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: VNGR

Facility ID: 00938

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245052**

2.STATE VENDOR OR MEDICAID NO. (L2) **154578700**

3. NAME AND ADDRESS OF FACILITY
(L3) **MOORHEAD REHABILITATION & HEALTHCARE CENTER**
(L4) **2810 SECOND AVENUE NORTH**
(L5) **MOORHEAD, MN** (L6) **56560**

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) **02/01/2017**

6. DATE OF SURVEY **09/05/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE - NE II 09/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 09/12/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1979** (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. **01111** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **05/04/2018** (L33)

DETERMINATION APPROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

020499

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

IJ was cited at F 689 -- IJ removed March 13, 2018 but remained at the lower s/s of G
IJ of K cited at F812 - IJ removed March 9, 2018 but remained at the lower s/s of E
3 G's cited at F 676, F 686 and F 697

On June 1, 2018, the Minnesota Department of Health and Office of the Centers for Medicare & Medicaid Services (CMS) completed a PCR to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 13, 2018 and April 13, 2018. Based on our visit, we have determined that this facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 13, 2018. The deficiencies not corrected are as follows:

F0607 -- S/S: C -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies
F0636 -- S/S: E -- 483.20(b)(1)(2)(i)(iii) -- Comprehensive Assessments & Timing
F0656 -- S/S: D -- 483.21(b)(1) -- Develop/implement Comprehensive Care Plan
F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
F0812 -- S/S: F -- 483.60(i)(1)(2) -- Food Procurement,store/prepare/serve-Sanitary

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

F0655 -- S/S: D -- 483.21(a)(1)-(3) -- Baseline Care Plan
F0698 -- S/S: D -- 483.25(l) -- Dialysis
F0726 -- S/S: D -- 483.35(a)(3)(4)(c) -- Competent Nursing Staff
F0865 -- S/S: F -- 483.75(a)(2)(h)(i) -- Qapi Prgm/plan, Disclosure/good Faith Attmpt

The most serious deficiencies in this facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required.

Also on June 1, 2018 the Office of Health Facility Complaints completed a PCR to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 23, 2018. Based on our visit, we have determined that this facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 23, 2018. The deficiencies not corrected are as follows:

F0686 -- S/S: G -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
F0697 -- S/S: G -- 483.25 (k) -- Pain Management

The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

On August 1, 2018, the Minnesota Department of Health and CMS completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 1, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our PCR, completed on June 1, 2018.

Also August 2, 2018 the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 1, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on June 1, 2018.

As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

On August 28, 2018, the CMS Region V Office notified you of the following actions:

• Mandatory termination effective September 13, 2018.

In addition, the following previously imposed remedies will remain in effect:

• State monitoring effective April 4, 2018.

• Discretionary denial of payment for new admissions effective June 1, 2018.

• Federal Civil Money Penalty.

On September 5, 2018, the Minnesota Departments of Health, OHFC and CMS completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 1, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 5, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on August 1, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 5, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of August 28, 2018:

• Mandatory termination effective September 13, 2018 be rescinded effective September 5, 2018.

• Discretionary denial of payment for new Medicare and Medicaid admissions effective June 1, 2018 be discontinued effective September 5, 2018. (42 CFR 488.417 (b))

• Federal Civil money penalty.

This facility is now in compliance.

Electronically delivered September 12, 2018

CMS Certification Number (CCN): 245052

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

Dear Administrator:

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 September 5, 2018 the above facility is certified for:

78 Skilled Nursing Facility/Nursing Facility Beds

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

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

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,

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

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 12, 2018

Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

RE: Project Number S5052027, H5052064, H5052065, and H5052066

Dear Administrator:

On March 30, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 4, 2018. (42 CFR 488.422)

On April 26, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- State monitoring effective April 4, 2018

- Discretionary denial of payment for new admissions effective June 1, 2018

- Federal Civil Money Penalty

Also, the CMS Region V Office notified you in their letter of April 26, 2018, 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 March 13, 2018.

This was based on the deficiencies cited by this Department during an extended survey completed on March 13, 2018 and by Minnesota Department of Health, Office of Health Facility Complaints for an abbreviated standard survey completed on March 13, 2018 that included an investigation of complaint numbers H5052064, H5052065, and H5052066. The most serious deficiencies were found to be a pattern
of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On June 1, 2018, the Minnesota Department of Health and Office of the Centers for Medicare & Medicaid Services (CMS), The Department of Health and Department Office of Health Facilities Complaints (OHFC) 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 March 13, 2018 and April 13, 2018. 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 March 13, 2018. As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

In addition you were notified of the following actions in our letter dated June 27, 2018:

- Civil money penalty would remain in effect. (42 CFR 488.430 through 488.444)

- Discretionary Denial of Payment for new admissions effective June 1, 2018 will remain in effect.

On August 1, 2018, the Minnesota Department of Health and CMS completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on June 1, 2018. Based on our visit, we determined that your facility had not corrected the deficiencies issued pursuant to our PCR, completed on June 1, 2018.

Also August 2, 2018 the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an PCR, completed on June 1, 2018. Based on our visit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on June 1, 2018.

As a result of the revisit findings, we notified you that the Category 1 remedy of state monitoring would remain in effect.

On August 28, 2018, the CMS Region V Office notified you of the following actions:

- Mandatory termination effective September 13, 2018.

In addition, the following previously imposed remedies will remain in effect:

- State monitoring effective April 4, 2018.

- Discretionary denial of payment for new admissions effective June 1, 2018.

- Federal Civil Money Penalty.

On September 5, 2018, the Minnesota Departments of Health, OHFC and CMS completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on August 1, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 5, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on August 1, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state

monitoring effective September 5, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of August 28, 2018:

- Mandatory termination effective September 13, 2018 be rescinded effective September 5, 2018

- Discretionary denial of payment for new Medicare and Medicaid admissions effective June 1, 2018 be discontinued effective September 5, 2018. (42 CFR 488.417 (b))

- Federal Civil money penalty.

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

As we notified you in our letter of March 30, 2018, 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 March 13, 2018.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VNGR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00938

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245052**

2. STATE VENDOR OR MEDICAID NO. (L2) **154578700**

3. NAME AND ADDRESS OF FACILITY
(L3) **MOORHEAD REHABILITATION & HEALTHCARE CENTER**
(L4) **2810 SECOND AVENUE NORTH**
(L5) **MOORHEAD, MN** (L6) **56560**

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) **02/01/2017**

6. DATE OF SURVEY **06/01/2018** (L34)

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

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

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

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

10. THE FACILITY IS CERTIFIED AS:
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
	78			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jonathan Anderson, HFE - NE II 06/01/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/27/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **03/01/1979** (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. **01111** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **05/04/2018** (L33)

DETERMINATION APPROVAL

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

IJ was cited at F 689 -- IJ removed March 13, 2018 but remained at the lower s/s of G
IJ of K cited at F812 - IJ removed March 9, 2018 but remained at the lower s/s of E
3 G's cited at F 676, F 686 and F 697

On June 1, 2018, the Minnesota Department of Health and Office of the Centers for Medicare & Medicaid Services (CMS) completed a PCR to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 13, 2018 and April 13, 2018. Based on our visit, we have determined that this facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 13, 2018. The deficiencies not corrected are as follows:

F0607 -- S/S: C -- 483.12(b)(1)-(3) -- Develop/implement Abuse/neglect Policies
F0636 -- S/S: E -- 483.20(b)(1)(2)(i)(iii) -- Comprehensive Assessments & Timing
F0656 -- S/S: D -- 483.21(b)(1) -- Develop/implement Comprehensive Care Plan
F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
F0812 -- S/S: F -- 483.60(i)(1)(2) -- Food Procurement,store/prepare/serve-Sanitary

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

F0655 -- S/S: D -- 483.21(a)(1)-(3) -- Baseline Care Plan
F0698 -- S/S: D -- 483.25(l) -- Dialysis
F0726 -- S/S: D -- 483.35(a)(3)(4)(c) -- Competent Nursing Staff
F0865 -- S/S: F -- 483.75(a)(2)(h)(i) -- Qapi Prgm/plan, Disclosure/good Faith Attmpt

The most serious deficiencies in this facility were found to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), whereby corrections are required.

Also on June 1, 2018 the Office of Health Facility Complaints completed a PCR to verify that this facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 23, 2018. Based on our visit, we have determined that this facility has not obtained substantial compliance with the deficiencies issued pursuant to our extended survey, completed on March 23, 2018. The deficiencies not corrected are as follows:

F0686 -- S/S: G -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
F0697 -- S/S: G -- 483.25 (k) -- Pain Management

The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G).

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Revised Letter

Electronically delivered
July 18, 2018

Mr. Jesse Doschadis, Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

RE: Project Number S5052027, H5052064, H5052065, H5052066

Dear Mr. Doschadis:

This letter is to replace the letter dated June 27, 2018. The following tags were not listed as additional deficiencies cited:

F0585 -- S/S: D -- 483.10(j)(1)-(4) -- Grievances
F0623 -- S/S: B -- 483.15(c)(3)-(6)(8) -- Notice Requirements Before Transfer/discharge
F0625 -- S/S: B -- 483.15(d)(1)(2) -- Notice of Bed Hold Policy Before/upon Trnsfr
F0657 -- S/S: D -- 483.21(b)(2)(i)-(iii) - - Care Plan Timing And Revision
F0761 -- S/S: F -- 483.45(g)(h)(1)(2) -- Label/store Drugs And Biologicals

On March 30, 2018, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 4, 2018. (42 CFR 488.422)

On April 26, 2018, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

• State Monitoring effective April 4, 2018.

• Discretionary denial of payment for new admissions effective June 1, 2018

• Federal Civil Money Penalty

Also, the CMS Region V Office notified you in their letter of April 26, 2018, 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 March 13, 2018.

This was based on the deficiencies cited by this Department during an extended survey completed on March 13, 2018 and by Minnesota Department of Health, Office of Health Facility Complaints for an

abbreviated standard survey completed on March 13, 2018 that included an investigation of complaint number H5052064, H5052065, H5052066. The most serious deficiencies were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On June 1, 2018, the Minnesota Department of Health and Office of the Centers for Medicare & Medicaid Services (CMS) completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 13, 2018 and April 13, 2018. 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 March 13, 2018. The deficiencies not corrected are as follows:

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F0656 -- S/S: D -- 483.21(b)(1) -- Develop/implement Comprehensive Care Plan
F0686 -- S/S: D -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
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In addition, at the time of this revisit, we identified the following deficiencies:

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F0726 -- S/S: D -- 483.35(a)(3)(4)(c) -- Competent Nursing Staff
F0865 -- S/S: F -- 483.75(a)(2)(h)(i) -- Qapi Prgm/plan, Disclosure/good Faith Attmpt
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F0657 -- S/S: D -- 483.21(b)(2)(i)-(iii) - - Care Plan Timing And Revision
F0761 -- S/S: F -- 483.45(g)(h)(1)(2) -- Label/store Drugs And Biologicals

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

Also on June 1, 2018 the Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 23, 2018. 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 March 23, 2018. The deficiencies not corrected are as follows:

F0686 -- S/S: G -- 483.25(b)(1)(i)(ii) -- Treatment/svcs To Prevent/heal Pressure Ulcer
F0697 -- S/S: G -- 483.25 (k) -- Pain Management

The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) as evidenced by the electronically 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 April 26, 2018:

- Civil money penalty will remain in effect. (42 CFR 488.430 through 488.444)

- Discretionary Denial of Payment for new admissions effective June 1, 2018

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy:

- Civil money penalty effective June 1, 2018. (42 CFR 488.430 through 488.444)

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

As we notified you in our letter of March 30, 2018, 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 March 13, 2018.

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

DEPARTMENT CONTACT

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

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following 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 ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC 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, the Department of Public Safety, State Fire Marshal Division staff, and/or Office of Health Facility Complaints staff if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would 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 fourth revisit.

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 September 13, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING ______ B. WING ______	R 06/01/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD REHABILITATION & HEALTHCARE CENTER	**2810 SECOND AVENUE NORTH MOORHEAD, MN 56560**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments An onsite revisit was conducted to determine compliance with CMS Appendix Z Emergency Preparedness Requirements. The facility is now in compliance with Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 5/29/18, and 6/1/18. The certification tags that were corrected can be found on the CMS2567B. Also there are tags that were not found corrected at the time of onsite PCR which are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 607} SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and	{F 607}		7/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 07/02/2018

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

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{F 607}	Continued From page 1	{F 607}		

§483.12(b)(3) Include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
Based on interview and document review the facility failed to develop an abuse policy to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to the state agency within the required timeframe's and ensure the results of all investigations are reported to the state agency within 5 working days of the incident. In addition, the facility failed to ensure staff received abuse prevention training for new and existing staff in the facilty. This deficient practice had the potential to affect all 54 residents residing in the facility.

Findings include:

Review of the facility policy titled Vulnerable Adult, reviewed 5/10/18, listed each resident would be evaluated and care planned for their individual susceptibility to abuse by other individuals, their risk for abusing others and specific measures to be taken to minimize the risk of abuse. The policy listed the assessment would be done upon admission, and reviewed quarterly and annually.

The policy did not address identification, investigation, protection and reporting of alleged violations of abuse, neglect, exploitation, mistreatment, injuries of unknown source and misappropriation of resident property and did not address training for new and existing employees on abuse prevention.

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.
1.It is the policy of this facility to report all incidents and do timely follow up on any incident that result in injury. All incidents and accidents are to be reviewed immediately for any potential abuse or neglect. In this case the review determined the actual policy was not complete and lacked the following elements:
The policy failed to include training on abuse prevention upon hire and annually for all employees.
The policy failed to include that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency The policy

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{F 607}	Continued From page 2 Review of the facility policy titled Resident Protection Manual Program statement, updated 5/28/18, revealed the program listed the following: -if the injury is unexplainable, if the findings of abuse are substantiated(physical, verbal, sexual, financial exploitation), if there is caregiver neglect, or if a therapeutic error resulted in injury a call must be made to the facility designated State Agencies within 2 hours of the initial findings -within 5 business days of the original report, Administrator, Director of Nursing and Director of Social Services will meet to make the final decision regarding the outcome of the investigation -each new employee will be assigned to new employee orientation, and attendance at a yearly in-service on the Resident Safety and Resident Rights is mandatory for all employee The policy failed to include that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency. The policy failed to include the results of the investigations would be reported to the State Agency within 5 working days of the incident.	{F 607}	failed state that results of the investigations would be reported to the State Agency within 5 working days of the incident The findings also concluded based on vulnerable adult policy that facility did not have system in place to address identification, investigation, protection and reporting of alleged violations of abuse, neglect, exploitation, mistreatment, injuries of unknown source and misappropriation of resident property and did not address training for new and existing employees on abuse prevention. 2.Because all residents receiving care in the facility are determined to be vulnerable adults, all are potentially affected by the cited deficiency. Since survey the policy has been revised to include training implementation, the 2 hours vs. 24-hour notification rule, and when the conclusion of investigation will be completed and timeframe of which it must be submitted. The vulnerable adult policy has been reviewed and a vulnerable adult assessment has been completed on high risk residents with staff educated on proper re-assessment as well as education for new and existing employees on abuse prevention. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all staff received in-service training regarding updated policy and assessing vulnerable adults. All new and existing staff will continue to have initial and yearly education of abuse prevention and review of policy. Amended policy is being	

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{F 607}	Continued From page 3 The policy failed to include training on abuse prevention upon hire and annually for all employees. On 6/1/18, at 4:31 p.m. the administrator confirmed the current facility policies and stated he had understood the corporate nurse consultant had revised the abuse policies to include the required components.	{F 607}	monitored weekly with random staff audited on VA, reporting and privacy updates with goal of auditing all staff within next month and intermittently thereafter for next 2 months. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the administrator to monitor the abuse prevention compliance and ensure along with SW vulnerable adult assessments completed and reviewed. All incidents will be immediately reported to the Administrator and if injury or abuse is noted, the administrator or designee will report a VA to common entry point within 2 hours of the incident. If no injury or abuse noted, this will then be reported within 24 hours and reviewed daily at stand up. If Incident occurs after business hours or on the weekend, the Administrator will collaborate with the DON and report in a timely manner. Once the report has been submitted, the Administrator or designee will report the investigation findings within 5 business days of report. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.Administrator/SW/DON will be responsible for this POC.	
{F 636} SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically	{F 636}		7/23/18

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{F 636}	Continued From page 4 a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.	{F 636}		

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{F 636}	Continued From page 5 §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure resident Care Area Assessments (CAA) included a comprehensive analysis of a resident's needs, strengths, goals, history and preferences for 1 of 3 resident (R37) reviewed for dialysis. Findings include: R37's admission Minimum Data Set (MDS) dated 4/30/18, indicated R37 had moderately impaired cognition, and had diagnoses, which included end-stage renal disease (ESRD), hyperkalemia and malnutrition. The MDS indicated R37 required extensive assistance for dressing, personal hygiene and toilet use, but could eat independently after set up assistance from staff. R37's MDS further indicated no weight gain or loss, received a mechanically altered diet and was receiving dialysis. R37's MDS indicated he	{F 636}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to ensure all residents are assessed correctly via assessments and MDS to coordinate appropriate care plans. R37 had multiple area in which the CAA had triggered actual problem but had not been properly assessed to ensure actual interventions were in place. In this case, after the surveyor reported R37 assessments were inaccurate based on documentation and MDS regional team met with dietary	

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{F 636}	Continued From page 6 was not receiving a therapeutic diet. R37's Annual Care Area Assessment (CAA) dated 5/3/18, identified seven care areas had triggered from the data entered into the MDS requiring analysis, the following areas were triggered; Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status, Dental Care and Pressure Ulcer. -Cognitive Loss/Dementia CAA, revealed the care area was an actual problem for R37, related to an active diagnosis of dementia without behavioral disturbances and chronic ischemic heart disease (CIHD). The CAA identified R37 was being treated for CIHD with medications and that these active diagnoses are likely contributors to a moderate cognitive impairment. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS) which included; neurological factors and ADL function, requiring additional assessment/analysis of R37's cognition and its relationship to medical problems and functional status. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks, which impacted R37's cognitive functioning. The CAA further lacked any other considerations that could affect R37's cognitive functioning from resident observation and resident and/or family input for care planning considerations, the overall objective and the impact of these needs on the resident or the rational for the care plan decision. -Nutritional Status CAA, revealed the care area was an actual problem for R37, however the CAA did not explain the nature of the problem, it only	{F 636}	manager and dietician to review what a CAA entails. R37 was reviewed and noted he is end stage renal, has cognitive issues, has poor dental status and all areas were revisited and corrected to assess the resident needs. All care plans have been reviewed and updated, CAA training has been reviewed and updated for managers on how to properly document on CAA's. 2.Because all residents are assessed to determine their appropriate plan of care based on their assessments all are potentially affected by the cited deficiency, on 7/2/2018, the MDS nurse reviewed accuracy of CAA's and MDS on R37. All other resident CAA's will be reviewed for timeliness and accuracy. Furthermore, all CAA's being created as of 7/2/2018 will be double checked by regional reimbursement coordinator prior to submission to ensure compliance. Dietary department also trained on CAA procedure. Policy on MDS/CAA was reviewed. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all staff received in-service training regarding state and federal requirements for documentation, assessments and proper follow up on all missing information to ensure clear and correct care plans. The training also emphasized the importance of the MDS nurse to follow up on items that are not being addressed during assessment period and ensuring care areas are complete.	

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{F 636}	Continued From page 7 indicated R37 had been eating very well since admission, R37 had no teeth and that no current labs were available. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included; cognitive, mental status and behavior problems that could interfere with eating, dental/oral problems, diseases and conditions that can affect appetite or nutritional needs and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks, which impacted R37's nutritional status. The CAA further lacked any other considerations that could affect R37's nutritional status from resident observation and resident and/or family input for care planning considerations. -Dental Care CAA, revealed the care area was an actual problem for R37 due to a diagnosis of dementia and R37 had "likely" carious teeth due to poor hygiene practices. However, the Nutritional Status CAA revealed R37 had no teeth. R37 did deny pain as well as chewing or swallowing difficulties and R37's current diet. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included; cognitive problems that contribute to oral/dental problems, disease and conditions that may be related to poor oral hygiene. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks, which impacted R37's dental care status. The CAA further lacked any other considerations that could affect R37's dental care status from resident observation and resident and/or family input for care planning considerations. On 6/1/18, at 10:54 a.m. MDS coordinator (MDSC)-A stated she was responsible for MDS	{F 636}	4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the MDS nurse that all residents will be reviewed at time of admission, annually and if significant change occurs to ensure CAA's are being completed thoroughly and completely. All triggers will be care planned and communicated to staff via care sheets and communication book if new interventions in place. Audits of CAA's, and significant changes will be completed for accuracy and timeliness; they will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area. All MDS's will be reviewed for accuracy and necessary changes as determined by audits. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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{F 636}	Continued From page 8 assessments for R37 including the CAAs dated 5/3/18. However, MDSC-A stated the CAA for Nutritional Status was completed by the dietary manager. MDSC-A reviewed R37's CAAs and stated the Nutrition Status CAA was not comprehensive and "lacking significant information". On 6/1/18, at 3:38 p.m. dietary manager (DM)-A confirmed completing the Nutritional Status CAA for R37, dated 5/3/18. DM-A stated her education for completing a CAA was that if it triggered for completion after the MDS, and then fill it out. DM-A stated the CAA would not be a comprehensive assessment. On 6/1/18, at 3:43 p.m. director of nursing (DON) stated R37's CAAs had "nothing in the boxes" and stated R37's CAA would not be considered a comprehensive assessment. A facility policy titled MDS/CAA Policy, reviewed 4/20/18, indicated the MDS and CAAs form a comprehensive system of assessment and problem identification that provides the foundation for care planning. CAA documentation explained the basis for the care plan. The documentation should include: causes and contributing factors, the nature of the condition or issue, complications contributing to the care area, risk factors related to the condition, factors that should be considered in developing the care plan, any need for further evaluation, resources and tools used for decision-making, conclusions that arose from the CAA process and completion of Section V of the MDS.	{F 636}		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		7/23/18

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F 655	Continued From page 9	F 655		

§483.21 Comprehensive Person-Centered Care Planning
§483.21(a) Baseline Care Plans
§483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must-
(i) Be developed within 48 hours of a resident's admission.
(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.

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F 655	Continued From page 10 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours of admission to address the individualized needs for 3 of 3 residents (R306, R503, R501) recently admitted. Findings include: R306 was admitted on 5/24/18, with multiple diagnoses including type II diabetes, hypertension (HTN), hyperlipidemia, gout, insomnia, schizophrenia, major depressive disorder, myalgia, Gastro-Esophageal reflux (GERD), pain and weakness, according to the undated facility admission record form. R306's admission care plan dated 5/29/18, identified the following: *R306 was at risk for falls, with a goal to be free of fall related injuries. Interventions included: encourage and remind R306 to use the call light for assistance, maintain R306's environment to be well lit and free of clutter, non-skid foot wear to prevent slipping. * R306 likes to visit and be around others. He will attend some groups as well as enjoy his independence. R306's goal to attend bingo and entertainment/social gatherings. He will eat meals in the dining room and socialize with others. Interventions included: invite R306 to scheduled activities such as bingo, entertainment, socials,	F 655	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide base line plans. R306, R503, and R501 did not have base line care plans completed as required within 48 hours of admission. The survey noted the lack of information and it was apparent staff were still not familiar with the form nor the policy of base line care plans nor who is responsible for gathering the data needed to formulate care plan for resident. The base line care plan has been revised and corrected and staff have copy in admission packet and are educated on expectations of nurse admitting patient to complete the base line care plan. 2.Because all residents have changing levels of care upon admission all are potentially affected by the cited deficiency, on 7/2/2018, the MDS nurse reviewed process of ensuring baseline care plans are followed up within 48 hours and brought to IDT for team review while copy in chart and one given to resident. The	

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F 655	Continued From page 11 and men's group. He likes a variety of shows on TV (television). He likes country music. He is friendly social and likes to visit. * R306's care plan lacked all other areas of quality of life and quality of care. Review of R306's electronic and hard copy medical record identified it lacked a base line care plan. Review of 306's progress notes 5/24/18, through 5/31/18, lacked evidence of a base line care plan completion. On 5/30/18, at 3:03 p.m. the director of nursing (DON) verified R306 was admitted on 5/24/18. The DON indicated the floor nurse on duty was responsible to complete the paperwork for new residents. The DON indicated the day following admission the care plan is reviewed at the standup meeting, and then is given to the MDSC (minimum data set coordinator) nurse to review it with the resident and then place it into the residents chart. After review of R306's electronic and paper chart, the DON verified R306 did not have a base line care plan. On 5/30/18, at 3:08 p.m. the MDSC indicated she completed the comprehensive assessments for newly admitted residents within 13 days of admission. The MDSC indicated the 48 hour (baseline) care plan was completed by the nurse on the floor at the time of admission. The MDSC reviewed R306's paper chart and verified a base line care plan was not in the chart. The MDSC indicated she would need to check with the floor nurse as to why there was not a base line care plan completed for R306.	F 655	process will be reviewed with all floor nurses and admission team as well to ensure staff understand expectations. All other resident care plans have been reviewed and updated for accuracy, MDS nurse has been educated on necessity of implementing base line care plans and importance of discussing with resident or POA. The policy on base line care plans has been reviewed and updated. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all nursing staff received in-service training regarding base line care plans. The training emphasized the importance of monitoring ADL's, and treatment information on care sheet follows the actual care performed. MDS nurse to visualize residents and ask staff through interview to confirm data. The education includes development of care plan after assessment of resident individual needs. The residents will also incorporate importance of reviewing base line care plan with residents. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic audits of assessments formulating base line care plan based on individual resident needs and all base line care plans. They will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure	

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F 655	Continued From page 12 On 5/30/18, at 3:12 p.m. licensed practical nurse (LPN)-C described her responsibilities with new admissions. LPN-C indicated the base line care plan was not part of her duties as the admitting nurse and was the responsibility of the clinical managers. R503's admission record form identified R503 was admitted to the facility on 5/23/18. R503's diagnosis information included diagnoses of chronic obstructive pulmonary disease (COPD), hypertension (HTN) and congestive heart failure (CHF). Review of R503's electronic and hard copy medical record lacked documentation of a base line care plan. Review of R503's care plan identified one area initiated on 5/25/18. The care plan included a focus identifying R503 was quite independent, but groups may be a way for him to meet people. The goal indicated R503 would attend bingo, young men's lunch, and possibly chapel service, and socialize around the facility. Interventions instructed staff to invite the resident to scheduled activities such as those listed in his goals. The care plan lacked all other areas of quality of life and quality of care. Review of 503's progress notes lacked evidence of a base line care plan completion. On 5/30/18, at 4:04 p.m. registered nurse (RN)-A indicated the registered nurses completed admission paperwork for new residents. RN-A indicated she believed the DON completed the	F 655	compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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F 655	Continued From page 13 care plans for all residents. RN-A and surveyor reviewed R503's paper chart and electronic chart and RN-A confirmed R503 did not have a base line care plan. On 5/31/18, at 1:30 p.m. R503 indicated no one had spoken to him about a care plan or his specific goals for cares when he first arrived. R503 indicated he had been here a week, and someone came and spoke to him today about his cares. On 5/31/18, at 1:39 p.m. DON confirmed R503 was admitted on 5/23/18. DON stated the usual facility practice was for the admitting nurse to address the base line care plan with the resident, complete the form, then provide a copy of the base line care plan to the resident and place it in the chart. DON indicated her expectation would be for the base line care plan to be completed by the nurse who admitted R503. Review of the facility base line CP (care plan) audit form, undated, provided by the facility was blank. R501's Admission Record form dated 6/1/18, indicated R501 was admitted to the facility on 5/27/18. R501's diagnoses included presence of bilateral artificial knee joint, pain and major depressive disorder. Review of R501's electronic and hard copy medical record lacked a baseline care plan. Review of R501's care plan identified one area	F 655		

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F 655	Continued From page 14	F 655		

initiated on 5/30/18. The care plan included a focus identifying R501 like independent activities with family and some group activities as well. The goal for R501 was to attend bingo, young ladies lunch, socials and maintain her independent activities. Interventions instructed staff to invite R501 to scheduled activities as outlined in the goal. The care plan lacked all other areas of quality of life and quality of care.

Review of R501's progress notes lacked evidence of completion of a baseline care plan.

Review of facility form titled Group 3, updated 5/29/18, indicated R501 required extensive assistance with activities of daily living (ADLs), wore glasses, required assist of one with transfer belt for transfers, used a wheelchair, had a regular diet, required repositioning every two hours. The form indicated R501 was alert and oriented, could direct own cares, required Polar care and was weight bearing as tolerated.

On 5/30/18, at 3:25 p.m. nursing assistant (NA)-E stated if a resident was new to the facility, then staff would ask the nurse for care instructions. NA-E stated if a resident had been here for a few days then they would look at the care sheet.

On 5/30/18, at 3:38 p.m. RN-B stated when a resident was admitted, the admitting nurse would complete an admission assessment and relay any care instruction to the NA verbally. RN-B stated a care plan would be started at a later time and that no paper care plans existed. RN-B reviewed R501's paper chart and confirmed no baseline care plan. RN-B again stated all care plans are electronic as far as she knew.

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F 655	Continued From page 15 On 5/30/18, at 3:45 p.m. social worker (SW) stated paper baseline care plans are given out by the minimum data set coordinator (MDSC) to the nursing staff. On 5/30/18, at 3:50 p.m. MDSC stated a 48 hour care plan, or baseline care plan, would be kept in the paper chart, as it was a paper form. MDSC stated the admitting nurse completed the baseline care plan and returns it to MDSC. The baseline care plan would then be discussed at an interdisciplinary team (IDT) meeting, or morning stand up. They would then go over it with the resident, and if they are agreeable with it, it would be filled in the chart. MDSC reviewed R501's paper chart and confirmed there was no baseline care plan. On 5/30/18, at 3:58 p.m. DON stated the admitting nurse would fill out the baseline care plan and then send to MDSC. The MDSC would then bring the care plan to IDT where they discuss the resident's care. After the IDT meeting, MDSC would bring the baseline care plan to the resident to discuss it and have them sign it. DON reviewed R501's paper chart and confirmed no baseline care plan was present. DON stated she would expect the baseline care plan to be completed. On 5/30/18, at 4:05 p.m. R501 stated she admitted to the facility on 5/27/18. R501 indicated no one had spoken to her about a baseline care plan, or her specific goals for her care. R501 stated that a nurse was meeting with her now, to do some admission paperwork. Review of the facility baseline CP (care plan) audit form, undated, provided by the facility was	F 655		

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F 655	Continued From page 16 blank. The facility policy titled, Care Plans-Comprehensive, reviewed 4/4/18, identified all new admits to have a baseline care plan in the admission packet and to be started by staff nurse upon admit. Once completed and reviewed within 48 hours, it will then be copied and given to resident for review or POA (power of attorney) and the original to be put in the resident's chart.	F 655		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its	{F 656}		7/23/18

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{F 656}	Continued From page 17 rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comprehensive care plan was developed for dialysis for 1 of 1 resident (R410) who received dialysis services, and for 1 of 1 resident (R107) reviewed for tracheostomy (a surgically created hole [stoma] in your windpipe [trachea] that provides an alternative airway for breathing) care. Findings include: R410 was observed On 5/31/18, at 8:03 a.m. with morning cares. R410 received assistance from nursing assistant (NA)-F and NA-G to wash and dress. R410 was observed to have a central venous catheter (a central line placed in a large vein) on his upper left chest. R410's Care Area Assessment (CAA) dated 4/26/18, identified R410 had diagnoses which included diabetes, stage renal disease and received renal dialysis. The CAA further identified	{F 656}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide consistent quality care to ensure residents have comprehensive care plans. R410 was noted to have central line and need dialysis however the care plan did not address these issues nor did the care sheets, so staff were aware how to monitor IV site or provide cares. R107 had a trach and the care plan did not address the trach, the expectations of care to trach and during care it was noted the staff needed further education on trach cares. In this case, after the survey determined	

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{F 656}	Continued From page 18 R410 was alert and orientated X (times) 4, had bilateral lower extremity amputations, required extensive assistance with dressing, grooming and bed mobility, required total staff assistance to transfer with a mechanical lift. R410's physician visit dated 4/24/18, identified R410 had an acute chronic kidney injury which required dialysis. R410's care plan revised 4/26/18, identified R410 had an alteration in kidney function evidenced by hemodialysis, 1 X a week, with a goal to reduce short term complications associated with impaired renal function and will have no signs or symptoms of infection or bleeding at fistula site. R410's care plan listed interventions to administer medications as ordered collaborating with physician and/or pharmacist for optimal medication dose times, assessment of skin condition weekly by licensed nurse, apply skin moisturizer as needed for dry, itchy skin and to consult as ordered by physician (nephrology, nutritional, social services). R410's care plan did not identify R410 had a central venous catheter, incorrectly listed R410 had a fistula (a surgical connection of a vein to an artery) in place, and did not include precautions or care of the catheter such as no blood draws/blood pressures or flushing of catheter, keep site dry, no tub baths, and covering site when showering. In addition the care plan lacked direction for what procedures to follow if catheter site developed leaking, bleeding, or signs of infection and emergency procedures staff should implement or whom the facility should contact in case of an emergency involving the dialysis catheter site.	{F 656}	these residents care plans were missing important information, both were revised and updated including care sheets for staff. Staff education on trach cares was also provided. 2.Because all residents are have changing levels of care all are potentially affected by the cited deficiency, on 7/2/2018, the MDS nurse reviewed process of ensuring accurate MDS's to formulate comprehensive care plans. All other resident care plans have been reviewed and updated for accuracy, and MDS nurse is aware of how to properly document on CAA's as well as ensure all assessments completed during look back period are completed, and correct information is gathered, and all aspects of care is care planned appropriately. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all nursing staff received in-service training regarding patients with dialysis and trachs to ensure they are understanding to resident needs, cares and how to perform basic checks to ensure trach site and IV sites are clean dry and intact and what to do if there is an emergency. MDS nurse to visualize residents and ask staff through interview to confirm data. The education included development of care plan after assessment of resident individual needs. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance	

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{F 656}	Continued From page 19 The facility's untitled nursing assistant care sheet identified R410 required extensive assistance with ADLs (activities of daily living), required assistance of two staff for transfers and toileting, utilized a power wheelchair, was alert and orientated, directed care for use of a shrinker stocking for the lower extremity amputations and pressure relief measures to lay down between meal; however did not direct care pertaining to dialysis needs or the dialysis catheter site. On 5/31/18, at 8:20 nursing assistant (NA)-F indicated R410's catheter was not to get wet and staff gave sponge baths as R410 allowed. NA-F indicated the nurses managed all other care regarding the catheter site. On 5/31/18, at 2:24 p.m. R 410 stated the catheter in his upper left chest area was used for dialysis. R410 indicated he chose to receive bed baths because the catheter could not get wet. R410 indicated he was not restricted on fluids; however, was not to add salt to things and was to eat extra protein. On 6/1/18, at 12:00 p.m. the director of nursing (DON) verified R410's computerized care plan. The DON indicated the computerized care plan was all inclusive for R410's daily and dialysis care. With review of the care plan the DON verified R410's care plan was not comprehensive regarding dialysis care, did not include specifics regarding R410's dialysis care, catheter or emergency contacts.	{F 656}	representative will perform the following systematic audits of assessments formulating care plan based on individual resident needs. They will be completed by MDS nurse 4 audits per week x 4 weeks then 2 audit weekly x 2 months to ensure compliance in this area by matching diagnoses with assessments and CAA's so an accurate care plan is developed based on the resident specific care areas, ex. Trach care, hospice, dialysis. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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{F 656}	Continued From page 20	{F 656}		

R107's admission Minimum Data Set (MDS) dated 2/20/18, indicated a cognition assessment was not completed, and R107 had diagnoses which included attention to tracheostomy, attention artificial opening of digestive tract, and cancer. The MDS indicated R107 required extensive assistance for all cares except eating, which he required total care. R107's MDS further indicated the use of oxygen, tracheostomy care and suctioning.

R107's quarterly MDS dated 5/1/18, indicated independent cognitive skills for daily decision making and diagnoses which included squamous cell carcinoma of skin of scalp and neck, chronic pain, attention to tracheostomy and anxiety. The MDS indicated R107 required total assistance with eating, extensive assistance with dressing and hygiene, limited assistance with toileting and was independent with all other ADLs. R107's MDS further indicated tracheostomy care and suctioning.

R107's CAA dated 2/28/18, indicated R107 had a tracheostomy in place due to oral pharyngeal cancer.

Review of R107's current care plan last revised 4/3/18, revealed that there was no care plan interventions related to R107's tracheostomy.

Review of facility provided Group 3 care sheets, updated 5/29/18, indicated under "Care Notes" R107 had a "Trach", but there was no instruction related to it's care or monitoring.

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{F 656}	Continued From page 21 On 5/31/18, at 6:50 a.m. R107 was lying on the bed with the head of bed elevated. R107 was completing a nebulized medication treatment via his tracheostomy. R107 had a oral suctioning device positioned on the nightstand and had the tubing beside him ready for use. On 5/31/18, at 11:15 a.m. licensed practical nurse (LPN)-A entered R107's room and set up supplies for tracheostomy care. LPN-A washed her hands and placed sterile gloves from the tracheostomy care kit. With sterile gloves donned, LPN-A had R107 raise the bed to working height and proceeded to squeeze R107's tracheostomy's outer cannula while gently pulling at the inner cannula. With the inner cannula not disengaging from it's lock (used to keep the inner cannula in place if the resident was to cough), LPN-A then tried loosening the Velcro collar. LPN-A again grabbed the outer and inner cannulas, one with each hand and tried to disengage the lock and could not. LPN-A stated she had not provided R107 tracheostomy cares prior and stated, "maybe I should get someone who knows how to do this" and exited the room. At 11:29 a.m. LPN-A returned to R107's room with LPN-B. LPN-B washed her hands and donned gloves, she then held the outer cannula with one hand and twisted the inner cannula with the other and the inner cannula disengaged and was able to be removed. LPN-B then left the room and LPN-A finished the tracheostomy cares. On 5/31/18, at 2:06 p.m. MDS coordinator (MDSC) verified she was responsible for care plans at the facility, including R107's. MDSC reviewed R107's current care plan and confirmed the care plan lacked information regarding R107's tracheostomy and therefore she would not	{F 656}		

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{F 656}	Continued From page 22 consider R107's care plan to be comprehensive. On 5/31/18, at 2:15 p.m. the DON stated comprehensive care plans were an overall guideline for resident care. DON reviewed R107's current care plan and confirmed R107's care plan lacked information regarding R107's tracheostomy and stated she would not consider R107's current care plan to be comprehensive. A facility policy titled, Care Plans - Comprehensive, reviewed 4/28/18, indicated the comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS; 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems...f. Identify the professional services that are responsible for each element of care...i. Reflect currently recognized standards of practice for problem areas and conditions...4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan; 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes.	{F 656}		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	{F 686}		7/23/18

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{F 686}	Continued From page 23 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and failed to implement interventions to promote healing and prevent worsening for 1 of 2 resident (R56) reviewed with current, stage 2 pressure ulcers on left buttocks. Finding include: R56's quarterly Minimum Data Set (MDS) dated 4/10/18, identified R56 was cognitively intact and had diagnoses which included hemiplegia (paralysis on one side of the body) or hemiparesis (slight paralysis or weakness on one side of the body), muscle weakness, stage 3 chronic kidney disease and depression. R56's MDS identified R56 was at risk for pressure ulcers, but did not currently have one, and had no healed pressure ulcers. Skin and ulcer treatments were pressure reducing device for chair and bed and application of nonsurgical dressings other than to feet. R56's MDS further identified she required extensive assistance with bed mobility, transfer, toileting and did not walk. R56's pressure ulcer care area assessment (CAA) dated 2/14/18, identified R56 had an actual problem/need. Pre-populated check marks identified extrinsic risk factors included pressure	{F 686}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide treatment and services to prevent pressure ulcers. One of the many ways that this has been achieved for resident #56 is by completing assessments and current documentation of wounds to ensure healing appropriately. R56 was noted to have stage 2 pressure area and area now developed another area with previous wound now developing into stage 3. After survey noted the inconsistency in R56 turning and repositioning and resident non-compliance of offloading OT and nursing have changed resident to q2h repositioning schedule and staff are to ensure even while up resident is offloaded either in room or using rail in hallway to stand with staff assist. It was also noted staff needed education on roho cushion,	

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{F 686}	Continued From page 24 and need for special mattress or seat cushion to reduce or relive pressure. Intrinsic risk factors identified altered mental status and cognitive loss. Diagnoses and conditions identified by pre-populated check marks included hemiplegia/hemiparesis, chronic or end-stage renal disease, depression and pain. Treatments and other factors included newly admitted or readmitted and functional limitation in range of motion. R56's CAA indicated pressure ulcer will be addressed in care plan to minimize risks. R56's pressure ulcer CAA indicated no referral was warranted. R56's care plan revised on 2/21/18, identified R56 was at risk for pressure ulcers due to altered skin integrity, history of pressure ulcers and decreased mobility. Interventions included completion of Braden Scale (pressure ulcer risk assessment) per policy, weekly skin inspections, not to massage over bony prominences and encourage regular offloading when up for a while during the day for activities. R56's interventions further instructed staff for nutritional and hydration support, pressure reduction wheelchair cushion and mattress and referral to therapy. Skin assement to be completed per policy and treatments as ordered. R56's care plan also identified she had physical function deficit related to self care impairment, ROM (range of motion) limitations to left arm and balance impaired. Interventions included extensive assistance with toileting and transfer assist of 1 staff and gait belt. On 5/30/18, at 12:30 p.m. R56 was in her room, after independently propelling self from dining room. R56 indicated she had a bed sore on her hip, and the physician had looked at it yesterday. R56 indicated she thought it was healing, and	{F 686}	staff were educated. Physician has been updated and resident skin has been improving. 2.Because all residents have diagnoses which could lead to alteration in skin integrity or due to illness have potential for skin breakdown all are potentially affected by the cited deficiency, wound documentation has been reviewed, interventions for prevention are in place and documented clearly on care sheets. Weekly skin audits are completed, and staff update DON on any new areas noted immediately including reporting of any bruises, skin tears, skin breakdown or rashes. All current resident with pressure ulcers were assessed for comprehensive assessment along with appropriate interventions. Implementation of those interventions is reviewed on rounds weekly. Staff to alert DON is resident refuses otherwise. Staff educated on importance of offloading, repositioning, care plan updated, care sheets updated. Weekly skin audits completed on bath day, dietary and therapy involved in interventions as needed to those at risk. No other residents were affected. The policy on wound care has been reviewed. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all staff received in-service training for monitoring skin and pressure areas, to ensure staff always use best pressure reduction tolls and understand differences in cushions and understand offloading to prevent further alterations in skin integrity. The training emphasizes the importance of	

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{F 686}	Continued From page 25 gave permission for surveyor to view during dressing change. On 5/31/18, at 6:45 a.m. R56 was observed in her room sitting on the edge of the bed with her shirt, pants and shoes on. Nursing assistant (NA)-B was in room and assisted her with morning cares. NA-B applied a gait belt and assisted R56 to stand then walk to the bathroom, while holding her hemi walker. NA-B assisted R56 to pull her pants down and revealed R56 had a large 2 x 6 inch tan dressing in place on her left buttocks. The surrounding skin was normal in color. R56's had a Roho cushion (pressure relieving cushion with air cells) in her wheelchair. When surveyor put her hand on the cushion, it was easily pushed down flat. NA-B assisted R56 to sit in the w/c, where R56 combed her hair and applied a jacket and scarf with assistance from NA-B. NA-B transported her in her wheelchair to the front nursing desk near the dining room. R56 propelled herself to the dining room at 7:10 a.m.. R56 remained in the dining room and drank coffee, water and ate cold cereal until she propelled herself back to her room at 7:40 a.m. to the activity room where she read the newspaper. At 7:47 a.m. R56 began to propel herself back to her room, when she was asked by a staff member if she wanted a ride which she agreed. R56 returned to her room where she brushed her teeth independently at the sink. At 7:58 a.m. R56 refilled a bag on her wheelchair with candy from her bedside table then propelled herself back to the dining room. R56 remained at the dining room table by the window, drinking water and doing a word search book from 8:01 a.m. until 9:52 a.m. when church service began. On 5/31/18, at 8:55 a.m. NA-B indicated R56	{F 686}	following all interventions for effective skin maintenance and reporting of changes in skin conditions. Education done on importance of comprehensive assessment of skin, pressure ulcers and implementation of appropriate interventions. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents with impaired skin integrity and updating MD, family and care plans with any changes to ensure appropriate follow through. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will ensure audits on all residents with pressure ulcers and those at risk per diagnosis, Braden or CAA trigger weekly x 4 weeks then on 6 residents weekly for 4 weeks to ensure compliance than 2 residents weekly x 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. DON will be responsible for this POC.	

