responsibility of the NAs to report to the nurse if there are vital signs is an out of range. LPN-A acknowledged that R122's current medications can effect blood pressure and pulse, but was unaware of R122's past abnormal vital signs. During interview on 5/7/13 at 1:15 p.m. RN-A reviewed the vital signs charted for R122 and stated the vital signs should have been rechecked, reported to the nurse, and to the physician. RN-A verified the abnormal vital signs were not followed up on or reported to the physician. RN-A stated when the physician or NP visits the resident, the vital sign review is done off the most recent vital signs obtained, they don't always see all the vital signs that were done for the last month. During interview on 5/7/13 at 3:20 p.m. facility pharmacist (P)-I stated she was not aware of R122's out of range vital sign readings. She stated she does not have access to care tracker where the vital signs are charted. P-I stated she reviews the last physician note regarding vital signs and they have all been within normal range. P-I stated she would expect the facility would	F 309		

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F 309	Continued From page 117 notify her if there were concerns with abnormal vital sign readings. P-I also stated the medications R122 is currently on would greatly effect the blood pressure and pulse and these should be monitored closely. The facility policy, entitled: Vital Sign Policy and Procedure (dated 1/07) instructed, "Vital signs will be monitored weekly and as needed. Licensed Practical Nurses or trained nursing assistants are responsible for obtaining vital signs. All vital sign results will be reported to the nurse."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to adequately monitor and assess pressure ulcers for 1 of 2 residents (R122) in the sample who had a pressure ulcer. Findings include: R122 quarterly minimum data set (MDS) dated 3/1/13 identified the resident was moderately	F 314	BPV, based on a comprehensive assessment of a resident, ensures that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives the necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Resources were contacted to assist in the development of a wound system to include product line selection and when to utilize each product; monitoring of pressure ulcers which would include location, staging, size, exudates, pain, description of wound bed and wound edges. Weekly wound rounds will occur. Training is scheduled for June 13, 2013 for nurses on the wound protocol. R122 pressure ulcer documentation and IPN was completed on May 3, 2013; family and MD	7/08/2013

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F 314	Continued From page 118 cognitively impaired, was an extensive assist with all activities of daily living (ADL's), and had no pressure ulcers. During observation on on 5/2/13 at 9:20 a.m. with registered nurse clinical manager (RN)-A R122 had a pressure areas on the buttocks. RN-A pointed out two small open areas on R122's left and right buttocks and stated she thought they appeared "better," although she was unable to verify the last time she had seen R122's pressure ulcers. RN-A stated she had nothing to currently measure the pressure ulcers with, but both the areas (one on the left buttocks and one on the right buttocks) appeared to be stage one pressure ulcers, and she would return "later in the day to measure them" and then document the measurements in the interdisciplinary progress notes (IPN). Upon review of R122's IPN identified the following notations: 3/29/13- "Coccyx is red. Applied as needed calmoseptine. Notified RN. 3/31/13- "Resident has red open area on his bottom. Calmoseptine cream applied. Will continue to monitor." 3/31/13- "Resident was repositioned every 2 hours and Calmoseptine was applied to his open area on his bottom..." 4/1/13- "Resident has two open areas on bottom. One on right upper buttocks and one on left upper buttocks. Stage one with no drainage. Staff have been applying Calmoseptine to area daily with cares, however, they have not minimized. Assisted staff with cleansing buttocks area. Applied skin barrier prep. Let dry. Applied	F 314	May 3, 2013; family and MD notified as of May 3, 2013. Follow up with the CNP on 5/5/13 for further treatment advisement. Response from MD regarding treatment on 5/7/13. Single use measuring tools are on the treatment carts. DON will audit charting weekly on each resident who has a pressure sore and assure wound/skin rounds are completed weekly for 8 weeks. Audit results will be reported to the QA committee monthly. DON is responsible for implementation of on-going wound program.	

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Calmoseptine over both open areas. Applied Mepilex dressings, one to each open area."
4/11/13- "Per RN request leave residents bottom wound/ sore open to air dry. Please apply calmo. Will continue to monitor."
5/1/13- "Resident continues to have two open areas on bottom. One area on right buttocks close to butt crease is stage two with no drainage. It appears smaller in area than previously recorded... Left area of buttocks is healed and is a stage 1 with a pinpoint stage two present close to butt crease, no drainage."

The facility did not complete ongoing weekly monitoring of R122's pressure ulcer that included location, staging, size, exudate, pain, description of wound bed and wound edges.

On 5/2/13 RN-A documented a note of the observed pressure ulcer with the surveyor. The 5/2/13 noted indicated, "In April it was noticed he had a stage one/stage two pressure areas on his bottom near his butt crease. The treatment followed out wound protocol... currently there is a stage one to the right buttocks that measures 4 cm x 3 cm with a stage two center near the crease that measures 0.3 cm x 0.3 cm. The left buttocks has a stage one near the crease that measures 3 cm x 3 cm and a stage two in the center which measures 0.2 cm x 0.2 cm. There is redness and purple colored skin noted on bottom..."

During interview on 5/7/13 at 11:50 a.m. RN-A stated staff were aware of R122's pressure ulcer at the end of April, but did not notified the physician or nurse practitioner about R122's pressure ulcers until 5/3/13. The facility followed

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F 314	Continued From page 120 their wound protocol (about one month after the facility identified R122 had pressure ulcers). RN-A verified they should have notified the physician about the pressure ulcer, to determine if the treatment was effective or if they wanted to change the treatment. RN-A verified there was no consistent (weekly) monitoring of the pressure ulcer characteristics that identified location, staging, size, exudate, pain, description of wound bed and wound edges. The facility policy titled Pressure Ulcer Treatment Policy and Procedure dated 2/23/04 instructed, "The physician or nurse practitioner will be notified of all new wounds, when there is a significant change in a wound, and when a wound is not healing... assess the ulcer and document appropriately."	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess falls for 1 of 5 residents (R78) who were at risk for falls, failed to ensure safe transfers for 2 of 2 residents (R122, R3) who needed	F 323	BPV assures that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The falls policy and procedure was reviewed and revised. Falls incident report form was reviewed and revised. Falls incident reports are to be completed for an observed fall or unobserved fall. All falls are reviewed by the daily (Monday through Friday) falls committee for completeness of the report, analysis and for any other recommendations to the plan of care. The Safety Risk Data Assessment is completed on admission and quarterly. Each fall is 'logged' onto the form. The ADON is	7-8-13

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F 323

Continued From page 121

assistance with transferring to prevent potential accident hazards.

Findings include:

R78's annual minimum data set (MDS) dated 2/1/13 identified R78 had severe cognitive impairment, needed extensive assistance with all transfers, and was unable to walk. R78's current plan of care dated April 2013 identified R78 was at risk for falls. The interventions included call light available at all times, have objects within reach, bed in low position, tabs alarm in wheelchair, and pressure alarm in bed.

R78 was observed on 5/1/13 at 11:50 a.m. sitting in her wheelchair in the dining room with a hoyer sling underneath her with a personal (tabs) alarms, (an alarm that would notify staff if R78 moved), clipped to the upper part of the back of her sweatshirt.

Review of R78's interdisciplinary progress notes (IPN) revealed the following:

4/17/13 at 9:54 p.m.- "Resident fell this evening around 9:20 p.m. Resident attempted to self transfer from wheelchair to bed. Resident was found on floor with back to the ground. Resident did receive a skin tear to the left elbow measuring 1 cm x 1 cm, skin was still intact and retracted back to normal position... Resident with left hip pain, was able to move leg up and down, no bruising at this time. Family not notified do to the late hour and doctor not updated..."
4/18/13 at 12:46 a.m.- "Resident complaining, crying with left hip pain, holding her hand on her hip and periodically pulling up stating her nerve

F 323

responsible for maintaining a spread sheet with information about each fall a resident experiences. The spread sheet is used at the falls committee to assist with analysis. Nursing staff training on June 3, 4, 5 and for all other staff on June 6 by the NHA to include the falls incident report changes, necessity to follow resident care plans and the use of the falls spread sheet. Falls committee meeting will occur daily (Monday through Friday) to review all incident reports from the time of the previous meeting. DON is responsible to assure that the falls incident reports are complete, and the Safety Risk Data Assessment is updated with each fall. Transfer methods are determined by the case managers with assistance from physical therapy as needed. Two person transfers or various mechanical devices are used for resident/staff safety. This will be re-iterated in the staff training. Nursing staff are/have conducted auditing of care/transfers 35 times per week for 4 weeks and 25 times per week for 4 weeks. Results will be reported to the QA committee who will determine the ongoing auditing plan.

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F 323	Continued From page 122 was making her do that. Crying 'what can I do it hurts so much.' Phone call placed to emergency room and received an order from triage nurse to send over via ambulance for evaluation of left hip pain from recent fall." 4/18/13 at 2:52 a.m.- "Emergency room stating resident fractured her left hip and is on her way to St. Cloud hospital." The facility provided a Falls Incident Report regarding R78's fall on 4/17/13 which included the investigation of the fall. The investigation indicated the current interventions which had been in place to prevent falls were call light in reach, call light on, anti-slip material, transfer belt, side rails, tab alarm, pressure alarm, body pillow, hi/ lo bed, bed by wall. The investigation indicated the resident fell when trying to self transfer from the wheelchair to bed, and the resident had her call light on. The interventions which were immediately put into place were "assessed for injury and put into bed; gave pain medication." The fall investigation was signed off by the director of nursing (DON), administrator (A)-E, and the licensed practical nurse (LPN)-G who was working when R78 fell. The investigation did not include if the tab alarm was sounding, any interviews with staff, nor did it identify if any new interventions should be implemented to decrease R78 risk of falling. Review of the Safety Risk Data Assessment dated 4/21/13, indicated the fall interventions included tab alarm bed and chair, side rails, bed against wall, pressure alarm bed, grab bar in bathroom, and hi/ low bed. The "safety interventions and/or environmental modifications implemented" were "Fell, tried to transfer self.	F 323		

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F 323	Continued From page 123 More frequent checks." During interview on 5/6/13 at 12:05 p.m. LPN-A stated she had "heard" about R78's fall and the facility was short staffed that evening. LPN-A stated another staff member told her an aide had been in R78's room prior to the fall, and told the resident she would come back to put her to bed, but never came back. The resident had been sitting there waiting to go to bed and "she (aide) never came back so she just transferred herself" and fell. During interview on 5/6/13 at 2:45 p.m. NA-L stated she was working when R78 fell on 4/17/13. NA-L stated she went in the residents room to check on R78's roommate and then saw the resident laying on the floor. NA-L stated the tabs alarm was not sounding because R78 was able to unclip her own tabs alarm and it was not hooked up to her at the time of the fall. NA-L stated "I always told [R78] not to unclip her tabs alarm; she did it all the time." NA-L stated no one had ever interviewed her about R78's fall and what had happened. NA-L stated the night R78 fell they were short one NA that evening, and she was working down that hallway herself. During interview on 5/7/13 at 12:05 p.m. DON stated she did the investigation of R78's fall. She "thought" she had interviewed the NA working with R78 on 4/17/13 at the time of the fall, however, she was unable to provide any documentation of the fall investigation or interviews completed with any staff regarding R78 fall to determine if there was a pattern or other interventions to help decrease R78 risk of falling.	F 323		

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F 323 Continued From page 124 F 323

During interview on 5/8/13 at 10:00 a.m. clinical manager (CM)-A stated the facility had not implemented any new interventions to be put into place for R78 to prevent further falls. CM-A verified an investigation was not completed after R78 fall on 4/17/13 to determine if other interventions could be implemented to decrease R78 risk for falls. CM-A was not aware R78 was able to remove the clip tab alarm and she had not spoken to any of the staff who were working the evening of 4/17/13 when R78 fell.

Review of the facility policy titled Falls Policy dated 1/2013 instructed staff "The interdisciplinary team, including the physical therapist, will review falls on a weekly basis at the weekly falls committee meetings... A falls investigation worksheet will be completed by the LPN/TMA at the time of each fall and appropriate interventions will be implemented immediately to try to prevent additional falls." The policy also instructs staff to determine if the plan of care was being followed during falls, and if it is not it is to be reported to the state agency. However, the facility did not do a investigation to determine if the residents current plan of care was in place and being followed.

R122 was not transferred as directed by the care plan to prevent potential accidents and injury.

R122 quarterly minimum data set (MDS) dated 3/1/13 identified R122 had moderate cognitive impairment, needed extensive assistance with all activities of daily living, and was totally dependent on staff for all transfers.

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F 323	Continued From page 125	F 323		

R122's current plan of care dated April 2013 identified R122 was an extensive assist of two with a standing PAL lift for all transfers.

During observation on 4/30/13 at 3:55 p.m. nursing assistant (NA)-A was observed coming out of R122's room alone with the standing PAL lift. NA-A stated he had just taken R122 to the bathroom using the standing lift. NA-A verified R122 was suppose to be an assist of two staff, however, the facility was short staffed and there was no other staff to assist with the transfer so he did it alone. NA-A stated he "usually" transfers R122 alone with the standing PAL lift as there is no other staff available to assist.

During interview on 5/1/13 at 12:30 p.m. family member (FM)-G stated she is at the facility on a daily basis in the afternoon. She was aware R122 had fainting spells in the past using the standing lift and believed it happened more often when there was "only one staff doing the transfer" with the standing lift. FM-G verified she had observed "many times" when only one staff transfers R122 using the standing lift.

During observation on 5/8/13 at 11:07 a.m. R122 was being transferred by the PAL mechanical lift with nursing assistant (NA)-M and NA-N. When R122 was raised up during the transfer, his arms were shaking while holding onto the handles, and his toes were just touching the platform of the standing lift. His feet were swaying, not applying any weight while in the mechanical lift. NA-M and NA-N verified R122 was not 'standing', his feet were just touching the platform of the lift.

During interview on 5/8/13 at 10:30 a.m. clinical

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F 323	Continued From page 126 manager (CM)-A stated she was not aware R122 was being transferred with only one staff member and verified the resident needed extensive assistance of two staff with all transfers. During interview on 5/8/13 at 11:20 p.m. physical therapist (PT)-F stated if R122 was not bearing any weight he needed to be reassessed. He continued to state any resident who uses a standing (PAL) lift needs to be able to bear weight for a safe transfer with this device. PT-F verified the therapy department had not seen R122 since 2011. Upon review of the undated PAL Lift Policy and Procedure instructed staff "The PAL lift is a mechanical lifting device that is meant to be used to provide safety for both residents and staff... Using the PAL lift requires two staff to assist." Although R122 was assessed to be an extensive assist of two for transfers with the standing PAL lift, the facility was transferring the resident with only one staff member. Also R122 was not bearing any weight even though he was using a mechanical standing lift in which he must be bearing weight. R3 was not transferred as directed by the care plan to prevent potential accidents and injury. R3 had diagnosis including spinal cord injury with paraplegia. R3's annual minimum data set (MDS) dated 3/21/13 indicated she was alert and orientated and needed assist of two with transfers. R3's current plan of care dated 3/25/13 indicated that she is alert and orientated and	F 323		

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F 323	Continued From page 127 transferred with a mechanical lift (hoyer) and assist of two staff. During interview on 5/3/13 at 2:00 p.m., R3 stated that there has been several times that NA-FF has transferred her with only assist of one. R3 stated this happens because they are short of staff and NA-FF has told her if the staffing doesn't get better he is going to quit.	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to 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. 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: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) 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	F 353	BPV provides sufficient nursing staffing to provide nursing and related services to 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. To assist in providing sufficient staffing new technological efforts are being tried (May 29 and 30 placed on web) to recruit nurses and NA's (as well as any other open position on the campus). Ads were placed May 30 and 31 to come out in early June. Contacts were made to include positions available in area church publications. Incentive programs to entice current staff to pick up shifts were implemented. Time limited recruitment bonus' were implemented. All efforts will be evaluated by the Recruitment and Retention committee for efficacy. Schedules will be posted with open shifts, so staff know what shifts are available to pick up.	7-8-13