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{F 686}	Continued From page 26 usually liked to hang out in the dining room during the day, did word search books and went to the active room. NA-B indicated R56 was able to express her needs by going back to her room and would put her call light on if she wanted to use the bathroom. NA-B indicated she took R56 to the bathroom about twice a day, and indicated she usually reminded R56 to use the bathroom around lunch time to see if she would go. NA-B indicated she was aware R56 had a sore on her bottom. NA-B indicated as nursing assistants they do not do anything with resident cushions. NA-B indicated she was provided education after the last survey. NA-B indicated the were provided a copy of the deficiencies and reviewed them. When surveyor asked her about education related to pressure ulcers, she indicated they discussed repositioning. When asked about R56's repositioning, NA-B indicated she should be checked every 2 hours and confirmed her nursing assistant care sheet instructed 1 staff to assist Q2 HRS (every 2 hours), resident can state need, for skin care. On 5/31/18, at 10:50 a.m. R56 was in the dining room at the same spot, sitting at the table in front of the window. R56 indicated she was in the dining room for the church activity, and did not leave during it. At 10:56 a.m. surveyor notified director of nursing (DON) that R56 had not been repositioned since 7:05 a.m. DON indicated she would assist R56, after she asked her permission, for repositioning and complete her wound assessment and dressing change. R56 agreed and left the dining room. On 5/31/18, at 11:05 a.m. occupational therapist (OT)-A indicated R56 was receiving occupational therapy at that time. She indicated R56 had a	{F 686}		

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{F 686}	Continued From page 27	{F 686}		

foam cushion in her wheelchair prior, but now was using a low profile Roho cushion that was 2 inches. OT-A joined R56 in the hallway and she indicated she had just checked R56's Roho cushion yesterday to assure it was full, but indicated she had checked it while R56 was sitting on it. OT-A indicated she would check the cushion to assure it was inflated when R56 got out of the wheelchair. DON also in hallway near R56 and she confirmed R56 should be repositioned every 2 hours. OT-A indicated she taught R56 repositioning techniques, and taught her to use the hand rails in the hallway for offloading. OT-A instructed R56 to show surveyor how she could reposition herself with the rails. R56 stopped and turned towards the hand rail in the hallway, put her right hand on the rail, but was unable to pull herself up. R56 then began propelling herself towards her room using her right arm to pull on the handrail as she went down the hall. OT-A indicated she had requested RN (registered nurse) Director of Quality (RDQ) to update the nursing assistant care sheets for R56 to be repositioned every 2 hours, but was informed in a return e-mail that it was not appropriate because R56 was alert.

On 5/31/18, at 11:18 a.m. DON, OT-A and NA-C entered R56's room. NA-C assisted R56 with a gait belt to transfer from her wheelchair and walk to the bathroom with her hemi-walker. OT-A checked R56's Roho cushion in her wheelchair and confirmed it was deflated. OT-A added air to the cushion using a hand pump. DON assisted R56 to remove her pants and brief. R56's skin was normal color around the dressing. When the dressing was removed, there was an excoriated (damaged, abraded) area 7.5 cm (centimeters) by 4 cm on the inner aspect of her left buttocks.

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{F 686}	Continued From page 28	{F 686}		

The dressing had a scant amount of red drainage. R56 had three superficial open areas, one in the center of the excoriated area, which DON indicated had bled, and two below this. All areas measured 1 cm by 0.5 cm. DON cleansed area, and applied a 4 inch by 4 inch Mepilex (foam dressing for wounds) to the area.

Review of R56's treatment administration record (TAR) identified a tissue tolerance assessment was completed on 5/10/18, and 5/28/18. Pressure Ulcer precaution every shift began on 5/29/18.

On 5/31/18, at 11:30 a.m. DON and surveyor reviewed R56's electronic record. DON confirmed R56's TAR identified tissue tolerance assessments were initialed, which indicated they were completed on 5/10/18, and 5/28/18, but she was unable to locate them. DON indicated the facility usual practice was to complete them in resident's electronic record. DON confirmed R56 did not have a tissue tolerance completed. DON indicated the frequency of R56's repositioning needs would be determined by the the tissue tolerance test. DON indicated she would expect R56's to be repositioned every 2 hours, her Roho cushion to be inflated and the tissue tolerance assessments to be completed.

Review of R56's nursing assistant care sheet, updated 5/29/18, for R56 identified; skin, 1 assist Q 2 HRS, resident can state need and care notes indicated alert/orientated, resident able to direct all care; keep left hand elevated; lotion at hand NOC encourage resident repo (reposition) PRN (as needed) and position side-lying.

Review of R56's Norton Scale for Predicting Risk of Pressure Ulcer, dated 5/4/18, identified a

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{F 686}	Continued From page 29 score of 10, high risk. Review of R56's Braden Scale for Predicting Pressure Sore Risk dated 5/4/18, identified a score of 16, low risk. Review of R56's weekly skin review 5/1/18, to 5/30/18 identified the following; -5/2/18, skin dry, open area, left buttock check open 2 X 1 cm, mepilex in place, will continue to monitor. Site: left gluteal fold, existing open are 2 X 1 cm. -5/9/18, skin dry, open area, left buttock cheek open 2 X 1 cm, mepilex in place, will continue to monitor. Site: left gluteal fold, existing open are 2 X 1 cm. -5/16/18, skin dry, open area, left buttock cheek open 2 X 1 cm, mepilex in place, almost resolved, tissue color pink and part scab, will continue to monitor. Site: left gluteal fold, existing open are 2 X 1 cm. -5/23/18, open area, resident has an open area to left buttocks. No further description. Review of R56's Wound Evaluation Flow Sheet Multiple weeks-V 4, from 5/4/18, to 5/22/18 identified the following; -5/4/18, Wound identified 5/4/18, site: left buttock, vascular 2 length, 1 width, 0.2 depth, stage II. wound type; pressure, no exudate, pain area not completed, granulation 100%, wound margins defined, current treatment; change mepilex to L) (left) buttocks q (every) 3 days and PRN if soiled or falls off. Current preventative interventions:	{F 686}		

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{F 686}	Continued From page 30 pressure redistribution mattress, w/c (wheelchair) cushion. Wound had not been debrided and change to care plan was reviewed. -5/12/18, Wound evaluation week 2 : length in cm: 108 (probable clerical error), width in cm: 1, depth in cm: 0.2, Stage II, no exudate, Pain scale 0, 100% granulation, periwound defined, current treatment; change mepilex to L) (left) buttocks q (every) 3 days and PRN if soiled or falls off, date treatment ordered 12/7/17. Current preventative interventions: pressure redistribution mattress, w/c cushion. No debridement, care plan reviewed, wound had not healed. -5/22/18, Wound evaluation week 3: length in cm: 1.8, width in cm: 1, no depth. Stage II, no exudate, pain scale 0, 100% granulation, periwound not described, current treatment; change mepilex to L) (left) buttocks q (every) 3 days and PRN, current preventative interventions: pressure redistribution mattress, w/c cushion. No debridement, care plan reviewed and wound had not healed. -5/22/18, Wound evaluation week 4; length in cm: 0.5, width in cm: 0.5, no depth. Stage II, no exudate, pain scale 0, 100% epithelial, wound margins defined, current treatment; change mepilex to L) (left) buttocks q (every) 3 days and PRN if soiled or falls off. Date treatment ordered 12/7/18, current preventative interventions: pressure redistribution mattress, w/c cushion. No debridement, care plan was not reviewed, wound had not healed. -5/29/18, no wound evalation documentation. R56's medical record lacked a comprehensive	{F 686}		

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{F 686}	Continued From page 31 pressure ulcer assessment. Review of R56's Occupational therapy evaluation and plan of treatment, dated 5/21/18, identified pressure ulcer of left buttock stage 2 onset of 5/2/18, revealed the following: -Short term goals included: pt (patient)/staff to increase ability to relieve pressure while seated in wheelchair with supervised and 25% verbal cues for schedule/form, target date 6/3/18. Pt/staff will demonstrate successful use of new/adapted seating systems as indicated by maintenance/improvement of L (left) buttocks wound 2 X 1 X 0.2 mc day of eval, for skin integrity mgmt. (management). Pt/staff will demonstrate ability to manage incontinence mgmt schedule/adapted methods with supervision and 25% cues to prevent worsening of skin integrity concerns. -Long term goals listed included; Pt/staff will demonstrate ability to manage pressure relief and incontinent mgmt techniques/equipment to maintain/improve skin integrity with no cues required. -Pt/caregiver goals; prevent worsening of pressure ulcer, heal if possible, and maximize function in SNF (skilled nursing facility). -Patient demonstrates good rehab potential as evidenced by supportive caregivers/staff and recent onset. -Patient/Caregiver participated in establishing POT (plan of treatment) -Pt has not had pressure ulcers in the past, has	{F 686}		

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{F 686}	Continued From page 32 resided in SNF with 24 hr (hour) cares for 6 years. -cognition; follows two-step w/o (without) (A) (assistance); safety awareness = impaired, new learning capacity = impaired. -Summary of evaluation identified physical, cognitive and psychosocial deficits. The summary also identified impairments in mobility and interpersonal habits, which resulted in limitations and/or participation restrictions. Review of OT-A documentation 5/21/18, to 5/31/18, identified the following; - 5/21/18, assessed areas of deficit and underlying impairments to positioning. Educated patient regarding process and goals. -5/22/18, implemented narrower wheelchair to prevent leaning, and a low profile Roho cushion for pressure relief. Fixed broken left elevating pedal. R56 reported comfort and visibly was not leaning upon re-assessment. -5/30/18, trained R56 in incontinence prevention methods, toileting schedule and use of call light to maintain/improve skin integrity. Educated R56 on side-lying in bed at night and R56 reported understanding of all education. Trained patient in repositioning techniques and w/c pull-ups using hall rails to improve pressure relief. R56 required moderate assist and 50% cues. Communicated to staff toileting schedule and repositioning to maximize generalization of skills. -5/31/18, trained NA in Roho cares and inflation of cushion if cushion does deflate. Did re-inflate	{F 686}		

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{F 686}	Continued From page 33 cushion during wound cares to desired level. NA indicated understood Roho cares and would pass on in report that day. Pump left in R56's room for staff to use or alert therapy with questions. Review of R56's order summary report signed 5/29/18, included orders: -change mepilex to L) buttocks q 3 days and PRN if soiled or falls off, as needed, every day shift every 3 days, for wound care, order date 12/6/17. -OT clarification, eval (evaluate) and tx (treat) 10 X in 30 days for w/c mgmt, self care training, and their act. one time a day until 6/24/18, order state 5/21/18. -Weekly skin check (Wed PM) every evening shift every Wed, order date 7/14/17. -Pressure ulcer precautions, order date 5/29/18. R56's primary physician 5/29/18, visit progress note was requested but not provided. On 5/31/18, at 1:41 p.m. DON confirmed she completed assessments for the facility residents. DON indicated R56's wound had worsened and the excoriation and 2 lower open areas were new. DON confirmed R56 now had 3 stage 2 open areas to her buttocks. DON confirmed she had not completed a comprehensive assessment of R56's pressure ulcers. DON indicated she ordered an air pressure mattress for R56's bed for pressure relief. DON indicated she was not sure if R56 currently had a regular or pressure relieving mattress on her bed, but would check and report if it was. She indicated the new air pressure mattress was ordered. and would be	{F 686}		

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{F 686}	Continued From page 34 initiated when received. DON confirmed R56's primary physician had examined R56's pressure ulcer on 5/29/19. DON indicated R56's pressure ulcer began on 5/4/18. DON indicated she felt R56 would need assistance to off load and reposition herself, and confirmed staff assistance was needed to lift her up. DON indicated RDQ and herself updated the nursing assistant care sheets on 5/25/18. DON confirmed they were considered a part of R56's care plan. On 5/31/18, at 1:55 p.m. a voice message was left for R56's primary physician, but a return phone call was not received. Review of facilty wound audits for R56 on 5/10/18, and 5/17/18 revealed that dietary notes did not reference the wound. No follow up documenation was noted. Review of facility policy titled Prevention of skin breakdown, reviewed 4/20/18, instructed utilization of RAI (resident assessment instruction) process, Braden Risk assessment and a comprehensive assessment in identification of risk factors. Evaluate turning and repositioning intervals or initiate tissue tolerance assessment per policy. Pressure ulcer treatment procedures included re-evaluation of turning and repositioning intervals or initiate tissue tolerance assessment, initiate Braden and comprehensive risk assessment. Daily wound monitoring should be initiated on treatment sheet. Procedure for treatment of pressure ulcers included assessment of the wound, diet should contain adequate hydration and nutrients to support healing which included guidance for protein and calorie intake. The policy also included procedures to avoid positioning on pressure	{F 686}		

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{F 686}	Continued From page 35 ulcer, use protective pressure reducing devises in bed and wheelchair sitting surface as ordered. The policy also instructed in bold lettering to provide ongoing education to all staff on pressure ulcer care and prevention.	{F 686}		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to to ensure coordination of care and communication related to hyperkalemia (high potassium levels in the blood) and nutritional interventions for 1 of 3 residents (R37) receiving hemodialysis. Findings include: R37's admission Minimum Data Set (MDS) dated 4/30/18, indicated R37 had moderately impaired cognition, and had diagnoses which included end-stage renal disease (ESRD), hyperkalemia and malnutrition. The MDS indicated R37 required extensive assistance for dressing, personal hygiene and toilet use, but could eat independently after set up assistance from staff. R37's MDS further indicated no weight gain or loss, received a mechanically altered diet and was receiving dialysis. R37's MDS indicated he was not receiving a therapeutic diet.	F 698	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide dialysis care to all residents based on appropriate diagnosis and assessment. R37 was noted to have hyperkalemia and no specific dialysis diet. According to care plan, nutritional assessment and staff the resident had no interventions in place and the appropriate diet had not been determined based on dialysis diagnosis. The dialysis company noted high potassium and yet resident still got bananas. The diet slip had been changed to state no bananas and no orange juice,	7/23/18

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F 698	Continued From page 36 R37's Care Area Assessment (CAA) dated 5/3/18, indicated R37 was admitted with diagnoses of ESRD and dementia and was dependent on renal dialysis three times per week. The CAA indicated R37 was forgetful and at times resistive to cares. R37's nutritional status indicated R37 had been eating well since admit, had no teeth and there was no current labs available for review. However, R37's nutritional status lacked information regarding diagnoses of ESRD or hyperkalemia and being dependent on dialysis. R37's care plan last revised 5/21/18, indicated R37 required hemodialysis due to ESRD and required a therapeutic diet. R37's care plan listed various interventions which included: consults as ordered by the physician (nephrology, nutritional and social services), diet per physician order, monitor any signs or symptoms of dysphagia (difficulty swallowing), provide snacks, diet and supplements as ordered, nutritional education will be provided as needed and at resident request, offer healthy snacks and obtain and monitor lab work as ordered. However, the care plan did not address R37's diagnosis of hyperkalemia or what foods to avoid while on hemodialysis. Review of R37's signed physician orders dated 5/4/18 indicated R37 was ordered a regular diet with mechanical soft texture, regular consistency, ground or chopped meat into quarter pieces. R37's physician orders lacked any further information regarding dialysis. Review of R37's Admission Nutrition Data V2. 1 dated 4/30/18, indicated R37 had diagnoses including ESRD, hyperkalemia and dependent on renal dialysis. The form indicated R37 had weight	F 698	a new nutritional assessment had not been completed. When the information was reviewed it was noted no recent labs were in chart either. A potassium was ordered, the nutritional assessment revised, diet reviewed, and care plan updated. Staff educated on renal diets. 2.Because many residents are on restrictions related to care needs and diagnosis, many are potentially affected by the cited deficiency. Dietician reviewed with MD along with dialysis team the order, clarified the diet resident should have based on diagnosis and instructed staff to follow care sheets and entered in communication book. All current residents on restrictions due to dialysis were reviewed and ensured information matched and staff were aware. Diet slips were updated, diet choices for dialysis diets were posted to ensure staff pack appropriate lunches. No other residents were affected. The policy on hemodialysis has been reviewed. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all staff (nursing and dietary) will receive in-service training monitoring diets and describing diets based on diagnoses. The training emphasizes the importance of following a plan of care, reviewing diagnosis, and appropriate monitoring. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the dietician to monitor resident's diets in relation to their diagnosis. Dietician will review nutritional assessments monthly and as needed to	

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F 698	Continued From page 37 loss, skin was intact, had risk factors for dehydration of age and decreased mobility, was edentulous, ate 75% of meals, had a normal potassium level (although no value was given) and refer to nutrition assessment. Review of R37's clinical record revealed no nutrition assessment since admission on 4/23/18. On 5/31/18, at 8:14 a.m. R37 was lying on his back in bed with his eyes closed. An over-the-bed table was next to the bed that had three opened Mt. Dew 12 oz cans and a 2% milk carton on the table. On 6/1/18, at 8:45 a.m. R37's dining room tray ticket, dated 6/1/18, was reviewed. The ticket indicated R37 had a regular diet which was mechanical soft and regular texture for liquids. Under "Special Notes" section of R37's ticket was a note for oatmeal with Propass x 2 servings. The ticket lacked identification of a therapeutic diet for ESRD. On 6/1/18, at 9:10 a.m. during a phone interview with dialysis registered nurse (DRN)-A stated R37 should have diet restrictions for dialysis including high protein and low potassium. DRN-A stated their manager had to call the facility last week because the facility was packing two bananas for R37's snack while at dialysis and R37 just had an issue with hyperkalemia (high potassium level). DRN-A stated he was instructed to keep checking R37's facility packed snacks for bananas due to the hyperkalemia. On 6/1/18, at 9:55 a.m. during a phone interview with dialysis dietician (DD)-A regarding R37, DD-A stated R37 had a critically high potassium	F 698	monitor and update interventions. Dietician will contact dialysis center and review labs monthly and as needed. The dietician or designated quality-assurance representative will perform the following systematic changes: audit 2 residents for 3 weeks than 1 resident for 5 weeks to ensure appropriate diet is given, the dialysis center has made no dietary changes, that lunches are appropriate for diet and resident not in compliance with waiver on file will be reviewed weekly for 3 weeks by dietician with dialysis to ensure no other concerns or issues arise due to non-compliance then monthly follow up for next 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.Dietician will be responsible for this POC.	

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F 698	Continued From page 38 level of 6.9 miliequivalents per liter (normal range 3.4 - 5.1) on 5/22/18. DD-A stated she called R37's facility and updated a staff RN on the high lab and to limit the amount of bananas and oranges/orange juice R37 consumed. DD-A stated R37 also had a critically high potassium level on 5/24/18. DD-A stated she would expect the facility to communicate the dietary needs of low potassium needs of R37 in some manner. On 6/1/18, at 10:16 cook (CK)-C stated R37's diet was regular, mechanical soft and he required dialysis. CK-C stated dietary staff was responsible to pack sack lunches for dialysis residents. She stated R37 would typically receive a mechanical soft turkey, ham, egg or tuna salad sandwich without cheese, lettuce, carrots or celery, apple sauce and hard boiled eggs with apple cranberry juice supplement. CK-C stated some aids would use other fruits such as grapes, bananas or mandarin orange. CK-C stated she was not aware of R37's high potassium levels. On 6/1/18, at 10:28 a.m. dietary manager (DM)-A stated she was the dietician for the facility. DM-A stated the dialysis dietician called her 2-3 days ago and updated her about R37's hyperkalemia and it was decided to eliminate bananas and orange juice due to R37 eating 2-3 bananas a day and a couple glasses of orange juice. DM-A stated the only way she communicated that information was to place "No bananas, no orange juice" on his tray ticket. DM-A reviewed R37's current tray ticket from that days breakfast. DM-A stated she changed it the day she spoke with DD-A. She pulled up the tray ticket computer system MenuMatrix and confirmed the information was added to the system to read "No bananas, no orange juice". DD-A stated the staff	F 698		

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F 698	Continued From page 39 person responsible for printing off the tray tickets CK-A will at times print the tickets out a few days ahead of time and the new order has not been printed out on tickets yet. DM-A stated the information should have been added to R37's care plan as well. DM-A stated the corporate dietician completed R37's admission nutrition assessment. On 6/1/18, at 10:50 a.m. CK-A confirmed she was responsible for printing out the tray tickets for resident meals. CK-A stated at times, if she would not be at the facility (weekend off, appointments etc.) that she would print out the ticket ahead of time. CK-A stated on Fridays she would print off Saturday, Sunday and Mondays tickets and then print out Tuesdays on Monday, Wednesdays on Tuesday and Thursday and Fridays on Wednesdays. On 6/1/18, at 10:54 a.m. MDS coordinator (MDSC)-A stated she would expect to see a new nutrition assessment since the new admission on 4/23/18. MDSC-A confirmed no new nutrition assessment was in R37's clinical record. MDSC-A stated she would have expected to see R37's, no bananas or orange juice on the care plan so all staff had access to it. On 6/1/18, at 11:09 a.m. director of nursing (DON) stated R37 was scheduled for a fistulagram (is a test to look for abnormal areas in your dialysis graft or arterio-venous fistula that may be causing problems) on 5/24/18, due to hyperkalemia. DON reviewed R37's care plan and confirmed no information regarding hyperkalemia, or that R37 should not eat bananas or drink orange juice. DON stated she would have expected that information to be	F 698		

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F 698	Continued From page 40	F 698		

included in the care plan, as well as a new admission nutrition assessment to have been completed.

On 6/1/18, at 11:28 a.m. nursing assistant (NA)-H stated she thought R37 had a banana this morning and R37 was supposed to have extra potassium.

On 6/1/18, at 11:40 a.m. NA-F stated she was not sure if R37 was to have bananas due to not having teeth, she would have to check his care plan. NA-F stated she had not received any education regarding R37 lately.

On 6/1/18, at 2:39 p.m. during a phone interview, consultant dietician (CD)-A stated she had met with R37 and discussed dialysis with DM-A around R37's admission date. CD-A stated she thought it was missed as to which person (CD-A or DM-A) was going to put in the admission nutrition assessment and confirmed the clinical record lacked an admission assessment from most recent admission. CD-A stated she would not address R37's history of hyperkalemia in the care plan, but would maybe place it in a progress note.

Review of facility policy titled Hemodialysis Policy reviewed 4/28/18, indicated the facility must conduct and coordinate the MDS/RAI process through appropriate assessments. The information should be coordinated with the dialysis provider to develop a coordinated plan of care. Dietary initial assessment and care plan, the dietary director in consultation with the dietician was responsible for completing the initial nutrition assessment and plan of care. The consultant dietician completes a monthly nutrition

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F 698	Continued From page 41 assessment and care plan review. These assessments are based upon food/fluid intake, weight patterns, diet adherence, and laboratory values.	F 698		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced	F 726		7/23/18

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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 726	Continued From page 42 by: Based on observation, interview and document review, the facility failed to ensure nursing staff received and demonstrated competency skills related to tracheostomy care for 1 of 1 resident (R107) reviewed for tracheostomy (a surgically created hole (stoma) in your windpipe (trachea) that provides an alternative airway for breathing) care. Findings include: R107's admission Minimum Data Set (MDS) dated 2/20/18, indicated a cognition assessment was not completed, and R107 had diagnoses which included attention to tracheostomy, attention artificial opening of digestive tract, and cancer. The MDS indicated R107 required extensive assistance for all cares except eating, which he required total care. R107's MDS further indicated the use of oxygen, tracheostomy care and suctioning. R107's quarterly MDS dated 5/1/18 indicated independent cognitive skills for daily decision making and diagnoses, which included squamous cell carcinoma of skin of scalp and neck, chronic pain, attention to tracheostomy and anxiety. The MDS indicated R107 required total assistance with eating, extensive assistance with dressing and hygiene, limited assistance with toileting and was independent with all other ADLs. R107's MDS further indicated tracheostomy care and suctioning. R107's Care Area Assessment (CAA) dated 2/28/18 indicated R107 had a tracheostomy in place due to oral pharyngeal cancer.	F 726	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to ensure that there are sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and highest practicable physical, mental, psychosocial well-being of each resident. Since survey findings, all staff have been educated and are competent tracheostomy care. Education and knowledge for trach care and displayed a return demonstration on cleaning and changing a trach. In addition, licensed nurses have been given additional training in nursing skill areas and needed proper competency testing of all areas as determined based on resident population, their job title, and areas identified through survey, staff, residents, families and the quality assurance committee. DON and designee immediately began proper competency trainings for all staff and new staff will be orientated through proper orientation system. 2.All residents can be affected by incompetent nursing staff. All employee files and training records were reviewed, current orientation for new hires after 7/2/2018 and other individualized	

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F 726	Continued From page 43 Review of R107's current care plan last revised 4/3/18, revealed that there was no care plan related to R107's tracheostomy. Review of facility provided Group 3 care sheets, updated 5/29/18, indicated under "Care Notes" R107 had a "Trach", but there was no instruction related to its care or monitoring. On 5/31/18, at 11:15 a.m. licensed practical nurse (LPN)-A entered R107's room and set up supplies for tracheostomy care. LPN-A washed her hands and placed sterile gloves from the tracheostomy care kit. With sterile gloves donned, LPN-A loosened the Velcro holding the tracheostomy neck plate and outer cannula in place and proceeded to squeeze R107's tracheostomy's outer cannula while gently pulling at the inner cannula. With the inner cannula not disengaging from its lock (used to keep the inner cannula in place if the resident was to cough), LPN-A then tried loosening the Velcro collar more. LPN-A again grabbed the outer and inner cannulas, one with each hand, tried to disengage the lock, and could not. LPN-A stated she had not provided R107 tracheostomy cares prior and stated "maybe I should get someone who knows how to do this". LPN-A then stated she was going to get some help. At 11:29 a.m. LPN-A returned to R107's room with LPN-B. LPN-B washed her hands and donned gloves, she then held the outer cannula with one hand and twisted the inner cannula with the other hand, and the inner cannula disengaged and was able to be removed. LPN-B placed the inner cannula, which had white and tan secretions noted to the inner cannula into a small carton lined with plastic, filled with a solution of half hydrogen peroxide and half sterile water, and then left the room. At 11:32 a.m.	F 726	education provided since survey. The DON along with staffing and ED determined a series of trainings, in-services, 1:1 trainings, return demonstrations, packets for review for all staff based on their individualized training requirements. On 7/2/2018 skills lab and form review was held for all nurses. 3.Upon review and completion of all competencies, re-orientation and annual training requirements, the DON or designee will complete a 1:1 performance evaluation with each nursing employee to ensure competent staff, and review what other training and education needs should also be included for quality assurance purposes. All new hires will have completion of orientation and training consistent with facility policy. All casual employees unable to complete necessary training will not be allowed to work at facility until after completion and 1:1 review with DON. Staff will be audited starting 7/16 on the job by nursing management for aspects of care, charting, skills, medications and policies related to job expectations. Audits will be done on random nurses every week during different care functions to ensure 4 nurses per week are reviewed alternating shifts over next 3 months. 4.Beginning 7/16/18 the DON, ADON and MDS nurse will provide all nurses with above educational training and will review, monitor and assist staff to ensure completion. Ongoing monthly in-services will be provided and tracked by DON (or designee) to assure continued compliance. Education programs will	

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F 726	Continued From page 44 LPN-A placed new sterile gloves, grabbed a cotton tipped applicator, wetted it in the same carton containing the inner cannula and held the cannula with one hand and cleaned the exterior of the inner cannula and returned it to the same carton. LPN-A then grabbed a new cotton tipped applicator and wetted it with a hydrogen peroxide and sterile water solution from a separate carton and cleaned the exterior cannula. LPN-A then grabbed the inner cannula with one hand and used a small white pipe cleaner to clean the inner cannula of small chunks of the white and tan secretions. She then poured sterile water over inner cannula and shook the excess water off using an up and down bobbing motion and then replaced the inner cannula into the outer cannula, tightened the Velcro strap and placed a gauze dressing around the exterior cannula. On 5/31/18, at 11:43 a.m. LPN-A stated her tracheostomy care education included watching a video 2 to 3 months ago. LPN-A stated she normally worked the night shift, which did not include regular tracheostomy cares, as R107's tracheostomy care was done twice a day during the morning and evening shift. LPN-A stated she had never completed a return demonstration after tracheostomy care education and had not been checked off on her comprehension of tracheostomy care. On 5/31/18, at 1:00 p.m. LPN-B stated her tracheostomy care education included a licensed staff meeting with the director of nursing (DON), watched a video, a slide show of what to do for different tracheotomies and what to do in an emergent situation. LPN-B stated she had not completed a return demonstration and had not been checked off on her comprehension of	F 726	identify areas of weakness determined from performance reviews, resident needs and areas identified in the monthly QAPI reviews. All nursing staff's individual competencies will be completed by 7-20-2018. All new hires will have completed competencies during orientation. Monthly for 6 months the facility will continue to monitor that assigned annual and deemed appropriate trainings are completed monthly. Any deficiencies will be immediately corrected, and findings will be documented and reviewed at the monthly quality assurance committee meeting. 5.The DON will be responsible for the POC.	

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F 726	Continued From page 45	F 726		

tracheostomy care in the last two months.

On 5/31/18 at 1:27 p.m. DON stated tracheostomy care education was completed in the last month, which included: cleaning the cannulas, and suctioning. Education included watching "some" nurses do tracheostomy care, but stated she did not have a form for those that were watched. DON confirmed the tracheostomy care included how to remove an inner cannula and properly clean it. DON stated she would expect all licensed staff to know how to remove a cannula and clean it. DON stated she had focused her education to the day and evening shift nurses, but had not gotten to the night shift nurses yet. She stated there was a potential a night nurse would have to know how to complete tracheostomy cares.

Review of facility document, Trach Audit dated 5/22/18, indicated two residents currently with tracheotomies. The audit tool had review of "Trach care on MAR (medication administration record) /TAR" (treatment administration record), "Trach ties intact", "Inner cannula clean", "How often is trach changed", "Back up supplies in room" and "How are staff disinfecting inner cannula and trach area". The audit tool had information for both residents currently receiving tracheostomy care; however, the form indicated no information for how staff are disinfecting inner cannula and trach area for both residents.

Review of facility provided documents titled Licensed Nurse-Tracheostomy Competency Evaluation dated 5/21/18 and 5/23/18 revealed LPN-A had not had tracheostomy competency evaluated.

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F 726	Continued From page 46 Review of LPN-A's facility provided education documents revealed no training on tracheostomy care. A policy was requested for licensed nurse education, training and competency requirements, but none was provided.	F 726		
{F 812} SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outdated food items were not available for resident consumption. This had the potential to affect 53 of the 54 residents that received food from the kitchen.	{F 812}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	7/23/18

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{F 812}	Continued From page 47 Findings Include: During the initial tour of the kitchen of the walk-in refrigerator on 5/29/18, at 9:18 a.m. revealed a tray of approximately 20 apple sauce one cup covered containers dated 5/19/18, a clear container of ground ham dated 5/16/18 and a clear container of diced ham dated 5/18/18, a loaf of banana bread dated 5/11/18, and a pie dated 5/20/18. Dietician (DN)-A indicated the facilty were throwing away the apple sauce, pie and banana bread. DN-A indicated the dietary manager would be in later. On 5/29/18, at 9:40 a.m. dietary aide (DA)-A indicated she had received education since the last survey was completed. DA-A indicated she had received education on many items, including serving drinks and how to speak with residents. DA-A indicated she washed dishes, set up beverages, and cleaned the coolers, but did not handle the food. On 5/29/18, at 9:43 a.m. DA-B indicated she had received education since the last survey which included making sure food was warm for residents and to date all foods that go in the coolers. DA-B indicated foods should not be kept more than 5 days, nothing should be kept 7 days. DA-B indicated they checked the coolers every 3 days for outdated foods. On 5/29/18, at 9:47 a.m. cook (CK)-A indicated she provided some of the education to staff. CK-A indicated they reviewed multiple areas, such as cleaning and drying appliances and dishes, use only pasteurized eggs, use of adaptive equipment and menus. CK-A indicated they did not discuss the cooler or outdated food	{F 812}	requirements established by state and federal law. 1.It is the policy of this facility to ensure healthy and safe meal service. Some of the many ways that this has been done is ensuring clean environment and safely preparing and serving food and beverages to residents before their expiration dates. After the surveyor reported finding expired dates or undated items in kitchen it was determined staff not properly managing expired foods. Immediately the dietary manager threw out items and updated staff to monitor dates. The log sheet that had only been signed off 2 out of 9 days was addressed and monitored for daily checks. 2.Because all residents receive their meals here in facility all are potentially affected by the cited deficiency, 7/2/2018, the dietary manager did deep clean of the fridge to remove all outdated items. Cleaning out fridge items that are expired is now done daily with kitchen cleaning schedule. The staff have reviewed the policy and are aware of proper storage and dating open items. 3.To enhance currently compliant operations and under the direction of the director of dietary, on 7/2/2018 dietary staff reviewed proper storage and dates with dietary manager to ensure all items are safe to serve. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the director of dietary to monitor fridge for expired items. The director of dietary or designated quality-assurance representative will	

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{F 812}	Continued From page 48 items. CK-A indicated she threw away the pie, apple sauce and banana bread at the time of the initial tour. Ck-A indicated she has told staff to check the food dates, but "they don't do it." CK-A indicated she threw away the ground and diced ham also. she indicated they were 2 or 3 days past the date they should be used. CK-A indicated she did not notice the dates of the foods today. CK-A indicated if staff do not show up she does multiple tasks. On 5/29/18, at 9:52 a.m. DN-A indicated she worked at the facility and indicated the facility had provided staff education on various topics, including the use of pasteurized eggs, dating items and cleaning. DN-A confirmed the ground ham, diced ham, banana bread, pie and apple sauce were expired. On 5/29/18, at 2:00 p.m. dietary manager (DM)-A indicated she was new to the facility and CK-A provided the education to staff. DM-A indicated she was not aware there was a problem with expired foods in the fridge. DM-A indicated she may have been told, but indicated there were many items they had reviewed. DM-A indicated she checked the dates on refrigerated foods at least every other day, but due to the holiday weekend, the last time she checked was last Friday. DM-A indicated she believed most items could be kept 3 days after dated, either the prepared date or opened date. DM-A indicated staff followed the directions posted on the cooler door for actual use-by dates to be followed. DM-A indicated checking for outdated foods was on the facility daily cleaning schedule task list the dietary staff used. Review of the facility forms titled Daily Cleaning	{F 812}	perform audits to visualize contents of the fridge, dates, and storage to be done 2x per week for 4 weeks then 1x per week for 2 months to ensure compliance via dietary manager or designee. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly QAPI meeting for further review or corrective action. 5.Dietary manager and maintenance will be responsible for this POC.	

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{F 812}	Continued From page 49 Schedule from 5/21/18, to 5/5/29/18, identified the area marked "Check for label and date, throw out all outdated foods", was initialed or checked only 2 out of 9 days. Review of staff training provided indicated on 5/3/18, CK-A and DM-A reviewed policy of saving food, and taking down all temperatures in the kitchen. No specific training objectives or details were provided as requested. A facilty form titled Cold Food Storage, undated, identified prepared potentially hazardous foods; foods mixed with other ingredients "use by date" was 3 days after placing in refrigerator. Foods in original form, which included opened fruit sauces, "use-by date" was 7 days after placing in refrigerator. A facility form titled USDA (United States Department of Agriculture) Food Safety and Inspection Service, Storage Times for Refrigerated Foods, undated, identified ham, fully cooked slices was 3-4 days. Review of facility audit forms titled Superior Healthcare Management-Moorhead Kitchen Audit from 5/21/18, to 5/25/18 lacked audit questions regarding checking storage dates of refrigerated foods. On 5/30/18, at 12:10 p.m. the administrator confirmed the audits did not include checking storage dates of refrigerated foods. Administrator indicated he himself had gone through the coolers to assure foods were not past their storage dates. His expectation would be that staff routinely go through and remove foods past the storage date.	{F 812}		

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{F 812}	Continued From page 50 The facility policy titled Storing Prepared Foods, dated 2011, identified food or potentially hazardous food ingredients not stored in original containers must be discarded if not used within "use-by" date. The policy further instructed staff to store all extra portions in sealed shallow (2 inches deep), approved containers. Label, note "use by" date and refrigerate immediately. All items not stored in original container must be labeled and noted with "use by" date according to storage chart, and used or discarded within allowed days. Monitor all items daily for expiration dates or "use by" dates and discard all outdated items immediately.	{F 812}		
F 865 SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by:	F 865		7/23/18

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F 865

Continued From page 51

Based on interview and record review, the facility failed to maintain a quality assessment and assurance (QAA) committee that was effective in identifying and responding to quality deficiencies. This deficient practice had the potential to affect all 54 residents in the facility.

Findings include:

During an interview on 6/1/18 at 4:31 p.m., with the nursing consultant present, the administrator verified he was the lead for QAA. The administrator identified the following staff regularly attended the QAA meetings: director of nursing, director of social services, therapy director, medical director, Minimum Data Set coordinator (MDSC) and pharmacy consultant. The administrator identified the most recent quarterly meeting was conducted on 4/30/18.

The administrator identified the QAA meeting members discussed many of the tags cited during the facility survey of 3/13/18. The administrator indicated many new protocols were put in to place, staff were educated, new staff hired for dietary and MDSC position and audits were initiated to review the progress.

The nurse consultant (NC) identified the nursing staff had competency issues. The NC identified nursing staff had demonstrated problems with listening, charting, and documentation. The NC identified the facility had a system failure with providing information, orientation and follow-up on practices.

With review of the audits the NC indicated staff had been educated on how to perform audits and what was expected with negative findings. The

F 865

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

1.It is the policy of the facility to ensure that the Quality Assurance Performance Improvement committee identifies and develops appropriate action plans related to system failures. The facility failed to have appropriate action plans related to system failures including doing previous audits and monitoring for changes but not addressing the lack of education that led to continued problems with compliance. Administrator educated everyone on the QAPI program, the guidelines, processes and how to analyze data, etc. to begin to effectively address systemic failures to improve quality at facility.

2.Lack of appropriate action plans for system failures can affect all residents at the facility. At this meeting, opportunities for improvement were identified, prioritized, root cause was determined, and performance improvement plans were initiated, reviewed and continue to be monitored. The items tagged in survey will continue to be addressed and the staff competencies will also be added to the monitoring.