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F 353	Continued From page 128 review, the facility failed to provide adequate staffing to ensure residents received required assistance with activities of daily living during resident interviews and review of the Resident Council minutes. These concerns were voiced by 6 residents (R122, R26, R133, R3, and R24) out of 118 residents who currently reside in the facility. In addition, 6 of 8 family members (FM-G, FM-BB, FM-M, FM-CC, FM-H, and FM-AA) interviewed had concerns about personal cares not being performed due to a lack of staff.. Additionally, 19 staff (LPN-B, NA-V, TMA-B, NA-Q, TMA-C, NA-H, NA-A, NA-GG, NA-C, LPN-A, RN-D, LPN-E, NA-HH, NA-II, NA-U, NA-T, LPN-F, RN-B, NA-M), interviewed; expressed they were unable to care for residents properly due to insufficient staff. Findings include: A complaint was reported to state agency on 1/11/13 (H5427017) of the memory care unit at the facility being short staffed especially on weekends and on 3/12/13 (H5427019) of facility staff being observed turning the audible part of the call light off at the nursing stations and not answering the call light. In addition, it was reported some residents who required two person transfers were being transferred by one staff. These allegations were validated during the survey 4/29 thru 5/8/13. R122's quarterly minimum data set (MDS) dated 3/14/13 indicated moderate cognitive impairment. R122 was interviewed on 4/30/13 at 3:40 p.m.	F 353	and what is expected for the current day. DON is responsible for maintaining adequate staffing. DON will attend resident council to explain BPV plans for hiring staff. All staff will be trained and expected to answer call lights by the DON/ ADON on June 3, 4, 5 and by the NHA/DON on June 6th. Nursing staff will be expected to wear and utilize pagers to assist in responding to call lights. Cell phones are not to be on 'the person' of any staff (except administrator, and the DON and ADON when they are on call). Cell phones on the person of an employee must be approved by the person in charge of the building. Job fair to be held for all open positions on June 19 at the facility. Audits of who responded to call lights will occur 20 times each week for 8 weeks by the NHA. Pager and cell phone audits will occur 10 times per week for 4 weeks by the DON. Data will be reported to the QA committee for further direction. R122. Staff trained in safe patient handling. Emphasis on plan of care states two person transfer or two persons with	

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F 353	Continued From page 129 and stated when he asks to go to the bathroom at night staff told him they don't have time to take him to the bathroom and tell him to "poop or pee" in his pad. R122 stated about a month ago he put his call light on for help but the staff kept coming in and turning it off without helping him. He stated he started to scream for help, but finally just gave up because no one would help him R26 significant change minimum data set (MDS), completed on 1/4/13 indicated R26 was cognitively intact. R26 was interviewed initially on 4/29/13 at 3:45 p.m. R26 voiced concern regarding facility staffing and staffing turnover. She reported that staff change all the time and there had been four occasions when the new staff placed her call light out of her reach and she was unable to call for help. She reported being aware that she was not to ambulate by herself as she had a history of falls but feels due to staff shortage she had no option but to take herself to the bathroom. R26 was interviewed on a second occasion on 5/7/13 at 4:05 p.m. and again verified she was very concerned about shortage of nursing staff. She reports there are times when two staff are to help her and there is only one. R133 quarterly MDS completed on 1/18/13 indicated she was cognitively intact. R133 was interviewed on 4/30/12 at 9:27 a.m. She reported that did not feel the facility had enough staff. Indicated that will have to wait a long time to get some help just to use the bathroom. She also indicated for two days (day shift) the week prior, only one nursing assistant worked on her wing of the facility. R133 stated she told staff had "called	F 353	mechanical lift, then two persons must be involved. Nursing auditing 35 care/transfers per week for 4 weeks, then 25 per week for 4 weeks. Call light audits of 15 per week for 4 weeks by the NHA. All data will be reported to QA for further action needed. R26. Call light audit 15 times each week for 4 weeks. Nursing training on June 3, 4, and 5 included appropriate call light response and placement. Data reported to QA for further direction.	

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F 353	Continued From page 130 in" for the shifts and they were not replaced. She reported that the staff person tried to do the best she could but at one point, four resident call lights were on and the "yellers were yelling." She indicated that she felt it was impossible for the staff to work alone on her wing and provide adequate care to the residents. She indicated the nursing assistant was red in the face and sweating during the shifts and "I felt really bad for her." She also stated, " I told her just to sit on my bed and rest a few minutes before she had a heart attack." R133 was interviewed again on 5/5/13 at 1:30 p.m. and repeated her concerns regarding staffing shortage. She stated "I pay good money to be here and they should have more staff." R133 reported the primary reason, she was at the facility was due to problems with balance. She reported she was aware she was to have staff with her whenever she gets up, walks or goes to the bathroom. She reports urinary urgency at times and when she knows staff are short, will take herself to the bathroom, which she knows increases the chance of falling. She denied any incident of falling at the facility but reported that had fallen prior to her admission. She also reports she had episodes of being incontinent of urine as staff did not respond to her call light quickly enough. R133 indicated she felt very angry at the management of the facility for not ensuring enough staff to care for the residents. R3 complained of short staffing and not being transferred according to her plan of care because of insufficient staffing.	F 353	R133. No resident identified as 133. R3. Training on transfers occurred May 8 and 9. Training on transfers occurred on June 3, 4, and 5. Care/transfer audits	

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F 353	Continued From page 131 R3 had diagnosis including spinal cord injury with paraplegia. R3's annual minimum data set (MDS) dated 3/21/13 indicated she was alert and orientated and needed assist of two with transfers. R3's current plan of care dated 3/25/13 indicated that she was alert and orientated. The care plan also specified that R3 was to be transferred with a mechanical lift (Hoyer) and assistance of two staff. During an interview on 5/3/13 at 2:00 p.m., R3 stated there had been several times NA-FF had transferred her by herself. R3 then stated "this happens because they are short of staff and NA-FF has told her if the staffing doesn't get better he is going to quit." R3 did state she has not reported this to the facility but then stated "they know the staff are only using one staff to transfer." R24 was interviewed on 5/7/13 at 3:10 p.m. R24 voiced she was very concerned about the short staffing of the facility. He reported that it seemed like it was quite frequent that nursing assistants were expected to work a wing of the facility by themselves, which was not possible. He reported the facility has a lot of turnaround and just can't seem to keep enough staff. He indicated some staff leave as they don't get paid enough and go elsewhere. R24 reported 5 out of 7 days; there were not enough nursing assistants on his wing. He reported he had talked to the Director of Nurses about his concern about staffing and felt the facility was not doing enough to retain nursing assistants. R24 also reported he had fallen in the past, when he attempted to transfer himself to the bathroom and there were no nursing assistants around. Stated "I just could not wait any longer	F 353	each week, then 25 residents each week. Two persons are to used whenever a mechanical lift is the designated transfer. Safe patient handling training occurred on all of the training dates as well. Call light audits will occur 15 times each week for 4 weeks with the data reported to the QA committee for further direction. R24. Resident is self transferring. Nursing care/transfer audits for 35 residents each week for 4 weeks occurred, then 25 residents for 4 weeks. Call light audits 15 times each week for 4 weeks. Data to be reported at QA committee for further direction.	

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for help." He also reported episodes of urinary incontinence as the staff were busy with other residents and could not help him in time and he wet himself. R24 indicated this made him mad and angry.

There were 6 of 8 family members interviewed that identified concerns about personal cares not being performed due to a lack of staffing.

During interview on 5/1/13 at 12:30 p.m. FM-G stated the facility is often short staffed. FM-G stated her family member is supposed to have two people transfer him with the mechanical standing lift for safety, but she had observed "many" times only one staff transferring him with the lift because of the lack of staff.

A phone interview was completed 5/2/13 at 3:41 p.m. with FM-BB. FM-BB reported that her family member was no longer at the facility but was on the memory care unit in October and November of 2012. FM-BB reported she was very dissatisfied with the services that had been provided. She indicated she had observed staff transferring residents without the use of a transfer belt. She also felt the facility was very much in the business to make money and were not overly concerned about the care of the residents. She reported the nurses on the memory care unit seemed to be short and could not provide quality care to the residents. She also reported that her family and other residents had episodes of urinary incontinence, primary as there were not enough staff to respond quickly enough to the call light FM-BB stated her family had fallen while in the facility when she tried to get out of bed on

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F 353	Continued From page 133 her own. FM-BB stated luckily she did not get hurt. FM-BB also reported she had noticed her family member had a lot of bruising and felt this was related to staff being so rushed due to shortage. FM-BB indicated, she was at the facility as much as she could as she felt she needed to be there to make sure her family was getting the care she needed. During interview on 5/3/13 at 8:30 a.m. FM-M stated the facility is very short staffed. She stated because of the short staffing, staff is inconsistent and the care provided to the residents is not adequate as they don't know the residents. During interview on 5/3/13 at 1:42 p.m. FM-CC wanted to voice concern regarding staffing. Indicated she will visit her family member in the afternoon to ensure she is at the facility over a meal as her mother needs to be fed and a lot of times there are not enough staff to feed the residents their meals. She voiced concerns regarding how long it took for call lights to be answered and reported that it took at least 20 minutes for the staff to respond. FM-CC reported that a lot of times, staff are working 16 hour shifts and voiced concern regarding this. She also said the facility does not seem to be able to keep good staff and the morale of the nursing staff is "terrible" and is worried on the impact of this with the care of her mother. During interview on 5/6/13 at 3:20 p.m. FM-H stated the facility is very short staffed. She stated one evening her family member did not get their 8:00 p.m. medications until 10:30 p.m. because there was not enough staff to give the residents their medications. FM-H also stated when she comes to visit her family member, residents will	F 353		

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ask her if she is able to help them to the bathroom as they can't get help from staff to go and they can't wait any longer.

FM-AA was interviewed on 5/7/13 at 11:03 a.m. FM-AA reported felt the facility was very short of nursing staff. She reported that will have to wait a long time for someone to respond to her mother's call light. She also reported an incident where her family member had been left alone in the dining room, about 5-6 months previous. She indicated the nursing assistants had told her that her family member was forgotten. FM-AA blamed nursing shortage for the staff forgetting her family member in the dining room. She also reported she came to see her family about 6:45 p.m. on a Sunday night about 5 or 6 months previous and found her sitting in the dining room, by herself crying. FM-AA indicated her family member told her, she had been left all alone and that she could not get any help to get back to her room. FM-AA indicated a dietary aid was in the dining room at the time but her family reported the dietary aid did not pay attention to her. FM-AA indicated she talked to some nursing assistants who were working that evening and they admitted her mother had been forgotten in the dining room.
There were 19 staff members interviewed; expressed concerns as they were unable to care for residents properly due to insufficient staffing.

During interview on 4/29/13 at 6:06 p.m. LPN-B stated the facility had "quite a turn-over" in staff in the last several months. LPN-A stated the nursing assistants (NA) are "always" short staffed, and the memory care unit will often have one trained medication assistant (TMA)

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F 353	Continued From page 135 responsible to give medications for the whole unit, which makes it difficult to get the residents their medications according to their schedule. During an interview on 4/29/13 at 6:25 p.m., NA-V reported the last year, "it (staffing)has gotten real bad, people are getting burnt out, we can't get new hires and as soon as we get them, another one quits." NA-V stated she does see a difference in staffing levels between shifts, during the day there are eight aides, nurse managers, administrative desk staff and on evenings there are only 7 aides on for the entire east wing. NA-V further stated she does not feel there is enough time to complete all the cares for the residents. During interview on 4/29/13 at 6:44 p.m. TMA-B stated the facility is short staffed "on a normal basis." She stated at times she is the only TMA to give medications to two halls of residents, when core staffing is supposed to be one TMA or LPN for each hallway to pass medications. TMA-B stated the weekends are very short staffed for the NA's, so it is very difficult to get all of the resident cares done on the weekend. During interview on 4/29/13 at 7:00 p.m. NA-Q stated the NA's "are always short staffed; especially on the weekends." NA-Q stated she does her best to do cares for the residents, but can't possibly "keep an eye on all the residents." She stated she is often by herself down a hallway and she has to transfer residents who are a two person transfer by herself because there are no staff available to assist with transfers. During interview on 4/29/13 at 7:05 p.m. TMA-C stated in the last two or three months a lot of staff	F 353		

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F 353	Continued From page 136 have quit. TMA-C stated the facility is "always" short staffed, especially on the weekends. He stated the memory care unit is usually at least two NA short on the weekends, according to the facility's core staffing requirements. During an interview on 4/30/13 at 11:30 a.m., nursing assistant (NA)-H reported she felt very short of staff. She reported they (the staff) work short a lot of the time. Indicated that the week prior, worked on a wing by herself and needed to get the residents up, dressed for the day, fed breakfast/lunch and respond to residents as they requested. She indicated she was responsible for approximately 14 residents and also expected to help other nursing assistants if needed. She reported a staff person had "called in" and they were not replaced. She also reported the day prior to this interview, she was ill and had "called in" and was not replaced and so the other nursing assistants had to work short. NA-H reported that weekends were "really bad" as staff almost always worked short. She indicated that residents know when they are short as they see us working so hard and they also ask, who is working the wing. She reported when working short, she has been told to "slow down" by the residents. NA-H admitted to using a PAL lift (personal stand lift) by herself when she was aware the facility's policy is to be used by 2 staff. She also reported that she had transferred two person assists independently as she could not find any other staff. Stated she will get "written up" if she gets caught doing this but stated "what am I supposed to do?" NA-H has brought staffing concerns to management personal but they tell us they are trying to hire staff but they	F 353		

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F 353	Continued From page 137 have been saying this for a long time and nothing happens. During interview on 4/30/13 at 5:40 p.m. NA-A stated the facility is very short staffed. He stated "all" the NA's need to transfer residents alone, regardless if the residents are supposed to be a two person transfer. He stated he worries about the "girls" in the memory care unit as they are small and transferring "these big men" without assistance. NA-A stated he believed falls and accidents have happened as a direct result from being short staffed, however, he was unable to give specific details. NA-A verified he had just transferred R122, who was an extensive assist of two, on the standing lift (PAL) by himself as there was "no other staff available to help." During an interview on 5/1/13 at 11:00 a.m., NA-GG reported felt staffing was an issue for the facility. Admitted she would transfer a two person assist by herself at times when she was not able to find other staff to assist her. Also reported she would transfer residents by herself when using the PAL lift. NA-GG acknowledged the facility's policy's were to have two staff to transfer residents using this piece of equipment but reported she did not feel she had any other option. She acknowledged she would get reprimanded if the facility found out. Also reported she felt there were more falls and unexplained bruising on residents as staff are so rushed. NA-GG reported she was unable to identify any specific resident or incident. During interview on 5/1/13 at 2:50 p.m. NA-C stated the facility is always short staffed and the	F 353		

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only way they ever have enough staff is if another NA is willing to pick up a shift.

During interview on 5/2/13 at 9:10 a.m. LPN-A stated the facility is short staffed and it can be "frustrating" to try to get all of the resident cares done. LPN-A stated she was aware NA's had to transfer residents who were supposed to be a two person transfer by themselves. She stated if the NA's don't have another person to help them, and there is only one nurse passing medications, "there is no other choice" regarding transferring residents with only one staff when they are assessed to be a two person transfer for safety.

During an interview on 5/5/13 at 12:45 p.m., with RN-D reported that a resident had fallen the night previous. She indicated this resident had fallen previously and acknowledged the facility's short staffing probably was a factor in the falls. She reported there are not enough staff to watch resident's and ensure the resident's safety.

During an interview on 5/3/13 at 1:15 p.m., licensed practical nurse (LPN)-E stated staffing had been a significant issue for the past year at the facility. She reports there are times the wings of the facility are staffed by only one nursing assistant, especially on weekends. Indicates that staff shortages occur when staff "call in" and are not replaced and at times, the schedule "is short" (not enough staff scheduled). Indicated each wing at the facility does have residents, who are 2 person assists and when only one staff member is working, it is almost impossible for safe transfers. LPN-E indicated she was aware at

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times, residents are being transferred with a PAL lift with only one staff, which is against facility policy. LPN-E was unable to remember any specific incident but stated "knows it happens." LPN-E also reported it seemed like more residents were falling and having more bruising than previously when there were more staff at the facility.

During an interview on 5/5/13 at 1:40 p.m. NA-HH voiced concern regarding facility staffing. She reported working short at times at the facility and residents do not get the care they should be given. She also acknowledged transferring 2 person transfers by herself and using the PAL lift by herself, which she knows is wrong.