3.To enhance currently compliant operations and under the direction of the Administrator, education reviewed the elements and goals of the QAPI program,

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F 865	Continued From page 52 NC indicated the audits were not expected to be perfect and staff were to learn from them. The NC identified the QAA committee had identified what systems were not in place and were working together to get accountability. The NC indicated the facility had placed a lot of Band-Aid on problems rather than fix the problem because that is what had to be done. The NC indicated now with the audits it is noted that the problem is fixed but the staff is not educated. The NC indicated being aware of the facility problems and which citations were being recited with the revisit survey. The NC indicated she had seen improvements in the facility; however, indicated she was seeing struggles where improvement can be made. The requested facility policy was not provided.	F 865	assistance and tools for accurate data review, and proper identification of root cause while assuring goals are SMART (specific, measurable, attainable, realistic and time oriented). All staff will receive in-service training regarding QAPI program. 4.The QA committee will meet monthly to discuss action plans related to deficiencies noted during survey, review and analyze audits and determine appropriate continued monitoring or system changes in addition to other items already identified on the QAPI plan agenda. The medical director will be present quarterly and pharmacy consultant will be present at a minimum quarterly; if not present minutes will have submitted to them prior to meeting to allow for input during meeting, then will be reviewed and signed monthly. Audits are in place and reviewed monthly to assure that all supporting documentation from each department head is submitted to the Administrator the Monday prior to meeting for adequate time to review. After QAPI the minutes and supporting documentation will then be sent to RDCS and COO for review. This plan of correction will be monitored at the monthly QAPI meeting and audits to continue until such a time that shows consistent substantial compliance with the regulations and the facilities QAPI plan has been met, as determined by a representative of the regional executive team. 5.The Administrator or designee will be responsible for this POC.	

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	245052	A. BUILDING ______ B. WING ______	R 06/01/2018

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MOORHEAD REHABILITATION & HEALTHCARE CENTER	**2810 SECOND AVENUE NORTH** **MOORHEAD, MN 56560**

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{E 000}	Initial Comments An onsite revisit was conducted on 5/29/18, through 6/1/18, to determine compliance with CMS Appendix Z Emergency Preparedness Requirements. The facility is now in compliance with Appendix Z Emergency Preparedness Requirements.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 5/29/18, and 6/1/18. The certification tags that were corrected can be found on the CMS2567B. Also the tags which were not found corrected at the time of onsite PCR are located on the CMS2567. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}		
{F 585} SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been	{F 585}		7/23/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 07/19/2018

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

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{F 585}	Continued From page 1	{F 585}		

furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is

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{F 585}	Continued From page 2 responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents'	{F 585}		

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{F 585}	Continued From page 3 rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement their grievance procedure and ensure verbal grievances were addressed in a timely manner for 1 of 1 resident (R410) reviewed for grievances. Findings include: On 5/31/18, at 8:03 a.m. R410 was observed with morning cares. R410 received assistance from nursing assistant (NA)-F and NA-G to wash and dress. R410 requested NA-F to choose shorts and a tank top from the closet to wear for the day. NA-F informed R410 there were no shorts or tank tops in the closet. NA-F held two pair of jogging pants up for R410 to choose from. R410 responded that the choice of pants was not important because it was too warm to wear anything but shorts and tank tops. NA-F chose a pair of jogging pants and a T-shirt for R410 to wear. On 5/31/18, at 8:30 a.m. R410 indicated he had 9 pair of shorts missing and an unknown number of tank tops. R410 indicated the clothing items were labeled with his name, he had reported it to the facility staff in the past; however, the staff had not done anything about the missing items. R410 stated he did not like to wear any clothing other than tank tops and shorts.	{F 585}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to allow residents the right to file a grievance if they feel they are concerned with care within the facility and it is the policy of the facility to respond to those grievances. R410 was noted to have missing clothing and the aide reported it to the nurse but did not report to SW or fill out grievance form. No follow up was done regarding missing clothing. In this case, after the surveyor reported the resident concern, the SW went to laundry manager and explained concern. After looking in laundry room it was determined multiple pairs of shorts and couple tank tops were discovered without a name and therefore staff had not known who to return them to. Resident did get items returned and seemed happy with outcome. Laundry is not ensuring clothes are labeled prior to being sent to laundry. 2.Because all residents that reside in the facility calling it their home and therefor	

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{F 585}	Continued From page 4	{F 585}		

On 6/1/18, at 8:47 a.m. the director of social services (DSS) stated she had not been informed of R410's concern of missing clothing. After review of her files, the DSS verified she had no reports of R410's missing items. The DSS indicated she would expect staff to report concerns of missing items to her, and stated a grievance could be reported by a resident or staff. The DSS indicated all staff had recently been educated regarding the grievance process and provided with the paperwork to do so. The DSS indicated she would follow up with the resident and with facility housekeeping to see if the items could be located.

On 6/1/18, at 9:01 a.m. NA-F indicated she had informed the nurse about R410's missing shorts but was not aware of the missing shirts. NA-F indicated she did not know how long the items had been missing however, she had taken some time off of work and had reported R410's missing shorts prior to the time off. NA-F indicated she could inform social services of the missing items as well as nursing but had only told the nurse on duty at the time.

The undated facility form titled Resident Grievance Report, identified the following:
1. Who completes the form?
A. The resident who has the concern, or
B. The family member who has the concern, or
C. The staff person who is notified of the concern.
2. What is done with the completed form?
The report is given to the administrator or the departmental designee, so the proper assessment can be completed.
3. What does she designee do with the form?

have the right to express their concerns, all are potentially affected by the cited deficiency. On 7/12/2018, current residents were audited to ensure they understand they can file a grievance if they have concerns, that the facility will follow up timely, any outstanding grievances were resolved, and grievance review added to morning stand up. Staff were also reminded that they should forward all grievances to the SW or ED for follow up. No other residents were affected. The Policy and Procedure for grievances was reviewed.
3.To enhance currently compliant operations and under the direction of the SW, on 7/18/2018 all staff and residents received handout with policy and grievance form. The hand out explained our policy and resident rights and appropriate time frame for follow up. It also reminded resident to have staff assist with labeling items and ensuring any items that are expensive or sentimental should be kept off site or in drawers to prevent loss of property. A reminder was also given to staff and protocol hung in break room, so staff could review the policy and form.
4.Effective 7/18/2018, a quality-assurance program was implemented under the supervision of the SW to monitor resident grievances and resident inventories to ensure facility aware of resident items. The SW or designee will complete 4 audits per week x 4 weeks on residents to ensure no concerns are being unmet, then 2 audits weekly for 4 weeks. Any deficiencies will be corrected on the spot,

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{F 585}	Continued From page 5 A. Investigation: The administrator will assign an appropriate designee to complete the investigative report. The designee will contact the resident/family if further clarification is needed. B. Assessment: Using the information gathered through the appropriate staff. C. Planning: From the staff evaluation, an appropriate plan of action will be determined. D. Implementation: An approach for implementing the plan will be determined. 4. What is the resolution? A. The resolution and disposition sections of the report will be completed after the action plan has been implemented. The resident/family will again be contacted upon resolution of the problem. B. The concern report will again be routed to the administrator for final review and signature. C. The report will be filled in the Social Service Department.	{F 585}	and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.SW will be responsible for this POC.	
{F 607} SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review the	{F 607}	This Plan of Correction constitutes my	7/23/18

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{F 607}	Continued From page 6 facility failed to develop an abuse policy to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to the state agency within the required timeframe's and ensure the results of all investigations are reported to the state agency within 5 working days of the incident. In addition, the facility failed to ensure staff received abuse prevention training for new and existing staff in the facilty. This deficient practice had the potential to affect all 54 residents residing in the facility. Findings include: Review of the facility policy titled Vulnerable Adult, reviewed 5/10/18, listed each resident would be evaluated and care planned for their individual susceptibility to abuse by other individuals, their risk for abusing others and specific measures to be taken to minimize the risk of abuse. The policy listed the assessment would be done upon admission, and reviewed quarterly and annually. The policy did not address identification, investigation, protection and reporting of alleged violations of abuse, neglect, exploitation, mistreatment, injuries of unknown source and misappropriation of resident property and did not address training for new and existing employees on abuse prevention. Review of the facility policy titled Resident Protection Manual Program statement, updated 5/28/18, revealed the program listed the following: -if the injury is unexplainable, if the findings of	{F 607}	written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to report all incidents and do timely follow up on any incident that result in injury. All incidents and accidents are to be reviewed immediately for any potential abuse or neglect. In this case the review determined the actual policy was not complete and lacked the following elements: The policy failed to include training on abuse prevention upon hire and annually for all employees. The policy failed to include that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency The policy failed state that results of the investigations would be reported to the State Agency within 5 working days of the incident The findings also concluded based on vulnerable adult policy that facility did not have system in place to	

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{F 607}	Continued From page 7 abuse are substantiated(physical, verbal, sexual, financial exploitation), if there is caregiver neglect, or if a therapeutic error resulted in injury a call must be made to the facility designated State Agencies within 2 hours of the initial findings -within 5 business days of the original report, Administrator, Director of Nursing and Director of Social Services will meet to make the final decision regarding the outcome of the investigation -each new employee will be assigned to new employee orientation, and attendance at a yearly in-service on the Resident Safety and Resident Rights is mandatory for all employee The policy failed to include that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the State Survey Agency. The policy failed to include the results of the investigations would be reported to the State Agency within 5 working days of the incident. The policy failed to include training on abuse prevention upon hire and annually for all employees. On 6/1/18, at 4:31 p.m. the administrator	{F 607}	address identification, investigation, protection and reporting of alleged violations of abuse, neglect, exploitation, mistreatment, injuries of unknown source and misappropriation of resident property and did not address training for new and existing employees on abuse prevention. 2.Because all residents receiving care in the facility are determined to be vulnerable adults, all are potentially affected by the cited deficiency. Since survey the policy has been revised to include training implementation, the 2 hours vs. 24-hour notification rule, and when the conclusion of investigation will be completed and timeframe of which it must be submitted. The vulnerable adult policy has been reviewed and a vulnerable adult assessment has been completed on high risk residents with staff educated on proper re-assessment as well as education for new and existing employees on abuse prevention. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all staff received in-service training regarding updated policy and assessing vulnerable adults. All new and existing staff will continue to have initial and yearly education of abuse prevention and review of policy. Amended policy is being monitored weekly with random staff audited on VA, reporting and privacy updates with goal of auditing all staff within next month and intermittently thereafter for next 2 months. 4.Effective 7/16/2018, a quality-assurance	

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{F 607}	Continued From page 8 confirmed the current facility policies and stated he had understood the corporate nurse consultant had revised the abuse policies to include the required components.	{F 607}	program was implemented under the supervision of the administrator to monitor the abuse prevention compliance and ensure along with SW vulnerable adult assessments completed and reviewed. All incidents will be immediately reported to the Administrator and if injury or abuse is noted, the administrator or designee will report a VA to common entry point within 2 hours of the incident. If no injury or abuse noted, this will then be reported within 24 hours and reviewed daily at stand up. If Incident occurs after business hours or on the weekend, the Administrator will collaborate with the DON and report in a timely manner. Once the report has been submitted, the Administrator or designee will report the investigation findings within 5 business days of report. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.Administrator/SW/DON will be responsible for this POC.	
{F 623} SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a	{F 623}		7/23/18

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representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is

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{F 623}	Continued From page 10	{F 623}		

transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide

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{F 623}	Continued From page 11 written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that written notifications required for transfers were given to the residents, resident representatives, or the ombudsman for 1 of 2 residents(R305) reviewed for hospitalization. Findings include: R305's admission Minimum Data Set (MDS) dated 4/16/18, identified R503 had diagnoses which included diabetes mellitus, benign prostatic hyperplasia (BPH) and retention of urine. The MDS identified R305 was cognitively intact, had an indwelling catheter and required extensive assistance with toileting. Review of R305's progress notes revealed on 5/30/18, at 11:39 p.m. the facility had spoken with Sanford 5E med surg (hospital), R305 was having a procedure the next day and would likely be coming back to his room in the facility on Friday. Review of R305's medical record revealed no documentation that the resident's representative or that the Office of the State Long-Term Care (LTC) Ombudsman had been notified of R35's transfer in writing. On 5/31/18, at 9:03 a.m. director of nursing	{F 623}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility report all transfers and discharges to the ombudsmen. R305 was sent out for a procedure but due to significance of the procedure ended up staying in the hospital to be admitted and notification was not made regarding their transfer to the ombudsman office or POA as stipulated by regulations. When the surveyor noted these residents to have no documentation supporting notification it was noted that this practice had not yet been implemented within facility especially regarding residents sent out and then admitted. Immediately policy and procedure on transfers/discharges was reviewed, staff were educated, reminders sent to nursing stations with policy and requirements. Staff to ensure transfer documented in chart and POA and Ombudsmen notified.	

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{F 623}	Continued From page 12 (DON) indicated R305 went to the hospital to have a procedure completed with his nephrostomy tube. DON indicated she was not sure if he was kept overnight. DON indicated the usual practice was to notify a resident's representative and ombudsman for overnight hospitalizations. DON reviewed R305's electronic chart and confirmed she could not find documentation this was completed. DON indicated she expected the nurse to complete this during transfer, and the social worker to review to assure completed. The facility policy titled Transfer or Discharge, Emergency, revised 4/28/18, instructed staff to notify the representative (sponsor) or other family member and to ask if they would like bed held for any temporary transfers. The policy further identified all notices of discharges and transfers needed to be sent written transfer or discharge notification to office of ombudsmen. The facility policy titled Transfer or Discharge, Emergency, revised 4/28/18, instructed staff to notify the representative (sponsor) or other family member; ask if they would like bed held for any termporary transfers. The policy identified this could be doucmented in a progress note taht they would liek bed held.	{F 623}	2.Because all residents that reside in the facility do either discharge or have visits to ER, all are potentially affected by the cited deficiency. Immediately all residents being transferred or discharged were reviewed and update was noted to ombudsman. When staff note any resident leaving they are aware of notification needed and in turn make appropriate note in resident chart. Current residents were audited by director of nursing to ensure all had appropriate notification in place. No other residents were affected. 3.To enhance currently compliant operations and under the direction of social services, on 7/18/2018 all nursing staff will be re-trained regarding this policy and the importance of notifying ombudsman and POA and not forgetting those sent out as anticipated return but stay out on leave overnight. The training will emphasize this is to be done as soon as possible for transfers and up to 30 days prior for discharges and documentation of notification is critical. 4.Effective 7/18/2018, a quality-assurance program was implemented under the supervision of the SW to monitor any transfers and discharges to ensure appropriate notification given. The SW or designee will complete 2 audits per week x 4 weeks on residents that have transferred or discharged, then 1 audit weekly for 4 weeks ensure staff comply with current policy. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for	

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{F 623}	Continued From page 13	{F 623}	further review or corrective action. 5.SW will be responsible for this POC.	
{F 625} SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that notifications of bed hold policy required for residents that transfer to	{F 625}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission	7/23/18

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{F 625}	Continued From page 14	{F 625}		

{F 625} — Summary Statement of Deficiencies:

Continued From page 14

another facility were provided for 1 of 2 residents (R305) reviewed for hospitalization..

Findings include:

R305's admission Minimum Data Set (MDS) dated 4/16/18, identified R503 had diagnoses which included diabetes mellitus, benign prostatic hyperplasia (BPH) and retention of urine. The MDS identified R305 was cognitively intact, had an indwelling catheter and required extensive assistance with toileting.

Review of R305's progress notes revealed on 5/30/18, at 11:39 p.m. the facility had spoken with Sanford 5E med surg (hospital), R305 was having a procedure the next day and would likely be coming back to his room in the facility on Friday.

Review of R305's medical record revealed no documentation that the resident's representative or that the Office of the State Long-Term Care (LTC) Ombudsman had been notified of R35's transfer in writing.

Review of R305's medical record revealed no documentation that the resident or resident's representative were offered a bed hold policy.

On 5/31/18, at 9:03 a.m. director of nursing (DON) indicated R305 went to the hospital to have a procedure completed with his nephrostomy tube. DON indicated she was not sure if he was kept overnight. DON indicated the usual practice was to notify a resident's representative for overnight hospitalizations and complete the bed hold policy. DON reviewed R305's electronic chart and confirmed she could

{F 625} — Provider's Plan of Correction:

of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

1.It is the policy of this facility to ensure bed hold consent obtained from POA and copy given to hospital receiving resident and that POA also receives copy. R305 were sent to the hospital and no indication bed hold policy was sent to hospital or POA per regulation. When the surveyor reported lack of documentation that this occurred, it was noted that this practice had not yet been reviewed and implemented appropriately within facility. Immediately policy and procedure on bed holds was reviewed, staff were educated, reminders sent to nursing stations with policy and requirements.

2.Because all residents that reside in the facility make visits to hospitals on occasion or go on therapeutic leaves, all are potentially affected by the cited deficiency. Immediately all residents being transferred or on leave were reviewed and updated bed hold policy given out. When staff note any resident leaving they are aware to get POA consent for bed hold, send bed hold with resident to hospital or with resident taking leave and get copy to POA with note in resident chart. Current residents were audited by director of nursing to ensure all had appropriate notification in place. No other residents were affected.

3.To enhance currently compliant operations and under the direction of

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{F 625}	Continued From page 15 not find documentation this was completed. DON indicated she expected the nurse to complete this during transfer, and the social worker to review to assure completed. The facility policy titled Transfer or Discharge, Emergency, revised 4/28/18, instructed staff to notify the representative (sponsor) or other family member and to ask if they would like bed held for any temporary transfers.	{F 625}	social services, on 7/18/2018 all nursing staff will be re-trained regarding this policy and the importance of giving the bed hold and consent from POA if required. The training will emphasize this must be done with all residents being sent out of facility going out on leave or transferring to hospital. 4.Effective 7/18/2018, a quality-assurance program was implemented under the supervision of the SW to monitor any transfers to ensure appropriate notification given. The SW or designee will complete 2 audits per week x 4 weeks on residents that have transferred or left, then 1 audit weekly for 4 weeks ensure staff comply with current policy. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.SW will be responsible for this POC.	
{F 655} SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	{F 655}		7/23/18

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{F 655}	Continued From page 16 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a baseline care plan was developed and implemented within 48 hours of admission to address the individualized needs for 3 of 3 residents (R306, R503, R501) recently admitted.	{F 655}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	

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Findings include:

R306 was admitted on 5/24/18, with multiple diagnoses including type II diabetes, hypertension (HTN), hyperlipidemia, gout, insomnia, schizophrenia, major depressive disorder, myalgia, Gastro-Esophageal reflux (GERD), pain and weakness, according to the undated facility admission record form.

R306's admission care plan dated 5/29/18, identified the following:
*R306 was at risk for falls, with a goal to be free of fall related injuries. Interventions included: encourage and remind R306 to use the call light for assistance, maintain R306's environment to be well lit and free of clutter, non-skid foot wear to prevent slipping.
* R306 likes to visit and be around others. He will attend some groups as well as enjoy his independence. R306's goal to attend bingo and entertainment/social gatherings. He will eat meals in the dining room and socialize with others. Interventions included: invite R306 to scheduled activities such as bingo, entertainment, socials, and men's group. He likes a variety of shows on TV (television). He likes country music. He is friendly social and likes to visit.
* R306's care plan lacked all other areas of quality of life and quality of care.

Review of R306's electronic and hard copy medical record identified it lacked a base line care plan.

Review of 306's progress notes 5/24/18, through 5/31/18, lacked evidence of a base line care plan completion.

{F 655}

requirements established by state and federal law.
1.It is the policy of this facility to provide base line plans. R306, R503, and R501 did not have base line care plans completed as required within 48 hours of admission. The survey noted the lack of information and it was apparent staff were still not familiar with the form nor the policy of base line care plans nor who is responsible for gathering the data needed to formulate care plan for resident. The base line care plan has been revised and corrected and staff have copy in admission packet and are educated on expectations of nurse admitting patient to complete the base line care plan.
2.Because all residents have changing levels of care upon admission all are potentially affected by the cited deficiency, on 7/2/2018, the MDS nurse reviewed process of ensuring baseline care plans are followed up within 48 hours and brought to IDT for team review while copy in chart and one given to resident. The process will be reviewed with all floor nurses and admission team as well to ensure staff understand expectations. All other resident care plans have been reviewed and updated for accuracy, MDS nurse has been educated on necessity of implementing base line care plans and importance of discussing with resident or POA. The policy on base line care plans has been reviewed and updated.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all nursing staff received in-service training

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{F 655}	Continued From page 18 On 5/30/18, at 3:03 p.m. the director of nursing (DON) verified R306 was admitted on 5/24/18. The DON indicated the floor nurse on duty was responsible to complete the paperwork for new residents. The DON indicated the day following admission the care plan is reviewed at the standup meeting, and then is given to the MDSC (minimum data set coordinator) nurse to review it with the resident and then place it into the residents chart. After review of R306's electronic and paper chart, the DON verified R306 did not have a base line care plan. On 5/30/18, at 3:08 p.m. the MDSC indicated she completed the comprehensive assessments for newly admitted residents within 13 days of admission. The MDSC indicated the 48 hour (baseline) care plan was completed by the nurse on the floor at the time of admission. The MDSC reviewed R306's paper chart and verified a base line care plan was not in the chart. The MDSC indicated she would need to check with the floor nurse as to why there was not a base line care plan completed for R306. On 5/30/18, at 3:12 p.m. licensed practical nurse (LPN)-C described her responsibilities with new admissions. LPN-C indicated the base line care plan was not part of her duties as the admitting nurse and was the responsibility of the clinical managers. R503's admission record form identified R503 was admitted to the facility on 5/23/18. R503's	{F 655}	regarding base line care plans. The training emphasized the importance of monitoring ADL's, and treatment information on care sheet follows the actual care performed. MDS nurse to visualize residents and ask staff through interview to confirm data. The education includes development of care plan after assessment of resident individual needs. The residents will also incorporate importance of reviewing base line care plan with residents. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic audits of assessments formulating base line care plan based on individual resident needs and all base line care plans. They will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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diagnosis information included diagnoses of chronic obstructive pulmonary disease (COPD), hypertension (HTN) and congestive heart failure (CHF).

Review of R503's electronic and hard copy medical record lacked documentation of a base line care plan.

Review of R503's care plan identified one area initiated on 5/25/18. The care plan included a focus identifying R503 was quite independent, but groups may be a way for him to meet people. The goal indicated R503 would attend bingo, young men's lunch, and possibly chapel service, and socialize around the facility. Interventions instructed staff to invite the resident to scheduled activities such as those listed in his goals. The care plan lacked all other areas of quality of life and quality of care.

Review of 503's progress notes lacked evidence of a base line care plan completion.

On 5/30/18, at 4:04 p.m. registered nurse (RN)-A indicated the registered nurses completed admission paperwork for new residents. RN-A indicated she believed the director of nursing (DON) completed the care plans for all residents. RN-A and surveyor reviewed R503's paper chart and electronic chart and RN-A confirmed R503 did not have a base line care plan.

On 5/31/18, at 1:30 p.m. R503 indicated no one had spoken to him about a care plan or his specific goals for cares when he first arrived. R503 indicated he had been here a week, and someone came and spoke to him today about his cares.

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On 5/31/18, at 1:39 p.m. DON confirmed R503 was admitted on 5/23/18. DON stated the usual facility practice was for the admitting nurse to address the base line care plan with the resident, complete the form, then provide a copy of the base line care plan to the resident and place it in the chart. DON indicated her expectation would be for the base line care plan to be completed by the nurse who admitted R503.

Review of the facility base line CP (care plan) audit form, undated, provided by the facility was blank.

R501

R501's Admission Record form dated 6/1/18, indicated R501 was admitted to the facility on 5/27/18. R501's diagnoses included presence of bilateral artificial knee joint, pain and major depressive disorder.

Review of R501's electronic and hard copy medical record lacked a baseline care plan.

Review of R501's care plan identified one area initiated on 5/30/18. The care plan included a focus identifying R501 like independent activities with family and some group activities as well. The goal for R501 was to attend bingo, young ladies lunch, socials and maintain her independent activities. Interventions instructed staff to invite R501 to scheduled activities as outlined in the goal. The care plan lacked all other areas of quality of life and quality of care.

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{F 655}	Continued From page 21	{F 655}		

Review of R501's progress notes lacked evidence of completion of a baseline care plan.

Review of facility form titled Group 3, updated 5/29/18, indicated R501 required extensive assistance with activities of daily living (ADLs), wore glasses, required assist of one with transfer belt for transfers, used a wheelchair, had a regular diet, required repositioning every two hours. The form indicated R501 was alert and oriented, could direct own cares, required Polar care and was weight bearing as tolerated.

On 5/30/18, at 3:25 p.m. nursing assistant (NA)-E stated if a resident was new to the facility, then staff would ask the nurse for care instructions. NA-E stated if a resident had been here for a few days then they would look at the care sheet.

On 5/30/18, at 3:38 p.m. registered nurse (RN)-B stated when a resident was admitted, the admitting nurse would complete an admission assessment and relay any care instruction to the NA verbally. RN-B stated a care plan would be started at a later time and that no paper care plans existed. RN-B reviewed R501's paper chart and confirmed no baseline care plan. RN-B again stated all care plans are electronic as far as she knew.

On 5/30/18, at 3:45p.m. social worker (SW) stated paper baseline care plans are given out by the minimum data set coordinator (MDSC) to the nursing staff.

On 5/30/18, at 3:50 p.m. MDSC stated a 48 hour care plan, or baseline care plan, would be kept in the paper chart, as it was a paper form. MDSC

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{F 655} Continued From page 22 {F 655}

stated the admitting nurse completed the baseline care plan and returns it to MDSC. The baseline care plan would then be discussed at an interdisciplinary team (IDT) meeting, or morning stand up. We then would go over it with the resident, and if they are agreeable with it, it would be filled in the chart. MDSC reviewed R501's paper chart and confirmed there was no baseline care plan.

On 5/30/18, at 3:58 p.m. director of nursing (DON) stated the admitting nurse would fill out the baseline care plan and then send to MDSC. The MDSC would then bring the care plan to IDT where we discuss the resident's care. After the IDT meeting, MDSC would bring the baseline care plan to the resident to discuss it and have them sign it. DON reviewed R501's paper chart and confirmed no baseline care plan was present. DON stated she would expect the baseline care plan to be completed.

On 5/30/18, at 4:05 p.m. R501 stated she admitted to the facility on 5/27/18. R501 indicated no one had spoken to her about a baseline care plan, or her specific goals for her care. R501 stated that a nurse was meeting with her now, to do some admission paperwork.

Review of the facility baseline CP (care plan) audit form, undated, provided by the facility was blank.

The facility policy titled Care Plans-Comprehensive, reviewed 4/4/18, identified all new admits to have a baseline care plan in the admission packet and to be started by staff nurse upon admit. Once completed and reviewed within 48 hours, it will then be copied and given to

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{F 655}	Continued From page 23 resident for review or POA (power of attorney) and the original to be put in the resident's chart.	{F 655}		
{F 656} SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the	{F 656}		7/23/18

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{F 656}	Continued From page 24 community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a comprehensive care plan was developed for dialysis for 1 of 1 resident (R410) who received dialysis services and for 1 of 1 resident (R107) reviewed for tracheostomy (a surgically created hole (stoma) in your windpipe (trachea) that provides an alternative airway for breathing) care. Findings include: On 5/31/18, at 8:03 a.m. R410 was observed with morning cares. R410 received assistance from nursing assistant (NA)-F and NA-G to wash and dress. R410 was observed to have a central venous catheter (a central line placed in a large vein) on his upper left chest. R410's care area assessment (CAA) dated 4/26/18, identified R410 had diagnoses which included diabetes, stage renal disease and received renal dialysis. The CAA further identified R410 was alert and orientated X (times) 4, had bilateral lower extremity amputations, required extensive assistance with dressing, grooming and bed mobility, required total staff assistance to transfer with a mechanical lift. R410's physician visit dated 4/24/18, identified R410 had an acute chronic kidney injury which	{F 656}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide consistent quality care to ensure residents have comprehensive care plans. R410 was noted to have central line and need dialysis however the care plan did not address these issues nor did the care sheets, so staff were aware how to monitor IV site or provide cares. R107 had a trach and the care plan did not address the trach, the expectations of care to trach and during care it was noted the staff needed further education on trach cares. In this case, after the survey determined these residents care plans were missing important information, both were revised and updated including care sheets for staff. Staff education on trach cares was also provided. 2.Because all residents are have changing levels of care all are potentially affected by the cited deficiency, on	

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{F 656}	Continued From page 25 required dialysis. R410's care plan revised 4/26/18, identified R410 had an alteration in kidney function evidenced by hemodialysis, 1 X a week, with a goal to reduce short term complications associated with impaired renal function and will have no signs or symptoms of infection or bleeding at fistula site. R410's care plan listed interventions to administer medications as ordered collaborating with Physician and/or pharmacist for optimal medication dose times, assessment of skin condition weekly by licensed nurse, apply skin moisturizer as needed for dry, itchy skin and to consult as ordered by Physician (nephrology, nutritional, social services). R410's care plan did not identify R410 had a central venous catheter, incorrectly listed R410 had a fistula (a surgical connection of a vein to an artery) in place, and did not include precautions or care of the catheter such as no blood draws or flushing of catheter, keep site dry, no tub baths, and covering site when showering. In addition the care plan lacked direction for what procedures to follow if catheter site developed leaking, bleeding, or signs of infection and emergency procedures staff should implement or whom the facility should contact in case of an emergency involving the dialysis catheter site. The facility's untitled nursing assistant care sheet identified R410 required extensive assistance with ADLs (activities of daily living), required assistance of two staff for transfers and toileting, utilized a power wheelchair, was alert and orientated, directed care for use of a shrinker stocking for the lower extremity amputations and pressure relief measures to lay down between	{F 656}	7/2/2018, the MDS nurse reviewed process of ensuring accurate MDS's to formulate comprehensive care plans. All other resident care plans have been reviewed and updated for accuracy, and MDS nurse is aware of how to properly document on CAA's as well as ensure all assessments completed during look back period are completed, and correct information is gathered, and all aspects of care is care planned appropriately. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all nursing staff received in-service training regarding patients with dialysis and trachs to ensure they are understanding to resident needs, cares and how to perform basic checks to ensure trach site and IV sites are clean dry and intact and what to do if there is an emergency. MDS nurse to visualize residents and ask staff through interview to confirm data. The education included development of care plan after assessment of resident individual needs. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic audits of assessments formulating care plan based on individual resident needs. They will be completed by MDS nurse 4 audits per week x 4 weeks then 2 audit weekly x 2 months to ensure compliance in this area by matching diagnoses with assessments and CAA's	

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{F 656}	Continued From page 26 meal; however did not direct care pertaining to dialysis needs or the dialysis catheter site. On 5/31/18, at 8:20 nursing assistant (NA)-F indicated R410's catheter was not to get wet and staff gave sponge baths as R410 allowed. NA-F indicated the nurses managed all other care regarding the catheter site. On 5/31/18, at 2:24 p.m. R 410 stated the catheter in his upper left chest area was used for dialysis. R410 indicated he chose to receive bed baths because the catheter could not get wet. R410 indicated he was not restricted on fluids; however, was not to add salt to things and was to eat extra protein. On 6/1/18, at 12:00 p.m. The director of nursing (DON) verified R410's computerized care plan. The DON indicated the computerized care plan was all inclusive for R410's daily and dialysis care. With review of the care plan the DON verified R410's care plan was not comprehensive regarding dialysis care, did not include specifics regarding R410's dialysis care, catheter or emergency contacts. R107's admission Minimum Data Set (MDS) dated 2/20/18, indicated a cognition assessment was not completed, and R107 had diagnoses which included attention to tracheostomy, attention artificial opening of digestive tract, and cancer. The MDS indicated R107 required	{F 656}	so an accurate care plan is developed based on the resident specific care areas, ex. Trach care, hospice, dialysis. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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{F 656}	Continued From page 27	{F 656}		

extensive assistance for all cares except eating, which he required total care. R107's MDS further indicated the use of oxygen, tracheostomy care and suctioning.

R107's quarterly MDS dated 5/1/18, indicated independent cognitive skills for daily decision making and diagnoses which included squamous cell carcinoma of skin of scalp and neck, chronic pain, attention to tracheostomy and anxiety. The MDS indicated R107 required total assistance with eating, extensive assistance with dressing and hygiene, limited assistance with toileting and was independent with all other ADLs. R107's MDS further indicated tracheostomy care and suctioning.

R107's Care Area Assessment (CAA) dated 2/28/18, indicated R107 had a tracheostomy in place due to oral pharyngeal cancer.

Review of R107's current care plan last revised 4/3/18, revealed that there was no care plan interventions related to R107's tracheostomy.

Review of facility provided Group 3 care sheets, updated 5/29/18, indicated under "Care Notes" R107 had a "Trach", but there was no instruction related to it's care or monitoring.

On 5/31/18, at 6:50 a.m. R107 was lying on the bed with the head of bed elevated. R107 was completing a nebulized medication treatment via his tracheostomy. R107 had a oral suctioning device positioned on the nightstand and had the tubing beside him ready for use.

On 5/31/18, at 11:15 a.m. licensed practical nurse (LPN)-A entered R107's room and set up supplies

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{F 656}	Continued From page 28 for tracheostomy care. LPN-A washed her hands and placed sterile gloves from the tracheostomy care kit. With sterile gloves donned, LPN-A had R107 raise the bed to working height and proceeded to squeeze R107's tracheostomy's outer cannula while gently pulling at the inner cannula. With the inner cannula not disengaging from it's lock (used to keep the inner cannula in place if the resident was to cough), LPN-A then tried loosening the Velcro collar. LPN-A again grabbed the outer and inner cannulas, one with each hand and tried to disengage the lock and could not. LPN-A stated she had not provided R107 tracheostomy cares prior and stated "maybe I should get someone who knows how to do this" and exited the room. At 11:29 a.m. LPN-A returned to R107's room with LPN-B. LPN-B washed her hands and donned gloves, she then held the outer cannula with one hand and twisted the inner cannula with the other and the inner cannula disengaged and was able to be removed. LPN-B then left the room and LPN-A finished the tracheostomy cares. On 5/31/18, at 2:06 p.m. MDS coordinator (MDSC) verified she was responsible for care plans at the facility, including R107's. MDSC reviewed R107's current care plan and confirmed the care plan lacked information regarding R107's tracheostomy and therefore she would not consider R107's care plan to be comprehensive. On 5/31/18, at 2:15 p.m. director of nursing (DON) stated comprehensive care plans were an overall guideline for resident care. DON reviewed R107's current care plan and confirmed R107's care plan lacked information regarding R107's tracheostomy and stated she would not consider R107's current care plan to be comprehensive.	{F 656}		

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{F 656}	Continued From page 29 A facility policy titled Care Plans - Comprehensive, reviewed 4/28/18, indicated the comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS; 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems...f. Identify the professional services that are responsible for each element of care...i. Reflect currently recognized standards of practice for problem areas and conditions...4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan; 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes.	{F 656}		
{F 657} SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s).	{F 657}		7/23/18

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{F 657}	Continued From page 30 An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the care plan was updated for 1 of 3 residents (R37) reviewed for dialysis. Findings include: R37's admission Minimum Data Set (MDS) dated 4/30/18, indicated R37 had moderately impaired cognition, and had diagnoses which included end-stage renal disease (ESRD), hyperkalemia and malnutrition. The MDS indicated R37 required extensive assistance for dressing, personal hygiene and toilet use, but could eat independently after set up assistance from staff. R37's MDS further indicated no weight gain or loss, received a mechanically altered diet and was receiving dialysis. R37's MDS indicated he was not receiving a therapeutic diet. R37's Care Area Assessment (CAA) dated 5/3/18, indicated R37 was admitted with diagnoses of ESRD and dementia and was dependent on renal dialysis three times per week. The CAA indicated R37 was forgetful and at times	{F 657}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide consistent quality care to ensure residents have timely up to date care plans. R37 was noted to need dialysis however the care plan did not address these issues nor did the care sheets. In this case, after the survey determined the residents care plan was missing important information, dietary, dialysis, nursing and MDS reviewed information and updated diet, labs and needs accordingly. 2.Because all residents have changing levels of care all are potentially affected by the cited deficiency, on 7/2/2018, the MDS nurse reviewed process of ensuring accurate MDS s to formulate accurate	

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{F 657}	Continued From page 31 resistive to cares. R37's nutritional status indicated R37 had been eating well since admit, had no teeth and there was no current labs available for review. However, R37's nutritional status lacked information regarding diagnoses of ESRD or hyperkalemia and being dependent on dialysis. R37's care plan last revised 5/21/18, indicated R37 required hemodialysis due to ESRD and required a therapeutic diet. R37's care plan listed various interventions which included: consults as ordered by the physician (nephrology, nutritional and social services), diet per physician order, monitor any signs or symptoms of dysphagia (difficulty swallowing), provide snacks, diet and supplements as ordered, nutritional education will be provided as needed and at resident request, offer healthy snacks and obtain and monitor lab work as ordered. However, the care plan did not address R37's diagnosis of hyperkalemia or what foods to avoid while on hemodialysis. Review of R37's signed physician orders dated 5/4/18 indicated R37 was ordered a regular diet with mechanical soft texture, regular consistency, ground or chopped meat into quarter pieces. R37's physician orders lacked any further information regarding dialysis. Review of R37's Admission Nutrition Data V2. 1 dated 4/30/18, indicated R37 had diagnoses including ESRD, hyperkalemia and dependent on renal dialysis. The form indicated R37 had weight loss, skin was intact, had risk factors for dehydration of age and decreased mobility, was edentulous, ate 75% of meals, had a normal potassium level (although no value was given) and refer to nutrition assessment.	{F 657}	care plans. All other resident care plans have been reviewed and updated for accuracy, and MDS nurse is aware of how to properly document on CAA s as well as ensure all assessments completed during look back period are completed, and correct information is gathered, and all aspects of care is care planned appropriately. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 nursing staff received in-service training regarding patients with dialysis to ensure they are understanding to resident needs, and dietary staff to ensure they review specialized diets. Diet slips updated, and dietician and dialysis dietician confirmed all orders. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic audits of assessments formulating care plan based on individual resident needs. They will be completed by MDS nurse 4 audits per week x 4 weeks then 2 audit weekly x 2 months to ensure compliance in this area by matching diagnoses with assessments and CAA s so an accurate care plan is developed based on the resident specific care areas, ex. hospice, dialysis etc. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the	

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{F 657}	Continued From page 32	{F 657}		

Review of R37's clinical record revealed no nutrition assessment since admission on 4/23/18.

On 5/31/18, at 8:14 a.m. R37 was lying on his back in bed with his eyes closed. An over-the-bed table was next to the bed that had three opened Mt. Dew 12 oz cans and a 2% milk carton on the table.

On 6/1/18, at 8:45 a.m. R37's dining room tray ticket, dated 6/1/18, was reviewed. The ticket indicated R37 had a regular diet which was mechanical soft and regular texture for liquids. Under "Special Notes" section of R37's ticket was a note for oatmeal with Propass x 2 servings. The ticket lacked identification of a therapeutic diet for ESRD.

On 6/1/18, at 9:10 a.m. during a phone interview with dialysis registered nurse (DRN)-A stated R37 should have diet restrictions for dialysis including high protein and low potassium. DRN-A stated their manager had to call the facility last week because the facility was packing two bananas for R37's snack while at dialysis and R37 just had an issue with hyperkalemia (high potassioum level). DRN-A stated he was instructed to keep checking R37's facility packed snacks for bananas due to the hyperkalemia.

On 6/1/18, at 9:55 a.m. during a phone interview with dialysis dietician (DD)-A regarding R37, DD-A stated R37 had a critically high potassium level of 6.9 miliequivalents per liter (normal range 3.4 - 5.1) on 5/22/18. DD-A stated she called R37's facility and updated a staff RN on the high lab and to limit the amount of bananas and oranges/orange juice R37 consumed. DD-A

monthly quality-assurance committee meeting for further review or corrective action.
5.MDS nurse will be responsible for this POC.

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stated R37 also had a critically high potassium level on 5/24/18. DD-A stated she would expect the facility to communicate the dietary needs of low potassium needs of R37 in some manner.

On 6/1/18, at 10:16 cook (CK)-C stated R37's diet was regular, mechanical soft and he required dialysis. CK-C stated dietary staff was responsible to pack sack lunches for dialysis residents. She stated R37 would typically receive a mechanical soft turkey, ham, egg or tuna salad sandwich without cheese, lettuce, carrots or celery, apple sauce and hard boiled eggs with apple cranberry juice supplement. CK-C stated some aids would use other fruits such as grapes, bananas or mandarin orange. CK-C stated she was not aware of R37's high potassium levels.

On 6/1/18, at 10:28 a.m. dietary manager (DM)-A stated she was the dietician for the facility. DM-A stated the dialysis dietician called her 2-3 days ago and updated her about R37's hyperkalemia and it was decided to eliminate bananas and orange juice due to R37 eating 2-3 bananas a day and a couple glasses of orange juice. DM-A stated the only way she communicated that information was to place "No bananas, no orange juice" on his tray ticket. DM-A reviewed R37's current tray ticket from that days breakfast. DM-A stated she changed it the day she spoke with DD-A. She pulled up the tray ticket computer system MenuMatrix and confirmed the information was added to the system to read "No bananas, no orange juice". DD-A stated the staff person responsible for printing off the tray tickets CK-A will at times print the tickets out a few days ahead of time and the new order has not been printed out on tickets yet. DM-A stated the information should have been added to R37's

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care plan as well. DM-A stated the corporate dietician completed R37's admission nutrition assessment.

On 6/1/18, at 10:50 a.m. CK-A confirmed she was responsible for printing out the tray tickets for resident meals. CK-A stated at times, if she would not be at the facility (weekend off, appointments etc.) that she would print out the ticket ahead of time. CK-A stated on Fridays she would print off Saturday, Sunday and Mondays tickets and then print out Tuesdays on Monday, Wednesdays on Tuesday and Thursday and Fridays on Wednesdays.

On 6/1/18, at 10:54 a.m. MDS coordinator (MDSC)-A stated she would expect to see a new nutrition assessment since the new admission on 4/23/18. MDSC-A confirmed no new nutrition assessment was in R37's clinical record. MDSC-A stated she would have expected to see R37's, no bananas or orange juice on the care plan so all staff had access to it.