During interview on 5/5/13 at 1:40 p.m. with NA-HH, NA-U, NA-II, NA-T, NA-GG and NA-H, a discussion was completed regarding call light response. The nursing assistants reported they are to wear a beeper, which will alert them to a call light sounding. They indicated they are able to disengage the beeping sound with this beeper. They reported they have been instructed not to disengage the beeping sound but acknowledge not following this guideline. In addition, they do acknowledge, that at times, they will turn off the call light in resident's rooms, without responding to resident's request. They also acknowledged telling the resident "will be back as soon as they can to help them" and they do try to respond as quickly as possible but sometimes, don't get back to the resident as fast as they would like. They also reported there have been occasions, when they have forgotten about the resident's request and the resident had to put the call light on for the

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F 353	Continued From page 140 second time. During an interview on 5/5/13 at 1:55 p.m., LPN-F reported concerns regarding staffing, especially on the Memory Care unit. LPN-F reported she was "tired of working so short." She indicated the Memory Care unit has three staff short during the weekend as two of the shifts were scheduled short and one of the staff "called in" and this person was not replaced. She indicated due to the staffing shortage, she is responsible to administer all medications and do all the treatments on both wings of the Memory Care unit. She reported management staff have been talked to many times without any resolution of the staffing issue. She indicated she loves working with the residents but does not feel they are getting the care they deserve. Due to the staff shortage, she called her daughter, who is not employed by the facility but does work in health care, to come to the facility this morning and dish out resident's breakfast, Stated " we just did not have enough staff to do it all this morning." During an interview on 5/6/13 at 8:45 a.m. registered nurse (RN)-B reported she felt the facility was understaffed. Indicated felt the Memory Care unit was the shortest in staffing compliant and frequently worked short. RN-B reported that when staff are short on the memory care unit, residents would not get their weekly bath and walked as care planned. Stated there is just not enough staff to get it all done. RN-B also reported at times staff are very rushed with resident cares and therefore, the residents do not get as much attention as they should get. She has also had families complain about staffing and	F 353		

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reported to her that nursing assistants are forgetting to put in resident's teeth, hearing aids or glasses.

During interview on 5/8/13 at 11:05 a.m. NA-M stated the facility is "always short staffed." She stated there "are many times" when she had to transfer a resident who is a two person transfer alone. NA-M stated there is not enough help to get another person to assist with a transfer and the cares need to be done. NA-M also stated staff is instructed to turn resident call lights off "as soon as possible." She stated staff will go in and turn call lights off, and then tell the resident they will come back to help when they can. She verified at times this can be over 20 minutes before they can return to help the resident.

Resident council meeting minutes were reviewed from March 2012 to April 2013.
In August, September and November concerns were raised regarding staff turning call lights off and saying "I'll be right back", but not returning. The activity director (AD) who attended the meetings filled out a Resident Council Response Form (RCRF) on 8/31/12 and 9/28/12 outlining the issue and gave it to the DON. The November 30, 2012 council notes indicated the "issue has been raised several times and nursing is aware" and the DON as well as the administrator will be alerted again.

During an interview on 5/3/13 at 8:32 a.m., AD stated the residents have brought up the issue of waiting a long time for help after they put their call lights on three times since August of 2012. She

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stated when issues are brought up she will fill out a RCRF and give it to appropriate department manager to address. AD states in August 2012 she completed a RCRF stating "numerous complaints of long waits to have call light answered (no specific times), staff coming into room and turning call light off, and telling resident "will be right back." She reported that residents who attended Resident Council reported the staff "do not get right back" and at times forget they need to respond to the call light. AD reported she gave a written complaint from the resident council members to the director of nurses (DON) in August and when no response was received; she resubmitted the concern again in September. AD stated the staffing issue was again brought up in November 2012 and as she had not gotten any response from the DON, she sent an email to the facility's administrator. AD was unable to provide documentation as to the feedback or message received from the administrator as their email system crashed and all email messages were lost.

During an interview with the schedule coordinator (SC) on 5/8/13 at 2:30 p.m., she acknowledged the facility was short twenty two (22) positions specifically one registered nurse, three licensed practical nurses, and eighteen (18) nursing assistants. She also reported there have been times when the two week schedule had been posted with holes in them (no staff coverage). She indicated she would attempt to fill in these holes but some of the time, there were no staff to fill them and then the wings would work short. She also reported that when a staff person "called in," she would try to replace them with a staff person, who would work an extra shift. She

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indicated that some of the time, no staff would agree to work the extra shift and then the wing would work short. SC reported when schedules were posted short or she was unable to find a staff to cover an open shift, she did inform the DON of this.

During an interview with the DON on 5/7/13 at 2:40 p.m., the DON reported she felt there were enough staff to provide a safe environment for residents. She also acknowledged at times, the wings do work short and she is informed of when this occurs. She also acknowledged being informed when the nursing schedule is posted with open shifts.

During an interview with the Administrator on 5/8/13 at 10:05 a.m., she acknowledged the nursing department does have staffing issues. She indicated she was not aware staff were working shifts with less than core numbers or the schedule was being posted with open shifts.

Based on interview, and document review the facility failed to ensure that a physicians were notified of changes in a residents condition which included fainting spells during transfers, abnormal vital signs and development of a pressure ulcer for 1 of 1 residents (R122) who had a change in condition that needed physician intervention. Refer to F157 for additional information.

Based on interview and documentation review, the facility failed to provide care for 1 of 1 resident (R43) in a dignified and respectful manner with regards to the resident's personal preference. Refer to F241 for additional information.

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F 353	Continued From page 144 Based on observation, interview, and document review the facility failed to comprehensively assess falls for 1 of 5 residents (R78) who were at risk for falls, failed to ensure safe transfers for 2 of 2 residents (R122, R3) who needed assistance with transferring to prevent potential accident hazards. Refer to F323 for additional information.	F 353		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain safe dishwashing temperatures in a manner to prevent the potential spread of food borne illness for 117 of 118 residents who currently resided in the facility and received food/fluids from the facility kitchen. Findings include: During the initial tour of the kitchen on 4/29/13 at 1:35 p.m. with dietary aide (DA)-E, staff was observed utilizing the high temperature dish machine which registered the final rinse at 178	F 371	BPV stores, prepares, distributes and serves food under sanitary conditions. On April 30, the dishwasher was inspected and had blown a fuse. Fuse replaced April 30, 2013, with appropriate temperatures since. The policy and procedure for when to use alternative sanitizing has been reviewed and revised. Dishwasher temperatures are logged three times per day. The food service director or designee will check the temperature audits for temperature compliance a minimum of three times weekly for 30 days and no less than once weekly going forward. Staff were trained on the new policies and procedures on May 30, 2013. Food service director is responsible to assure all dishes, utensils and etc are sanitized.	5-30-2013

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 145 degrees Fahrenheit (F). Review of the April dishwashing temperature log recorded three times per day, indicated 12 low rinse temperatures ranging from 163-178 degrees F between April 2-26, 2013 with 43 time slots having no temperatures recorded. 88% of the rinse temperatures in a two day period (April 24-26, 2013) were consistently lower than 180 degrees F. No temperatures for either wash or rinse were recorded between April 27-29, 2013 at time of survey. During an interview on 4/29/13 at 1:35 p.m. with DA-A stated the rinse temperatures were low and Ecolab was called today to fix the dishwasher. DA-A stated they record the temperature that is on the dish machine, but "don't know why I didn't today". DA-A and DA-B offered no other information when asked what they should do when the dish machine temperatures were low. During an interview on 4/29/13 at 1:50 p.m., the dietary manager, (DM)-A stated she was made aware today of the final rinse temperatures not being hot enough and a call had been placed to Ecolab on Friday, April 26, 2013 by another manager about the temperatures. DM-A stated when the temperatures are low they use Eco-San in the final rinse. Staff will put 1/3 cup in the rinse compartment and check with a chemical strip the parts per million (ppm) after every three trays. DM-A verified there was no record that either temperatures or the chemical strip identifying the ppm had been taken since 4/27/13, stating "I don't know why they didn't record temperatures or strips". During an interview on 4/29/13 at 3:50 p.m., the	F 371		