On 6/1/18, at 11:09 a.m. director of nursing (DON) stated R37 was scheduled for a fistulagram (is a test to look for abnormal areas in your dialysis graft or arterio-venous fistula that may be causing problems) on 5/24/18, due to hyperkalemia. DON reviewed R37's care plan and confirmed no information regarding hyperkalemia, or that R37 should not eat bananas or drink orange juice. DON stated she would have expected that information to be included in the care plan, as well as a new admission nutrition assessment to have been completed.

On 6/1/18, at 11:28 a.m. nursing assistant (NA)-H

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{F 657}	Continued From page 35 stated she thought R37 had a banana this morning and R37 was supposed to have extra potassium. On 6/1/18, at 11:40 a.m. NA-F stated she was not aware if R37 was to have bananas due to not having teeth she she would have to check his care plan. NA-F stated she had not received any education regarding R37 lately. A facility policy titled Care Plans - Comprehensive, reviewed 4/28/18, indicated the comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS; 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems...f. Identify the professional services that are responsible for each element of care...i. Reflect currently recognized standards of practice for problem areas and conditions...4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan; 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes.	{F 657}		
{F 686} SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent	{F 686}		7/23/18

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{F 686}	Continued From page 36 pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and failed to implement interventions to promote healing and prevent worsening for 1 of 2 resident (R56) reviewed with current, stage 2 pressure ulcers on left buttocks. Finding include: R56's quarterly Minimum Data Set (MDS) dated 4/10/18, identified R56 was cognitively intact and had diagnoses which included hemiplegia (paralysis on one side of the body) or hemiparesis (slight paralysis or weakness on one side of the body), muscle weakness, stage 3 chronic kidney disease and depression. R56's MDS identified R56 was at risk for pressure ulcers, but did not currently have one, and had no healed pressure ulcers. Skin and ulcer treatments were pressure reducing device for chair and bed and application of nonsurgical dressings other than to feet. R56's MDS further identified she required extensive assistance with bed mobility, transfer, toileting and did not walk. R56's pressure ulcer care area assessment (CAA) dated 2/14/18, identified R56 had an actual problem/need. Pre-populated check marks identified extrinsic risk factors included pressure	{F 686}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide treatment and services to prevent pressure ulcers. One of the many ways that this has been achieved for resident #56 is by completing assessments and current documentation of wounds to ensure healing appropriately. R56 was noted to have stage 2 pressure area and area now developed another area with previous wound now developing into stage 3. After survey noted the inconsistency in R56 turning and repositioning and resident non-compliance of offloading OT and nursing have changed resident to q2h repositioning schedule and staff are to ensure even while up resident is offloaded either in room or using rail in hallway to stand with staff assist. It was also noted staff needed education on roho cushion,	

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{F 686}	Continued From page 37 and need for special mattress or seat cushion to reduce or relive pressure. Intrinsic risk factors identified altered mental status and cognitive loss. Diagnoses and conditions identified by pre-populated check marks included hemiplegia/hemiparesis, chronic or end-stage renal disease, depression and pain. Treatments and other factors included newly admitted or readmitted and functional limitation in range of motion. R56's CAA indicated pressure ulcer will be addressed in care plan to minimize risks. R56's pressure ulcer CAA indicated no referral was warranted. R56's care plan revised on 2/21/18, identified R56 was at risk for pressure ulcers due to altered skin integrity, history of pressure ulcers and decreased mobility. Interventions included completion of Braden Scale (pressure ulcer risk assessment) per policy, weekly skin inspections, not to massage over bony prominences and encourage regular offloading when up for a while during the day for activities. R56's interventions further instructed staff for nutritional and hydration support, pressure reduction wheelchair cushion and mattress and referral to therapy. Skin assement to be completed per policy and treatments as ordered. R56's care plan also identified she had physical function deficit related to self care impairment, ROM (range of motion) limitations to left arm and balance impaired. Interventions included extensive assistance with toileting and transfer assist of 1 staff and gait belt. On 5/30/18, at 12:30 p.m. R56 was in her room, after independently propelling self from dining room. R56 indicated she had a bed sore on her hip, and the physician had looked at it yesterday. R56 indicated she thought it was healing, and	{F 686}	staff were educated. Physician has been updated and resident skin has been improving. 2.Because all residents have diagnoses which could lead to alteration in skin integrity or due to illness have potential for skin breakdown all are potentially affected by the cited deficiency, wound documentation has been reviewed, interventions for prevention are in place and documented clearly on care sheets. Weekly skin audits are completed, and staff update DON on any new areas noted immediately including reporting of any bruises, skin tears, skin breakdown or rashes. All current resident with pressure ulcers were assessed for comprehensive assessment along with appropriate interventions. Implementation of those interventions is reviewed on rounds weekly. Staff to alert DON is resident refuses otherwise. Staff educated on importance of offloading, repositioning, care plan updated, care sheets updated. Weekly skin audits completed on bath day, dietary and therapy involved in interventions as needed to those at risk. No other residents were affected. The policy on wound care has been reviewed. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all staff received in-service training for monitoring skin and pressure areas, to ensure staff always use best pressure reduction tolls and understand differences in cushions and understand offloading to prevent further alterations in skin integrity. The training emphasizes the importance of	

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{F 686}	Continued From page 38 gave permission for surveyor to view during dressing change. On 5/31/18, at 6:45 a.m. R56 was observed in her room sitting on the edge of the bed with her shirt, pants and shoes on. Nursing assistant (NA)-B was in room and assisted her with morning cares. NA-B applied a gait belt and assisted R56 to stand then walk to the bathroom, while holding her hemi walker. NA-B assisted R56 to pull her pants down and revealed R56 had a large 2 x 6 inch tan dressing in place on her left buttocks. The surrounding skin was normal in color. R56's had a Roho cushion (pressure relieving cushion with air cells) in her wheelchair. When surveyor put her hand on the cushion, it was easily pushed down flat. NA-B assisted R56 to sit in the w/c, where R56 combed her hair and applied a jacket and scarf with assistance from NA-B. NA-B transported her in her wheelchair to the front nursing desk near the dining room. R56 propelled herself to the dining room at 7:10 a.m.. R56 remained in the dining room and drank coffee, water and ate cold cereal until she propelled herself back to her room at 7:40 a.m. to the activity room where she read the newspaper. At 7:47 a.m. R56 began to propel herself back to her room, when she was asked by a staff member if she wanted a ride which she agreed. R56 returned to her room where she brushed her teeth independently at the sink. At 7:58 a.m. R56 refilled a bag on her wheelchair with candy from her bedside table then propelled herself back to the dining room. R56 remained at the dining room table by the window, drinking water and doing a word search book from 8:01 a.m. until 9:52 a.m. when church service began. On 5/31/18, at 8:55 a.m. NA-B indicated R56	{F 686}	following all interventions for effective skin maintenance and reporting of changes in skin conditions. Education done on importance of comprehensive assessment of skin, pressure ulcers and implementation of appropriate interventions. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents with impaired skin integrity and updating MD, family and care plans with any changes to ensure appropriate follow through. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will ensure audits on all residents with pressure ulcers and those at risk per diagnosis, Braden or CAA trigger weekly x 4 weeks then on 6 residents weekly for 4 weeks to ensure compliance than 2 residents weekly x 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. DON will be responsible for this POC.	

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{F 686} Continued From page 39 {F 686}

usually liked to hang out in the dining room during the day, did word search books and went to the active room. NA-B indicated R56 was able to express her needs by going back to her room and would put her call light on if she wanted to use the bathroom. NA-B indicated she took R56 to the bathroom about twice a day, and indicated she usually reminded R56 to use the bathroom around lunch time to see if she would go. NA-B indicated she was aware R56 had a sore on her bottom. NA-B indicated as nursing assistants they do not do anything with resident cushions. NA-B indicated she was provided education after the last survey. NA-B indicated the were provided a copy of the deficiencies and reviewed them. When surveyor asked her about education related to pressure ulcers, she indicated they discussed repositioning. When asked about R56's repositioning, NA-B indicated she should be checked every 2 hours and confirmed her nursing assistant care sheet instructed 1 staff to assist Q2 HRS (every 2 hours), resident can state need, for skin care.

On 5/31/18, at 10:50 a.m. R56 was in the dining room at the same spot, sitting at the table in front of the window. R56 indicated she was in the dining room for the church activity, and did not leave during it. At 10:56 a.m. surveyor notified director of nursing (DON) that R56 had not been repositioned since 7:05 a.m. DON indicated she would assist R56, after she asked her permission, for repositioning and complete her wound assessment and dressing change. R56 agreed and left the dining room.

On 5/31/18, at 11:05 a.m. occupational therapist (OT)-A indicated R56 was receiving occupational therapy at that time. She indicated R56 had a

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{F 686}	Continued From page 40 foam cushion in her wheelchair prior, but now was using a low profile Roho cushion that was 2 inches. OT-A joined R56 in the hallway and she indicated she had just checked R56's Roho cushion yesterday to assure it was full, but indicated she had checked it while R56 was sitting on it. OT-A indicated she would check the cushion to assure it was inflated when R56 got out of the wheelchair. DON also in hallway near R56 and she confirmed R56 should be repositioned every 2 hours. OT-A indicated she taught R56 repositioning techniques, and taught her to use the hand rails in the hallway for offloading. OT-A instructed R56 to show surveyor how she could reposition herself with the rails. R56 stopped and turned towards the hand rail in the hallway, put her right hand on the rail, but was unable to pull herself up. R56 then began propelling herself towards her room using her right arm to pull on the handrail as she went down the hall. OT-A indicated she had requested RN (registered nurse) Director of Quality (RDQ) to update the nursing assistant care sheets for R56 to be repositioned every 2 hours, but was informed in a return e-mail that it was not appropriate because R56 was alert. On 5/31/18, at 11:18 a.m. DON, OT-A and NA-C entered R56's room. NA-C assisted R56 with a gait belt to transfer from her wheelchair and walk to the bathroom with her hemi-walker. OT-A checked R56's Roho cushion in her wheelchair and confirmed it was deflated. OT-A added air to the cushion using a hand pump. DON assisted R56 to remove her pants and brief. R56's skin was normal color around the dressing. When the dressing was removed, there was an excoriated (damaged, abraded) area 7.5 cm (centimeters) by 4 cm on the inner aspect of her left buttocks.	{F 686}		

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{F 686}	Continued From page 41 The dressing had a scant amount of red drainage. R56 had three superficial open areas, one in the center of the excoriated area, which DON indicated had bled, and two below this. All areas measured 1 cm by 0.5 cm. DON cleansed area, and applied a 4 inch by 4 inch Mepilex (foam dressing for wounds) to the area. Review of R56's treatment administration record (TAR) identified a tissue tolerance assessment was completed on 5/10/18, and 5/28/18. Pressure Ulcer precaution every shift began on 5/29/18. On 5/31/18, at 11:30 a.m. DON and surveyor reviewed R56's electronic record. DON confirmed R56's TAR identified tissue tolerance assessments were initialed, which indicated they were completed on 5/10/18, and 5/28/18, but she was unable to locate them. DON indicated the facility usual practice was to complete them in resident's electronic record. DON confirmed R56 did not have a tissue tolerance completed. DON indicated the frequency of R56's repositioning needs would be determined by the the tissue tolerance test. DON indicated she would expect R56's to be repositioned every 2 hours, her Roho cushion to be inflated and the tissue tolerance assessments to be completed. Review of R56's nursing assistant care sheet, updated 5/29/18, for R56 identified; skin, 1 assist Q 2 HRS, resident can state need and care notes indicated alert/orientated, resident able to direct all care; keep left hand elevated; lotion at hand NOC encourage resident repo (reposition) PRN (as needed) and position side-lying. Review of R56's Norton Scale for Predicting Risk of Pressure Ulcer, dated 5/4/18, identified a	{F 686}		

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{F 686}	Continued From page 42 score of 10, high risk. Review of R56's Braden Scale for Predicting Pressure Sore Risk dated 5/4/18, identified a score of 16, low risk. Review of R56's weekly skin review 5/1/18, to 5/30/18 identified the following; -5/2/18, skin dry, open area, left buttock check open 2 X 1 cm, mepilex in place, will continue to monitor. Site: left gluteal fold, existing open are 2 X 1 cm. -5/9/18, skin dry, open area, left buttock cheek open 2 X 1 cm, mepilex in place, will continue to monitor. Site: left gluteal fold, existing open are 2 X 1 cm. -5/16/18, skin dry, open area, left buttock cheek open 2 X 1 cm, mepilex in place, almost resolved, tissue color pink and part scab, will continue to monitor. Site: left gluteal fold, existing open are 2 X 1 cm. -5/23/18, open area, resident has an open area to left buttocks. No further description. Review of R56's Wound Evaluation Flow Sheet Multiple weeks-V 4, from 5/4/18, to 5/22/18 identified the following; -5/4/18, Wound identified 5/4/18, site: left buttock, vascular 2 length, 1 width, 0.2 depth, stage II. wound type; pressure, no exudate, pain area not completed, granulation 100%, wound margins defined, current treatment; change mepilex to L) (left) buttocks q (every) 3 days and PRN if soiled or falls off. Current preventative interventions:	{F 686}		

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{F 686}	Continued From page 43 pressure redistribution mattress, w/c (wheelchair) cushion. Wound had not been debrided and change to care plan was reviewed. -5/12/18, Wound evaluation week 2 : length in cm: 108 (probable clerical error), width in cm: 1, depth in cm: 0.2, Stage II, no exudate, Pain scale 0, 100% granulation, periwound defined, current treatment; change mepilex to L) (left) buttocks q (every) 3 days and PRN if soiled or falls off, date treatment ordered 12/7/17. Current preventative interventions: pressure redistribution mattress, w/c cushion. No debridement, care plan reviewed, wound had not healed. -5/22/18, Wound evaluation week 3: length in cm: 1.8, width in cm: 1, no depth. Stage II, no exudate, pain scale 0, 100% granulation, periwound not described, current treatment; change mepilex to L) (left) buttocks q (every) 3 days and PRN, current preventative interventions: pressure redistribution mattress, w/c cushion. No debridement, care plan reviewed and wound had not healed. -5/22/18, Wound evaluation week 4; length in cm: 0.5, width in cm: 0.5, no depth. Stage II, no exudate, pain scale 0, 100% epithelial, wound margins defined, current treatment; change mepilex to L) (left) buttocks q (every) 3 days and PRN if soiled or falls off. Date treatment ordered 12/7/18, current preventative interventions: pressure redistribution mattress, w/c cushion. No debridement, care plan was not reviewed, wound had not healed. -5/29/18, no wound evalation documentation. R56's medical record lacked a comprehensive	{F 686}		

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{F 686}	Continued From page 44 pressure ulcer assessment. Review of R56's Occupational therapy evaluation and plan of treatment, dated 5/21/18, identified pressure ulcer of left buttock stage 2 onset of 5/2/18, revealed the following: -Short term goals included: pt (patient)/staff to increase ability to relieve pressure while seated in wheelchair with supervised and 25% verbal cues for schedule/form, target date 6/3/18. Pt/staff will demonstrate successful use of new/adapted seating systems as indicated by maintenance/improvement of L (left) buttocks wound 2 X 1 X 0.2 mc day of eval, for skin integrity mgmt. (management). Pt/staff will demonstrate ability to manage incontinence mgmt schedule/adapted methods with supervision and 25% cues to prevent worsening of skin integrity concerns. -Long term goals listed included; Pt/staff will demonstrate ability to manage pressure relief and incontinent mgmt techniques/equipment to maintain/improve skin integrity with no cues required. -Pt/caregiver goals; prevent worsening of pressure ulcer, heal if possible, and maximize function in SNF (skilled nursing facility). -Patient demonstrates good rehab potential as evidenced by supportive caregivers/staff and recent onset. -Patient/Caregiver participated in establishing POT (plan of treatment) -Pt has not had pressure ulcers in the past, has	{F 686}		

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{F 686}	Continued From page 45	{F 686}		

Continued From page 45
resided in SNF with 24 hr (hour) cares for 6 years.

-cognition; follows two-step w/o (without) (A) (assistance); safety awareness = impaired, new learning capacity = impaired.

-Summary of evaluation identified physical, cognitive and psychosocial deficits. The summary also identified impairments in mobility and interpersonal habits, which resulted in limitations and/or participation restrictions.

Review of OT-A documentation 5/21/18, to 5/31/18, identified the following;

- 5/21/18, assessed areas of deficit and underlying impairments to positioning. Educated patient regarding process and goals.

-5/22/18, implemented narrower wheelchair to prevent leaning, and a low profile Roho cushion for pressure relief. Fixed broken left elevating pedal. R56 reported comfort and visibly was not leaning upon re-assessment.

-5/30/18, trained R56 in incontinence prevention methods, toileting schedule and use of call light to maintain/improve skin integrity. Educated R56 on side-lying in bed at night and R56 reported understanding of all education. Trained patient in repositioning techniques and w/c pull-ups using hall rails to improve pressure relief. R56 required moderate assist and 50% cues. Communicated to staff toileting schedule and repositioning to maximize generalization of skills.

-5/31/18, trained NA in Roho cares and inflation of cushion if cushion does deflate. Did re-inflate

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{F 686}	Continued From page 46	{F 686}		

cushion during wound cares to desired level. NA indicated understood Roho cares and would pass on in report that day. Pump left in R56's room for staff to use or alert therapy with questions.

Review of R56's order summary report signed 5/29/18, included orders:

-change mepilex to L) buttocks q 3 days and PRN if soiled or falls off, as needed, every day shift every 3 days, for wound care, order date 12/6/17.

-OT clarification, eval (evaluate) and tx (treat) 10 X in 30 days for w/c mgmt, self care training, and their act. one time a day until 6/24/18, order state 5/21/18.

-Weekly skin check (Wed PM) every evening shift every Wed, order date 7/14/17.

-Pressure ulcer precautions, order date 5/29/18.

R56's primary physician 5/29/18, visit progress note was requested but not provided.

On 5/31/18, at 1:41 p.m. DON confirmed she completed assessments for the facility residents. DON indicated R56's wound had worsened and the excoriation and 2 lower open areas were new. DON confirmed R56 now had 3 stage 2 open areas to her buttocks. DON confirmed she had not completed a comprehensive assessment of R56's pressure ulcers. DON indicated she ordered an air pressure mattress for R56's bed for pressure relief. DON indicated she was not sure if R56 currently had a regular or pressure relieving mattress on her bed, but would check and report if it was. She indicated the new air pressure mattress was ordered. and would be

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{F 686}	Continued From page 47 initiated when received. DON confirmed R56's primary physician had examined R56's pressure ulcer on 5/29/19. DON indicated R56's pressure ulcer began on 5/4/18. DON indicated she felt R56 would need assistance to off load and reposition herself, and confirmed staff assistance was needed to lift her up. DON indicated RDQ and herself updated the nursing assistant care sheets on 5/25/18. DON confirmed they were considered a part of R56's care plan. On 5/31/18, at 1:55 p.m. a voice message was left for R56's primary physician, but a return phone call was not received. Review of facilty wound audits for R56 on 5/10/18, and 5/17/18 revealed that dietary notes did not reference the wound. No follow up documenation was noted. Review of facility policy titled Prevention of skin breakdown, reviewed 4/20/18, instructed utilization of RAI (resident assessment instruction) process, Braden Risk assessment and a comprehensive assessment in identification of risk factors. Evaluate turning and repositioning intervals or initiate tissue tolerance assessment per policy. Pressure ulcer treatment procedures included re-evaluation of turning and repositioning intervals or initiate tissue tolerance assessment, initiate Braden and comprehensive risk assessment. Daily wound monitoring should be initiated on treatment sheet. Procedure for treatment of pressure ulcers included assessment of the wound, diet should contain adequate hydration and nutrients to support healing which included guidance for protein and calorie intake. The policy also included procedures to avoid positioning on pressure	{F 686}		

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{F 686}	Continued From page 48 ulcer, use protective pressure reducing devises in bed and wheelchair sitting surface as ordered. The policy also instructed in bold lettering to provide ongoing education to all staff on pressure ulcer care and prevention.	{F 686}		
{F 698} SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to to ensure coordination of care and communication related to hyperkalemia (high potassium levels in the blood) and nutritional interventions for 1 of 3 residents (R37) receiving hemodialysis. Findings include: R37's admission Minimum Data Set (MDS) dated 4/30/18, indicated R37 had moderately impaired cognition, and had diagnoses which included end-stage renal disease (ESRD), hyperkalemia and malnutrition. The MDS indicated R37 required extensive assistance for dressing, personal hygiene and toilet use, but could eat independently after set up assistance from staff. R37's MDS further indicated no weight gain or loss, received a mechanically altered diet and was receiving dialysis. R37's MDS indicated he was not receiving a therapeutic diet.	{F 698}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide dialysis care to all residents based on appropriate diagnosis and assessment. R37 was noted to have hyperkalemia and no specific dialysis diet. According to care plan, nutritional assessment and staff the resident had no interventions in place and the appropriate diet had not been determined based on dialysis diagnosis. The dialysis company noted high potassium and yet resident still got bananas. The diet slip had been changed to state no bananas and no orange juice,	7/23/18

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{F 698}	Continued From page 49 R37's Care Area Assessment (CAA) dated 5/3/18, indicated R37 was admitted with diagnoses of ESRD and dementia and was dependent on renal dialysis three times per week. The CAA indicated R37 was forgetful and at times resistive to cares. R37's nutritional status indicated R37 had been eating well since admit, had no teeth and there was no current labs available for review. However, R37's nutritional status lacked information regarding diagnoses of ESRD or hyperkalemia and being dependent on dialysis. R37's care plan last revised 5/21/18, indicated R37 required hemodialysis due to ESRD and required a therapeutic diet. R37's care plan listed various interventions which included: consults as ordered by the physician (nephrology, nutritional and social services), diet per physician order, monitor any signs or symptoms of dysphagia (difficulty swallowing), provide snacks, diet and supplements as ordered, nutritional education will be provided as needed and at resident request, offer healthy snacks and obtain and monitor lab work as ordered. However, the care plan did not address R37's diagnosis of hyperkalemia or what foods to avoid while on hemodialysis. Review of R37's signed physician orders dated 5/4/18 indicated R37 was ordered a regular diet with mechanical soft texture, regular consistency, ground or chopped meat into quarter pieces. R37's physician orders lacked any further information regarding dialysis. Review of R37's Admission Nutrition Data V2. 1 dated 4/30/18, indicated R37 had diagnoses including ESRD, hyperkalemia and dependent on renal dialysis. The form indicated R37 had weight	{F 698}	a new nutritional assessment had not been completed. When the information was reviewed it was noted no recent labs were in chart either. A potassium was ordered, the nutritional assessment revised, diet reviewed, and care plan updated. Staff educated on renal diets. 2.Because many residents are on restrictions related to care needs and diagnosis, many are potentially affected by the cited deficiency. Dietician reviewed with MD along with dialysis team the order, clarified the diet resident should have based on diagnosis and instructed staff to follow care sheets and entered in communication book. All current residents on restrictions due to dialysis were reviewed and ensured information matched and staff were aware. Diet slips were updated, diet choices for dialysis diets were posted to ensure staff pack appropriate lunches. No other residents were affected. The policy on hemodialysis has been reviewed. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 7/12/2018 all staff (nursing and dietary) will receive in-service training monitoring diets and describing diets based on diagnoses. The training emphasizes the importance of following a plan of care, reviewing diagnosis, and appropriate monitoring. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the dietician to monitor resident’s diets in relation to their diagnosis. Dietician will review nutritional assessments monthly and as needed to	

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{F 698}	Continued From page 50 loss, skin was intact, had risk factors for dehydration of age and decreased mobility, was edentulous, ate 75% of meals, had a normal potassium level (although no value was given) and refer to nutrition assessment. Review of R37's clinical record revealed no nutrition assessment since admission on 4/23/18. On 5/31/18, at 8:14 a.m. R37 was lying on his back in bed with his eyes closed. An over-the-bed table was next to the bed that had three opened Mt. Dew 12 oz cans and a 2% milk carton on the table. On 6/1/18, at 8:45 a.m. R37's dining room tray ticket, dated 6/1/18, was reviewed. The ticket indicated R37 had a regular diet which was mechanical soft and regular texture for liquids. Under "Special Notes" section of R37's ticket was a note for oatmeal with Propass x 2 servings. The ticket lacked identification of a therapeutic diet for ESRD. On 6/1/18, at 9:10 a.m. during a phone interview with dialysis registered nurse (DRN)-A stated R37 should have diet restrictions for dialysis including high protein and low potassium. DRN-A stated their manager had to call the facility last week because the facility was packing two bananas for R37's snack while at dialysis and R37 just had an issue with hyperkalemia (high potassium level). DRN-A stated he was instructed to keep checking R37's facility packed snacks for bananas due to the hyperkalemia. On 6/1/18, at 9:55 a.m. during a phone interview with dialysis dietician (DD)-A regarding R37, DD-A stated R37 had a critically high potassium	{F 698}	monitor and update interventions. Dietician will contact dialysis center and review labs monthly and as needed. The dietician or designated quality-assurance representative will perform the following systematic changes: audit 2 residents for 3 weeks than 1 resident for 5 weeks to ensure appropriate diet is given, the dialysis center has made no dietary changes, that lunches are appropriate for diet and resident not in compliance with waiver on file will be reviewed weekly for 3 weeks by dietician with dialysis to ensure no other concerns or issues arise due to non-compliance then monthly follow up for next 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.Dietician will be responsible for this POC.	

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{F 698}	Continued From page 51 level of 6.9 miliequivalents per liter (normal range 3.4 - 5.1) on 5/22/18. DD-A stated she called R37's facility and updated a staff RN on the high lab and to limit the amount of bananas and oranges/orange juice R37 consumed. DD-A stated R37 also had a critically high potassium level on 5/24/18. DD-A stated she would expect the facility to communicate the dietary needs of low potassium needs of R37 in some manner. On 6/1/18, at 10:16 cook (CK)-C stated R37's diet was regular, mechanical soft and he required dialysis. CK-C stated dietary staff was responsible to pack sack lunches for dialysis residents. She stated R37 would typically receive a mechanical soft turkey, ham, egg or tuna salad sandwich without cheese, lettuce, carrots or celery, apple sauce and hard boiled eggs with apple cranberry juice supplement. CK-C stated some aids would use other fruits such as grapes, bananas or mandarin orange. CK-C stated she was not aware of R37's high potassium levels. On 6/1/18, at 10:28 a.m. dietary manager (DM)-A stated she was the dietician for the facility. DM-A stated the dialysis dietician called her 2-3 days ago and updated her about R37's hyperkalemia and it was decided to eliminate bananas and orange juice due to R37 eating 2-3 bananas a day and a couple glasses of orange juice. DM-A stated the only way she communicated that information was to place "No bananas, no orange juice" on his tray ticket. DM-A reviewed R37's current tray ticket from that days breakfast. DM-A stated she changed it the day she spoke with DD-A. She pulled up the tray ticket computer system MenuMatrix and confirmed the information was added to the system to read "No bananas, no orange juice". DD-A stated the staff	{F 698}		

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{F 698}	Continued From page 52 person responsible for printing off the tray tickets CK-A will at times print the tickets out a few days ahead of time and the new order has not been printed out on tickets yet. DM-A stated the information should have been added to R37's care plan as well. DM-A stated the corporate dietician completed R37's admission nutrition assessment. On 6/1/18, at 10:50 a.m. CK-A confirmed she was responsible for printing out the tray tickets for resident meals. CK-A stated at times, if she would not be at the facility (weekend off, appointments etc.) that she would print out the ticket ahead of time. CK-A stated on Fridays she would print off Saturday, Sunday and Mondays tickets and then print out Tuesdays on Monday, Wednesdays on Tuesday and Thursday and Fridays on Wednesdays. On 6/1/18, at 10:54 a.m. MDS coordinator (MDSC)-A stated she would expect to see a new nutrition assessment since the new admission on 4/23/18. MDSC-A confirmed no new nutrition assessment was in R37's clinical record. MDSC-A stated she would have expected to see R37's, no bananas or orange juice on the care plan so all staff had access to it. On 6/1/18, at 11:09 a.m. director of nursing (DON) stated R37 was scheduled for a fistulagram (is a test to look for abnormal areas in your dialysis graft or arterio-venous fistula that may be causing problems) on 5/24/18, due to hyperkalemia. DON reviewed R37's care plan and confirmed no information regarding hyperkalemia, or that R37 should not eat bananas or drink orange juice. DON stated she would have expected that information to be	{F 698}		

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{F 698}	Continued From page 53 included in the care plan, as well as a new admission nutrition assessment to have been completed. On 6/1/18, at 11:28 a.m. nursing assistant (NA)-H stated she thought R37 had a banana this morning and R37 was supposed to have extra potassium. On 6/1/18, at 11:40 a.m. NA-F stated she was not sure if R37 was to have bananas due to not having teeth, she would have to check his care plan. NA-F stated she had not received any education regarding R37 lately. On 6/1/18, at 2:39 p.m. during a phone interview, consultant dietician (CD)-A stated she had met with R37 and discussed dialysis with DM-A around R37's admission date. CD-A stated she thought it was missed as to which person (CD-A or DM-A) was going to put in the admission nutrition assessment and confirmed the clinical record lacked an admission assessment from most recent admission. CD-A stated she would not address R37's history of hyperkalemia in the care plan, but would maybe place it in a progress note. Review of facility policy titled Hemodialysis Policy reviewed 4/28/18, indicated the facility must conduct and coordinate the MDS/RAI process through appropriate assessments. The information should be coordinated with the dialysis provider to develop a coordinated plan of care. Dietary initial assessment and care plan, the dietary director in consultation with the dietician was responsible for completing the initial nutrition assessment and plan of care. The consultant dietician completes a monthly nutrition	{F 698}		

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{F 698}	Continued From page 54 assessment and care plan review. These assessments are based upon food/fluid intake, weight patterns, diet adherence, and laboratory values.	{F 698}		
{F 761} SS=F	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate labeling and storage of medications for 3 of 3 observed medication carts. The facility also failed	{F 761}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an	7/23/18

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD REHABILITATION & HEALTHCARE CENTER	**2810 SECOND AVENUE NORTH MOORHEAD, MN 56560**

(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

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to ensure emergency kit controlled medications were stored with a double lock system in 1 of 1 emergency kits for 1 of 1 facility medication storage rooms. This deficient practice had the potential to affect all 54 residents who resided in the facility.

Findings include;

On 5/29/18, at 4:20 p.m. medication cart 1 was observed with licensed practical nurse (LPN)-E and was found to have the following;

- R208's insulin pen had no pharmacy label (pharmacy label includes; resident name,prescribing physician, medication, dosage, route and instructions), opened on 5/28/18

- R800's Levemir vital had no pharmacy label.

- R800's Humalog Kwik pen had no date when opened. LPN-E indicated pen used a few times. LPN-E stated she believed the pen was good for 14 days, but indicated she was not sure. LPN-E indicated she would Google medications if not sure of expiration dates, and if no date found on medication, she would use manufacturer expiration date.

- R14's Lantus pen, long lasting, had no date when opened.

- R4's Novolog flex pen had no date when opened.

-R4's Atrovent inhaler had no pharmacy label and no date when opened.

- R4's Symbicort inhaler had no pharmacy label,

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admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.
1.It is the policy of the facility to follow safely store and appropriately discard medications of discharged residents. Multiple medications were noted to be unlabeled, not dated when opened and/or have no resident name. The Ekit was not relocked upon opening and medications were not stored correctly. This was reviewed with staff immediately; medications must belong to the resident sharing medications is not allowed, med carts never to be left unlocked and unattended, medications must be labeled, all insulin pens or dosed containers must be dated, and medications must be always stored in secured cart prior to giving. The Ekit should be re-sealed once prior seal is removed and seal number logged.
2.Because all resident rely on facility to ensure proper medication administration and right to their own medications this citation has the potential to affect all residents. Resident medications were removed from med cart for discharged residents, any meds missing were ordered, all meds dated, labels on all meds and e-kit always relocked after removal of a medication. The policy on medication storage was reviewed. No other residents were affected.
3. To enhance currently compliant operations and under the direction of the director of nurses, on 7/17/2018 all

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no box found and no date when opened.

- R801's Anora inhaler had no pharmacy label on inhaler or box. No date when opened.

- R801's Ventolin inhaler had no name or pharmacy label. No date when opened. LPN-E indicated R801 had no current order for Ventolin inhaler, which was discontinued 5/23/18. LPN-E moved R801' Ventolin inhaler to the bottom of the cart to be removed from the cart later. LPN-E indicated if a medication is not ordered when readmitted from a hospital, the admitting nurse would discontinue the medication. LPN-E indicated night nursing staff were responsible to pull discontinued medications from the medication cart.

-2 bisacodyl suppositories were stored with inhalers, with no pharmacy labels. LPN-E indicated bisacodyl suppositories were stored in the refrigerator, and should not be stored with inhalers, because oral and rectal medications stored together could cause contamination.

LPN-E indicated insulin labels sometimes fall off, if that happened nursing staff just put on a house label or would write resident's name on it. Medications sent from hospital with a resident often have no label, and sometimes no open date. LPN-e indicated they were used anyway, but the insulin pens should have pharmacy label and open date. LPN-E indicated night nursing staff were responsible for checking expired medications, and they should be checked during medicaiton pass also. LPN-E indicated she was unsure if pharmacy would send label when it fell off if needed.

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nursing staff were in-serviced on use of new Omnicell, nurses were educated on medication storage and labeling as well as dating meds.
4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the DON/ADON to check all med carts and medication passes. The DON or designee will complete 2 med cart audits per week x 4 weeks, then 1 audit weekly x2 months to ensure compliance. Nurse and TMA's will review med pass expectations and appropriate medication labeling and storing: 3 staff per week x 4 weeks, then 1 staff weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.Pharmacy and DON will be responsible for this POC.

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{F 761}	Continued From page 57	{F 761}		

On 5/30/18, at 10:08 a.m. medication cart 2 was observed with trained medication aide (TMA)-A and was found to have the following;

- Calcitonin medication had no pharmacy label or date when opened. TMA-A unable to identify who's medication it belonged to.

- 2 epinephrine pens with no pharmacy labels or expiration date.

- Albuterol inhaler, no pharmacy label, no resident's name and no date when opened.

-Ventolin inhaler, no pharmacy label.

- R10's Alphagan dated 3/7/18, had no expiration date.

-Spiriva inhaler, no pharmacy label, no date when opened.

- R410's Levemir vial had no date when opened.

- R307's Fluticasone 50 mcg, no date when opened.

- R 48's Fluticasone had no date when opened.

-R802's Levemir vial, had no date when opened.

TMA-A indicated she was unsure if there was a posting for expired medications in the facility, but indicated if she was unsure, she would Google it or ask a nurse. TMA-A indicated it was important to discard expired medications, because if used past the expiration date the properties change, which could affect the body.

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{F 761}	Continued From page 58	{F 761}		

On 5/30/18, at 10:15 a.m. medication cart 3 was observed with LPN-J, and found to have the following;

- R803's Levemir had no date when opened. LPN-J indicated it was good for 28 days. LPN-J indicated she opened it on Monday, and if she didn't know when it was opened, she would have gotten a new vial per policy.

- R52's Lantus pen, which had 220 units remaining in a 250 unit pen, had no pharmacy label on it. Pen taken from Omnicare emergency kit. LPN-J indicated she was not aware of the policy for labeling pens taken from emergency kit. A second Lantus pen for R52 had no pharmacy label.

- R804's Levemir vial, dated 4/18/18, expired 5/8/18 but remained on cart.

On 5/31/18, at 2:25 p.m. observation of medication room with LPN-I revealed the following;

-multiple discontinued medications were stored in bags on the counter.

-emergency kit was not double locked with zip tie tag. No documentation was recorded on the controlled substance log to indicate when the red lock was removed. LPN-J confirmed the box was unlocked, and that no documentation was present on the controlled substance log to indicate when the box was accessed. LPN-J secured the box with a red numbered zip tie, and reported her finding to the director of nursing (DON).

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{F 761}	Continued From page 59 On 6/1/18, at 9:04 a.m. LPN-J stated the emergency kit had not been verified unlocked, and no one had verified the medications in the emergency kit. She indicated the procedure was to document removal of narcotics from the emergency kit, contact pharmacy for authorization and verify it was removed. LPN-J indicated night nursing staff were responsible to check for expired medications weekly. LPN-J indicated the DON also checked the medication carts for expired medications either weekly or monthly. LPN-J indicated DON had checked the medication carts last week. On 6/1/18, at 10:26 a.m. consultant pharmacist (CP)-A during phone interview indicated medications should have labels with resident names and dose to be given. CP-A indicated open dates need to be on opened vials, because the medication was only good for a certain amount of days. CP-A indicated usual protocol was to contact pharmacy to request a label if medication order changed, and pharmacy would send the new label for the medication. CP-A futher indicated pharmacy should always include a label on the medication, as well as the medication box. CP-A indicated hospital should be informed labels needed on medications when discharged to facility. CP-A stated administration of medications without labels by nursing is not the correct procedure. CP-A indicated the emergency kit needed to be locked at all times. If medicaiton removed from emergency kit, authorization from pharmacy was needed. On 6/1/18, at 10:46 a.m. DON indicated the expectation for medications used at the facility was to have all medications properly labeled to	{F 761}		

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{F 761}	Continued From page 60 prevent medication errors, and ensure that medications were not expired. DON was provided a list of medications on 5/31/18, at 4:30 p.m. that identified medications found without proper labels and missing opened dates. DON reviewed the medication list and confirmed the medications were improperly labeled, and were removed from the carts and reordered. DON indicated nursing staff were expected to record the opened date and expiration date on the label sticker on the medication container when the medication was opened to prevent administering expired medications. DON indicated her expectation was for nursing staff to place a sticker on medications to notify nursing staff of order changes. DON indicated Omnicare pharmacy had performed training for nursing staff in the past. DON indicated emergency kit needed to be locked at all times to prevent diversion of narcotic medications. DON indicated the facility procedure was for pharmacy to be notified if emergency kit medication was needed, and the nurse to record the authorization code on the controlled substance log received from pharmacy. After removing the medication the emergency kit was re-locked with a numbered red tag, which would also be recorded on the controlled substance log. DON indicated her expectation was for the emergency kit to be checked every shift during the controlled medication count. The facility policy titled Labeling of Medication Containers, reviewed 4/20/18, identified all medications maintained in the facility shall be properly labeled in accordance with current state and federal regulations. The policy further instructed staff to return to the issuing pharmacy any medication packaging or containers that are	{F 761}		

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{F 761}	Continued From page 61 inadequately or improperly labeled. Labels shall include all necessary information including resident's name, prescribing physican's name, name of the issuing pharmacy, name, strength and quantity of the drug, expiration date, directions for use. Only the dispensing pharmacy can label or alter the label on medication container or package. The policy further instructed nursing staff to inform the pharmacy of any changes in physician orders for a mediation. No medications can be shared or used if not resident's medication. The facility policy titled Medication Reconciliation Policy created 12/27/18, (12/17/17?) identified the facility shall comply with all laws, regulations, and other requirements related to reconciling all medications in e-kit. The policy indicated medications available for immediate need will be kept in an e-kit in the medication room in locked box. When a medication is needed the pharmacy is called and a request of authorization is completed, faxed to pharmacy and faced back with authorization code. The policy further instructs staff to relock the box wit a red beaded security tie with a specific identification number and document on carbon copy to confirm it is locked.	{F 761}		
{F 812} SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	{F 812}		7/23/18

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{F 812}	Continued From page 62 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure outdated food items were not available for resident consumption. This had the potential to affect 53 of the 54 residents that received food from the kitchen. Findings Include: During the initial tour of the kitchen of the walk-in refrigerator on 5/29/18, at 9:18 a.m. revealed a tray of approximately 20 apple sauce one cup covered containers dated 5/19/18, a clear container of ground ham dated 5/16/18 and a clear container of diced ham dated 5/18/18, a loaf of banana bread dated 5/11/18, and a pie dated 5/20/18. Dietician (DN)-A indicated the facilty were throwing away the apple sauce, pie and banana bread. DN-A indicated the dietary manager would be in later. On 5/29/18, at 9:40 a.m. dietary aide (DA)-A indicated she had received education since the last survey was completed. DA-A indicated she had received education on many items, including	{F 812}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to ensure healthy and safe meal service. Some of the many ways that this has been done is ensuring clean environment and safely preparing and serving food and beverages to residents before their expiration dates. After the surveyor reported finding expired dates or undated items in kitchen it was determined staff not properly managing expired foods. Immediately the dietary manager threw out items and updated staff to monitor dates. The log sheet that had only been signed off 2 out of 9 days was addressed and monitored for daily checks. 2.Because all residents receive their	

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{F 812}	Continued From page 63 serving drinks and how to speak with residents. DA-A indicated she washed dishes, set up beverages, and cleaned the coolers, but did not handle the food. On 5/29/18, at 9:43 a.m. DA-B indicated she had received education since the last survey which included making sure food was warm for residents and to date all foods that go in the coolers. DA-B indicated foods should not be kept more than 5 days, nothing should be kept 7 days. DA-B indicated they checked the coolers every 3 days for outdated foods. On 5/29/18, at 9:47 a.m. cook (CK)-A indicated she provided some of the education to staff. CK-A indicated they reviewed multiple areas, such as cleaning and drying appliances and dishes, use only pasteurized eggs, use of adaptive equipment and menus. CK-A indicated they did not discuss the cooler or outdated food items. CK-A indicated she threw away the pie, apple sauce and banana bread at the time of the initial tour. Ck-A indicated she has told staff to check the food dates, but "they don't do it." CK-A indicated she threw away the ground and diced ham also. she indicated they were 2 or 3 days past the date they should be used. CK-A indicated she did not notice the dates of the foods today. CK-A indicated if staff do not show up she does multiple tasks. On 5/29/18, at 9:52 a.m. DN-A indicated she worked at the facility and indicated the facility had provided staff education on various topics, including the use of pasteurized eggs, dating items and cleaning. DN-A confirmed the ground ham, diced ham, banana bread, pie and apple sauce were expired.	{F 812}	meals here in facility all are potentially affected by the cited deficiency, 7/2/2018, the dietary manager did deep clean of the fridge to remove all outdated items. Cleaning out fridge items that are expired is now done daily with kitchen cleaning schedule. The staff have reviewed the policy and are aware of proper storage and dating open items. 3.To enhance currently compliant operations and under the direction of the director of dietary, on 7/2/2018 dietary staff reviewed proper storage and dates with dietary manager to ensure all items are safe to serve. 4.Effective 7/16/2018, a quality-assurance program was implemented under the supervision of the director of dietary to monitor fridge for expired items. The director of dietary or designated quality-assurance representative will perform audits to visualize contents of the fridge, dates, and storage to be done 2x per week for 4 weeks then 1x per week for 2 months to ensure compliance via dietary manager or designee. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly QAPI meeting for further review or corrective action. 5.Dietary manager and maintenance will be responsible for this POC.	

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{F 812}	Continued From page 64	{F 812}		

On 5/29/18, at 2:00 p.m. dietary manager (DM)-A indicated she was new to the facility and CK-A provided the education to staff. DM-A indicated she was not aware there was a problem with expired foods in the fridge. DM-A indicated she may have been told, but indicated there were many items they had reviewed. DM-A indicated she checked the dates on refrigerated foods at least every other day, but due to the holiday weekend, the last time she checked was last Friday. DM-A indicated she believed most items could be kept 3 days after dated, either the prepared date or opened date. DM-A indicated staff followed the directions posted on the cooler door for actual use-by dates to be followed. DM-A indicated checking for outdated foods was on the facility daily cleaning schedule task list the dietary staff used.

Review of the facility forms titled Daily Cleaning Schedule from 5/21/18, to 5/5/29/18, identified the area marked "Check for label and date, throw out all outdated foods", was initialed or checked only 2 out of 9 days.

Review of staff training provided indicated on 5/3/18, CK-A and DM-A reviewed policy of saving food, and taking down all temperatures in the kitchen. No specific training objectives or details were provided as requested.

A facilty form titled Cold Food Storage, undated, identified prepared potentially hazardous foods; foods mixed with other ingredients "use by date" was 3 days after placing in refrigerator. Foods in original form, which included opened fruit sauces, "use-by date" was 7 days after placing in refrigerator.

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{F 812}	Continued From page 65 A facility form titled USDA (United States Department of Agriculture) Food Safety and Inspection Service, Storage Times for Refrigerated Foods, undated, identified ham, fully cooked slices was 3-4 days. Review of facility audit forms titled Superior Healthcare Management-Moorhead Kitchen Audit from 5/21/18, to 5/25/18 lacked audit questions regarding checking storage dates of refrigerated foods. On 5/30/18, at 12:10 p.m. the administrator confirmed the audits did not include checking storage dates of refrigerated foods. Administrator indicated he himself had gone through the coolers to assure foods were not past their storage dates. His expectation would be that staff routinely go through and remove foods past the storage date. The facility policy titled Storing Prepared Foods, dated 2011, identified food or potentially hazardous food ingredients not stored in original containers must be discarded if not used within "use-by" date. The policy further instructed staff to store all extra portions in sealed shallow (2 inches deep), approved containers. Label, note "use by" date and refrigerate immediately. All items not stored in original container must be labeled and noted with "use by" date according to storage chart, and used or discarded within allowed days. Monitor all items daily for expiration dates or "use by" dates and discard all outdated items immediately.	{F 812}		
{F 865} SS=F	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i)	{F 865}		7/23/18

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{F 865}	Continued From page 66 §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain a quality assessment and assurance (QAA) committee that was effective in identifying and responding to quality deficiencies. This deficient practice had the potential to affect all 54 residents in the facility. Findings include: During an interview on 6/1/18 at 4:31 p.m., with the nursing consultant present, the administrator verified he was the lead for QAA. The administrator identified the following staff regularly attended the QAA meetings: director of nursing, director of social services, therapy director, medical director, Minimum Data Set coordinator (MDSC) and pharmacy consultant. The administrator identified the most recent	{F 865}	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to ensure that the Quality Assurance Performance Improvement committee identifies and develops appropriate action plans related to system failures. The facility failed to have appropriate action plans related to system failures including doing previous audits and monitoring for changes but not addressing the lack of education that led	

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{F 865}	Continued From page 67 quarterly meeting was conducted on 4/30/18. The administrator identified the QAA meeting members discussed many of the tags cited during the facility survey of 3/13/18. The administrator indicated many new protocols were put in to place, staff were educated, new staff hired for dietary and MDSC position and audits were initiated to review the progress. The nurse consultant (NC) identified the nursing staff had competency issues. The NC identified nursing staff had demonstrated problems with listening, charting, and documentation. The NC identified the facility had a system failure with providing information, orientation and follow-up on practices. With review of the audits the NC indicated staff had been educated on how to perform audits and what was expected with negative findings. The NC indicated the audits were not expected to be perfect and staff were to learn from them. The NC identified the QAA committee had identified what systems were not in place and were working together to get accountability. The NC indicated the facility had placed a lot of Band-Aid on problems rather than fix the problem because that is what had to be done. The NC indicated now with the audits it is noted that the problem is fixed but the staff is not educated. The NC indicated being aware of the facility problems and which citations were being recited with the revisit survey. The NC indicated she had seen improvements in the facility; however, indicated she was seeing struggles where improvement can be made.	{F 865}	to continued problems with compliance. Administrator educated everyone on the QAPI program, the guidelines, processes and how to analyze data, etc. to begin to effectively address systemic failures to improve quality at facility. 2.Lack of appropriate action plans for system failures can affect all residents at the facility. At this meeting, opportunities for improvement were identified, prioritized, root cause was determined, and performance improvement plans were initiated, reviewed and continue to be monitored. The items tagged in survey will continue to be addressed and the staff competencies will also be added to the monitoring. 3.To enhance currently compliant operations and under the direction of the Administrator, education reviewed the elements and goals of the QAPI program, assistance and tools for accurate data review, and proper identification of root cause while assuring goals are SMART (specific, measurable, attainable, realistic and time oriented). All staff will receive in-service training regarding QAPI program. 4.The QA committee will meet monthly to discuss action plans related to deficiencies noted during survey, review and analyze audits and determine appropriate continued monitoring or system changes in addition to other items already identified on the QAPI plan agenda. The medical director will be present quarterly and pharmacy consultant will be present at a minimum quarterly; if not present minutes will have	

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{F 865}	Continued From page 68 The requested facility policy was not provided.	{F 865}	submitted to them prior to meeting to allow for input during meeting, then will be reviewed and signed monthly. Audits are in place and reviewed monthly to assure that all supporting documentation from each department head is submitted to the Administrator the Monday prior to meeting for adequate time to review. After QAPI the minutes and supporting documentation will then be sent to RDCS and COO for review. This plan of correction will be monitored at the monthly QAPI meeting and audits to continue until such a time that shows consistent substantial compliance with the regulations and the facilities' QAPI plan has been met, as determined by a representative of the regional executive team. 5.The Administrator or designee will be responsible for this POC.	

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E 000	Initial Comments An Emergency Preparedness Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 4/13/18 following a Minnesota Department of Health survey on 3/13/18. At this Comparative Federal Monitoring Survey, Moorhead Rehabilitation and Healthcare Center was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.73 - Emergency Preparedness. Moorhead Rehabilitation and Healthcare Center has a total of 78 dually certified beds. At the time of the survey, the census was 53.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (3) Address patient/client population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.** *Note: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC, FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an emergency preparedness	E 007	This Plan of Correction constitutes my written allegation of compliance for the	5/21/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/04/2018

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

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E 007	Continued From page 1 plan that included succession planning. This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: On 4/12/18 at 3:30pm, the facility's "Emergency Preparedness [EP]" binder was reviewed with the Administrator and Maintenance Director. It was noted that the EP plan lacked detail of which staff would assume specific roles in another staff's absence. The Administrator verified that the EP plan was missing the succession planning component.	E 007	deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.A succession plan has been created by the ED and will go into the Emergency Preparedness Binder. 2.The succession plan will discuss temporary, unplanned absence of the Executive Director: Short-Term & Long-Term. As well as planning for a permanent change. 3.It will also discuss an emergency succession plan and will include a list of who will be in charge if the person above them on the chain of command is no longer able. 4.This plan will be revised annually and as needed. 5.Staff were trained on the emergency preparedness binder on 4/24/18 at an all staff meeting. 6.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 7.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	
E 015 SS=C	Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1) [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency	E 015		5/21/18

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E 015	Continued From page 2	E 015		

plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:

(1) The provision of subsistence needs for staff and patients whether they evacuate or shelter in place, include, but are not limited to the following:
(i) Food, water, medical and pharmaceutical supplies
(ii) Alternate sources of energy to maintain the following:
(A) Temperatures to protect patient health and safety and for the safe and sanitary storage of provisions.
(B) Emergency lighting.
(C) Fire detection, extinguishing, and alarm systems.
(D) Sewage and waste disposal.

*[For Inpatient Hospice at §418.113(b)(6)(iii):] Policies and procedures.
(6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following:
(iii) The provision of subsistence needs for hospice employees and patients, whether they evacuate or shelter in place, include, but are not limited to the following:
(A) Food, water, medical, and pharmaceutical supplies.
(B) Alternate sources of energy to maintain the following:
(1) Temperatures to protect patient health

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E 015	Continued From page 3 and safety and for the safe and sanitary storage of provisions. (2) Emergency lighting. (3) Fire detection, extinguishing, and alarm systems. (C) Sewage and waste disposal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to include in the emergency preparedness (EP) plan how the facility was to provide for medical and pharmaceutical supplies in the event of a facility evacuation or if residents were going to be sheltered in place. This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: On 4/12/18 at 1:30pm, record review of the binder titled "Emergency Preparedness" (no date) revealed the EP plan failed to address how the facility was going to provide medical and pharmaceutical supplies in the event of an emergency. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm.	E 015	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.A letter was obtained on 5/1/18 from the facility's new pharmacy. The letter addresses how the pharmacy will work with the facility to provide pharmaceuticals in the event of an emergency. 2.An agreement/letter is being acquired from the facility's Medical Supplier to address how they will supply the facility with the proper medical supplies needed in the event of an emergency. 3.These will be placed into the emergency preparedness binders and will reviewed annually and changed if needed. 4.Staff were trained on the emergency preparedness binder on 4/24/18 at an all staff meeting. 5.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 6.The DOM and ED are responsible for this POC.	

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E 018 SS=C	Procedures for Tracking of Staff and Patients CFR(s): 483.73(b)(2) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually.] At a minimum, the policies and procedures must address the following:] (2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and location of the receiving facility or other location. *[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the location of on-duty staff and sheltered residents in the [PRTF's, LTC, ICF/IID or PACE] care during and after an emergency. If on-duty staff and sheltered residents are relocated during the emergency, the [PRTF's, LTC, ICF/IID or PACE] must document the specific name and location of the receiving facility or other location. *[For Inpatient Hospice at §418.113(b)(6):] Policies and procedures. (ii) Safe evacuation from the hospice, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s) and primary and alternate means of communication with external sources of	E 018		5/21/18

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E 018	Continued From page 5	E 018		

assistance.
(v) A system to track the location of hospice employees' on-duty and sheltered patients in the hospice's care during an emergency. If the on-duty employees or sheltered patients are relocated during the emergency, the hospice must document the specific name and location of the receiving facility or other location.

*[For CMHCs at §485.920(b):] Policies and procedures. (2) Safe evacuation from the CMHC, which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance.

*[For OPOs at § 486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.

*[For ESRD at § 494.62(b):] Policies and procedures. (2) Safe evacuation from the dialysis facility, which includes staff responsibilities, and needs of the patients.
This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to develop policies and procedures for tracking of staff and patients in accordance with 42 CFR, Section 483.73(b)(2). This had the potential to affect all 53 residents currently resided in the facility at the time of the survey.

Findings include:

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and

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E 018	Continued From page 6 On 4/12/18 at 1:30pm, record review of the binder titled "Emergency Preparedness" (no date) revealed the policies and procedures did not account for tracking of staff and patients in the event of an emergency. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm.	E 018	federal law. 1.The facility evacuation plan has been updated and now includes a tracking procedure to inform staff on the procedures for tracking patients, employees, and volunteers in the event of an emergency. 2.This will be reviewed annually and changed as needed. 3.Staff were trained on the emergency preparedness binder on 4/24/18 at an all staff meeting. 4.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 5.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility].	E 022		5/21/18

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E 022	Continued From page 7 *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop policies and procedures for sheltering in place for residents, staff and volunteers in the facility in the event of an emergency. This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: Review of the facility's emergency preparedness plan revealed that there was no policies and procedures for sheltering in place for residents, staff and volunteers in the facility during an emergency. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm.	E 022	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.A shelter in place plan has been developed and includes how the facility be able to remain in operation for a 72-hour period while keeping its residents, staff members, volunteers, and hospice employees safe. 2.This will be reviewed annually and changed as needed. 3.Staff were trained on the emergency preparedness binder on 4/24/18 at an all staff meeting. 4.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 5.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	

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E 023	Continued From page 8	E 023		
E 023 SS=C	Policies/Procedures for Medical Documentation CFR(s): 483.73(b)(5) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (5) A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. [(5) or (3),(4),(6)] A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records. *[For RNHCIs at §403.748(b):] Policies and procedures. (5) A system of care documentation that does the following: (i) Preserves patient information. (ii) Protects confidentiality of patient information. (iii) Secures and maintains the availability of records. *[For OPOs at §486.360(b):] Policies and procedures. (2) A system of medical documentation that preserves potential and actual donor information, protects confidentiality of potential and actual donor information, and secures and maintains the availability of records.	E 023		5/21/18

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E 023	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop policy and procedure for medical documents in accordance with 42 CFR, Section 483.73(b)(5). This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: Review of the facility's emergency preparedness plan revealed that the facility had no system in place that would preserve patient information, protect confidentiality of patient information, and secure and maintain availability of records in the event of an emergency. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm.	E 023	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.The facility has obtained a HIPAA Waiver for disasters, which discusses what provisions may be waived, when and to what entities it applies to, and how healthcare information can be shared in severe disaster. 2.The facility's evacuation plan has also been updated and now includes the procedure for preserving patient health information. It discusses how medication carts; emergency drug kits and medical charts would be bought with to the evacuation location and how MARS and TARS would be printed out with the emergency laptop and printer. 3.This plan will be reviewed annually and changed as needed. 4.Staff were trained on the emergency preparedness binder on 4/24/18 at an all staff meeting. 5.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 6.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	

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	245052	A. BUILDING ______ B. WING ______	04/13/2018

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E 024	Continued From page 10	E 024		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to develop policies and procedures for volunteers in accordance with 42 CFR, Section 483.73(b)(6). This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: On 4/12/18 at 1:30pm, record review of the binder titled "Emergency Preparedness" (no date)	E 024	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.A staffing plan has been developed and discusses how the Incident Commander	5/21/18

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E 024	Continued From page 11 revealed the policies and procedures did not account for management of volunteers in the event of an emergency. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm.	E 024	will designate a staff member to call all off duty staff and request that they come to the facility or relocation site. This designated staff member will then call all volunteers and ask for assistance. 2.A memorandum of understanding has been signed by three of our sister facilities who are willing to send staff to our facility in the event of an emergency. The facility evacuation plan has also been updated and now includes a tracking procedure to inform staff on the procedures for tracking patients, employees, and volunteers in the event of an emergency 3.This plan will be reviewed annually and changed as needed. 4.Staff were trained on the emergency preparedness binder on 4/24/18 at an all staff meeting. 5.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 6.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must	E 026		5/21/18

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E 026	Continued From page 12 address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure their policies and procedures addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: On 4/12/18 at 3:30pm, the emergency preparedness policies and procedure manual was reviewed with the Administrator and the Maintenance Director. Record review revealed that the facility did not have policies and procedures in its emergency plan describing the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. During the review, the Administrator verified and provided information which was not adequate to	E 026	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.The facility has obtained an information sheet on HIPAA Waivers for disasters, which discusses how The Secretary of HHS may waive certain provisions of the rule under the Project Bioshield Act of 2004 (PL 108-276) and Section 1135(b)(7) of the Social Security Act. 2.The facility’s evacuation plan has also been updated and discusses the facility’s role in providing care and treatment at alternate care sites under an 1135 waiver. 3.Staff were trained on the emergency preparedness binder on 4/24/18 at an all	

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E 026	Continued From page 13 the regulation.	E 026	staff meeting. 4.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 5.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	
E 030 SS=C	Names and Contact Information CFR(s): 483.73(c)(1) [(c) The [facility, except RNHCIs, hospices, transplant centers, and HHAs] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:] (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. *[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs. (v) Volunteers.	E 030		5/21/18

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E 030	Continued From page 14 *[For ASCs at §416.45(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Volunteers. *[For Hospices at §418.113(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Hospice employees. (ii) Entities providing services under arrangement. (iii) Patients' physicians. (iv) Other hospices. *[For OPOs at §486.360(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Volunteers. (iv) Other OPOs. (v) Transplant and donor hospitals in the OPO's Donation Service Area (DSA). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain a list of names and contact information in accordance with 42 CFR, Section 483.73(c)(1). This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include:	E 030	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and	

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E 030	Continued From page 15 The facility's emergency preparedness plan lacked documentation of some of the residents' physicians', other long term care facilities' and volunteers' contact information. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm.	E 030	federal law. 1.The facility's emergency preparedness binder has been updated and now includes all patient physician phone numbers as well as phone numbers for other local care centers and hospitals. 2.Phone numbers of all emergency volunteers have also been included. 3.Staff were trained on the emergency preparedness binder on 4/24/18 at an all staff meeting. 4.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 5.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	
E 033 SS=C	Methods for Sharing Information CFR(s): 483.73(c)(4)-(6) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (4) A method for sharing information and medical documentation for patients under the [facility's] care, as necessary, with other health providers to maintain the continuity of care. (5) A means, in the event of an evacuation, to release patient information as permitted under 45 CFR 164.510(b)(1)(ii). [This provision is not required for HHAs under §484.22(c), CORFs under §485.68(c), and RHCs/FQHCs under	E 033		5/21/18

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E 033	Continued From page 16 §491.12(c).] (6) [(4) or (5)]A means of providing information about the general condition and location of patients under the [facility's] care as permitted under 45 CFR 164.510(b)(4). *[For RNHCIs at §403.748(c):] (4) A method for sharing information and care documentation for patients under the RNHCI's care, as necessary, with care providers to maintain the continuity of care, based on the written election statement made by the patient or his or her legal representative. *[For RHCs/FQHCs at §491.12(c):] (4) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a communication plan which included a method of sharing information and medical documentation for residents under the facility's care, with other health providers to maintain continuity of care. This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: Review of the facility's emergency preparedness plan with the Administrator and the Maintenance Director on 4/12/18 at 3:30pm revealed that the facility did not develop a communication plan that included methods for sharing information and medical documentation for residents under the	E 033	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.A communication plan as well as policies and procedures have been created and address the following: sharing information and medial documentation, A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii), A means of providing	

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E 033	Continued From page 17 facility's care, with other health providers to maintain the continuity of care. This finding was confirmed by the Administrator.	E 033	information about the general condition and location of residents under the facility's care as permitted under 164.510(b)(4) and A method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. 2.This plan will be reviewed annually and updated as needed. 3.Staff were trained on the emergency preparedness binder on 4/24/18 at an all staff meeting. 4.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 5.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a communication plan that	E 035	This Plan of Correction constitutes my written allegation of compliance for the	5/21/18

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E 035	Continued From page 18 included a method for sharing information from the emergency plan that the facility had determined was appropriate with residents, their families or representatives. This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: Review of the "Emergency Preparedness" plan with the Administrator and the Maintenance Director revealed that the facility did not develop a communication plan which included a method for sharing information from the emergency plan that the facility had determined was appropriate with residents, their families or representatives. This finding was confirmed by the Administrator and Maintenance Director on 4/12/18 at 3:30pm.	E 035	deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.A communication plan as well as policies and procedures have been created and address the following: sharing information and medial documentation, A means, in the event of an evacuation, to release resident information as permitted under 45 CFR 164.510(b)(1)(ii), A means of providing information about the general condition and location of residents under the facility's care as permitted under 164.510(b)(4) and A method for sharing information from the emergency plan that the facility has determined is appropriate with residents and their families or representatives. 2.This plan will be reviewed annually and updated as needed. 3.Staff were trained on the emergency preparedness binder on 4/24/18 at an all staff meeting. 4.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 5.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	
E 036 SS=C	EP Training and Testing CFR(s): 483.73(d)	E 036		5/21/18

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E 036	Continued From page 19 (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. *[For ICF/IIDs at §483.475(d):] Training and testing. The ICF/IID must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually. The ICF/IID must meet the requirements for evacuation drills and training at §483.470(h). *[For ESRD Facilities at §494.62(d):] Training, testing, and orientation. The dialysis facility must develop and maintain an emergency preparedness training, testing and patient orientation program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be reviewed and updated at least annually. This REQUIREMENT is not met as evidenced by:	E 036		

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E 036	Continued From page 20 Based on interview and record review, the facility failed to develop and maintain an emergency preparedness (EP) training and testing program based on the facility's emergency plan and risk assessment. This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: In an interview with the Administrator and the Maintenance Director on 4/12/18 at 3:30pm, the Administrator confirmed that there was no documentation to indicate that the facility had a training and testing program based on the emergency plan and risks identified by the facility. The Administrator further stated that there had been no education and training provided to staff, individuals providing services under arrangement and volunteers.	E 036	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.On 4/18/18 the facility hosted an Emergency Management Meeting for facilities throughout clay county. The meeting was conducted by the Clay county emergency manager (Bryan Green) and Assistant fire chief (Chad Stangland). 2.On 4/24/18 the ED and DOM held an all staff meeting and trained/educated employees on the emergency preparedness binder. 3.Quizzes on emergency preparedness were handed out to staff and then put in their files upon completion. 4.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 5.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness	E 037		5/21/18

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E 037	Continued From page 21 policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the	E 037		

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E 037	Continued From page 22	E 037		

procedures necessary to protect patients and others.

*[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
(ii) After initial training, provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures.
(iv) Maintain documentation of all emergency preparedness training.

*[For PACE at §460.84(d):] (1) The PACE organization must do all of the following:
(i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles.
(ii) Provide emergency preparedness training at least annually.
(iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency.
(iv) Maintain documentation of all training.

*[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following:
(i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent

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E 037	Continued From page 23 with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must	E 037		

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E 037	Continued From page 24 demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an emergency preparedness training program in accordance with 42 CFR, Section 483.73 (d)(1). This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: Record review of the binder titled "Emergency Preparedness" (no date) revealed that there was no emergency preparedness training program in place for staff, individuals providing services under arrangement and volunteers. This finding was verified by the Administrator on 4/13/18 at 10:17am. The Administrator further stated that there was no documentation to indicate that any training related to emergency preparedness had been done.	E 037	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.On 4/18/18 the facility hosted an Emergency Management Meeting for facilities throughout clay county. The meeting was conducted by the Clay county emergency manager (Bryan Green) and Assistant fire chief (Chad Stangland). 2.On 4/24/18 the ED and DOM held an all staff meeting and trained/educated employees on the emergency preparedness binder. 3.Quizzes on emergency preparedness were handed out to staff and then put in their files upon completion. 4.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 5.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	
E 039	EP Testing Requirements	E 039		5/21/18

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E 039 SS=C	Continued From page 25 CFR(s): 483.73(d)(2) (2) Testing. The [facility, except for LTC facilities, RNHCIs and OPOs] must conduct exercises to test the emergency plan at least annually. The [facility, except for RNHCIs and OPOs] must do all of the following: *[For LTC Facilities at §483.73(d):] (2) Testing. The LTC facility must conduct exercises to test the emergency plan at least annually, including unannounced staff drills using the emergency procedures. The LTC facility must do all of the following:] (i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event. (ii) Conduct an additional exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based. (B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the	E 039		

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E 039	Continued From page 26 [facility's] emergency plan, as needed. *[For RNHCIs at §403.748 and OPOs at §486.360] (d)(2) Testing. The [RNHCI and OPO] must conduct exercises to test the emergency plan. The [RNHCI and OPO] must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the [RNHCI's and OPO's] response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an emergency preparedness testing program in accordance with 42 CFR, Section 483.73(d)(2). This had the potential to affect all 53 residents currently resided in the facility at the time of the survey. Findings include: Record review of the binder titled "Emergency Preparedness" (no date) revealed that there was no emergency preparedness testing program in place. There was no documentation that the facility had participated in a community-based exercise. In an interview with the Administrator on 4/13/18 at 10:17am, he verified that there was no	E 039	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.On 4/18/18 the facility hosted an Emergency Management Meeting for facilities throughout clay county. The meeting was conducted by the Clay county emergency manager (Bryan Green) and Assistant fire chief (Chad Stangland). 2.On 4/24/18 the ED and DOM held an all staff meeting and trained/educated	

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E 039	Continued From page 27 emergency preparedness testing program in place.	E 039	employees on the emergency preparedness binder. 3.Quizzes on emergency preparedness were handed out to staff and then put in their files upon completion. 4.The ED has been in contact with the Clay County Emergency Manager and is working on getting a date established to perform a tabletop exercise with all staff. 5.A community-based exercise will be performed annually. 6.Staff will be educated/trained on the emergency preparedness binder annually and it will become part of our new employee orientation process. 7.The Director of Maintenance (DOM) and Executive Director (ED) are responsible for this POC.	
F 000	INITIAL COMMENTS A health comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on April 13, 2018 following a Minnesota Department of Health survey on March 13, 2018. Survey Dates: April 9 to April 13, 2018 Survey Census: 53 Medicare: 12 Medicaid: 34 Other: 7 Total: 53 Total Sample: 36	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8)	F 561		5/21/18

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F 561	Continued From page 28 §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to promote and facilitate a preference for receiving showers instead of bed baths for one resident (R39) of one resident reviewed for choices in the sample of 37. Findings include: Record Review of R39's Admission Record listed	F 561	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	

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F 561

Continued From page 29

diagnoses but not limited: chronic kidney disease, stage 5, dependence on renal dialysis, obesity, low back pain, chronic pulmonary edema, chronic obstructive pulmonary disease and heart failure.

Record Review of R39's Quarterly Minimum Data Set (MDS) dated 3/7/18 with the heading "Section C-cognitive Pattern," R39 scored a 14 in a Brief Interview for Mental Status (BIMS) which indicated that R39 was cognitively intact. In the same MDS with the heading "Section G Functional Status," under "G0110 B. Transfer," specified that R39 was "Total dependence -Full staff performance all the time..."with "Two+ persons physical assist."

During an interview on 4/10/18 at 11:51am, R39 stated, "I've received one shower in 3 months." When asked how did it make he feel, R39 replied, "It makes me feel like a dog...I would give my dog a bath once a week." When R39 was asked about his bathing preference, R39 stated that he preferred showers.

During an interview on 4/11/18 at 11:46am with the Unit Coordinator, she stated that her responsibilities included documenting resident's bath preferences in a bath book and providing updates. When the Unit Coordinator was asked on how baths and showers were documented, she replied that it was documented in Point Click Care (PCC) which is an electronic computer system that health care providers utilize to record care.

Record review of R39's "New Admission Preference & Other" located in the bath book in the nursing station, dated 10/10/17 indicated that R39 prefered to be showered on Mondays and

F 561

1.It is the policy of the facility to promote and facilitate self -determination of resident’s individual choices about aspects of his or her life in the facility that are significant to the resident. One of the many ways that this has been achieved for resident #39 is by reviewing resident shower schedule with resident and determining when his showers will be around his schedule as well as educated staff on importance of following resident care plans and providing all care as directed by care sheets. R39 care sheets and care plans updated and shower sheets have been reviewed.
2.Because all residents count on staff for activities of daily living all are potentially affected by the cited deficiency, residents and their baths have been reviewed. Baths are being audited and staff as well as residents are monitored routinely to assure compliance. All residents have been reviewed for bath choices. No other residents were affected. The Policy and Procedure for bathing was reviewed.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all staff will receive in-service training regarding state and federal requirements for bathing requirements, dignity, respect and resident cares. The training will focus on the resident choice for planning their cares, staff compliance, importance of ensuring residents can be clean and dry and skin intact.
4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the director of nurses to

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F 561	Continued From page 30 Fridays. Record review of a print out that was recorded in PCC, R39's delivery of care regarding baths from 2/2/18 to 4/10/18 revealed that R39 had received bed baths and only received his preferred showers twice, one on 3/2/18 and the other on 3/16/18 in two months. During an interview on 4/11/18 at 1pm with the Director of Nursing (DON), the DON was asked on how she ensured that nursing assistants (NA) were complying with resident's preference in showering. The DON stated, "I look at charts, talk to residents and look at the schedule. If documentation is missing, I will talk to the NA." The DON was then asked to review R39's "New Admission Preference & Other" sheet and R39's print out of showers and bed baths given from 2/2/18 to 4/10/18. After reviewing both documents, the DON acknowledged that R39 had requested showers twice a week and not bed baths. The DON also confirmed that during the time of 2/2/18 to 4/10/18, R39 received his preferred showers (3/2/18 and 3/16/18) only twice in those two months. When asked about the standards of care, the DON replied, "unacceptable."	F 561	monitor bathing schedules and staff follow through. The director of nurses or designated quality-assurance representative will perform the following systematic changes: audits of baths and completion of baths/showers to done as follows: 6 residents a week for 3 weeks, then on 3 residents weekly for 2 months to ensure compliance. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON will be responsible for this POC.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive	F 578		5/21/18

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F 578	Continued From page 31 the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all places where advance directives were noted matched for one (R36) resident in the sample of 37.	F 578	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that	

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F 578	Continued From page 32 Findings include: A review of R36's hard chart document titled, "Uniform Code Level Directives for Cardiopulmonary Resuscitation" signed by the physician on 12/27/2017 which was noted to have R36 as a "Code Level 1: All available reasonable technology is used in the event of cardiac or respiratory arrest." The form was signed by R36 on 12/22/17. A review of R36's electronic health record (EHR) under the "Census" tab R36 was shown as "Full Code" on the top of the page, but in the "Custom Information" section was "Code Status: Code level 2: DNR" (do not resuscitate). When printed on 04/12/2018, this tab becomes the "Admission Record" [a cover sheet to a multipage document that contains demographic information, preferences, contact information, and limited medical information]. Review of the printed document revealed, "Other Information: Code Status: Code level 2-DNR" in the middle of the first page, and almost at the bottom of the second page "Advance Directive: Full Code." In an interview on 04/12/2018 at 1pm, the Regional Director of Clinical Services, after reviewing R36's chart, stated "We literally just did an audit of all the charts for advance directives. The electronic health record and hard chart do not match for her code status."	F 578	one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide residents the right to formulate their own advance directives. One of the many ways that this has been achieved for R37 is by reviewing the advance directive on file and ensuring with resident and POA correct code status on file. R37 had order for full code in chart and on face sheet in EMR however it was noted in EMR that mid-way through face sheet it also stated DNR. The current order in place for full code has been clarified and noted in EMAR. The chart has been corrected and R37 profile updated. In this case, after the surveyor reported the contradictory advance directives on file, the staff was reminded to notify SW if they find any orders that are not clear and ensure resident and POA are actively involved in determining their wishes. All hard charts have been reviewed as of 4/5/2018 and EMR reviewed by 4/20/2018. 2.Because all residents are required to have advance directives on file all are potentially affected by the cited deficiency, 4/3/2018, the SW printed new POLST from MN.GOV and is initiating a plan to review to update over next quarter as well as ensure all are current up to date. Orders will be signed, reviewed and in chart. In addition, all new residents will be updated on policy and ensure current advance directives are admitted with resident and reviewed for accuracy. All charts immediately were audited for	

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F 578	Continued From page 33	F 578	discrepancies of which 4 were not compliant and updated immediately. No other residents were affected. The Policy and Procedure for advanced directives was also reviewed and updated. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 in-service training for admissions, social service and nursing was completed regarding state and federal requirements for advance directives and ensuring consistent documentation in hard chart with order from physician and listed on profile. The training emphasized the importance of ensuring all residents come in with proper advance directives, POLST on hand or initiated for chart and reviewed with resident and POA to ensure right status is chosen and that order in chart and on face sheet in EMR match residents wishes. Reviewed with staff at nursing meeting on 5/9/2018 to reinforce consistency in orders. 4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the SW to ensure compliance of advance directives. The SW or designated quality-assurance representative will perform the following systematic changes: all resident charts audited for current advanced directives listed in chart and in EMR. Then the SW or designee will complete 2 audits per week x 4 weeks, then 1 audit weekly x2 months Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly	

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	245052	A. BUILDING ______ B. WING ______	04/13/2018

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F 578	Continued From page 34	F 578	quality-assurance committee meeting. 5.Admissions and SW will be responsible for this POC.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580		5/21/18

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F 580	Continued From page 35 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to immediately notify the resident's attending physician of a significant change in condition for one resident (R55) in the sample of 37. Findings include: Review of R55's Admission Record revealed R55 was admitted to the facility on 3/13/18 with diagnoses that included but not limited to: acute respiratory failure, type 2 diabetes mellitus, chronic obstructive pulmonary disease, constipation and subdural hemorrhage. Review of R55's nurse's notes revealed the following: 3/20/18: "Resident had a small emesis [vomiting] this morning while at PT [Physical Therapy]/OT [Occupational Therapy]." 3/25/18: Nursing Note: "Resident had emesis x [times] 1."	F 580	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide notification of changes to providers and family. R55 was noted to have emesis, fever and overall decline in health. Although some documentation was done, no temperature was taken, lung sounds not assessed, and no physician was contacted regarding the acute changes. Over 2 days resident was sick and when staff did receive chest x-ray it was not immediately called to physician. Resident has since had resolution of aspiration pneumonia and staff educated on timely	

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F 580 Continued From page 36

4/8/18: "Resident was sitting up in bed for dinner this shift. Resident later experienced episodes of emesis x 2. Emesis contents consist of a meal and desert [sic]."
4/8/18 11:45am: "Temp 99.5"
4/8/18 1:25pm: "Resident had elevated temp > [above] 100 so PRN [as needed] TYl [Tylenol] administered. Resident has a nasal congestion..."

During an interview on 4/10/18 at 11:30am with R55's daughter (Z2), Z2 stated staff was not closely monitoring R55's condition. Z2 stated, "I had to ask the aide to take my dad's temperature today. Had I not asked, no one would ever have known he had a fever. He has a 100.5 temperature."

On 4/10/18 at 11:15am, R55 was observed in bed, flushed face and breathing through mouth. While Z2 was voicing her concerns regarding her dad's temperature, Z2 also stated, "He doesn't look good today, he feels so warm." Licensed Practical Nurse (LPN)1 responded to Z2 and stated, "Oh! I have a Tylenol prepared for him. That should take care of his temperature."

Review of R55's nurse's notes dated 4/10/18 at 1:36pm revealed, "Resident is running a temp [temperature] 100.3 and lung sounds are wheezy." At 5:23pm, "Resident is alert and oriented, lethargic today, wheezing in lungs." At 7:25pm, "Results [x-ray] received: Possible pneumonia or aspiration. Review of R55's chest x-ray result dated 4/10/18 revealed, "Cardiomegaly with retrocardiac consolidation could represent pneumonia or aspiration."

Review of R55's nurse's notes dated 4/11/18 at 12:40pm revealed R55's physician assistant had

F 580

follow up on medical symptoms, immediately calling physician with update on resident change and expecting no less than 8 hours to get response from MD or call again. If still no response update medical director.
2.Because all residents count on staff for timely and appropriate care all are potentially affected by the cited deficiency, monitoring for change in condition has been reviewed and expectations of staff to urgently address resident changes by notifying MD immediately were discussed. All residents have been reviewed to ensure no signs or symptoms of acute issues have developed. Also, all residents that have any acute changes to their care have been reviewed to ensure timely notification completed and resident needs have been addressed No other residents were affected. The Policy and Procedure for change of condition was also reviewed and updated.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff received in-service training regarding state and federal requirements for monitoring for changes in condition and updated on the findings of R37. The training emphasizes the importance of taking all resident concerns seriously, monitoring symptoms and follow up, following all interventions for effective maintenance and reporting of changes promptly to MD.
4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the director of nurses to

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F 580	Continued From page 37 been informed of R55's x-ray results. Note that after the chest x-ray results became available to the nursing staff on 4/10/18 at 7:25pm that it was not until 4/11/18 at 12:40pm, 17 hours later when R55's physician assistant had been notified of R55's x-ray results. During an interview on 4/12/18 at 11:40am with the Director of Nursing (DON), the DON stated, when asked about the nurse's interventions when R55 has episodes of vomiting, the DON stated, "Find the cause, the source of vomiting, contact the physician." The DON confirmed that R55's nurses' notes lacked documentation that R55's physician had been notified of R55's emesis and elevated temperature. During an interview on 4/11/18 at 11:30am with the Physician Assistant (PA), the PA confirmed that R55 had aspiration pneumonia based on R55's chest x-ray results, symptoms and his findings upon his examination. When asked if he had been notified of R55's episodes of emesis and elevated temperature, the PA stated, "No, I have not been made aware of his emesis and elevated temperature until 4/10/18. I just ordered two antibiotic medications for [R55]." The PA also stated that he expected the nurses to notify him or the physician for any change in condition as soon as possible. The PA stated, "Had I been promptly informed of his fever and vomiting, I would have treated him sooner." Review of the facility's policy created on 12/27/17 and reviewed on 4/3/18 titled, Change in a Resident's Condition or Status indicated, "Our facility shall promptly notify the resident, his or her Attending Physician, and representative of	F 580	monitor residents for change in condition. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will ensure audits done weekly to monitor change of condition and new orders for all residents for 1 week, then 6 residents a week for 2 weeks, then on 3 residents weekly for 4 weeks. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON will be responsible for this POC.	

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F 580	Continued From page 38 changes in the resident's medical/mental condition and/or status...The Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been:...A Significant change in the resident's physical/emotional/mental condition; A need to alter the resident's medical treatment significantly."	F 580		
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must	F 585		5/21/18

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F 585	Continued From page 39 include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the	F 585		

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F 585	Continued From page 40 provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based interview and record review the facility failed to ensure a resident grievance regarding missing items was responded to in a timely manner. This deficient practice affected one (R31) of one resident in the sample of 37. Findings Include: During an interview on 4/10/18 at 12:56pm, Z4 stated that R31 was missing "several pairs of sweatpants and pajama pants and a blue neck pillow." Z4 indicated that the items had been missing for approximately two months and that	F 585	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to allow residents the right to file a grievance if they feel they are concerned with care within the facility and it is the policy of the	

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F 585	Continued From page 41 this was reported to the facility. Z4 stated that the items were not replaced and that here was no response from the facility, except for the facility requesting receipts for the missing items. Z4 stated that she was unable to locate receipts for R31's missing items. On 4/12/18 at 3:47pm, the Social Service Worker (SSW) confirmed that she had received a grievance from R31's family related to missing items. The SSW stated that she had asked the family for prices of the missing items however they were never provided by R31's family. The SSW confirmed that she had never followed-up on R31's missing items. Review of facility's "Grievance Policy", dated 12/27/18 (sic), stated "It is the facility's goal that concerns be addressed and resolved as soon as possible...The Process: 1. Investigation of the specific details surrounding the issue of concern, as documented by the individual filling the grievance report. 2. Assessment of the problem and the cause. 3. Development of an appropriate plan of action. 4. Implementation of that plan..."	F 585	facility to respond to those grievances. R31 was noted to have missing clothing and neck pillow and grievance was not official, it was noted to have been reported without follow up. The family was contacted for prices and family did not respond, unfortunately the issue was then not followed up on again. In this case, after the surveyor reported the resident concern, the SW and ED discussed and came up with fair market value to reimburse resident $40 for items. 2.Because all residents that reside in the facility calling it their home and therefor have the right to express their concerns, all are potentially affected by the cited deficiency. On 4/13/2018, current residents were audited to ensure they understand they can file a grievance if they have concerns, that the facility will follow up timely, any outstanding grievances were resolved, and grievance review added to morning stand up. No other residents were affected. The Policy and Procedure for grievances was reviewed. 3.To enhance currently compliant operations and under the direction of the SW, on 5/9/2018 all staff and residents received handout with policy and grievance form. The hand out explained our policy and resident rights and appropriate time frame for follow up. It also reminded resident to have staff assist with labeling items and ensuring any items that are expensive or sentimental should be kept off site or in drawers to prevent loss of property. 4.Effective 4/28/2018, a quality-assurance	

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F 585	Continued From page 42	F 585	program was implemented under the supervision of the SW to monitor resident grievances and resident inventories to ensure facility aware of resident items. The SW or designee will complete 4 audits per week x 4 weeks on residents to ensure no concerns are being unmet, then 2 audits weekly for 4 weeks. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.SW will be responsible for this POC	
F 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop an abuse policy that: (a) included mistreatment and exploitation as types of alleged violations; (b) prohibited staff from taking, keeping and/or distributing photographs and recordings that demean or humiliate a	F 607	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of	5/21/18

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F 607	Continued From page 43 resident; (c) ensured that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to the administrator and state agency within the required reporting timeframes; and (d) ensured the results of all investigations are reported to the administrator or his or her designated representative and to the state agency within 5 working days of the incident. This deficient practice had the potential to affect all 53 residents residing in the facility. Findings include: Review of the facility's abuse policy titled "Vulnerable Adult," revised 12/23/17, stated "1. During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor, after securing the resident's safety. Following the review of the situation, the Supervisor will immediately report to the House Supervisor who will then report it to the Director of Nursing/Administrator...3. The Supervisor, Director of Nursing or Administrator will immediately institute an internal investigation of the reported allegation or incident...4. The Director of Nursing or Administrator shall determine if the incident/allegation meets the criteria for 'Reportable Incident.' All incidents deemed reportable under MN [Minnesota] statute are submitted to MDH [Minnesota Department of Heath] via the on-line Reporting System within the 2 hour period...6. If the Director of Nursing or Administrator determines the internal report does not meet the criteria for reporting under either state or federal guidelines, the Director of Nursing or Administrator will note that decision in writing	F 607	Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to report all incidents and do timely follow up on any incident that result in injury. The deficiency of this practice was noted during state visit and policy and procedure had been updated. The current policy states all incidents that are reportable will be reported within 2 hours if allegation of abuse or neglect, 24 hours if no abuse, all will be reported to ED, statements will be completed within 5 working days and no resident will be exploited by use of pictures or videos, no staff shall demean or humiliate a resident. Staff educated on additional information added to the policy. Nursing and SW were also educated on importance of reporting all vulnerable adult cases to the OHFC (office of health facility complaints). All incidents and accidents are to be reviewed immediately for any potential abuse or neglect. A resident protection manual was created, put at nursing stations and educated to all staff to ensure the components of abuse and neglect are identified and immediately followed up on and added to policy. 2.Because all residents are considered vulnerable all are potentially affected by this citation and have potential for abuse/neglect. On 5/9/2018, the director of nursing incorporated the changes to the abuse/neglect policy. Since survey all incidents and accidents are reviewed, and any resident sustaining injury has been reviewed and reported immediately within 2-hour time frame if deemed necessary by	

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F 607	Continued From page 44 on the Incident Report." The policy failed to include that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with state law through established procedures prior to the start of the investigation. The policy failed to include mistreatment and exploitation as types of alleged violations and failed to include a component that prohibits staff from taking, keeping and/or distributing photographs and recordings that demean or humiliate a resident. The policy failed to include that the results of all investigations are to be reported to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident. On 04/13/18 at 08:19am, the Executive Director (ED) was made aware of the above findings related to the missing components of the abuse policy. The ED confirmed that all allegations of abuse are to be reported to the administrator and	F 607	state regulations. No other residents were affected. The Policy and Procedure for abuse/neglect was reviewed and updated. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all staff with assistance from SW received in-service training regarding the policy requirements. The training will review abuse/neglect policy and safety, reporting and resident exploitation. Staff educated on following plan of care, appropriate interventions, timeliness of reporting to OHFC. No other residents were affected. 4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the SW to any incidents/accidents to ensure protocol and policy followed. SW will audit all staff to ensure understanding of policy. All incidents will be immediately reported to DON and further discussed daily at stand up, unless injury then reported to OHFC with 2 hours, if allegations without abuse file in 24 hours, and update to ED. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON and SW will be responsible for this POC.	