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F 371	Continued From page 146 Ecolab representative (ER) stated he did not receive a work order until today (4/29/13). ER connected his computer to the Ecolab system (detergent and rinse compartments) that was attached to the dish machine to access data that includes temperatures. ER stated in March the dish machine registered 100% of rinse temperatures at 180 degrees or higher and that April 24th is first time an issue came up. Data indicated that on April 24, 2013 only 24% of the temps met the 180 degree F rinse guideline, April 25- 29%, April 26- 27%, April 28- 35% and as of 4 p.m. on April 29, only 22% of the rinse temperatures were at or above 180 degrees. ER stated if the machine temperatures are low he was told the facility uses 1/3 cup Eco-Sanitizer in the rinse compartment for every 3 trays and further stated that they then should be verifying the effectiveness by checking the ppm on chemical strips. During an interview on 4/29/13 at 4:50 p.m., DA-C stated "if the dish machine is beeping, they go to "the book" and do what it tells us to do, such as changing or filling the white detergent container". DA-C and DA-D both stated they were not sure what to do if the dish machine temperatures were low. DM-A stated she was surprised that they did not know what to do. During an interview on 4/29/13 at 4:55 p.m., DM-B stated "I called Ecolab on Friday, I should have followed up on it, but I did not". On Friday she was aware the Ecolab unit was beeping, but did not go back to look at what the problem was. DM-B verified it is protocol to use the sanitizer at times when the dish machine temperatures are low, but did not tell staff to use the Eco-Sanitizer	F 371		

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F 371	Continued From page 147 all weekend. DM-A opted to use disposable dishware for the supper meal. During an interview on Interview on 5/1/13 at 1:28 p.m., DM-A verified she does not have a policy for using the Eco-San solution when dish machine temps are low nor does she have a dishwashing policy. DM-A verified that the system needed to be changed.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their	F 441	BPV has established and maintains an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The program investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections. Policies, procedures have been reviewed and revised. A policy for culturing of prolonged eye infection has been developed. Each resident will be assigned his/her own glucometer. It will be terminally cleaned upon death or discharge. The handwashing policy for nursing staff has been reviewed and revised. Policy/procedure for eye infectons and eye cultures were reviewed and revised. The DON will be responsible for monitoring/auditing infections and assuring facility practices have been followed. Infection data/analysis will be	7-8-2013

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F 441	Continued From page 148 hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the infection control program included tracking, trending, and analysis of resident and employee infections which would assist in determining a potential outbreak. This affected 4 of 15 residents (R109, R68, R177 & R137) on the B wing who had "pink eye" and could potentially affect 120 residents, who currently reside in the facility. In addition, the facility failed to ensure infection control practices were followed regarding hand hygiene, use of gloves and cleansing of the glucose testing equipment for 1 of 2 resident (R106) observation of glucose monitoring which had the potential to affect 31 residents at the facility, who had blood glucose monitoring and insulin injections. Findings include: The facility infection control program did not include tracking, trending, and analysis of resident and employee infections, which affected 4 of 15 residents (R109, R68, and R177) who	F 441	Reported to the QA committee. Training on the above will occur June 3, 4 and 5th. Additional training will be scheduled. R109. Infection resolved and has not recurred. R68. Infection resolved and has not recurred. R177. Resident died at the hospital on 11/28/12. R137. Infection resolved and has not recurred. Residents hands are washed pre and post meals on memory care.	

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F 441	Continued From page 149	F 441		

resided on the B wing of the facility.

During an interview on 5/2/13 at 3:41 p.m. with a family member (FM)-BB. She reported there had been an outbreak of " Pink Eye " on the B wing of the Memory Care unit and her family member (R177) "got it". She voiced she was very upset about this as felt the facility did not address the spread of this infection.
On 5/6/13 at 8:15 a.m. registered nurse care manager (RN-B) stated there was an outbreak of "Pink Eye" on the B wing of the Memory Care unit in from November to December 2012. She was unsure how these infections were tracked and did not know what the facility's reporting mechanism for infections, other than urinary tract infections. RN-B stated there were four residents (R109, R68, R177 & R137) who all resided on the B wing that were treated for conjunctivitis (pink eye) infection.
Review of the facility Infection Control summary report for the last quarter of 2012 indicated in October, one eye infection was detected but the location was not identified. November, 2012 there was one eye infection, but no location identified. December 2012, two eye infections were identified but no location given.
Review of R109, R68, R177 and R137 record identified the following:
R109 was initially treated for conjunctivitis, starting on 10/21/12 as had pus from one eye and conjunctiva redness to the left eye. She received Ofloxacin 0.3% eye drop (used to treat bacterial infections of the eye) twice per day for five days. According to the nurses ' progress noted from 10/21/12 to 10/24/12, the residents left eye continued to be red and mattery. On 10/28/12, her family voiced concern about R109's eye still

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F 441	Continued From page 150 being red and on 10/29/12 Ofloxacin 0.3% was restarted and administered four times per day for an additional five days. This medication was again ordered on 11/16/12, for an additional week due to continued redness and mattery discharge from the left eye. On 12/26/12, the resident's family again voiced concern regarding the continued redness of the eye. A nurses' progress note, written 12/26/12, noted "continues to have redness noted to her sclera and redness also to the area surrounding her eye. Resident continues to itch area throughout the day. She is not able to communicate if she is experiencing eye pain." The Ofloxacin 0.3% was restarted on 12/27/12 and the resident received her last dose on 1/1/2012. No cultures of the eye drainage was completed throughout the multiple treatments of conjunctivitis. R68 was treated for conjunctivitis, using Polytrim eye drops (a medication used to treat bacterial infections such as conjunctivitis) in each eye three times per day for seven days. R68's physician was contacted on 11/9/12 about R68 having mattery discharged from both eyes with a reddened and irritated sclera. The physician notification, also reported another resident in the same area was recently treated for "pink eye." R177 was treated for conjunctivitis on 11/9/12, when a physician was faxed requesting R177 be treated as the resident had mattery discharge from both eye and her eyes were reddened with irritated sclera. The 11/9/12 fax noted that another resident in the same area had a recent episode of "pink eye." The physician ordered Ciprofloxacin 0.3% ophthalmic solution eye drops (a medication used to treat bacterial infections such as conjunctivitis) to both eyes four times daily for five days. A nurse's progress note,	F 441		

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F 441	Continued From page 151 dated 11/15/12, indicated R177's eyes were still red and R177 continued to rub them. An order was received on 11/16/12 to restart the Ciprofloxacin 0.3% ophthalmic solution to both eyes for 7 days. R137 was treated for puffy and red eyelids on 12/10/12 but was not on the B wing of the facility. There was no indication if any of the staff from B wing had worked with R137 for possible cross contamination from the residents on the B wing. In addition, the report identified nursing assistant (NA)-FF was ill on 12/25/12 with "pink eye." There was no indication if NA-FF had contact with residents on the B wing of the facility, also this illness was not identified on the facility's monthly report of infections. The facility's Infection Control Program Summary policy, last revised on 1/23/2009, indicated a major element of the program was a system for detection, investigation and control of facility outbreaks of infectious diseases, which was not done. The Surveillance policy, last reviewed on 3/2/12, directed staff to analyze clusters and/or significant increase in the rate of infections. Surveillance was to consist of data collection, determination of the presence of an infection, and evaluation, analysis and interpretation of the data. Surveillance was to include information on infections in personnel as well as residents. The undated facility policy Conjunctivitis Policy & Procedure directed all members of the health care team to encourage resident to not touch or rub their eyes if conjunctivitis is noted and to assist resident with frequent hand washing. Staffs were to wash before and after resident care and in between resident care procedures and after removing gloves. The facility did not monitor for adherence to their policy or Standard	F 441		

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F 441	Continued From page 152	F 441		

Precautions related to the eye infections even though there was a pattern of eye infections on the B wing of the facility.
An interview with the assistant director of nurses (ADON), who was identified as coordinator of the Infection Control program for the facility, was completed on 5/6/13 at 11:30 a.m. She stated she was aware of the eye infections on the B wing and a staff member, who also had an eye infection but stated there were no investigation, analysis or additional interventions were implemented even though this was identified.
An interview with the director of nurses (DON) was completed on 5/7/13 at 12:30 p.m. The DON reported that no additional training or monitoring was done as result of the eye infections.