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F 607	Continued From page 45 the state agency immediately. Review of the Centers for Medicare & Medicaid Services (CMS) "Survey and Certification Memorandum 16-33-NH", dated 8/5/16, indicated "Each resident has the right to be free from all types of abuse, including mental abuse. Mental abuse includes, but is not limited to, abuse that is facilitated or caused by nursing home staff taking or using photographs or recordings in any manner that would demean or humiliate a resident(s)...Each nursing home must develop and implement written policies and procedures that prohibit all forms of abuse, including mental abuse. Each nursing home must review and/or revise their written abuse prevention policies and procedures to include and ensure that nursing home staff are prohibited from taking or using photographs or recordings in any manner that would demean or humiliate a resident(s). This would include using any type of equipment (e.g., cameras, smart phones, and other electronic devices) to take, keep, or distribute photographs and recordings on social media."	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in	F 609		5/21/18

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	245052	A. BUILDING ______ B. WING ______	04/13/2018

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F 609	Continued From page 46 serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey 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 record review, the facility's staff failed to report an allegation of possible abuse immediately to the administrator, and the facility failed to report this allegation to the State within the required time of two hours for one (R20) resident and failed to report allegations of resident-to-resident abuse immediately to the administrator affecting two residents (R22 and R258) of 17 residents reviewed for abuse in the sample of 37. Findings include: 1. Record Review of R20's Admission Record included but were not limited to the following diagnoses: cerebral infarction (stroke), hemiplegia (paralysis on one side) and hemiparesis partial paralysis) affecting right side, age related osteoporosis (bone loss) and weakness.	F 609	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to report all incidents and do timely follow up on any incident that results in injury. In this case R20 was noted to have voiced a concern over not feeling safe due to staff being rough with her. It was brought up at resident council and not reviewed until morning meeting. When staff did speak with resident she didn't state she felt afraid just didn't like the way that staff was with her. No incident report was filed, no	

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F 609

Continued From page 47

Record Review of R20's annual Minimum Data System (MDS) dated 3/9/18 under the heading "Section C-cognitive Pattern," R20 scored a 14 in a Brief Interview for Mental Status (BIMS) which indicated that R20 was cognitively intact. In the same MDS under the heading of "Section G Functional Status," specified R20 "required extensive assistance" with bed mobility, transfer, dressing, toilet use and personal hygiene.

Resident Council Meeting was conducted at the facility on 4/11/18 at 3pm with all residents invited to address any concerns without staff members being present as part of the survey process. At the start of meeting, the 3/29/18 resident council minutes were read to the residents to evaluate if the facility had addressed their expressed concerns. While reading the minutes, there was an incident involving a nursing assistant being "rough" and calling the resident "mean." R20 spoke up and identified herself as being that resident. R20 was asked if it had been resolved. R20 stated that she spoke to the social worker (SW) felt that it was addressed but she "doesn't feel safe all the time." At the end of the Resident Council Meeting, R20 was asked if she would be willing to stay and speak about the incident privately. R20 agreed.

During an interview on 4/11/8 at 3:30pm, R20 was asked to clarify the incident. R20 stated that nursing assistant (NA)4 was "too rough. She told me that I'm mean and then she ignores me." R20 added that NA4 spoke harshly to her when NA4 asks,"What do you want?" and NA4 spoke this way often. When R20 was asked if NA4 was still assigned to care for her, R20 replied that NA4 continued to care for her as recent as last night.

F 609

OHFC completed, and comment was not taken seriously. R22 and R258 were noted to have been involved in altercations upon review no notification given to ED regarding event or behavior. Nursing and SW were also educated on importance of reporting all vulnerable adult cases to the OHFC (office of health facility complaints) and ensuring ED has been notified of those events.
2.Because all residents are potentially affected by the cited deficiency and lack of follow through, on 4/4/2018, the director of nursing reviewed with all staff the importance of reporting suspected violations. A new resident protection manual was created to educate staff on components of the abuse program. The program further educates staff on when to report and what to report to ensure that this type of situation does not occur again. The program also has an incident report guide to assist staff to determine what is reportable and who to notify when. Further discussed was the proper procedure for incident and accidents and the notification process to ensure DON and SW are aware of any situation for immediate follow up and the ED if any abuse/neglect noted. Policy and procedure for reportable events was reviewed. No other residents were affected.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding requirements for reporting violations. Staff were also advised with every incident regardless of how small or if no injury the

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F 609	Continued From page 48 R20 was asked to describe what rough meant. R20 explained that "she [NA4] pulls my briefs off so roughly that it removed my bandages. That's unnecessary." R20 was asked when this occurred. R20 stated that this occurred about a week ago. R20 was asked if she reported this to anyone, and R20 replied that she told the Director of Nursing (DON). R20 was asked about the DON's response, R20 stated, "(The DON) didn't say much." When R20 was asked if she identified the name of the NA who was rough to the DON, R20 reported that she had. Record review of document with (name of facility) as the heading with the title "Fix It Ticket" revealed information R20 relayed to the facility regarding the incident of NA4 being rough. It was dated as being reported by R20 on 3/29/18 with an occurrence date of 3/28/18 in the evening. In the same document, below the caption, "Description of Correction," it revealed, "CNA (certified nursing assistant) was rough with resident and [sic] said 'you are mean!'" At the end of the document, it was signed by the Executive Director and the DON with the date of 4/2/18 for both signatures. During an interview on 4/11/18 at 4:23pm with the Activity Director (AD), the AD was asked about what was discussed during the Care Conference held on 4/10/18 which was approximately 12 days after R20 reported being treated roughly by a nursing assistant. The AD stated, "...pretty normal meeting. Nothing unusual." The AD was asked if the incident involving NA4 was mentioned. The AD stated, "Yes, she (R20) did say (name of the nursing assistant) is rough and told resident,[that] she is mean." On the same day, at 4:51pm, the AD was asked on how the "Fix It Ticket" was	F 609	DON needs to be informed immediately as well as doctor, family/POA and documented accordingly in point click care. Documentations must include follow up nurses notes, and appropriate notification made to POA, MD, DON, ED and OHFC is necessary via DON or SW. This was reviewed again on 5/9/2018. 4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the SW to monitor all incidents to ensure anyone with injury or suspected abuse is reported immediately to OHFC. All incidents, accidents and injuries will be logged to ensure follow up completed per resident protection manual and investigation log. The SW or designated quality-assurance representative will perform the following systematic changes: the DON in conjunction with SW will make report immediately (within 2 hours) if any abuse/neglect or injury was suspected – if allegation with no injury up to 24 hours. The ED will be notified. All incidents/accidents or suspected abuse/neglect situations will be reviewed at stand up daily. The DON or designee will complete 6 audits per week x 2 weeks then 4 audits weekly x 2 weeks then 2 audits per month for 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON, ED and SW will be responsible for	

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F 609	Continued From page 49 processed. The AD recalled writing it up on 3/29/18, after the resident council meeting when R20 told him that NA4 was treating her roughly. The AD then placed this document on 3/29/18 into the DON's box. The AD was asked if he knew the name of the NA when he wrote the report up. The AD stated that he did, and that he should have included it in his "Fix It Ticket" report. The AD was asked if he spoke to the DON immediately or soon after R20 reported that a nursing assistant was rough on 3/29/18. The AD replied, "I didn't sense it was that urgent, but I guess I was wrong." The AD was asked if the DON ever questioned him about the details of the incident or ask for the name of the NA, which he knew, who was described as rough by R20. The AD stated that the DON "never asked about it." During an interview on 4/11/18 at 3:50pm with the DON, the DON recalled the 3/29/18 incident involving R20. The DON stated that she retrieved the "Fix It Ticket" the next day from her box. DON could not recall the name of the NA (nursing assistant) who was rough with R20, but followed her statement by stating that she did speak to R20 on 3/30/18, but R20 would not "say the name" of the NA. DON did recall R20 telling her that the NA was rough when changing clothes. During an interview on 4/12/18 at 4:12pm with the Executive Director, DON and the SW, the Executive Director was told that R20 did not feel safe, and the information in "Fix It Ticket" dated 3/29/18 which included R20's statement,"CNA was rough with resident and said you are mean" was reviewed with them. The Executive Director stated that R20 never complained to him, and he was not aware of abuse or roughness. The Executive Director added if he had known there	F 609	this POC.	

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would have been disciplinary action. However, the 3/29/18 "Fix It Ticket" that had just been reviewed with them had his signature and was dated 4/2/18.

During an interview on 4/13/18 at 8:19am with the Executive Director and the Social Worker (SW)present, the Executive Director was asked if the allegation which occurred 14 days ago on 3/29/18 involving R20 being treated roughly by a NA was reported to the State. The ED stated,"No."

Review of the facility's Policies and Procedures for the "Vulnerable Adult" with a review date of 12/23/17 revealed, "The Director of Nursing or Administrator shall determine if the incident/allegation meets the criteria for "Reportable Incident" All incidents deemed reportable under MN (Minnesota) statue are submitted to MDH (Minnesota Department of Health) via the on-line Reporting System within the 2 hour period."

2. Review of R17's document titled "# [number] 150 Physical", dated 1/13/18 at 11:30am, stated "Pt [patient] was at nursing station talking to nurse. Pt [R22's initials] approached and was also talking to nurse and sitting in his walker. Did not say anything to this pt. This pt saw [R22's initials], yelled at him to get away and struck him in the chest with the back of a closed fist. Pt [R22's initials] was removed from the area, and this pt was redirected. Pt [R22's initials] did not appear to have sustained any injury at this time. This pt was very agitated and made no excuse fro (sic) his action."

Review of the initial report to the state agency

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titled "Nursing Home Incident Reporting-Investigation Report Summary 309606" submitted on 1/13/18 at 1:25pm, indicated that on 1/13/18 at 11:30am "Resident [R17's initials] was at nursing station talking to the nurse resident [R22's initials] approached and was also talking to the nurse while sitting on his walker. [R22's initials] did not say anything to [R17's initials]. [R17's initials] saw [R22's initials] and yelled at him and then struck him in the chest with the back of his closed fist."

Review of the results of the final investigation reported to the state agency titled "Nursing Home Incident Reporting-Investigation Report Summary 10156" submitted on 1/17/18 at 6:42am, under "Investigation Summary" stated "Resident [R17's initials] does not like resident [R22's initials]. He says that [R22's initials] is aggravating and is always making noise, etc. Resident [R22's initials] did not sustain any bruising or apparent injuries from the altercation."

There was no evidence that this incident was immediately reported to the administrator.

During an interview on 4/13/18 at 8:19am, the Executive Director could not provide evidence that the above incident involving R17 and R22 was immediately reported to the administrator.

3. Review of the initial report to the state agency titled "Nursing Home Incident Reporting-Investigation Report Summary 309535" submitted on 1/11/18 at 12:16pm, indicated that on 1/11/18 at 12:00pm "Resident [R3's initials] hit resident [R258's initials] on her head because he thought that she was trying to take his soda."

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F 609	Continued From page 52 Review of the results of the final investigation reported to the state agency titled "Nursing Home Incident Reporting-Investigation Report Summary 10093" submitted on 1/15/18 at 2:22pm, under "Investigation Summary" stated "Resident [R3's initials] has been extremely agitated and restless lately. MD [physician], resident's guardian. Amongst others have been contacted in regards to resident's current behavior and its effect on staff and other residents. Currently, SW [social work] is working to have other interventions put in place for [R3's initials]." There was no evidence that this incident was immediately reported to the administrator. During an interview on 4/13/18 at 8:19am, the Executive Director could not provide evidence that the above incident involving R3 and R258 was immediately reported to the administrator.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 610		5/21/18

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F 610	Continued From page 53 Survey 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 record review the facility failed to thoroughly investigate and protect a resident in an allegation of possible abuse for one (R20) resident and failed to thoroughly investigate allegations of resident-to-resident abuse affecting two residents (R22 and R258) of 17 residents reviewed for abuse in the sample of 37. Findings include: 1. Record Review of R20's Admission Record included but were not limited to the following diagnoses: cerebral infarction (stroke), hemiplegia (paralysis on one side) and hemiparesis partial paralysis) affecting right side, age related osteoporosis (bone loss) and weakness. Record Review of R20's annual Minimum Data System (MDS) dated 3/9/18 under the heading "Section C-cognitive Pattern," R20 scored a 14 in a Brief Interview for Mental Status (BIMS) which indicated that R20 was cognitively intact. In the same MDS under the heading of "Section G Functional Status," specified R20 "required extensive assistance" with bed mobility, transfer, dressing, toilet use and personal hygiene. Resident Council Meeting was conducted at the facility on 4/11/18 at 3pm with all residents invited to address any concerns without staff members being present as part of the survey process. At the start of meeting, the 3/29/18 resident council minutes were read to the residents to evaluate if	F 610	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to investigate, prevent and correct alleged violations of residents. In this case in this case R20 stated she felt afraid and concerned about care with a staff member. No incident reporting done, nor interventions taken or reported as required. R22 and R258 had altercations with physical behaviors, no incident completed, no update given to ED. In this case, after the surveyor reported the faulty system, the policy and procedure on abuse/neglect and reporting had been reviewed and updated. All staff were in-serviced, and information put at nursing station in case staff need clarification while survey was still in process. Nursing, ED and social services coordinator were also educated on importance of investigating all incident and reporting all vulnerable adult cases to the OHFC (office of health facility complaints). 2.Because all residents are potentially affected by the cited deficiency and lack of follow through, after the state survey, ED	

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the facility had addressed their expressed concerns. While reading the minutes, there was an incident involving a nursing assistant being "rough" and calling the resident "mean." R20 spoke up and identified herself as being that resident. R20 was asked if it had been resolved. R20 stated that she spoke to the social worker (SW) and felt it was addressed but she "doesn't feel safe all the time." At the end of the Resident Council Meeting, R20 was asked if she would be willing to stay and speak about the incident privately. R20 agreed.

During an interview on 4/11/8 at 3:30pm, R20 was asked to clarify the incident. R20 stated that nursing assistant (NA)4 was "too rough. She told me that I'm mean and then she ignores me." R20 added that NA4 spoke harshly to her when she asks "What do you want?" and spoke this way often. When R20 was asked if NA4 was still assigned to care for her, R20 replied that NA4 continued to care for her as recent as last night. R20 was asked to describe what rough meant. R20 explained that "she [NA4] pulls my briefs off so roughly that it removed my bandages. That's unnecessary." R20 was asked when this occurred. R20 stated that this occurred about a week ago. R20 was asked if she reported this to anyone, and R20 replied that she told the Director of Nursing (DON). R20 was asked about the DON's response, R20 stated, "(The DON) didn't say much." When R20 was asked if she identified the name of NA who was rough to the DON, R20 reported that she had.

Record review of a document with (name of facility) as the heading with the title "Fix It Ticket" revealed information R20 relayed to the facility regarding the incident of NA4 being rough. It was

F 610

and director of nursing reviewed with all staff the importance of investigating and reporting suspected violations. A new resident protection manual was created to educate staff on components of the abuse program. The program further educates staff on what should be investigated, what is abuse/neglect and determining root cause of incident, when to report and what to report to ensure that this type of situation does not occur again. The program also has an incident report guide to assist staff to determine what is reportable and who to notify when. Further discussed was the proper procedure for incident and accidents and the notification process to ensure DON and ED are aware of any situation for immediate follow up. OHFC notified as required. Policy and procedure for abuse/neglect was reviewed. No other residents were affected.

3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all staff will receive a review in in-service training regarding requirements for investigating, preventing and correctly handling all incidents and accidents. Staff will also be advised with every incident regardless of how small or if no injury the DON needs to be informed immediately as well as doctor, family/POA and documented accordingly in point click care. Documentations must include follow up nurse’s notes, and appropriate notification made to POA, MD, DON, ED and OHFC is necessary via DON or SW.

4.Effective 4/28/2018, a quality-assurance

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dated as being reported by R20 on 3/29/18 with an occurrence date of 3/28/18 in the evening. In the same document, below the caption, "Description of Correction," it revealed, "CNA (certified nursing assistant) was rough with resident and [sic] said 'you are mean!'" At the end of the document, it was signed by the Executive Director and the DON with the date of 4/2/18 for both signatures. Other Fix It Tickets were reviewed and these same tickets addressed other concerns such as hallways being too cluttered and laundry items missing.

During an interview on 4/11/18 at 4:23pm with the Activity Director (AD), the AD was asked about what was discussed during the Care Conference which was approximately 12 days after R20 reported being treated roughly by a nursing assistant. The AD stated, "...pretty normal meeting. Nothing unusual." The AD was asked if an incident of roughness was mentioned. The AD stated, "Yes, she (R20) did say (name of the nursing assistant) is rough and told resident, {that} she is mean." On that same day at 4:51pm the ED was asked how the "Fix It Ticket" was processed. The AD was asked on how the "Fix It Ticket" was processed. The AD recalled writing it up and placing it into the DON's box on 3/29/18. The AD was asked if he knew the name of the NA when he wrote the report up. The AD stated that he did, and that he should have included it in his "Fix It Ticket" report. The AD was asked if he spoke to the DON immediately or soon after R20 reported that a nursing assistant was rough on 3/29/18. The AD replied, I didn't sense it was that urgent, but I guess I'm was wrong." The AD was asked if the DON ever questioned him about the details of the incident or ask for the name of the NA, which he knew, who was described as rough

program was implemented under the supervision of the DON and ED to monitor all incidents to ensure anyone with injury or suspected abuse is reported immediately to OHFC. All incidents, accidents and injuries will be logged to ensure follow up completed per resident protection manual and investigation log. The DON or designated quality-assurance representative will perform the following systematic changes: the DON in conjunction with SW will make report immediately if any abuse/neglect or injury was suspected. All incidents/accidents or suspected abuse/neglect situations will be reviewed at stand up daily. The DON or designee will complete 3 audits per week x 2 weeks then 1 audits weekly x 2 weeks then 2 audits per month for 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.DON, ED and SW will be responsible for this POC.

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by R20. The AD stated that the DON "never asked about it."

During an interview on 4/11/18 at 3:50pm with the DON, the DON recalled the 3/29/18 incident involving R20. The DON could not recall the name of the NA (nursing assistant) who was rough with R20, but followed her statement by stating that she did speak to R20 on 3/30/18, but R20 would not "say the name" of the NA. The DON recalled R20 telling her that the NA was rough when changing clothes. The DON was then asked if she had any documentation regarding this incident. The DON replied, "I wrote notes, but don't know where they are..." The DON was questioned if she asked R20 if she felt safe, the DON replied that she hadn't. Because R20 was not asked if she felt safe and the name of the nursing assistant was not obtained, the steps necessary to protect R20 from NA4 were not immediately initiated by the facility. The DON could not recall speaking to the Activity Director regarding the incident involving R20.

During an interview on 4/11/18 at 4pm with the Social Worker (SW), the SW stated that there was a Care Conference with R20 which was conducted on 4/10/18 at 11:30am with the DON, the SW and the Activity Director (AD) being present. The SW recalled that (name of the nursing assistant) was "mean." The SW added, "Don't recall what was said, but there was a discussion."

During an interview on 4/12/18 at 4:12pm with the Executive Director, DON and the SW, the Executive Director was told that R20 did not feel safe, and the information in "Fix It Ticket" dated 3/29/18 which included R20's statement, "CNA

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was rough with resident and said you are mean." was reviewed with them. The Executive Director stated the R20 never complained to him, and he was not aware of abuse or roughness.The Executive Director added if he had known there would have been disciplinary action. However, The "Fix It Ticket" with R20's allegation that had just been discussed with him, was signed and dated 3/29/18 by the Executive Director.

During an interview on 4/11/18 approximately at 7pm which was 13 days after R20 reported being treated roughly by NA4, the Executive Director stated that NA4, who was scheduled to work that day, would be assigned to another wing (separate wing from R20's room) with nursing supervision, and NA4 would not be assigned to care for R20. The Executive Director added that other residents were interviewed to address the quality of care nursing assistants were providing. This occurred after surveyor intervention.

Review of the facility's Policies and Procedures for the "Vulnerable Adult" with a review date of 12/23/17 revealed, "2. Upon report to a Supervisor of the suspected abuse, the employee in question may be interviewed, re-assigned duties or suspended pending investigation. This is for the protection of the resident. 3.The Supervisor, Director of Nursing or Administrator will immediately institute an internal Investigation of the reported allegation or incident. The investigation may include: a. Interviews of staff b.Resident interviews c.Witness interviews d. Environmental review e.Resident health status f. Behavior review..."

2. Review of R17's document titled "# [number] 150 Physical", dated 1/13/18 at 11:30am, stated

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"Pt [patient] was at nursing station talking to nurse. Pt [R22's initials] approached and was also talking to nurse and sitting in his walker. Did not say anything to this pt. This pt saw [R22's initials], yelled at him to get away and struck him in the chest with the back of a closed fist. Pt [R22's initials] was removed from the area, and this pt was redirected. Pt [R22's initials] did not appear to have sustained any injury at this time. This pt was very agitated and made no excuse fro (sic) his action."

Review of the initial report to the state agency titled "Nursing Home Incident Reporting-Investigation Report Summary 309606" submitted on 1/13/18 at 1:25pm, indicated that on 1/13/18 at 11:30am "Resident [R17's initials] was at nursing station talking to the nurse resident [R22's initials] approached and was also talking to the nurse while sitting on his walker. [R22's initials] did not say anything to [R17's initials]. [R17's initials] saw [R22's initials] and yelled at him and then struck him in the chest with the back of his closed fist."

Review of the results of the final investigation reported to the state agency titled "Nursing Home Incident Reporting-Investigation Report Summary 10156" submitted on 1/17/18 at 6:42am, under "Investigation Summary" stated "Resident [R17's initials] does not like resident [R22's initials]. He says that [R22's initials] is aggravating and is always making noise, etc. Resident [R22's initials] did not sustain any bruising or apparent injuries from the altercation." The report failed to provide evidence that a thorough investigation was conducted.

During an interview on 4/13/18 at 8:19am, the

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Executive Director could not provide evidence that the above incident involving R17 and R22 was thoroughly investigation was conducted.

3. Review of the initial report to the state agency titled "Nursing Home Incident Reporting-Investigation Report Summary 309535" submitted on 1/11/18 at 12:16pm, indicated that on 1/11/18 at 12:00pm "Resident [R3's initials] hit resident [R258's initials] on her head because he thought that she was trying to take his soda."

Review of the results of the final investigation reported to the state agency titled "Nursing Home Incident Reporting-Investigation Report Summary 10093" submitted on 1/15/18 at 2:22pm, under "Investigation Summary" stated "Resident [R3's initials] has been extremely agitated and restless lately. MD [physician], resident's guardian. Amongst others have been contacted in regards to resident's current behavior and its effect on staff and other residents. Currently, SW [social work] is working to have other interventions put in place for [R3's initials]." The report failed to provide evidence that a thorough investigation was conducted.

During an interview on 4/13/18 at 8:19am, the Executive Director could not provide evidence that the above incident involving R3 and R258 was thoroughly investigated.

F 623 SS=B — Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) — F 623 — 5/21/18

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's

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F 623	Continued From page 60 representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section	F 623		

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must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

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F 623	Continued From page 62 §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that written notifications required for transfers were given to the residents, resident representatives, or the ombudsman for two (R35 and R55) of eight residents reviewed for hospitalization in the sample of 37. Findings include: 1.A. Review of R35's progress notes revealed under "Nursing Note" dated 2/20/18, "This nurse called and spoke with pt's [patient's] sister, [name R35's sister], regarding getting sent to [name of the hospital]..." Review of R35's medical record revealed no documentation that the resident's representative or that the Office of the State Long-Term Care (LTC) Ombudsman had been notified of R35's transfer in writing. B. Review of R35's progress notes revealed under "Nursing Note" dated 3/9/18, "...resident is reported [and] observed to have a hole in his G/J [gastric/jejunum] tube...on-call NP [nurse practitioner], [name of NP] is called [and] updated	F 623	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility report all transfers and discharges to the ombudsmen. R35 and R55 were all sent to the hospital and notification was not made regarding their transfer to the ombudsman office as stipulated should be by regulations. When the surveyor noted these residents to have no documentation supporting notification it was noted that this practice had not yet been implemented within facility. Immediately policy and procedure on transfers/discharges was updated, staff were educated, reminders sent to nursing stations with policy and requirements. 2.Because all residents that reside in the facility do either discharge or have visits to	

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F 623	Continued From page 63 on his present status. Order is given to have him sent to the ER [emergency room]...Ambulance arrives [at 2:42pm] and departs at [2:55pm]..." Further review of R35's progress notes revealed that there was no documentation that a written notice required for transfer was provided to the resident's representative or the Office of the State LTC Ombudsman. C. Review of R35's progress notes revealed under "SBAR [situation, background, assessment, recommendation] - Change of Condition" dated 3/15/18, "...Resident complains of pain/discomfort in the general area of his throat and upper chest ...On-call [provider] updated and order is given to have resident taken to the ER [emergency room] for further evaluation..." Review of R35's medical record revealed no documentation that a written notice before transfer was provided to the resident's representative or the Office of the State LTC Ombudsman. D. Review of R35's progress notes revealed under "Nursing Note" dated 3/21/18, "Staff having issues with g-tube lumen is broken and leaks and is clogged. Unable to successfully unclog after several interventions...Contacted on call MD [medical doctor] for order to send to ER to have the tube replaced. Order to send resident to ER to have g tube replaced per [name of doctor]...ED [emergency department] stated they will not replace gtube [sic] tonight. Resident will be NPO [nothing by mouth] until he is seen in the morning by the appropriate personnel...Sister was also notified."	F 623	ER, all are potentially affected by the cited deficiency. Immediately all residents being transferred or discharged were reviewed and update was noted to ombudsman. When staff note any resident leaving they are aware of notification needed and in turn make appropriate note in resident chart. Current residents were audited by director of nursing to ensure all had appropriate notification in place. No other residents were affected. The Policy and Procedure for transfers/discharges was revised on 3/29/2018; reviewed on 4/17/2018 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff will attend in-service training regarding this policy and the importance of notifying ombudsman. The training will emphasize this is to be done as soon as possible for transfers and up to 30 days prior for discharges and documentation of notification is critical. 4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the SW in conjunction with DON to monitor any transfers and discharges to ensure appropriate notification given. The SW or designee will complete 2 audits per week x 4 weeks on residents that have transferred or discharged, then 1 audit weekly for 4 weeks ensure staff comply with current policy. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for	

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F 623	Continued From page 64 Further review of R35's medical record revealed no documentation that the resident's representative nor the Office of the State LTC Ombudsman was notified of R35's transfer in writing. In an interview with the Social Worker (SW) on 4/11/18 at 3:15pm, the SW stated, "I inform the ombudsman as it [transfer] happens. I don't have a record of them [R35's sister and the ombudsman] receiving the notice." 2. Review of R55's nurse's notes dated 4/9/2018 at 2:58am revealed, "Resident was sent to the ER [emergency room] due to his feeding tube being pulled out. Writer went in to change resident feeding, notice resident feeding tube was pulled out. Resident was unsure to what happen. Resident VS [vital signs] are WNLs [within normal limits], Dr.[name of physician] on call was informed. Got an order from Dr.[name of physician] to send resident to the ER. DON [Director of Nursing] was notify [sic], resident daughter was called and informed family will be going to meet resident at the hospital." Review of R55's medical record revealed no documentation that the Office of the State LTC Ombudsman was notified of R55's transfer in writing. During an interview on 4/11/18 at 2:58pm, the SW stated that the Office of the State LTC Ombudsman was not notified because R55 was not admitted to the hospital and returned to the facility in less than 24 hours. The SW stated that the Ombudsman will be notified only if R55 was admitted to the hospital.	F 623	further review or corrective action. 5.SW will be responsible for this POC.	

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F 623	Continued From page 65 Review of the facility's "Transfer or Discharge, Emergency" policy with the last revision on 3/28/18 revealed, "...Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures:...e. Notify the representative (sponsor) or other family member...All notices of discharges and transfers need to be sent written transfer or discharge notification to office of ombudsmen."	F 623		
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the	F 625		5/21/18

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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 625	Continued From page 66 resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that notifications of bed hold policy required for residents that transfer to another facility were provided for two (R35 and R44) of eight residents reviewed for hospitalization in the sample of 37. Findings include: 1.A. Review of R35's progress notes revealed under "Nursing Note" dated 2/20/18, "This nurse called and spoke with pt's [patient's] sister, [name R35's sister], regarding getting sent to [name of the hospital]..." Review of R35's medical record revealed no documentation that the resident or resident's representative had been notified of the facility's bed hold policy in writing. B. Review of R35's progress notes revealed under "Nursing Note" dated 3/9/18, "...resident is reported [and] observed to have a hole in his G/J [gastric/jejunum] tube...on-call NP [nurse practitioner], [name of NP] is called [and] updated on his present status. Order is given to have him sent to the ER [emergency room]...Ambulance arrives [at 2:42pm] and departs at [2:55pm]..." Further review of R35's progress notes revealed no documentation that a written notice that specified the facility's bed-hold policy permitting the resident to return and resume residence in the facility was provided to the resident or to the	F 625	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to ensure bed hold consent obtained from POA and copy given to hospital receiving resident and that POA also receives copy. R35 and R44 were sent to the hospital and no indication bed hold policy was sent to hospital or POA per regulation. When the surveyor reported lack of documentation that this occurred, it was noted that this practice had not yet been reviewed and implemented appropriately within facility. Immediately policy and procedure on bed holds was updated, staff were educated, reminders sent to nursing stations with policy and requirements. 2.Because all residents that reside in the facility make visits to hospitals on occasion or go on therapeutic leaves, all are potentially affected by the cited deficiency. Immediately all residents being transferred or on leave were reviewed and updated bed hold policy given out. When staff note any resident leaving they are aware to get POA consent for bed hold, send bed hold with resident to hospital or	

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resident's representative.

C. Review of R35's progress notes revealed under "SBAR [situation, background, assessment, recommendation] - Change of Condition" dated 3/15/18, "...Resident complains of pain/discomfort in the general area of his throat and upper chest...On-call [provider] updated and order is given to have resident taken to the ER [emergency room] for further evaluation..."

R35's medical record failed to include documentation that a second notice of bed-hold policy was provided to the resident or the resident's representative at the time of the emergency transfer.

D. Review of R35's progress notes revealed under "Nursing Note" dated 3/21/18, ""Staff having issues with g-tube lumen is broken and leaks and is clogged. Unable to successfully unclog after several interventions...Contacted on call MD [medical doctor] for order to send to ER to have the tube replaced. Order to send resident to ER to have g tube replaced per [name of doctor]...ED [emergency department] stated they will not replace gtube [sic] tonight. Resident will be NPO [nothing by mouth] until he is seen in the morning by the appropriate personnel...Sister was also notified."

Further review of R35's medical record revealed no documentation that the resident or resident's representative was notified of the bed-hold policy in writing.

In an interview with the Social Worker (SW) on 4/11/18 at 3:15pm, the SW stated, "If the resident was not admitted, we don't send a bed-hold

with resident taking leave and get copy to POA with note in resident chart. Current residents were audited by director of nursing to ensure all had appropriate notification in place. No other residents were affected. The Policy and Procedure for bed holds was reviewed on 4/17/2018
3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all staff will attend in-service training regarding this policy and the importance of bed holds. The training will emphasize this must be done with all residents being sent out of facility going out on leave or transferring to hospital.
4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the SW in conjunction with DON to monitor any transfers to ensure appropriate notification given. The SW or designee will complete 2 audits per week x 4 weeks on residents that have transferred or left, then 1 audit weekly for 4 weeks ensure staff comply with current policy. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.SW will be responsible for this POC.

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notice. If the resident came back within 24 hours, we don't issue the bed-hold notice." The SW further stated, "For [R35], I would normally call the sister. It's either we get a verbal consent for bed-hold from the responsible party or we fax the notice to the hospital [hospital discharge planner] for the resident to sign." The SW also stated, "The nurses are supposed to give the bed-hold notice upon transfer but if they did not do it then I do. I don't have a record of them [R35 or R35's sister] receiving the notice."

In an interview with the Director of Nursing (DON) on 4/12/18 at 6:48pm, the DON stated, "[There was] no documentation in the progress notes that the nurses provided the bed-hold notice." The DON further stated, "They [nurses] are supposed to document if they provided it to the resident, sent it with or faxed it to the hospital and asked the sister to come in so at least the sister could get him to sign it."

2. Review of R44's nurse's notes dated 4/7/18 at 7:29am revealed, "Situation: Resident has SOB [shortness of breath], lowO2 [oxygen] sats [saturation] and wheezing, increased RR [respiratory rate], febrile and rhonchi [continuous low pitched, rattling lung sounds] to bilateral lungs (upper and lower)...Resident c/o [complained of] cough yesterday but O2 sats, RR and temp [temperature] WNL [within normal limits] This started : this morning at 0630 [6:30am] Background: Has had a mild cough off and on for approximately 2 weeks...Assessment or Appearance...possible URI [upper respiratory infection] with presence of temperature of 100.6 at 0800 [8am]. Recommendations: Possible abx [antibiotic] and/or to send to ED [emergency

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F 625	Continued From page 69 department] for evaluation. Review of R44's nurse's notes dated 4/7/18 at 1:43pm revealed, "Resident was admitted to med/surg [medical/surgical] status room #445, with acute respiratory failure and fluid overload and hypervolemia [a decreased volume of circulating blood in the body]." Review of R44 clinical record revealed no evidence that R44 or resident's representative had been notified in writing of the facility's bed hold policy. During an interview on 4/11/18 2:58pm with the SW, the SW stated that she could not find the bed hold notice for R44 in the medical record. Review of the facility's "Transfer or Discharge, Emergency" policy with the last revision on 3/28/18 revealed, "...Should it become necessary to make an emergency transfer or discharge to a hospital or other related institution, our facility will implement the following procedures:...e. Notify the representative (sponsor) or other family member; ask if they would like bed held for any temporary transfers. This can be documented in a progress note that they would like bed held... " Review of the facility's undated "Minnesota Notice of Bed-Hold Policy" revealed, "The notice of Bed-Hold Policy is provided to the resident/financially responsible party upon admission and at the time of leave..."	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		5/21/18

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F 641	Continued From page 70 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to accurately code the Minimum Data Set (MDS) related to dental status for one (R9) resident reviewed for dental in the sample of 37. Findings include: An observation on 4/10/2018 at 10:54am revealed R9 was missing some teeth. Review of the undated "Admission Record," revealed R9 had an admission date of 4/08/2016 with medical diagnoses that included anemia, pain, abnormal weight loss, and nausea. In an interview on 04/11/2018 at 10:08am, the Social Services Worker (SSW) stated she did does not coordinate dental and stated the Unit Coordinator handled dental appointments. In an interview on 04/11/2018 at 10:15am, the Unit Coordinator stated R9 had been seen by the dental company and would look for documentation. The only documentation that the Unit Coordinator could provide was dated January 2017, which indicated that R9 had dental caries and broken teeth. A review of the MDS assessments revealed a "Significant Change in Status Assessment" dated 3/01/2017, Section L "D. Oral / Dental Status" was checked for "Obvious or likely cavity or broken natural teeth." Review of the Annual MDS assessment dated 01/17/2018, indicated that	F 641	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide accurate assessments on all residents. R9 MDS did not properly indicate dental issues. In this case, after the survey indicated the incorrect information immediately the documentation was reviewed on these residents. R9 was noted to have poor oral hygiene and multiple broken teeth and care plan has been updated. 2.Because all residents receive their level of care based on their assessments all are potentially affected by the cited deficiency, on 4/18/2018, the MDS nurse reviewed how information is gathered and importance of doing hands on review with residents to ensure accurate information. In addition, nursing staff were educated on importance of documenting appropriately on residents and reviewing care sheets to ensure staff providing correct cares. All current resident MDS's were reviewed for accuracy and resubmitted when necessary or if determined to need significant change. Through this process 3 discrepancies	

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F 641	Continued From page 71 Section L was checked for "Z. None of the above were present." In an interview on 04/12/18 at 2:40pm, after reviewing the MDS dated 1/17/2018 Section L's, the MDS Coordinator stated, "I coded the MDS in error...it's obvious he has decay and broken teeth. The MDS was coded wrong."	F 641	were noted and addressed immediately to ensure proper documentation; MDS corrected. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9//2018 all nursing staff were in-serviced training requirements for assessments and MDS/care plans. MDS nurse was educated on importance of seeing residents they assess and ensure accuracy. All residents will be reviewed quarterly and annually, and staff interviews will be critical piece in gathering data. All triggers will be care planned and communicated to staff via care sheets and communication book if new interventions in place. 4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic changes: after corrections determined, audit of all MDS's for accuracy will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		5/21/18

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F 655	Continued From page 73 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to develop baseline care plans within 48 hours of a resident's admission that included goals and interventions that address resident's current needs and failed to provide the resident/resident representative with a summary of the baseline care plan for four residents (R31, R107, R35 and R55) in the sample of 37. Findings include: 1. Review of R31's admission Minimal Data Set (MDS) dated 2/9/18 indicated R31 was admitted to the facility on 2/2/18. Review of R31's "Baseline Care Plan", dated 2/2/18, revealed that it lacked the necessary interventions related to the listed goals and problem areas for R31. Review of R31's medical record revealed a base care plan dated 2/2/18. There was no evidence that a copy of the baseline care plan itself or the summary was given to the resident. During an interview on 4/11/18 at 12:06pm, the Regional Director of Clinical Services (RDCS) confirmed that R31's baseline care plan lacked interventions and that there was no documentation that a copy or summary of the baseline care plan was provided to R31.	F 655	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide base line plans. R31, R107, R35, and R55 did not have adequate base line care plans. R31 had no baseline care plan, R107 had not been completed, R35 had not been reviewed with patient or family and R55 had no interventions in place for care plan. The survey noted the base line care plan is not thorough enough for gathering the data needed to formulate care plan for resident. The base line care plan has been revised and initiated 5/4/2018. 2.Because all residents have changing levels of care upon admission all are potentially affected by the cited deficiency, on 4/17/2018, the MDS nurse reviewed process of ensuring accurate MDS's to formulate baseline care plans. All other resident care plans have been reviewed and updated for accuracy, MDS nurse has been educated on necessity of implementing base line care plans and	

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F 655	Continued From page 74 2. A review of the undated "Admission Record" [a cover sheet to a multipage document that contains demographic information, preferences, contact information, and limited medical information] indicated that R107 was admitted to the facility on 04/03/2018. Observation of R107 on 04/09/2018 at 2:22pm revealed an above knee amputation. During the observation R107 complained of pain to Licensed Practical Nurse (LPN)1. Review of R107's paper chart revealed a document titled, "hospital H & P (history and physical)," signed by the hospital physician on 03/13/2018 with a handwritten note that R107 had a "L (left) gluteal 5 x2.8 cm (centimeter) decub (decubitus - a pressure wound) unstageable." The typed portion of the H & P indicated that R107 had been hospitalized from 02/11/2018 to 03/12/2018 with a complicated UTI (urinary tract infection) with MSSA (methicillin-susceptible Staphylococcus aureus) with MSSA sepsis (the body's overwhelming and life-threatening response to infection that can lead to tissue damage, organ failure, and death). Review of the document titled, "discharge physician orders" revealed R107 had bilateral nephrostomy tubes (Percutaneous nephrostomy (PCN) tube is a catheter (plastic tube) that is inserted through your skin into your kidney. The tube is placed to drain urine from your body into a collecting bag outside your body.) Review of R107's paper chart under the "Care Plan" divider revealed the section was empty. In an interview on 04/10/2018 at 12:05pm, LPN1 stated if there was a care plan, it would be in the electronic health record (EHR.)	F 655	importance of discussing with resident or POA. The policy on care plans has been reviewed and updated. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff received in-service training regarding base line care plans. The training emphasized the importance of monitoring ADL's, and treatment information on care sheet follows the actual care performed. MDS nurse to visualize residents and ask staff through interview to confirm data. The education included development of care plan after assessment of resident individual needs. 4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic audits of assessments formulating base line care plan based on individual resident needs. They will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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A review of R107's EHR document titled, "Medication Administration Record" indicated the resident was receiving enoxaparin (an anticoagulant) 40mg (milligrams)/0.4ml (milliliters) daily, insulin daily, nafcillin (an antibiotic) 2 grams intravenously every four hours through 04/05/2018, oxycodone 7.5mg every 4 hours as needed for pain, wound care to a coccyx wound, and nephrostomy tube care each shift.