The facility multi-use glucometer was not properly sanitized after and between resident use to minimize the risk of blood borne pathogens (infections). In addition, the nursing staff failed to follow the policy pertaining to hand sanitizing and the use of gloves during an injection.

R106 was observed at 7:30 a.m. on 5/1/13, with licensed practical nurse (LPN)-D testing R106's blood sugar level with the facility's multi-use Assure Platinum glucometer. LPN-D cleaned R106's finger with an alcohol wipe, prepared the glucometer with a testing strip, pricked R106's finger with a lancet and obtained blood on the testing strip. After reading the results of the glucose testing, LPN-D proceeded to prepare to inject R106 with her morning dose of insulin (Novolog flex pen 70/30). LPN-D wiped the resident's abdomen with an alcohol swab and then fanned the area with her hands to increase the dry time of the alcohol swab. She then

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F 441	Continued From page 153 injected R106 with 47 units of Novolog 70/30 into the resident's abdomen. LPN-D did not wear gloves, wash or sanitize her hands throughout this observation. After the insulin was injected, LPN-D carried the Novolog flex pen and the glucometer to the medication cart. She proceeded to place two squirts of Purell hand sanitizer into her hands and rubbed her hands vigorously. She then placed the glucometer into her hands and rubbed the glucometer with the residual Purell hand sanitizer in her own hands. LPN-D reported they clean the glucometer in this manner between residents. She also stated " they (facility's administrative staff) want us to use this other stuff to clean the machine " but reported she felt it is toxic and hard on her hands. She then left the medication cart and went to the nurses' station. She was heard to say "Where is that stuff". She then returned to the medication cart with a container of Super SaniWipes which she identified as a germicidal and the solution that the facility wanted her to use to clean the glucometer. LPN-D stated " I use it at the end of the day to wipe the top of my medication cart and will then I wipe the glucometer off " . The above observation was discussed with LPN-D at 7:50 a.m. and stated she forgot to sanitize or wash her hands prior to testing R106's blood glucose. In addition, she stated she should have worn gloves to inject the insulin and during blood glucose testing. The above observation with the DON was completed on 5/3/13 at 11:15 a.m. The DON verified the policies regarding glucometer testing, glucometer cleaning, and hand hygiene had not	F 441		

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F 441	Continued From page 154 been followed. The manufacture's for Purell hand sanitizer indicated the hand sanitizer solution was only used to "clean hands only." The manufacture's recommendation for cleaning the Assure Platinum glucometer specified that a dilution of 1 ml of household bleach (5-6% sodium hypochlorite solution) in 9 ml of water be used and in accordance to center for disease control (CDC) guidelines, the manufacture recommended the Assure Platinum meter be cleaned in this manner between resident tests in a multi-resident setting. The facility policy Blood Glucose Testing, last reviewed on 1/2013, directed staff to wash the resident's hands with soap and warm water and dry thoroughly, which was not done. The policies also directed staff to clean and disinfect the meter between each resident by using an alcohol sponge to remove heavy soil from glucose meter and then use a germicidal wipe and thoroughly wet the surface. The surface must remain visibly wet for two minutes and then to let the meter air dry. This policy was not followed. The facility policy Standard Precautions, revised 3/2/2012, directed staff to wash hands before and after resident care and that singe use gloves were to be worn for all contact with body secretions and excretions, which included blood. This policy was not followed. The facility policy Procedure For Subcutaneous Injections, last reviewed June, 2012 directed staff to wash their hands and glove prior to prior to administering the medication and after the syringe has properly been disposed of, to remove	F 441		

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F 441	Continued From page 155 the gloves and wash their hands again. This policy was not followed.	F 441		
F 496 SS = D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program. This REQUIREMENT is not met as evidenced by:	F 496	BPV assures NA's are on the NA registry before allowing them to serve as a nurse aide. During the interview process, a call is placed to the registry and a fax is received to verify that the individual has met the competency evaluation requirements. NA-H last verified date of employment was 4-27-13. This information was received on May 9, 2013. Every six months the state registry sends a list of employees on the registry. BPV will compare that list with the list of active and terminated NA's. If there are discrepancies, they will be addressed at that time. The results of the comparison will be reported to the QA committee. The DON is responsible to assure all NA's are on the registry.	7/8/`2013

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F 496	Continued From page 156 Based on interview and document review, the facility failed to ensure nursing assistant registry was current for 1 of 5 nursing assistants (NA-H) reviewed. Findings include: During an interview on 5/7/13 at 10:05 a.m., the DON indicated NA-H was current on the nursing assistant registry and there was a mix-up with the names she needed to "straighten out." Upon further review on 5/9/13 at 1:20 p.m. of documentation submitted by the DON, the nursing assistant registry was contacted and indicated that NA-H's registry certificate had expired on 1/3/10. During an interview on 5/9/13 at 1:40 p.m., the administrator (A)-F stated she was not aware that NA-H's certificate had expired and she was taken off the schedule. A-F stated the DON was responsible to check the NA registry every year when an employee receives a performance review and "somehow it got missed." Review of the facility policy "Abuse Prevention Policy/Procedure" revised 5/7/13 indicates "checking with the appropriate licensing boards and registries."	F 496		

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

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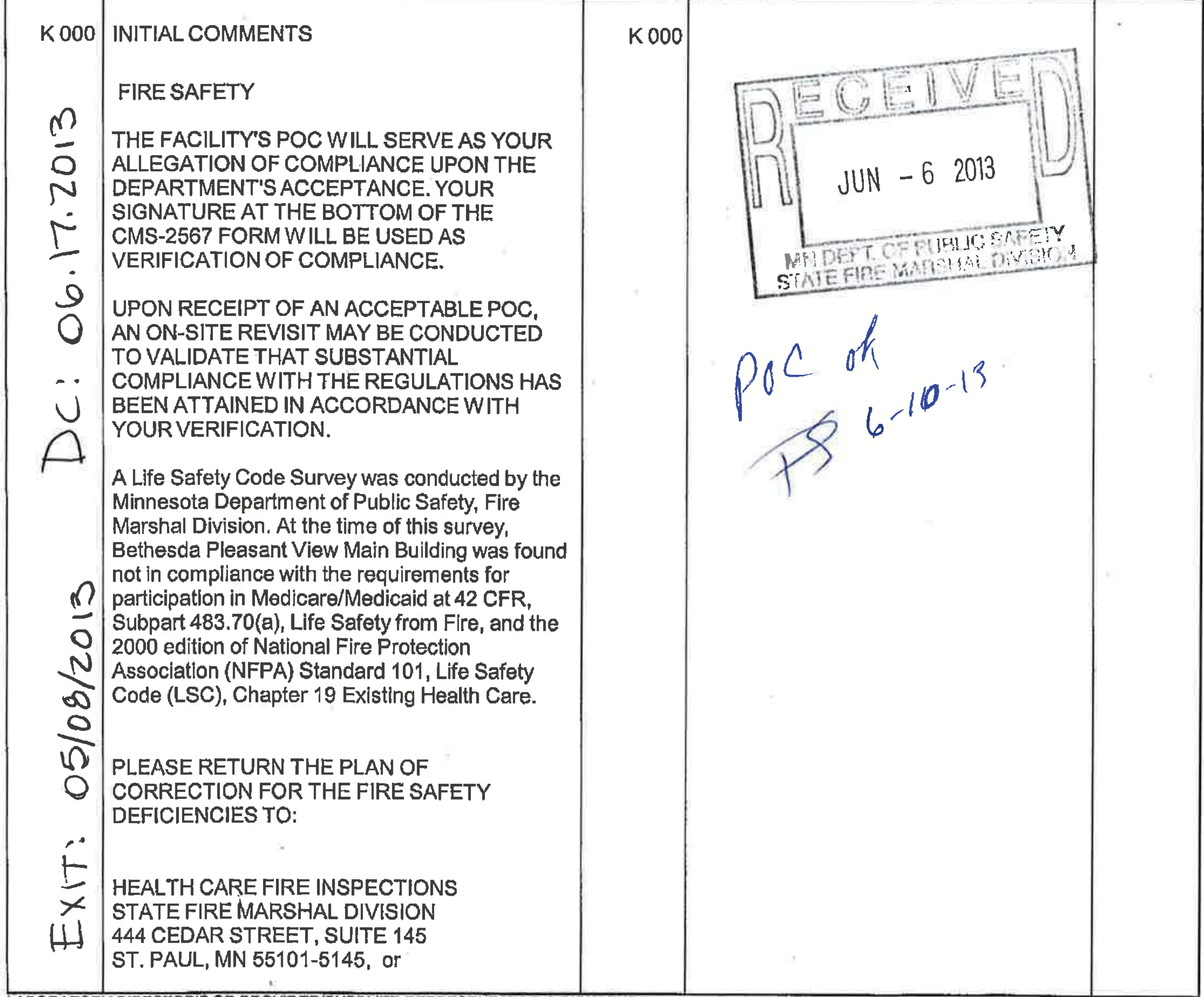