Review of R107's "Care Plan" tab in the EHR for R107 revealed two pages initiated on 04/05/2018. One had a focus of "The resident is likely a short stay for strength and antibiotics. He is alert x4 and can make his own choices. He is not too interested in group activities but enjoys visiting. He also stays in close touch with his sister." and the other a focus of "The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) [blank]." No goal was listed for the second focus, and two interventions were listed:
"I am assist x1 for dressing (encourage pt [patient] to don prosthesis). I independent [sic] in room for stand-pivot transfers and toileting. W/c (wheelchair) level in hallways."

In an interview on 04/11/2018 at 10:25am, the MDS (Minimum Data Set) Coordinator stated the process for baseline care plans was that she starts them, then takes that with the admit paperwork and MAR to stand up (meeting), then gives it to the social worker and activities to do their thing. Then, it comes back to her, and she writes it up for a summary. When asked about R107's baseline care plan, she said it was right there. The MDS Coordinator looked thru three stapled sets of paper from her file stacker and

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stated "Oh, I don't have it so it must not have been brought back to me yet." When questioned that R107 was admitted on April 3rd and if he had a baseline Care Plan, the MDS Coordinator stated, "no, it's not back to me yet."

In an interview on 04/11/2018 at 12:04pm, the Regional Director of Clinical Services (RDCS) responded to a question regarding what was the process for baseline care plans. The RDCS stated, "Called temporary care plan, we actually just came up with a form through a pathway on the AANAC (American Association of Nurse Assessment Coordination) site. There is no process or policy for a baseline care plan. The process changed around the first (of the month)." The RDCS stated it was an expectation that nursing staff would complete the baseline care plan and that the AANAC form was more of a follow up to admission orders. The RDCS stated that there were no interventions to the AANAC baseline care plan form.

In an interview on 04/11/2018 at 2:30pm, the MDS Coordinator entered the conference room holding up an AANAC form and stated that she had R107's care plan. When asked if that was the baseline care plan, she stated that it would be considered the baseline care plan and it was completed on 4/11/2018.

3. Review of R35's Admission Record indicated R35 was admitted to the facility on 2/15/18.

In an interview on 4/9/18 at approximately 5pm with R35 revealed that R35 was oriented to person and place. R35 was interviewable but communicated by writing notes due to the presence of tracheostomy (a surgically made hole

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MOORHEAD REHABILITATION & HEALTHCARE CENTER	**2810 SECOND AVENUE NORTH MOORHEAD, MN 56560**

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that goes through the front of the neck into the trachea, or windpipe which makes the person unable to talk).

Review of R35's medical record revealed a base care plan dated 2/15/18. Review of R35's baseline care plan did not include instructions and necessary information to properly care for R35. Also, there was no evidence that a copy of the baseline care plan itself or the summary was given to the resident or resident representative.

During an interview on 4/12/18 at 6:35pm, the Director of Nursing (DON) stated, "There are things that we need to add [to the baseline care plan]. It is missing a lot of information." When the DON was asked if there was any documentation that a copy or summary was provided to the resident or responsible party, she stated, "I didn't see anything [documentation in the progress notes] within 48 hours." The DON further stated, "[The nurses were] supposed to talk to the resident or go over the baseline care plan with the resident, provide a copy and document that she actually did this with the resident."

4. Review of R55's Admission Record revealed R55 was admitted to the facility on 3/13/18 with diagnoses that included but not limited to: acute respiratory failure, type 2 diabetes mellitus, chronic obstructive pulmonary disease, constipation and subdural hemorrhage.

Review of R55's baseline care plans with admission date of 3/13/18 revealed a check mark for his cognition, communication, vision, hearing, dietary orders, dietary risks, dietary goal, therapy services, functional goals, Activities of Daily Living (ADL), equipment, bowel and bladder and

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F 655	Continued From page 78 skin concerns. Further review of R55's baseline care plan revealed no interim goals approaches and interventions to address R55's needs. During an interview on 4/11/18 at 12:08pm, the Regional Director of Clinical Services (RDCS), read R55's baseline care plan and stated, "The current baseline care plan that they are using is built up with the assessment. This is more of admission follow up to admission orders." The RDCS stated, "I expect to see in the baseline care plans have written approaches and interventions. When asked if R55's care plan had interventions to meet R55's needs, the RDCS stated there was none.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		5/21/18

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F 656	Continued From page 79 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive care plan related to risk for aspiration for one (R55) of one resident reviewed for tube feeding; and, to address care problems related to tracheostomy (a surgically created hole (stoma) in your windpipe (trachea) that provides an alternative airway for breathing) for one (R35) of one resident reviewed for respiratory care in the sample of 37. Findings include: 1. Review of R55's Admission Record revealed R55 was admitted to the facility on 3/13/18 with diagnoses that included but not limited to: acute respiratory failure, type 2 diabetes mellitus,	F 656	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide consistent quality care to ensure residents have comprehensive care plans. R55 is at risk for aspiration and needs to be assessed for potential signs and symptoms of aspiration. Care plan did not address any risks or how to monitor for aspiration in tube feeding patient which	

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chronic obstructive pulmonary disease, constipation and subdural hemorrhage.

Review of R55's Admission Assessment Minimum Data Set (MDS) dated 3/20/18 revealed R55's Brief Interview for Mental Status (BIMS) score was five that indicated R55 had severe cognitive impairments. Review of the same MDS revealed R55 required extensive assistance with transfer, bed mobility and toilet use.

Review of R55's Care Area Assessment (CAA) for Feeding Tube dated 3/26/18 revealed, "Describe impact of this problem/need on the resident and your rationale for care plan decision." The answer was "At risk for malnutrition, dehydration and aspiration."

Review of R55's Speech Therapist's (ST) evaluation plan and treatment dated 3/19/18 revealed diagnosis of dysphagia (difficulty in swallowing). Review of the same ST notes for R55 revealed, "Risk Factors: Pt [patient] at risk for aspiration with documented dysphagia."

Review of R55's physician's order dated 3/20/18 revealed an order for Osmolite (tube feeding formula) 1.2 liters (L) at 80 milliliter (ml)/hour via Percutaneous Endoscopic Gastrostomy (PEG - a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus) tube.

Review of R55's care plan dated 4/2/18 indicated, "Dependent on tube feeding/inadequate food and beverage intake due to: acute respiratory failure." R55's care plan goal revealed, "Maintain

F 656 (Plan of Correction)

should be done every shift. R35 has tracheostomy. The care plan had not instructions or information related to trach care or maintenance. In this case, after the survey determined R55 needed care plan updated, monitoring for risk of aspiration was added. R35 care plan was updated to include trach care and monitoring.

2.Because all residents care is directed by the care plan all are potentially affected by the cited deficiency, on 4/17/2018, the MDS nurse reviewed process of ensuring accurate MDS's to formulate comprehensive care plans. All other resident care plans have been reviewed and updated for accuracy, residents with trach's and tube feeding's have been updated, MDS nurse has reviewed RAI information on care planning and importance of also including areas outside of care area triggers for monitoring residents with other diagnoses or treatments that directly impact their overall wellbeing. The policy on MDS and CAA has been reviewed.

3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff received in-service training regarding monitoring for patients with trach's and tube feedings. The training emphasized the importance of monitoring care plans and ensuring staff know when a specific diagnosis is presented, certain cares are standard for maintaining optimum level of health based on nursing education such as monitoring trach care including but not limited to; monitoring trach sites for

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F 656	Continued From page 81 nutritional status and body weight." R55's care plan interventions included: Enteral formula and feedings as ordered; monitor intake and output; monitor lab data as available; monthly weights; nothing by mouth; screen/evaluation by rehab service as needed and water flushes as ordered. During an interview on 4/12/18 at 2:09pm with the Speech Therapist (ST), the ST stated that R55 who had a swallowing disorder and a feeding tube puts him at risk for aspiration. The ST further stated that the staff should provide direct supervision when feeding R55. When asked what interventions should be put in place to monitor R55's risk for aspiration, the ST stated, "Listen to [R55's] lung sounds every shift or at least daily to check for developing signs of pneumonia; check [R55's] vital signs more often." When asked if a care plan for R55 had been developed after the ST had evaluated R55 for care and treatment, the ST stated, "I haven't had a care plan made for him." During an interview on 4/12/18 at 10:02am, the MDS Coordinator reviewed R55's CAA on Feeding Tube and stated that the Interdisciplinary team decided to develop a care plan for R55 because R55 was at risk for aspiration, dehydration and malnutrition. When asked if R55's current care plan dated 4/2/18 was comprehensive, addressed R55's risk for aspiration and if interventions were in place to prevent risk for aspirations, the MDS Coordinator stated, "There is nothing in the care plan. I don't know why it is not there." 2. R35 was admitted to the facility on 2/15/18 with diagnoses which included the following: squamous cell carcinoma of skin of scalp and	F 656	infection, changing trach ties, changing trach if disposable or inner cannula. MDS nurse to review care plans after addressing triggers to ensure aspects of needs outside triggers and RAI are included in care plan. 4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic audits of assessments formulating care plan based on individual resident needs. They will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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neck; personal history of malignant neoplasm of unspecified site if lip, oral cavity, and pharynx; and, encounter for attention to tracheostomy.

Review of R35's current care plans revealed that there was no care plan related to R35's tracheostomy. Review of R35's resolved care plans revealed that there was a care plan related to R35's tracheostomy upon admission but was marked resolved on 4/3/18.

Review of the R35's Order Summary Report for the month of April 2018 revealed the following order: "...Trach [tracheostomy] cares BID [twice daily] two times a day Trach size 6..."

Review of R35's current care plans and order summary report revealed no interventions or orders related to the care of R35's tracheostomy and how often the inner cannula (part of the tracheostomy tube that fits inside the outer cannula (outer tube that holds the tracheostomy open) which has a lock to keep it from being coughed out and is removed for cleaning) should be replaced nor was there any instruction to monitor for signs and symptoms of infection or complications.

Review of the Kardex (a medical information system used by nursing staff as a way to communicate important information on their patients) for R35's hallway revealed under "Care Notes" that R35 had a trach but there was no instruction related to its care.

In an interview with the Director of Nursing (DON) on 4/12/18 at approximately 6:35pm, when asked about the care plan for R35's tracheostomy care, the DON stated "I did not see any care plan

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addressing the trach." When the DON was asked if R35 needed a care plan related to the tracheostomy, she stated, "Yes Ma'am."

Review of the facility's "Care Plans - Comprehensive" policy with the review date of 12/23/17, indicated, "...2. The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS; 3. Each resident's comprehensive care plan is designed to: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems...f. Identify the professional services that are responsible for each element of care...i. Reflect currently recognized standards of practice for problem areas and conditions...4. Areas of concern that are triggered during the resident assessment are evaluated using specific assessment tools (including Care Area Assessments) before interventions are added to the care plan; 5. Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes...6. Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making..."

According to Long Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual published on October 2016 under Section 4.6 "When Is the RAI Not Enough?" on page 4-7, "...facilities are responsible for assessing all care issues that are relevant to individual residents, regardless of whether or not they are covered by the RAI (42 CFR 483.20(b)), including monitoring each resident's condition and responding with

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F 656	Continued From page 84 appropriate interventions." The Manual also stated under "Limitations of the RAI-related instruments...The RAI provides tools related to assessment including substantial detail for completing the MDS, how CATs [Care Area Triggers] are triggered, and a framework for the CAA [Care Area Assessment] process. However, the process of completing the MDS and related portions of the RAI does not constitute the entire assessment that may be needed to address issues and manage the care of individual residents. Neither the MDS nor the remainder of the RAI includes all of the steps, relevant factors, analyses, or conclusions needed for clinical problem solving and decision making for the care of nursing home residents..."	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the	F 657		5/21/18

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F 657	Continued From page 85 resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that care plans were updated for three (R9, R36, R40) of 19 residents reviewed for care plans in the sample of 37. Findings include: 1. Review of R9's undated "Admission Record," [a cover sheet to a multipage document that contains demographic information, preferences, contact information, and limited medical information] indicated R9 was admitted on 04/08/2016 with medical diagnoses that included but were not lmited to dementia with behavioral disturbance, chronic ischemic heart disease, hallucinations, abnormal weight loss, anxiety disorder and receiving hospice services as of 2/28/2017. Review of R9's care plan revealed a focus of "Patient is on Hospice care related to: End of life care r/t (related to) Dx (diagnosis) of Dementia secondary of behaviors, falls, dysphagia Date Initiated: 04/14/2017." The goal was "Patient will be comfortable and have needs meet Date Initiated: 04/14/2017, Revision on: 11/24/2017, Target Date: 04/17/2018."	F 657	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide consistent quality care to ensure residents have comprehensive care plans. R9 is on hospice and it was determined that there is no care plan coordination with hospice services and staff are not clear on what hospice does or when they do it thus not providing continuity in care. R36 is on dialysis and in reviewing care plan with dialysis policy and protocol care did not match. R40 had multiple interventions in place due to suicidal ideation noted upon admission. The resident is not suicidal, and the care plan had not been updated. In this case, after the survey determined facility needed to work with dialysis to create communication protocol and update care plan related to dialysis patients. Hospice also met with facility and updated care plan and set days and times	

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Interventions to reach the goal included:
"Allow patient to verbalize fears and concerns about dying process, Date Initiated: 04/14/2017; Coordinate Care Plan with my Hospice, Date Initiated: 04/14/2017, Revision on: 11/24/2017; Evaluate effectiveness of medications/interventions to address comfort, Date Initiated: 04/14/2017; Keep my family informed of change in condition, Date Initiated: 04/14/2017
Revision on: 11/24/2017; and Notify hospice of any change in condition or medication changes Date Initiated: 04/14/2017."

In an interview on 04/12/18 at 11:47am regarding a patient care plan for hospice that coordinates the care, the Director of Nursing (DON) stated, "We have a care plan in the system that includes that they are on hospice." When asked how care was delineated, the DON responded, "Hospice sends us a care plan that tells us what they will do." The DON also stated they have monthly meetings with hospice.

On 04/12/18 at 5:45pm the Unit Coordinator (UC) provided the following information regarding the monthly meetings which revealed:
"Care Conference Summary" dated 02/13/18 revealed a care conference for R9 that included a signature of the Licensed Social Worker (LSW) from the hospice service.
"Care Conference Summary" dated 08/24/17 revealed a care conference for R9 that included a signature of the LSW from the hospice service.

In an interview on 04/13/18 at 8:23am Licensed Practical Nurse (LPN)3 responded to a question about the services R9's hospice provides. LPN3 stated, "The Hospice CNA (certified nurse aide)

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for cares, group sheets updated so staff are aware of hospice cares. R40 care plan updated based on assessment resident is no longer at risk for self-harm.
2.Because all residents care is directed by the care plan, all are potentially affected by the cited deficiency, on 4/17/2018, the MDS nurse reviewed process of ensuring accurate MDS's to formulate comprehensive care plans. All other resident care plans have been reviewed and updated for accuracy, MDS nurse and DON have communicated needs with hospice and dialysis and discussed the need to join services for comprehensive care plan. Care plans and care sheets will reflect necessary changes. The policy and procedure for hospice services, dialysis and care planning have been reviewed and updated.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff received in-service training regarding dialysis communication, hospice services, importance of incorporating in care plan and building comprehensive care plans.
4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic audits of assessments formulating care plan based on individual resident needs. They will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure

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F 657	Continued From page 87 comes 3 or 2 times a week;" at which time the UC, also at the nurse's station, stated, "only 1 time per week." LPN3 stated, "typically, what they do depends on what time they come. If early, they might do morning cares. If it is his bath day, they might try to bathe him and help with ADLs (activities of daily living, e.g. shaving, dressing, toileting). If (they are) here at breakfast, they will provide socialization and encourage him to eat. They have a form they fill out to let us know what they did. The hospice nurse comes every 1 - 2 weeks. She may attempt to do vital signs. She'll check with nursing regarding weight, ADL (Activities of Daily Living) changes and last bowel movement." In an interview on 04/13/2018 at 8:30am regarding what care hospice provides for R9, Nurse Aide (NA) 4 stated, "Well, I don't work this hall often, but typically, if it's a morning visit, Hospice will get him up, give him a bath if it's his bath day or a partial bath." When asked how she (NA4) knew what care and how often hospice provides cares, NA4 pulled a care sheet from her pocket, turned to R9's information and stated, "it says he's on hospice, but it doesn't mention how often they come; there is a hospice schedule at the front I could go check." When asked what the sheet was called that NA4 had in her pocket, at 9:45am on 4/13/2018, the UC stated, "don't really have a name, so we'll call it the Daily Care Sheet." A review of the "Daily Care Sheet" for R9's information revealed, "Care Notes: On Hospice; Alert/Pleasantly Confused; with meals, take a bite, take a drink; lotion skin AM (morning)/HS (bedtime); oral cares; chart behaviors; report	F 657	compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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refusals; talk about marines. Report refusals of cares."

In an interview on 04/13/18 at 10:40am, the Regional Director of Clinical Services (RDCS) stated the facility did not have a care plan policy for hospice services. In response to the query if R9's care plan showed a coordination of cares between the facility and the hospice services, the RDCS stated, "No, it's something I will be working on."

2. Review of R36's undated "Admission Record," revealed an original admission date to the facility of 06/05/2017 and a readmission date of 12/05/2017, with medical diagnosis of end stage renal disease (ESRD).

Review of R36's care plan, revealed a focus of: "The resident needs dialysis r/t renal failure/ESRD. Fistula to LUE (left upper extremity). Receives dialysis M/W/F [Monday, Wednesday, Friday] at [facility name]. Date Initiated: 06/06/2017." The care plan's goal, "The resident will have no s/sx (signs/symptoms) of complications from dialysis through the review date. Date Initiated: 06/06/2017 Revision on: 01/08/2018 Target Date: 06/04/2018." Interventions to achieve the goal were: "Apply Lidocaine-Prilocaine cream to my dialysis shunt 30-60 minutes prior to my appointment MWF. Date Initiated: 12/07/2017; Do not draw blood or take B/P [blood pressure] in arm with graft. Date Initiated: 06/06/2017; Emergency protocol - if bleeding occurs, apply pressure with clean gauze for 10-15 minutes. If bleeding not controlled, call 911. Notify physician if edema, chest pains, elevated blood pressure, or shortness of breath occurs. Date Initiated: 01/17/2018; Encourage me

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to go for the scheduled dialysis appointments. I receive dialysis on Monday and Friday at 1:30PM and Wednesday at 1200 at [facility name]. Date Initiated: 06/06/2017 Revision on: 12/07/2017; Monitor for dry skin and apply lotion as needed. Date Initiated: 06/06/2017; Monitor intake and output. Date Initiated: 06/06/2017; Monitor labs and report to doctor as needed. Date Initiated: 06/06/2017; Monitor thrill/bruit q (every) shift and update Dr. [name] as needed. Date Initiated: 08/23/2017."

A review of the facility's policy titled, "Hemodialysis Policy" created 12/27/2017 and reviewed 04/03/2018, revealed:
" ...D. Comprehensive Care Plan. . .The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing and psychosocial needs.

1. The care plan should address the following:
-Identify potential risks and complications of dialysis (CHF, pulmonary edema, drug toxicity, electrolyte imbalance)
-Measurable goal for potential risks and complications.
-Monitor for complications.
-Frequency of monitoring vital signs, respiratory distress, chest pain, headache, seizure, etc.
-Monitoring of shunt or access site for signs of infection.
-Alteration of fluid volume.
-Potential for bleeding.
-Care of the access site.
-Potential for infection.
-Alteration in nutrition.
-Alteration in skin integrity.

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F 657	Continued From page 90 -Medications with appropriate scheduling as they related to dialysis. -Compatible goals and interventions between the SNF (skilled nursing facility) and dialysis provider." In an interview on 04/13/18 at 10:40 AM, regarding R36's care plan, the RDCS confirmed, "The care plan does not match the requirements of the policy." 3. On 4/09/18, a clinical record review revealed R40 was admitted to the facility on 11/07/17 with diagnoses that included but no limited to Parkinson's disease, anxiety, dementia with Lewy bodies, and major depression disorder. Review of R40's care plan dated 11/09/17 revealed R40's behavior related to suicidal ideation had the following interventions that included: placing his dresser in the closet to prevent injuries; low bed with mats placed on the floor on either side; remove head and foot board; and, place padding on the wall at the head of the bed. Observations on 4/09/18, 4/10/18, 4/11/18 and 4/12/18 at 09:00am revealed R40's bed with the headboard and the foot board attached. The wall behind his head was not padded. The dresser was not in the closet and there were no mats on the floor. On 4/11/18 at 10:14am, during an interview with the Minimum Data Set (MDS) Coordinator, she was unsure if the resident was still suicidal and agreed that if he was not, the care plan needs updating.	F 657		

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F 657	Continued From page 91 On 4/11/18 at 11:30am, during an interview with (Registered Nurse) RN1 stated that R40 was no longer suicidal and R40's care plan needed to be revised. RN1 also stated that the mats created a fall hazard for him and were discontinued. On 4/11/18 12:00 pm, during an interview with the Director of Nursing (DON), the DON confirmed that R40 was no longer suicidal. The DON stated, "[R40's] care plan needed to be revised."	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow standards of practice related to medication administration, borrowing of medications and carrying out physician's orders for two residents (R44 and R55); and, checking of gastrostomy tube placements for two residents (R55 and R35) of three residents observed during Medication Pass. Findings include: 1. Review of R44's physician's orders revealed the following: a. 4/9/18 - Guailfenesin (cough medication) syrup 10 milliliters (ml) every four hours as needed for cough. b. 4/9/18 - Lactulose (laxative) solution give 30 ml	F 658	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide quality care. R44 was not given medications as directed by physician nor medication directions. Multiple medication errors occurred. R55 has g-tube and medications were mixed together, g-tube placement was not checked, medications pushed all are not standards of medication administration. R35	5/21/18

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by mouth two times a day for constipation.
c. 4/9/18 - Miralax (laxative) give 17 grams (gm) by mouth every 24 hours as needed for constipation. Mix in eight ounces (oz) of water, juice, soda, coffee or tea prior to administration.

On 4/10/18 at 9:19am, Licensed Practical Nurse (LPN)1 was observed preparing R44's oral medications. LPN1 poured the cough medication into a calibrated medication cup and poured more than 10ml. LPN1 verified the amount and confirmed that she prepared more than 10ml. LPN1 stated, "Yeah it's a little over 10."

During the same observation, LPN1 was observed pouring the lactulose solution into a calibrated medication cup and poured 20 ml instead of 30 ml. The surveyor also observed LPN1 borrowed R207's lactulose medication for R44's use. LPN1 confirmed that she had only 20ml available to give to R44.

LPN1 was observed preparing R44's Miralax medication. LPN1 poured the Miralax powder into a cup and mixed it with 4oz of water.

On 4/10/18 at 9:30am, LPN1 administered R44's Guailfenesin more that the ordered dose; Lactulose less than what was ordered and the Miralax mixed with water that was less than the ordered amount along with all R44's other medications.

2. Review of R55's physician's orders revealed:
a. 3/23/18 - Diclofenac Sodium (pain medication) gel 1% apply transdermally two times a day for pain.
b. 3/14/18 - Aspirin EC (enteric-coated) low strength tablet delayed Release give 81 milligram

medications were also mixed and g-tube placement was not checked prior to administering medications. In this case, after the survey determined there were significant errors, medication review showed meds not available for residents and pharmacy advised to send immediately. Staff were instructed to reach out to DON if they are not receiving medication refills timely and educated that using other resident medications is not allowed. Also reviewed with nurses the proper way to administer g-tube medications, g-tube placement, nebulizer treatments, and dosing medications. Medication errors were documented, and education completed.
2.Because all residents have the right to quality care and receive medications from the facility all are potentially affected by the cited deficiency, on 4/12/2018 the DON and RDCS reviewed with staff proper medication administration, g-tubes and using residents own medications not borrowing. All medications have been reviewed to ensure supply is available, MAR reflects g-tube placement and cups ordered for proper dosing. Medication administration policy reviewed. No other residents were affected.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff will receive in-service training on medication administration, doing 3 checks, medication refills, borrowing meds, and g-tube medication training.
4.Effective 4/28/2018, a quality-assurance program was implemented under the

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F 658	Continued From page 93 (mg) via Percutaneous Endoscopic Gastrostomy (PEG - a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus) one time a day. c. 3/20/18 - Fluticasone Propionate Suspension (used to treat nasal symptoms such as congestion, sneezing and runny nose) two sprays in both nostrils one time a day. d. 3/19/18 - Ipratropium bromide 0.5mg and albuterol sulfate (bronchodilator) 3ml inhale orally four times a day. e.3/13/18 Bumetanide (diuretic) 1mg via PEG tube once daily. f. 3/13/18 Carvedilol (for high blood pressure) 3.125mg via PEG tube twice daily. g. 3/14/18 Escitalopram (antidepressant) 10mg via PEG tube once daily. h. 3/14/18 Finasteride (to reduce enlarged prostate) 5mg via PEG tube once daily. i. . 3/14/18 Lisinopril (for high blood pressure) 10mg via PEG tube once daily. j. 4/8/18 Acetaminophen (analgesic) 650mg by mouth every four hours as needed for pain and fever. k. 3/19/18 Ferrous sulfate (iron) elixir 220/5ml 1tsp 5ml via PEG tube two times a day. l. 3/13/19 Docusate Sodium (stool softener) liquid 50mg/5ml give 10ml via PEG tube two times a day. On 4/9/18 at 9:45am the surveyor noted that Diclofenac Sodium gel had a label instruction that indicated, "Use the dosing card attached inside this carton box label." The label also indicated to apply 4 gm to affected areas. Observation revealed that LPN1 did not use the dosing card.	F 658	supervision of the DON to monitor medication administration policy and procedures. The DON or designated quality-assurance representative will perform competencies on all staff administering medications and use of g-tubes. DON will then audit med passes 4 audits per week x 4 weeks then 2 audit weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON nurse will be responsible for this POC.	

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F 658	Continued From page 94 LPN1 put a small amount of the gel onto her finger and applied the gel onto R55's shoulders. On 4/10/18 at 9:50am, LPN1 was observed preparing R55's medications. LPN1 put the following tablets in one pouch, crushed at one time and poured in one cup: Aspirin EC, Bumetanide, Carvedilol, Escitalopram, Finasteride, Lisinopril and Acetaminophen. LPN1 entered R55's room, mixed the crushed medications with warm water. LPN1 opened the gastrostomy tube (GT) port, attached the syringe to the GT port then flushed the GT with 50 ml of water. Observation revealed that LPN1 did not check the placement of the GT before flushing the water. Then LPN1 removed the syringe and reattached the syringe (without the plunger) back to the GT port, poured R55's diluted medications into the barrel of the syringe and used the plunger of the syringe to push the diluted medications down to the tube. Further observation revealed that LPN1 flushed the GT with 50 ml of water then used the same syringe to aspirate the Ferrous Sulfate elixir from the medication cup. Using the same syringe, LPN aspirated the docusate sodium liquid from the other medication cup. LPN1 mixed the two liquid medications in one syringe, attached the syringe to the GT port and used the plunger to push the liquid medications down the tube. On 4/9/18 at 10am, LPN1 was observed administering nasal spray to R55. LPN1 sprayed one spray instead of two sprays in each nostril.	F 658		

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F 658	Continued From page 95 On 4/9/18 at 10:20am, LPN1 was unable to find R55's face mask for his nebulizer treatment (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs). LPN1 then use a mouth piece to administer R55's nebulizer treatment. R55's opened his mouth, then LPN1 put the mouth piece into R55s' mouth and turned on the nebulizer machine. Observation revealed that LPN1 did not provide R55 instructions to breathe in an out during the procedure. R55 fell asleep during the administration of the nebulizer treatment and was not able to adequately inhale the mist of the medication. During an interview on 4/11/18 at 10:30am, LPN1 stated that she did not have enough Lactulose to give R44. LPN1 also stated, "I only gave 20 ml." LPN1 further stated that she had to give R44's Miralax to supplement the missing dose of lactulose. When asked if R44 had asked for a Miralax, LPN1 stated no. When asked about the borrowing R207's (discharged resident) lactulose medication, LPN1 stated that it was R207's medication. When asked if it was appropriate to borrow other resident's medication, LPN1 stated, "No. We don't want to toss out discharged medications, so we keep them as our back up supplies." LPN1 was also asked about the amount of water mixed in with R44's Miralax powder. LPN1 stated, "Our cups can only be filled up to five oz. I should have used two medication cups, 4 oz per cup to dilute the Miralax powder." During an interview on 4/11/18 at 11am with LPN1, LPN1 stated that she tried to locate the dosing card of the Diclofenac Sodium gel for R55. LPN1 further stated that she never saw the dosing card in the box and had never used it at	F 658		

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F 658	Continued From page 96 all. When asked if it was appropriate to crush R55's enteric coated aspirin, LPN1 stated, "No, it defeats the purpose of delayed release." When asked about the number of nasal spray she administered to R55, LPN1 stated, "I sprayed one for each nostril, I thought the order was one spray for each nostril." When asked about the nebulizer administration for R55, LPN1 stated, "I know I didn't have a face mask to use but I used a mouth piece. When asked if she instructed R55 to breath in and out, LPN1 stated, "No, not really." When asked if R55 nebulizer treatment was administered appropriately, LPN1 stated, "I guess not." LPN1 failed to follow standards of practice by failing to carry out the correct physician's orders of R44's guailfenesin, lactulose and Miralax and R55's aspirin EC, nasal spray and diflonac gel medications. LPN1 also failed to follow standards of practice by combining, crushing and administering R55's medication all at once via his GT. LPN1 also failed to follow standards of practice by using borrowed medication from another resident's supply; failed to check GT placement before medication administration for R55. LPN1 failed to ensure R55 was adequately inhaling the mist of the medication during a nebulizer treatment. Review of the facility's undated policy, "Administering Medication through an Enteral Tube" indicated, " Do not mix medications together prior to administering through an enteral tube. Administer each medication separately....Do	F 658		

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F 658	Continued From page 97 not crush or split medications for administration through an enteral tube unless first checking with the pharmacy or facility approved 'Do Not Crush Medication List'...Tablets that must be crushed prior to administration through an enteral tube require a specific order related to crushing...Do not crush enteric coated...Check gastric residual volume [GRV] to assess for tolerance of enteral feeding...When correct tube placement and acceptable GRV have been verified...Administer medication by gravity flow. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion...If administering more than one medication, flush with 15 mL (or prescribed amount) warm sterile or purified water between medications. Review of the facility's policy created on l2/27/2017 and reviewed on 4/3/2018, Medication Administration indicated, "Medications must be administered in accordance with the orders, including any required time frame ... The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication." According to the website, https://www.nursingcenter.com/ncblog/may-2011/8-rights-of-medication-administration, Lippincott Nursing Center, "Rights of Medication Administration" indicated, "Rights of Medication Administration" indicated, "1. Right patient check the name on the order and the patient...Ask patient to identify himself/herself. 2. Right medication. Check the medication label. Check the order.3. Right dose Check the order...4. Right	F 658		

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F 658	Continued From page 98 route Again, check the order and appropriateness of the route ordered. Confirm that the patient can take or receive the medication by the ordered route..." According to the website, https://crnns.ca/wp-content/uploads/2015/05/Medication-Guidelines.pdf, "Medication Guidelines for Registered Nurses" indicated, "Borrowing medications (using medication from one client's supply for another) increases the risk of medication errors. Organizations should identify and address the reasons why RNs administer borrowed medications (Grissinger, 2013). As always, follow agency policy regarding this practice." According to the website, www.ncsbn [National Council Acts (Board of Nursing].org, "Further standards...provision of care as ordered or prescribed by authorized health care providers..."	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to: assess, monitor and provide timely interventions to prevent aspiration	F 684	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission	5/21/18

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F 684	Continued From page 99 pneumonia for one (R55) of one resident reviewed for tube feeding; and, document skin changes for one (R39) of three residents reviewed for skin condition in the sample of 37. 1. Review of R55's Admission Record revealed R55 was admitted to the facility on 3/13/18 with diagnoses that included but not limited to: acute respiratory failure, type 2 diabetes mellitus, chronic obstructive pulmonary disease, constipation and subdural hemorrhage. Review of R55's Admission Assessment Minimum Data Set (MDS) dated 3/20/18 revealed R55's Brief Interview for Mental Status (BIMS) score was five that indicated R55 had severe cognitive impairments. Review of the same MDS revealed R55 required extensive assistance with transfer, bed mobility and toilet use. Review of R55's Care Area Assessment (CAA) for Feeding Tube dated 3/26/18 revealed, "Describe impact of this problem/need on the resident and your rationale for care plan decision." The answer was "At risk for malnutrition, dehydration and aspiration." Review of R55's Speech Therapist's (ST) evaluation plan and treatment dated 3/19/18 revealed diagnosis of dysphagia (difficulty in swallowing). Review of the same ST notes for R55 revealed, "Risk Factors: Pt [patient] at risk for aspiration with documented dysphagia." Review of R55's physician's order dated 3/20/18 revealed an Osmolite (tube feeding formula) 1.2 liters (L) at 80 milliliter (ml)/hour continuous via Percutaneous Endoscopic Gastrostomy (PEG - a procedure in which a flexible feeding tube is	F 684	of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide quality care. R55 was noted to have g-tube and during medication administration, tube was not checked for placement, lung sounds not checked, and has puree diet but not determined that resident can tolerate on top of feeds. Care plan and progress note updated. Dietician reviewed data. Bowel program also failed to keep resident from constipation which could have led to distention and emesis. R39 had an abscess which was continuously war, red and not being addressed. Resident finally sent in and had to have it drained. Staff did not update MD timely nor follow up on area that continued to worsen during stay. When survey noted substandard care immediately BM protocols were reviewed, g-tube protocols, and skin monitoring. 2.Because all residents depend on staff for care all are affected by the cited deficiency, on 4/17/2018, the DON reviewed all residents with g-tubes, constipation as noted in dashboard in EMR, skin changes and wounds. The policy on quality care was reviewed as was tube feedings and skin monitoring. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff will receive in-service training	

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placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus) tube.

Review of R55's physician order dated 4/5/2018 revealed an order for, "Oral intake at meals. Two puree [items] and 2 honey thick liquids/meal."

During an interview on 4/9/18 at 2:10pm with R55's son, Z1 stated that there had been numerous occasions where R55 had been vomiting. Z1 stated, "I wish they would turn off his feeding pump for a couple of hours so he has an appetite to eat. It seems that he is receiving this round the clock."

Review of R55' nurse's notes revealed the following:
3/20/18: "Resident had a small emesis [vomit] this morning while at PT [Physical Therapy]/OT [Occupational Therapy]."
3/25/18: Nursing Note: "Resident had emesis x (for) 1."
4/8/18: "Resident was sitting up in bed for dinner this shift. Resident later experienced episodes of emesis x 2. Emesis contents consist of a meal and desert [sic]."
4/8/18 11:45am: "Temp 99.5"
4/8/18 1:25pm: "Resident had elevated temp > [above] 100 so PRN [as needed] TYl [Tylenol] administered. Resident has a nasal congestion..."

During an interview on 4/10/18 at 11:30am with R55's daughter (Z2), Z2 stated that the staff was not closely monitoring R55's condition. Z2 stated, "I had to ask the aide to take my dad's temperature today. Had I not asked, no one would ever have known he had a fever. He has a

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regarding normal monitoring, reporting data to physicians and follow up with changes in resident status, reminded if no BM in 3 days follow protocol, how to manage and administer tube feedings, meds and assess for aspiration.
4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the DON to monitor residents care. The DON or designated quality-assurance representative will perform the following systematic changes: audits done weekly on overall quality of care for those with g-tubes, no bowel movements, skin and wound treatments and MD follow up; 5 residents for 2 weeks then on 2 residents weekly for 2 months to ensure compliance. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.DON will be responsible for this POC.

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100.5 temperature."

On 4/10/18 at 11:15am, R55 was observed in bed, flushed face and breathing through mouth. While Z2 was voicing her concerns regarding her dad's temperature, Z2 also stated, "He doesn't look good today, he feels so warm." Licensed Practical Nurse (LPN)1 responded to Z2 and stated, "Oh! I have a Tylenol prepared for him. That should take care of his temperature." During this time, LPN1 was observed administering R55's crushed medications through R55's gastrostomy tube (GT). The surveyor observed that R55's head of bed was elevated less than 30-degree angle. Without checking the placement of the GT, the surveyor observed LPN1 administered R55's crushed medications via gastrostomy tube (GT).

On 4/10/18 at 11:20am, the surveyor also observed LPN1 administered R55's nebulizer treatment (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs). The LPN1 did not assess R55's lung sounds before and after the administration of R55's nebulizer treatment to determnie effectivness of the treatment.

Review of R55's nurse's notes dated 4/10/18 at 1:36pm revealed, "Resident is running a temp [temperature] 100.3 and lung sounds are wheezy." At 5:23pm, "Resident is alert and oriented, lethargic today, wheezing in lungs." At 7:25pm, "Results [x-ray] received: Possible pneumonia or aspiration." These nurses' notes had no indication that R55's temperature had been reassessed to determine the effectiveness of the Tylenol which had been administered on 4/8/18 at 1:25pm.

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Review of R55's chest x-ray result dated 4/10/18 revealed, "Cardiomegaly with retrocardiac consolidation could represent pneumonia or aspiration."

Based on R55's record review, R55's chest x-ray results were available to the nursing staff on 4/10/18 at 7:25pm.

Review of R55's nurse's notes dated 4/11/18 at 12:40pm revealed R55's physician assistant had been notified of R55's x-ray results. This was almost 17 hours after the facility had the results of R55's chest x-ray.

Review of R55's nurse's notes from 4/10/18 at 5:23pm through 4/11/18 12:40pm indicated no further assessments had been done to check R55's vital signs, to evaluate R55's lungs sounds, to monitor signs and symptoms of aspiration and his overall condition.

During an interview on 4/10/18 at 11:45am with Z2, Z2 stated R55 had been constipated since 4/2/18 and was given a suppository. Z2 also stated that on 4/9/18, his brother, Z1 had told the staff that R55 needed another suppository for his constipation.

During an interview on 4/12/18 at 9:15am with R55's daughter (Z3), Z3 stated, "My dad's constipation may have caused his vomiting. But no one seem to know why he had been vomiting." Z3 stated, "When you haven't had your bowels in so many days, and your stomach is full and bloated, wouldn't you think that would cause you to vomit?"

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Review of R55's bowel movement record revealed R55 had a bowel movement on 4/3/18 after R55 had received a suppository on 4/2/18.

Review of R55's bowel movement records dated 4/4/18, 4/5/18, 4/6/18, 4/7/18, 4/8/18 and 4/9/18, a total of six days revealed R55 had not had a bowel movement.