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Bethesda Pleasant View Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	RECEIVED JUN - 6 2013 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION POC ok FS 6-10-13	

DC: 06.17.2013
EXIT: 05/08/2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Michelle Haefner	Administrator	6-5-13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By e-mail to: Barbara.lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The facility was inspected as 2 separate buildings: Bethesda Pleasant View Main Building is a 1-story building with a partial basement. The building was constructed at 5 different times. The original building was constructed in 1979 and was determined to be of Type V(111) construction. In 1994, an addition was added to the west of C Wing that was determined to be of Type II(000) construction. In 1999, an addition was added to the east of G Wing that was determined to be of Type II(000) construction. The facility is being down graded to a partially fire sprinklered protected facility due to K56 sprinkler coverage deficiency.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **01 - MAIN BUILDING 01** B. WING	04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

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K 000	Continued From page 2 The facility has a fire alarm system with smoke detection in the corridors that is monitored for automatic fire department notification. The facility has a capacity of 123 beds and had a census of 118 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 020 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observations, the facility has failed to maintain vertical opening protection as required by NFPA 101 - 2000 edition, section 19.3.1.1. This deficiency could allow the products of combustion to migrate readily between two levels of the facility an negatively affect all residents, staff and visitors in the event of an emergency. Findings include: On facility tour between 9:30 AM to 12:30 PM on 04/30/2013, it was observed that the soiled linen chute room located adjacent to the west nurses station is a walk-in style of chute room that is open to the lower level linen chute termination room. it was also noted that the door to this	K 020	The door latch to the soiled linen chute room was replaced on 5-9-13. It latches securely. No other door latches require replacement at this time. During maintenance rounds door latches. Environmental services director is responsible. Kick plate was installed on May 9, 2013 to the outer door of the soiled linen chute room.	5-9-13

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	245427	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/30/2013

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BETHESDA NH PLEASANTVIEW	901 SOUTHEAST WILLMAR AVENUE WILLMAR, MN 56201

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K 020	Continued From page 3 soiled linen chute room did not positively latch and tightly fit in the frame and that it also had a greater than 1/4 of an inch gap around the door knob that also did not fit tightly into the door. These deficient conditions that are affecting the soiled linen chute room's door do not allow it to provide the required vertical opening protection between the lower level chute termination room and the main level of the facility. This deficient practice was verified by the Maintenance Staff Member (LR).	K 020		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide proper protection for several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. The following deficient practices could affect residents, staff and visitors as smoke and fire in this rooms could	K 029	The penetrations listed in numbers 1, 2 and 3 below were filled to restore integrity to the fire wall on May 9, 2013. Item 4. A bid was received and accepted to install a damper. The work is scheduled for 6-13-13. All required dampers will be in place as of that date. Item 5. Each end of the open duct vent will be fire damped per HVAC recommendations. A bid was received and accepted. The work is scheduled for 6-13-13. Environmental Services director is responsible for compliance of K029.	7-8-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING 01 - MAIN BUILDING 01 B. WING ____	04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 029	Continued From page 4	K 029		

enter the corridor making it untenable.

Findings include:

On facility tour between 9:30 AM to 12:30 PM on 04/30/2013, observation revealed the following deficient conditions affecting several hazardous areas throughout the facility,

1. A penetration was found around a section of plastic "PEX" tubing that was located in the corridor wall of the main boiler room that is not sealed with approved intumescent calking,

2. Several penetrations were found around the pipes above the door located in the corridor wall of the kitchen's dry storage room located on the lower level that are not sealed with approved intumescent calking,

3. There were 4 vertical penetrations found around the pipes that are leading to the kitchen that is located above the lower level kitchen dry storage room that are not sealed with approved intumescent calking,

4. There is an open duct vent that is not equipped with a fire/smoke damper located above the door of the storage room that is on the lower level next to the boiler room, and

5. There is an open duct vent that is not equipped with a fire/smoke damper located above the door of the kitchen's dry storage room that is on the lower level of the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING 01 - MAIN BUILDING 01 B. WING	04/30/2013

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K 029	Continued From page 5 These deficient practices were verified by the Maintenance Staff Member (LR).	K 029		
K 047 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit and directional signs are displayed in accordance with section 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 This STANDARD is not met as evidenced by: Based on observation, the facility has failed to correctly position 1 of several operational exit signs that marks the means of egress path in accordance with NFPA Life Safety Code 101 (2000 edition), Sec. 7.10.5.2. This deficient practice could negatively affect 12 of 38 residents, staff and visitors, if the lack of properly positioned exit signs could misdirect and prevented a means of egress from being utilized in a timely manner in an emergency situation. Findings include: On facility tour between 9:30 AM to 12:30 PM on 04/30/2013, it was observed that the exit sign located on the lower level outside of the classroom by the south exit is located such that it will direct individuals to exit into a courtyard that is sealed off from the public way. The directional arrows equipped on the exit signs should be utilized to direct the individuals to the horizontal exit door which is located 10 feet further up and to the right in the egress corridor that does lead to the public way .	K 047	Bid received and accepted to add an exit sign to the horizontal exit door which is located 10 feet further up (from the lower level outside the classroom by the south exit) and to the right in the egress corridor that does lead to the public way. Work is scheduled to be done on 6-10-13. Environmental service coordinator is responsible to assure compliance with K047.	7-8-13

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	245427	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/30/2013

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K 047	Continued From page 6 This deficient practice was verified by the Maintenance Staff Member (LR).	K 047		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems (99). The failure to maintain the sprinkler system in compliance with NFPA 13 (99) could allow a delayed activation of the fire sprinkler system and could affect the residents, visitors and staff of the facility. Findings Include: On facility tour between 9:30 AM to 12:30 PM on 04/30/2013, it was observed that the following	K 056	Items were removed from the lower level west stairwell that were within 18 inches of the sprinkler deflector. Maintenance staff, while on rounds will monitor areas to assure no items exceed the 18 inch limit in the building. Environmental services director is responsible. A sprinkler bid was received and accepted. The work was completed June 4, 2013.	7-8-13

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	245427	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	04/30/2013

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K 056	Continued From page 7 deficient conditions were found affecting the fire sprinkler system: 1. The fire sprinkler head located in the lower level west end stairwell has storage that is located within 18 inches of the sprinkler deflector, and 2. The facility failed to ensure that the fire sprinkler system provides complete coverage for the spaces located below the 48 inch wide HVAC duct work located in the storage room located on the lower level next to the boiler room. These deficient practices were verified by the Maintenance Staff Member (LR).	K 056		

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

F5427022

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245427	A. BUILDING **02 - MEMORY UNIT** B. WING ______	04/30/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA NH PLEASANTVIEW	**901 SOUTHEAST WILLMAR AVENUE** **WILLMAR, MN 56201**

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K 000	INITIAL COMMENTS Surveyor: 27200 FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Bethesda Pleasant View New Additions Building 2 was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility was inspected as 2 separate buildings: Bethesda Pleasant View New Additions Building 2 is a 1-story building with basement. The building was constructed at 2 different times. The Memory Care Unit was added in 2005 to the west and connected B & C Wings and was determined to be of Type II(000) construction. The second addition was added to the north in 2010 and was determined to be of Type II(000) construction. The facility is sprinklered throughout and has a fire alarm system with smoke detection in the corridors that is monitored for automatic fire department notification. The facility has a capacity of 123 beds and had a census of 118 at the time of the survey.	K 000		

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

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