During an interview on 4/12/18 at 11:40am with the Director of Nursing (DON), when asked about protocols for caring R55 who had a tube feeding (TF), the DON stated, "Keep the head of bed elevated at 30 degrees while the TF is on, hold the TF during care if okay with the physician and do oral care." When asked about her expectation of nurses to ensure interventions are in place to prevent R55 from developing aspiration pneumonia, the DON stated, "Check for residual and check for GT placement before the start of feeding or medication administration, to position properly and elevate the head of bed." When asked about nursing interventions when R55 had episodes of vomiting, the DON stated, "Find the cause, the source of vomiting, contact the physician, listen to R55's lung sounds, see if anything changes in lung sounds for aspiration or wheezes. The nurse may administer R55's Tylenol since we have a standing order for Tylenol for pain or fever. The nurse should be checking R55's temperature at least half an hour later after the Tylenol was given." The DON also reviewed R55 nurses' notes and confirmed that the nurses' notes lacked indication of ongoing assessments and monitoring for signs and symptoms of aspiration. The DON also confirmed that the nurses' notes revealed no documentation that R55's physician had been notified of R55's emesis and elevated temperature. Lastly, the

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F 684	Continued From page 104 DON confirmed that the nurses failed to address his constipation timely. During an interview on 4/12/18 at 2:09pm with the Speech Therapist (ST), the ST stated she only had been working with R55 less than three weeks. The ST stated that R55 who had a swallowing disorder and a feeding tube puts him at risk for aspiration. The staff should provide direct supervision when feeding R55. When asked what interventions should take place to monitor R55's risk for aspiration, the ST stated, "Listen to [R55's] lung sounds every shift or at least daily to check for developing signs of pneumonia; check [R55's] vital signs more often. When asked if a care plan for R55 had been developed after the ST had evaluated R55 for care and treatment, the ST stated, "I haven't had a care plan made for him." Review of R55's overall care plan dated 4/2/18 failed to address problem for R55's risk for aspiration and failed to address interventions to prevent aspiration pneumonia related to R55's feeding tube and swallowing difficulty. The MDS coordinator when interviewed on 04/12/18 10:02am confirmed R55 did not have a care plan addressing R55's risk for aspiration. During an interview on 4/11/18 at 11:30am with the Physician Assistant (PA), the PA confirmed R55 had aspiration pneumonia based on R55's chest x-ray results, symptoms and his findings upon his examination. When asked if he had been notified of R55's episodes of emesis and elevated temperature, the PA stated, "No, I have not been made aware of his emesis and elevated temperature until 4/10/18. I just ordered two antibiotic medications for [R55]." The PA also	F 684		

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F 684	Continued From page 105 stated that he expected the nurses to notify him or the physician for any change in condition as soon as possible. The PA stated, "Had I been promptly informed of his fever and vomiting, I would have treated him sooner." When asked for causes of aspiration pneumonia, the PA stated, "Aspirating from your vomitus or the tube feeding. An elevated temperature can be an indication that R55 was slowly developing a pneumonia." The surveyor had requested the facility's policy on Feeding Tubes. At the end of the survey, the surveyor had not received the requested policy. According to the website, http://ccn.aacnjournals.org/content/32/3/71.full Critical Care Nurse, "Prevention of Aspiration" indicated, "Critically ill patients have an increased risk for aspirating oropharyngeal secretions and regurgitated gastric contents. For those who are tube-fed, aspiration of gastric contents is of greater concern...Expected Practice - Maintain head-of-bed elevation at an angle of 30° to 45°, unless contraindicated...For tube-fed patients, assess placement of the feeding tube at 4-hour intervals. For patients receiving gastric tube feedings, assess for gastro -intestinal intolerance to the feedings at 4-hour intervals...Supporting Evidence - Head-of-Bed Elevation. There is evidence that a sustained supine position (0° head-of-bed elevation) increases gastroesophageal reflux and the probability for aspiration...Thus, elevating the head of the bed to an angle of 30° to 45°, unless contraindicated, is recommended for patients at high risk for aspiration pneumonia. Assess Feeding Tube Placement at Regular Intervals - Expert panels recommend that correct feeding tube placement be verified at regular intervals to minimize the risk	F 684		

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F 684	Continued From page 106 for aspiration. If feedings are administered at the wrong site (such as the esophagus, or even the stomach of a patient who requires small-bowel feedings), the risk for aspiration is increased. Assess for Gastrointestinal Intolerance to Tube Feedings Guidelines developed jointly by the Society of Critical Care Medicine and the American Society for Parenteral and Enteral Nutrition recommend that patients be monitored for tolerance to enteral feedings by noting abdominal distention, complaints of abdominal pain, observing for passage of flatus and stool, and monitoring gastric residual volumes. Because gastric distention predisposes to regurgitation, it is recommended that gastric residual volumes (GRVs) be measured every 4 hours in critically ill patients...If patients are able to communicate, ask if they are experiencing abdominal discomfort or nausea. If vomiting is present, feedings should be stopped, and the physician notified...Evaluate the significance of a single abnormal finding...in relation to other indicators of GI intolerance to tube feedings, such as abdominal distention, abdominal discomfort, and nausea and vomiting." According to the website, https://consultgeri.org/try-this/general-assessment/issue-20, a clinical website of the Hartford Institute for Geriatric Nursing under Preventing Aspirations in Older Adults with Dysphagia indicated, "Best Practices: Assessment and Prevention Assessment ...Clinical symptoms of Aspiration: Sudden appearance of respiratory symptoms (such as severe coughing and cyanosis) associated with eating, drinking, or regurgitation of gastric contents. A voice change (such as hoarseness or a gurgling noise)...Observation for aspiration pneumonia	F 684		

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F 684	Continued From page 107 should be ongoing in high-risk persons...PREVENTION OF ASPIRATION DURING TUBE FEEDING...For patients with tube feedings, the following considerations are important...Keep the bed's backrest elevated to at least 30º during continuous feedings...When the tube-fed person is able to communicate, ask if any of the following signs of gastrointestinal intolerance are present: nausea, feeling of fullness, abdominal pain or cramping. These signs are indicative of slowed gastric emptying that may, in turn, increase the probability for regurgitation and aspiration of gastric contents...Measure gastric residual volumes every 4 to 6 hours during continuous feedings and immediately before each intermittent feeding. This assessment is especially important when the tube-fed person is unable to communicate signs of gastrointestinal intolerance." 2. Record Review of R39's Admission Record included but were not limited to the following diagnoses: chronic kidney disease, stage 5, dependence on renal dialysis, obesity, low back pain, chronic pulmonary edema, chronic obstructive pulmonary disease heart failure and diabetes. Record Review of R39's Quarterly Minimum Data Set (MDS) dated 3/7/18 with the heading "Section C-cognitive Pattern," R39 scored a 14 in a Brief Interview for Mental Status (BIMS) which indicated that R39 was cognitively intact. In the same MDS with the heading "Section G Functional Status," specified that R39 was "Total dependence-Full staff performance all the time..." with "Two+person(s) physical assist." In addition, under "Section M-Skin Conditions," R39 was identified as being at risk for developing pressure	F 684		

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F 684	Continued From page 108 ulcers. Review of physician assistant notes with the heading "Nursing Home Note" dated 11/8/17 under "CHIEF COMPLAINT/HPI [history of present illness]" revealed, "Staff report that resident has an area of erythema [reddening of the skin] and induration [becoming hardened] to the abdomen, right lower quadrant. Tender to touch. Negative for fevers..." Under the heading of "ASSESSMENT AND PLAN: 1. Soft tissue infection of the abdomen, right lower quadrant area. Will treat with doxycycline (antibiotic to fight infection) 150 [mg-milligrams] by mouth every day x [times] 7 days warm moist packs applied twice a day for 30 minutes x 7 days, with a protective dressing." Record review of R39's care plan revealed that there were no documentation for continued assessment of the right lower quadrant for redness, swelling, pain, drainage and/or the order to incorporate protective dressings with warm moist packs twice a day for seven days as interventions to address the soft tissue infection identified by the physician assistant on 11/11/17 in R39's care plan. Record review of R39's "Weekly Skin review-V3" dated 11/13/17 at 10:17pm revealed, "Pre-existing redness to groin and buttock...abscess [collection of pus that has built up within the tissue that includes symptoms of redness, pain, warmth and swelling] to right lower abdomen" which was the first nursing documentation that indicated R39 had any abnormalities to the abdomen. Record review of R39's "Weekly Skin review-V3"	F 684		

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dated 10/30/17, 10/23/17 and 10/16/17 indicated no documentation of any assessment of a developing abscess that would include symptoms of redness, pain, warmth, drainage and swelling.

Record review of R39's progress notes from 9/6/17 to 11/13/18 revealed no assessments that indicated that R38 was starting to experience redness, pain, warmth and/or swelling to the right lower quadrant.

Record review of R39's progress notes dated 11/14/17 at 9:17am which was the second documentation by a nursing staff which indicated, "Resident has Large {sic} abscess area to Rt [right] lower abdomen measures 18cm [centimeter] W [width] x 12cm L [length], with a core circumference of 4 cm. Area is red, firm, warm and tender to touch. Center of area with white/yellow dry flaky skin. Noted small amount of Purulent [containing pus] drainage, culture of drainage obtained and Physician updated."

Record review of R39's progress notes dated 11/14/18 at 9:49am indicated, "Pt [patient] has abscess to abdomen that continues to worsen despite [of] oral antibiotic use...Pt is experiencing pain at the site...Per [name of the physician assistant] send pt to ER [emergency room] to be evaluated.

Review of the Emergency Room (ER) notes titled (name of the hospital) under "ASSESSMENT/PLAN" dated 11/14/17 revealed, "1. Necrotic carbuncle [multiple pus points with dead tissue]: Surgery seen and evaluated and {had} done a bedside debridement (surgical removal of dead or infected tissue to promote healing)...on IV [intravenous] Vancomycin

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[antibiotic] which will be continued..."

During an interview with the Director of Nursing (DON) on 4/12/18 at 4pm, the DON was asked to review the progress notes for R39 from September to November of 2017, before 11/14/17 in her computer. The DON was asked if she could identify any nursing notes that indicated that R39 was starting to develop any signs of an abscess. The DON replied, "I didn't see it." The DON was then asked to review the "Weekly Skin review-V3" dated 10/30/17, 10/23/17 and 10/16/17. The DON was asked if there was any documentation of a developing abscess which would include redness, swelling, drainage or pain. The DON replied, "No..."

During an interview with R39 on 4/12/18 approximately 12:30pm, R39 was asked if he could recall the incident regarding his abscess. R39 stated that he thought it started with an insect bite, but he was not sure. When asked if he could show where the abscess was previously located, R39 pulled his shirt up and on his right lower quadrant was a pink, healed area.

During a phone interview with on 4/13/18 at 11:50am, the Medical Doctor (MD1) was asked what were her expectations of the nursing staff regarding skin changes to residents. MD1 stated that she expected, "complete clarity between me and the staff" regarding skin changes.

F 686 SS=D — Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) — F 686 — 5/21/18

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a

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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 686	Continued From page 111 resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure preventative measures were in place to prevent the development of pressure ulcer injury for one (R55) resident and to assess, document, and appropriately treat a pressure injury for one resident (R39) of five residents reviewed for pressure injuries in a sample of 37. Finding include: 1. Review of R55's Admission Record revealed R55 was admitted to the facility on 3/13/18 with diagnoses that included but not limited to: acute respiratory failure, type 2 diabetes mellitus, chronic obstructive pulmonary disease, constipation and subdural hemorrhage. Review of R55's Admission Minimum Data Set (MDS) Assessment dated 3/20/18 revealed R55's Brief Interview for Mental Status (BIMS) score was five that indicated R55 had severe cognitive impairments. Review of the same MDS revealed R55 required extensive assistance with transfer, bed mobility and toilet use. Under Section M of this same MDS, Risk of Pressure Ulcer, revealed	F 686	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide treatment and services to prevent pressure ulcers. R55 was noted to have been lying on back for a very long time. The nurse went to do dressing change and did not wash area that was reddened and noted it didn't have dressing when she went to put new one on. Documentation was inconsistent, and resident was not offloaded as necessary. R39 was noted to have reddened area that was covered with cream and dressing, but documentation showed no sign of a skin issue. On both residents wound care and documentation did not address resident's risk for skin breakdown and need for interventions. Care sheets	

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R55 was at risk of developing pressure ulcers. R55 did not have any pressure ulcers on admission.

Reviewed of R55's Weekly Skin Review revealed the following:
3/21/18 - redness to sacrum and to bilateral great toes.
3/28/18 - redness to sacrum and toes
4/4/18 - redness to toes and sacrum.

Review of R55's physician's order dated 3/24/18 revealed Mepilex (foam dressing) to sacral area daily. The order did not have instructions to clean the area before applying the Mepilex dressing.

Review of R55's care plan dated 3/19/18 revealed, "The resident has potential impairment to skin integrity of the heels and coccyx..." R55's care plan goal revealed, "The resident will maintain or develop clean and intact skin." R55's care plan intervention included: "Reposition resident every 2 hours and PRN [as needed]."

On 4/9/18 at 2:10pm, R55 was observed in bed lying on his back.

During an interview on 4/9/18 at 2:10pm with R55's son (Z1), Z1 stated that R55 complained of pain from lying in one position for long periods of time.

On 04/09/18 2:37pm, R55 was observed in bed positioned on his back with a pillow underneath his right side and legs. R55 was observed directly lying on his sacral area. R55's buttocks were not offloaded. R55 stated his buttocks were getting sore.

F 686

and care plans updated, assessments completed, and wound documentation implemented.
2.Because all residents have diagnoses which could lead to alteration in skin integrity or due to illness have potential for skin breakdown all are potentially affected by the cited deficiency, wound documentation has been reviewed, interventions for prevention are in place and documented clearly on care sheets. Weekly skin audits are completed, and staff update DON on any new areas noted immediately including reporting of any bruises, skin tears, skin breakdown or rashes. All current resident with pressure ulcers or at risk for developing pressure ulcers were assessed for comprehensive assessment along with appropriate interventions. Implementation of those interventions is reviewed on rounds weekly. Staff educated on importance of offloading, repositioning, care plan updated, care sheets updated. No other residents were affected. The policy on wound care has been updated.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all staff received in-service training for monitoring skin and pressure areas, to ensure staff always turn and reposition appropriately, understanding of offloading to prevent further alterations in skin integrity, always applying dressings to clean areas and all skin issues need to me documented and, measured. The training emphasizes the importance of following all interventions for effective skin maintenance and

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On 04/10/18 8:51am R55 was observed in bed on his back, head of bed (HOB) elevated. R55 buttocks/sacral was directly in contact with the surface of the mattress of the bed.

04/10/18 10:33am LPN1 was observed providing wound care on R55's sacral area. When LPN1 entered R55's room to do the wound dressing change, the surveyor observed that R55's sacral had no dressing. The surveyor observed R55's buttocks were reddened with approximately 15 centimeters (cm) length by 15 cm width and noted a small open area on his sacral area. When asked to describe R55's skin integrity on his sacral area, LPN1 stated, it was a scab. The surveyor observed LPN1 took a foam dressing and applied it to R55's sacral area. The surveyor observed LPN1 did not clean R55's open area before LPN1 applied the foam dressing. When asked if LPN1 had cleanse the sacral area before applying the wound dressing, LPN1 stated no.

Review of "Prevention and Treatment of Pressure Ulcers: Quick Reference Guide" by National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance, Second edition published 2014 under "Wound Care: Cleaning," indicated, "Cleansing is an important first step in preparing the pressure ulcer wound bed to heal by removing surface debris and dressing remnants and allowing better wound visualization for assessment ...1. Cleanse the pressure ulcer at the time of each dressing change ..."

Further observations of R55 revealed the following:
4/10/18 11:15am, Resident in bed lying on his back, HOB elevated, buttocks not offloaded.

F 686

reporting of changes in skin conditions. Education done on importance of comprehensive assessment of skin, pressure ulcers and implementation of appropriate interventions.
4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents with impaired skin integrity and updating MD, family and care plans with any changes to ensure appropriate follow through. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will ensure audit all residents with pressure ulcers or those at risk weekly x 4 weeks then on 6 residents weekly for 4 weeks to ensure compliance than 2 residents weekly x 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.DON will be responsible for this POC.

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F 686	Continued From page 114 4/10 18 1:30pm, Resident in bed lying on his back, HOB elevated, buttocks not offloaded. 4/10/18 3:45pm, Resident in bed lying on his back, HOB elevated, buttocks not offloaded. 4/11/18 8:20am, Resident in bed lying on his back, HOB elevated, buttocks not offloaded. 4/11/18 9:30am, Resident in bed lying on his back, HOB elevated, buttocks not offloaded. 4/11/18 2:00pm, Resident in bed laying on his back, HOB elevated, buttocks not offloaded. 4/11/18 4:30pm, Resident in bed laying on his back, HOB elevated, buttocks not offloaded. 4/12/18: 9am, Resident in bed laying on his back, HOB elevated, buttocks not offloaded. During an interview on 4/11/18 at 2pm, NA1 stated she had provided incontinence care to R55 on 4/10/18 at 7:40am and repositioned R55 with a pillow on his side. When asked if the pillow placed underneath R55's right side helped relieved the pressure on R55's buttocks. NA1 stated no. NA1 stated, "If he continues to stay on that area, the sore will get worse and we don't want that to happen." During an interview on 4/12/18 at 8:20am with NA2, NA2 stated, "I put pillows on his side but I am not able to turn him to his side all the way. When asked, if putting a pillow on R55's side relieved pressure on R55's buttocks, NA2 stated no. During an interview on 4/12/18 at 11:45am with the Director of Nursing, (DON), the DON stated that she had assessed R55's sacral area on 4/11/18 but had not entered her wound assessments notes on R55's clinical record. The DON stated that "[R55] had reddened buttocks	F 686		

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but blanchable and with some excoriations seen." When asked to describe R55's sacral area, the DON stated, R55 had 0.4cm length and 0.4cm width open area, Stage 2 (partial thickness loss of dermis presenting as a shallow open ulcer) pressure ulcer. When asked if R55 had open areas on his sacral area when R55 was admitted to the facility, the DON stated, R55 had redness. When asked about possible interventions to prevent R55 from developing a pressure ulcer injury, the DON stated, "Turn him every two hours, offload the area, monitor sites and report for any changes, and notify the physician."

Review of the facility's policy with the heading of "Wound Care" with a revised date of 12/23/17, there were no preventative measures incorporated into its policy for pressure injuries.

2. Record Review of R39's Admission Record included but were not limited to the following diagnoses: chronic kidney disease, stage 5, dependence on renal dialysis, obesity, low back pain, chronic pulmonary edema, chronic obstructive pulmonary disease heart failure and diabetes.

Record Review of R39's Quarterly Minimum Data Set (MDS) dated 3/7/18 with the heading "Section C-cognitive Pattern," R39 scored a 14 in a Brief Interview for Mental Status (BIMS) which indicated that R39 was cognitively intact. In the same MDS with the heading "Section G Functional Status," specified that R39 was "Total dependence-Full staff performance all the time..." with "Two+person(s) physical assist." In addition, under "Section M-Skin Conditions," R39 was identified as being at risk for developing pressure ulcers. R39 did not have any pressure ulcers on

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F 686	Continued From page 116 admission. During an observation on 4/12/18 at 3:50pm, a dressing change to R39's gluteal area was completed by Licensed Practical Nurse (LPN)2. It was observed that R38's gluteal area was redden with one small (less than a size of a dime) skin breakdown. The LPN2 applied lotrisone cream (antifungal cream that reduces redness, swelling and itchiness) to the redden gluteal areas and applied a mepilex (foam dressing) dressing to the one open skin area. When the LPN2 was asked as to how the skin was progressing, LPN2 stated that it was "getting better." When the LPN2 was asked, if R39 had the skin breakdown previously, the LPN2 stated that this breakdown was observed before this dressing change. Record review of R39's "Weekly Skin review-V3" dated 4/9/18, 3/26/18, 3/19/18 and 2/12/18 revealed that there were no documentation of an open skin to R39's gluteal area for nearly 60 days which contradicted LPN2's statement that R39's open skin breakdown to the gluteal area was not newly identified on 4/12/18. Review of R39's care plan under the heading of "Pressure ulcer actual or at risk..." there was no documentation that indicated that a skin breakdown was identified by the nursing staff and/or any interventions were in place to promote healing. Review of R39's progress notes dated from 2/2/18 to 4/10/18 revealed that there were no nursing notes that identified any skin breakdown to R39's gluteal area.	F 686		

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F 686	Continued From page 117 During an interview on 4/12/18 at 4pm with the DON, the DON was asked as what the expectations were of her nurses when a resident has redness or skin breakdown. The DON replied, "I would expect them to notify me, and call the physician. I would look if the current protocol is not working, and look for a new order. My role (DON serves as the facility's wound care nurse) is to look at residents' skin. I don't officially look at all redden areas. I focus on open areas." The DON was asked if she knew that R39 had an open skin area to the gluteal area, the DON replied that she did not. The DON was asked how she tracked residents with wound care concerns, the DON replied that she had a book. When the DON was asked to locate this book for review, the DON, without being asked, stated that one of her nursing assistants had informed her that R39's skin was "not healing as it should" and added "when you have minute, take a look at it." When the book was reviewed, R39's name had already been written in by the DON. The DON was then asked if she could recall the name and when the nursing assistant notified her of R39's skin changes, the DON could not. The DON was asked if there were any documentation of this interaction between her and the nursing assistant, the DON replied, "No." The DON was questioned, if she asked the nursing assistant if R39 had a skin breakdown, she could not recall if she had. During a phone interview with on 4/13/18 at 11:50am, the Medical Doctor (MD1) was asked what were her expectations of the nursing staff regarding skin changes to residents. MD1 stated that she expected, "complete clarity between me and the staff" regarding skin changes. MD1 was asked if she had been made aware of the skin breakdown to R39's gluteal area, MD1 replied	F 686		

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that she had not been notified. MD1 added, "There should be notification. Not acceptable."

Under Policy with the heading of "Wound Care" with the name of the facility's organization name with a revised date of 12/23/17 it indicated, "The purpose of this procedure is to provide guidelines for the care of wounds to promote healing... 2. Review the resident's care plan to assess for any special needs of the resident..."Under the heading of "Documentation" it indicated, "The following information should be recorded in the resident's medical record...6. All assessment data (i.e., wound bed color, size, drainage, etc.) obtained when inspecting the wound."

Review of "Prevention and Treatment of Pressure Ulcers: Quick Reference Guide" by National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance, Second edition published 2014 under "General Repositioning for All Individuals," indicated, "1. Reposition all individuals at risk of, or with existing pressure ulcers, unless contra-indicated 2. Consider the condition of the individual and the pressure redistribution support surface...Repositioning Frequency. Determine repositioning frequency with consideration to the individual's: tissue tolerance level of activity and mobility, general medical condition, overall treatment objectives...Establish pressure relief schedules that prescribe the frequency and duration of weight shifts...Regularly assess the individual's skin condition and general comfort. Reconsider the frequency and method of repositioning if the individual is not responding as expected to the repositioning regime. Frequent assessment of the individual's skin condition will help to identify the

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F 686	Continued From page 119 early signs of pressure damage and, as such, her/his tolerance of the planned repositioning schedule. If changes in skin condition should occur, the repositioning care plan needs to be re-evaluated...Repositioning Techniques 1. Reposition the individual in such a way that pressure is relieved or redistributed. When choosing a particular position for the individual, it is important to assess whether the pressure is actually relieved or redistributed. 2. Avoid positioning the individual on bony prominences with existing non-blanchable erythema...Repositioning Individuals in Bed 1. Use the 30° tilted side-lying position (alternately, right side, back, left side) or the prone position if the individual can tolerate this and her/his medical condition allows...2. Avoid lying postures that increase pressure, such as the 90° side-lying position...Limit head-of-bed elevation to 30° for an individual on bed rest unless contraindicated by medical condition or feeding and digestive considerations...Individuals should be positioned and supported to prevent sliding down in bed and creating shear forces...If sitting in bed is necessary, avoid head-of-bed elevation or a slouched position that places pressure and shear on the sacrum and coccyx."	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences,	F 695		5/21/18

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F 695	Continued From page 120 and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to: perform tracheostomy (a surgically created hole (stoma) in the windpipe (trachea) that provides an alternative airway for breathing) care aseptically (using methods to protect against infection by pathogenic microorganisms); and, put a process in place to monitor when the inner cannula was due to be changed for one (R35) of one resident reviewed for respiratory care in the sample of 37. Findings include: R35 was admitted to the facility on 2/15/18 with diagnoses which included the following: squamous cell carcinoma of skin of scalp and neck; personal history of malignant neoplasm of unspecified site if lip, oral cavity, and pharynx; and, encounter for attention to tracheostomy. Observation of LPN3 (Licensed Practical Nurse) providing tracheostomy care to R35 on 4/11/18 at 9:50am revealed that the LPN3 prepared one part of saline and two parts of hydrogen peroxide (used as an antiseptic) to make the cleaning solution and pure saline for rinsing. LPN3 soaked the reusable inner cannula in the cleaning solution and used the brush from the tracheostomy care kit to clean the inner cannula which had visible yellow colored phlegm and secretions inside the tubing. Using the same cleaning solution, LPN3 used a cotton tipped applicator to clean the outer cannula. LPN3 used another cotton tipped applicator to clean the stoma but used the same cleaning solution with visible yellow colored phlegm.	F 695	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide tracheostomy care to all residents based on appropriate diagnosis and assessment. One of the many ways that this has been achieved for R35 is determining when inner cannula should be changed. R35 has trach and it was noted that the MAR did not note when trach should be changed. Also noted policy on cleaning was not effective for proper disinfection. MD and MAR are updated. Care sheets and care plans updated. 2.Because all residents are required to have proper access and assistance with respiratory/trach equipment all are potentially affected by the cited deficiency. DON reviewed trach care and trach change orders to ensure staff updated on when to change out, monitor and clean equipment. All current residents assessed for trach changes and added to MAR. No other residents were affected. The policy on trach care has been reviewed and updated. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all staff will	

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According to the website, https://my.clevelandclinic.org/health/treatments/17568-tracheostomy-care, "...Hold the inner cannula over the basin and pour the hydrogen peroxide over and into it. Use as much hydrogen peroxide as you need to clean the inner cannula thoroughly..."

Review of the facility's "Tracheostomy Care" policy dated 12/27/17 revealed under "General Guidelines," "1. Aseptic technique must be used: a. During cleaning and sterilization of reusable tracheostomy tubes;...c. During tracheostomy tube changes, either reusable or disposable..."

Further review of the policy revealed under "Site and Stoma Care," "...2. Clean the stoma with two peroxide-soaked gauze pads...3. Rinse the stoma with saline-soaked gauze pads...4. Wipe with dry gauze...5. Disinfect the stoma with the antiseptic-soaked gauze pads...Allow to air dry or wipe with clean, dry gauze..."

Review of R35's current eMAR (electronic medication administration report) and eTAR (electronic treatment administration report) revealed that there was no process in place to monitor when R35's inner cannula was due to be changed.

In an interview with RN1 (Registered Nurse) on 4/12/18 at 3:17pm, the surveyor asked RN1 on how the nurses knew when the inner cannula was due to be changed. RN1 stated, "We have an order to change that, it's on the MAR." RN1 reviewed the eMAR and eTAR and verified that there was nothing in place to alert nurses when the inner cannula was due to be changed. RN1

F 695

receive in-service training for appropriate trach cares and trach changes and if they do not see such orders in place to initiate the conversation with the MD to update these orders. Residents with trach's have been reviewed to ensure compliance. The training emphasizes the importance of following a plan of care, reviewing diagnosis, and appropriate monitoring.
4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents with a trach. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will all residents for 6 weeks to ensure trach changed per order, cleaned per policy and documented appropriately in MAR. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.DON will be responsible for this POC.

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F 695	Continued From page 122 further stated, "There should be a physician order in the electronic health record when it should be changed." During interview on 4/12/18 at 6:35pm with the Director of Nursing (DON), the surveyor relayed the observation of LPN3 providing tracheostomy care and asked the DON of her expectations when the nurses were providing tracheostomy care. The DON stated, "It [tracheostomy care] should be according to the policy." When asked about the facility's process to monitor when R35's inner cannula was due to be changed, the DON stated, "We need to start putting that to trigger the nurses to see that it is due to be changed." A facility "Tracheotomy Care" policy dated 12/27/17 indicated under "General Guidelines," "...4. Tracheostomy tubes should be changed as ordered and as needed (at least monthly)..."	F 695		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record review, the facility failed to adhere to fluid restrictions for one resident (R38) of three residents reviewed for dialysis in the sample of 37. Findings include:	F 698	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet	5/21/18

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F 698	Continued From page 123 Record review of R38's physician order dated of 10/6/17 indicated, "1000cc [cubic centimeters]/day Fluid Restriction. Dietary provides 720cc, remaining 280cc for nursing/pleasure. Record intakes q [every] shift and document non-compliance, education/reminders given pm [post meridiem, after noon]. Every shift." During an interview on 4/10/18 at 11:57am with R38 while he was in his room, R38 was asked what amount of fluids R38 was allowed in his fluid restriction diet. R38 replied, "1500cc." On R38's bedside table there was a plastic drinking cup with an attached straw filled with approximately 550cc of water. Record review of R38's care plan under the heading of "Alteration in Respiratory Status..." the intervention listed was "has 1500ml [milliliter] fluid restriction per 24 hours" with a revision date of 3/30/17. In the same care plan under the heading of "Alteration in elimination of bowel... Encourage fluids" was listed as an intervention. Both interventions contradicted the physician's order that restricted R38's fluid intake to 1000cc per day. During an interview on 4/12/18 at 1:20pm with Nursing Assistant, (NA)6 who was provided care for R38, NA6 was asked how R38's fluid restriction was communicated to her. NA6 then presented her care plan for aides which consisted of two pages which listed the names of residents and information regarding diet, toileting, preferences, skin devices and other needs. When the care plan for aides was reviewed, under R38's name, it indicated that R38 was on a	F 698	requirements established by state and federal law. 1.It is the policy of the facility to provide dialysis care to all residents based on appropriate diagnosis and assessment. One of the many ways that this has been achieved for R38 is determining actual order for fluid intake to be 1000cc per day. After survey noted that faulty information on resident fluid restriction it was immediately addressed and the care sheets, care plan and dietary were updated. Resident will not get pitchers of water to his room. 2.Because many residents are on restrictions related to care needs and diagnosis, many are potentially affected by the cited deficiency. DON reviewed with MD the order, clarified the 1000cc and instructed staff to follow care sheets and entered in communication book. All current residents on restrictions due to dialysis were reviewed and ensured information matched and staff were aware. No other residents were affected. The policy on hemodialysis has been reviewed. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all staff will receive in-service training monitoring fluid intakes and ensuring staff are not giving resident more than they should have. The training emphasizes the importance of following a plan of care, reviewing diagnosis, and appropriate monitoring. 4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the director of nurses to	

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F 698	Continued From page 124	F 698		

"Dialysis Diet, 1500mL restriction..." NA6 confirmed that this care plan was the most recent and indicated that R38 was restricted to 1500cc on the sheet which was 500cc more than R38 was allowed.

During an interview on 4/12/18 at 1:35pm with NA7, NA7 was assigned to pass water to residents. NA7 was asked how she adhered to residents' fluid restrictions when passing water. NA7 presented an instruction sheet with "Fluid Restrictions" printed on the top. Review of this instruction sheet, listed R38's fluid restriction as 1000cc. NA7 was then asked how she followed these instructions when passing water to R38. NA7 replied, "I put more ice than water, make it mostly ice. I fill it to the top."

During an observation on 04/11/18 10:31am in R38's room, there was a plastic drinking cup with blue lines across it for the purpose of measuring the amount of fluid in the container. The amount of water measured in R38's plastic drinking cup was 500cc.

During an observation on 4/12/18 at 1:09pm in R38's room, the same plastic drinking cup on R38's bedside table was measured at 550cc with water and ice.

During an interview on 4/12/18 at 2:10pm with LPN2, LPN2 was asked to look at the amount of fluids that was in R38's drinking cup. The LPN2 replied, "600cc." The LPN2 was then asked how many cc's was R38 allowed to drink in a day. The LPN2 answered, "1000cc" and added, "that's a problem." LPN2 was asked to review R38's care plan, and confirmed that the care plan listed 1500cc instead of 1000cc as one of the

monitor residents on dialysis for fluid intake. The director of nurses or designated quality-assurance representative will perform the following systematic changes: audit 2 residents for 3 weeks than 1 resident for 5 weeks to ensure no pitchers left in room and resident not consuming more than the doctors order. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.DON will be responsible for this POC.

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F 698	Continued From page 125	F 698		

intervention for R38 which is contrary to physician's orders.

During an interview on 4/12/18 at 4:30pm with the DON, the DON was asked to review the care plan for aides. The DON confirmed that the care plan that was given to the aides included 1500cc instead of the 1000cc for R38 which was not the prescribed amount of fluids ordered by the physician. The DON stated, "This is incorrect." The DON was asked to review R38's care plan which included 1500cc of fluids as the allowed amount in R38's fluid restriction diet. After reviewing the care plan the DON stated, "He is getting over what he is supposed to get." The DON was informed that R38 was served over 500cc of water in his drinking cup (referred as water pitcher) during water pass. The DON stated, "Not the standard of care you want to maintain. Not at all... He should not get the water pitcher."

Under the Policy with the heading of "Care Plans-Comprehensive" with the name of the facility's organization name with a revised date of 12/23/17 it indicated, "The comprehensive care plan is based on a thorough assessment... Identifying problem areas and their causes, and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making. No single discipline can manage the task in isolation. The resident's physician (primary healthcare provider) is integral to this process."

Under the Policy with the heading of "Hemodialysis Policy" with the name of the

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F 698	Continued From page 126 facility's organization name with a revised date of 4/3/18 it indicated under "General Communication and Coordination of Care: The care center dietary staff, the dietary director and consultant RD [registered dietitian] participate in acting with other interdisciplinary team members to visit and observe resident's food and fluid intake and preferences. This information is useful in: Planning food and fluid choice into the restricted diet."	F 698		
F 755 SS=E	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		5/21/18

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F 755	Continued From page 127 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure route administration on resident's medication labels matched the physician's orders for one resident (R55); and failed to ensure medications were disposed properly upon discharged for one (R207) of three residents observed during a Medication Pass. Findings include: 1. Review of R55's physician orders dated 3/13/18 revealed: Bumetanide (diuretic) 1 milligram (mg) via Percutaneous Endoscopic Gastrostomy (PEG - a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus) tube two times a daily; Carvedilol (for high blood pressure) 3.125mg via PEG tube twice daily; Escitalopram (anti-depressant) 10mg via PEG tube one time a day; Finasteride (relieves symptoms of enlarged prostate) 5mg via PEG tube one time a day and Lisinopril 10mg via PEG-tube one time a day. On 4/10/18 at 9:50am, LPN1 was observed preparing R55's medications. LPN took R55's medications from the medication cart.	F 755	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to follow drug administration policies and appropriately discard medications of discharged residents. R55 had an order for meds to be given via g-tube medications stated given by mouth. The discrepancy was not noted by the nurses administering nor the pharmacy when dispensed. The order was clarified, and pharmacy instructed to follow doctor orders. R44 received medication for R207 who had been discharged it was stated facility used other meds to save money. This was reviewed with staff and medications must belong to the resident sharing medications is not allowed. If a resident is discharged medication should be removed and either sent with resident, returned to pharmacy, or discarded. 2.Because all resident rely on facility to ensure proper medication administration and right to their own medications this	

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F 755	Continued From page 128 Review of the medication labels for the following medications for R55 revealed, "Bumetanide 1mg one tab by mouth two times a daily; Carvedilol 3.125mg one tab by mouth twice daily; Escitalopram 10mg one tablet by mouth once daily; Finasteride 5mg one tablet by mouth once daily and Lisinopril 10mg one tablet by mouth once daily." The routes on R55's medication labels indicated that R55's medications were to be given by mouth however, R55's physician's order indicated that R55's medications were to be administered R55's PEG tube. During an interview on 4/11/18 at11am, when asked for the medication labels provided by the pharmacy that did not match with R55's physician's order, LPN1 stated she didn't notice the routes on the medication labels did not match the physician's order. 2. Review of R44's physician's orders dated 4/9/18 revealed Lactulose (laxative) solution give 30 milliliter (ml) by mouth two times a day for constipation. On a medication pass observation on 4/10/18 at 9:19am, LPN1 was observed preparing Lactulose solution for R44. The surveyor observed that the Lactulose given to R44 was R207's medication. During an interview on 4/11/18 at 10:30am, when asked about using R207's Lactulose for R44, LPN1 stated, it belonged to R207's who was discharged from the facility. When asked if it was appropriate to borrow other resident's medication, LPN1 stated, "No. We don't want to toss out discharged medications, so we keep them as our	F 755	citation has the potential to affect all residents. Resident medications were removed from med cart for discharged residents, any meds missing were ordered, and orders for those receiving meds via other means (not po) were reviewed. The policy on discharged residents was reviewed and updated. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff will be in-serviced on using residents medications, not substituting, removing meds from cart not in use and monitoring right route when reviewing the 5R's to medication administration. 4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the director of nurses to check all med carts and orders for residents with g-tubes. The DON or designee will complete 2 med cart audits per week x 4 weeks, then 1 audit weekly x2 months to ensure compliance. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.Pharmacy and DON will be responsible for this POC.	

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F 755	Continued From page 129 back up supplies." LPN1 stated, "But we have a dispensing box to put in left over medications for discharge residents and the pharmacy will come pick them up." Review of R207's medical record indicated R207 was discharged from the facility on 3/23/18. On 4/12/18, the surveyor requested for the facility's policy on Disposals of Medications. At the end of the survey on 4/13/18, the surveyor had not received the requested information.	F 755		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the facility was free of a medication error rate of five percent or greater. The facility had a medication error rate of 36.59 percent with 15 errors out of 41 opportunities for error involving three residents (R35, R44, and R55) who were observed during the medication pass. Findings include: 1. Review of R35's physician's orders revealed the following: a. 4/1/18 - Zinc Sulfate Capsule Give 200 mg (milligrams) via PEG-tube (percutaneous endoscopic gastrostomy) one time a day for	F 759	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to safely administer medications to the residents. This was not during medication administration audit in which 3 residents (R35, R44, and R55) received wrong meds, wrong doses, wrong route, and not assessed properly for medication	5/21/18

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Continued From page 130

dietary supplement.

On 4/10/18 at 9:41am, LPN2 was observed preparing R35's PEG-tube medications. LPN2 dispensed one pill of stock supply of Zinc Sulfate 220mg, crushed the medication, placed it in a medication cup and mixed it with approximately 3ml (milliliter) of water, and then administered it to R35 via PEG-tube separately with the remainder of the scheduled morning medications. LPN2 verified that Zinc Sulfate 220mg was administered to R35.

On 04/13/18 at 10:18am, the Director of Nursing (DON) was informed regarding the surveyor's observation with LPN2 during the medication pass. No additional information was provided.

2. Review of R44's physician's orders revealed the following:
a. 4/9/18 - Guailfenesin (cough medication) syrup 10 milliliters (ml) every four hours as needed for cough.
b. 4/9/18 - Lactulose (laxative) solution give 30 ml by mouth two times a day for constipation.
c. 4/9/18 - Miralax (laxative) give 17 grams (gm) by mouth every 24 hours as needed for constipation. Mix in eight ounces (oz) of water, juice, soda, coffee or tea prior to administration.

On 4/10/18 at 9:19am, Licensed Practical Nurse (LPN)1 was observed preparing R44's oral medications. LPN1 poured the cough medication into a calibrated medication cup and poured more than 10ml. LPN1 verified the amount and confirmed that she prepared more than 10ml. LPN1 stated, "Yeah it's a little over 10."

During the same observation, LPN1 was

F 759

administration such as neb treatments and checking placement of g-tube. When the surveyor notified nurse leadership regarding errors and magnitude of errors immediately staff were addressed, educated and counseled on poor practice. Every effort was made immediately to ensure same mistakes would not happen again.
2.Because all residents rely on staff for safe care all are potentially affected by the cited deficiency, staff were reminded to ensure all residents have their own medications, follow proper indication and administration and always use the 5R's when giving medications. All resident's medications and orders reviewed. No other residents were affected. The policy on medication administration has been updated.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff will be in-serviced on safe medication administration, medication errors, review survey findings, g-tube use for medications and proper assessments.
4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor medication administration. The director of nurses or designated quality-assurance representative will perform the following systematic audits: medication competency on all staff then med pass audits 3 staff per week x 4 weeks, then 1 staff weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot,

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F 759	Continued From page 131 observed pouring the lactulose solution into a calibrated medication cup and poured 20 ml instead of 30 ml. The surveyor also observed LPN1 borrowed R207's lactulose medication for R44's use. LPN1 confirmed that she had only 20ml available to give to R44. LPN1 was observed preparing R44's Miralax medication. LPN1 poured the Miralax powder into a cup and mixed it with 4oz of water. On 4/10/18 at 9:30am, LPN1 administered R44's Guailfenesin more that the ordered dose; Lactulose less than what was ordered and the Miralax mixed with water that was less than the ordered amount along with all R44's other medications. 3. Review of R55's physician's orders revealed: a. 3/23/18 - Diclofenac Sodium (pain medication) gel 1% apply transdermally two times a day for pain. b. 3/14/18 - Aspirin EC (enteric-coated) low strength tablet delayed Release give 81 milligram (mg) via Percutaneous Endoscopic Gastrostomy (PEG - a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and esophagus) one time a day. c. 3/20/18 - Fluticasone Propionate Suspension (used to treat nasal symptoms such as congestion, sneezing and runny nose) two sprays in both nostrils one time a day. d. 3/19/18 - Ipratropium bromide 0.5mg and albuterol sulfate (bronchodilator) 3ml inhale orally four times a day. e.3/13/18 Bumetanide (diuretic) 1mg via PEG	F 759	and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.The Pharmacy and DON will be responsible for this POC.	

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F 759	Continued From page 132 tube once daily. f. 3/13/18 Carvedilol (for high blood pressure) 3.125mg via PEG tube twice daily. g. 3/14/18 Escitalopram (antidepressant) 10mg via PEG tube once daily. h. 3/14/18 Finasteride (to reduce enlarged prostate) 5mg via PEG tube once daily. i. . 3/14/18 Lisinopril (for high blood pressure) 10mg via PEG tube once daily. j. 4/8/18 Acetaminophen (analgesic) 650mg by mouth every four hours as needed for pain and fever. k. 3/19/18 Ferrous sulfate (iron) elixir 220/5ml 1tsp 5ml via PEG tube two times a day. l. 3/13/19 Docusate Sodium (stool softener) liquid 50mg/5ml give 10ml via PEG tube two times a day. On 4/10/18 at 9:45am the surveyor noted that Diclofenac Sodium gel had a label instruction that indicated, "Use the dosing card attached inside this carton box label." The label also indicated to apply 4 gm to affected areas. Observation revealed that LPN1 did not use the dosing card. LPN1 put a small amount of the gel onto her finger and applied the gel onto R55's shoulders. On 4/10/18 at 9:50am, LPN1 was observed preparing R55's medications. LPN1 put the following tablets in one pouch, crushed at one time and poured in one cup: Aspirin EC, Bumetanide, Carvedilol, Escitalopram, Finasteride, Lisinopril and Acetaminophen. LPN1 entered R55's room, mixed the crushed medications with warm water. LPN1 opened the gastrostomy tube (GT) port, attached the syringe to the GT port then flushed the GT with 50 ml of water.	F 759		

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MOORHEAD REHABILITATION & HEALTHCARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560

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F 759		F 759		

Continued From page 133

Observation revealed that LPN1 did not check the placement of the GT before flushing the water. Then LPN1 removed the syringe and reattached the syringe (without the plunger) back to the GT port, poured R55's diluted medications into the barrel of the syringe and used the plunger of the syringe to push the diluted medications down to the tube.

Further observation revealed that LPN1 flushed the GT with 50 ml of water then used the same syringe to aspirate the Ferrous Sulfate elixir from the medication cup. Using the same syringe, LPN aspirated the docusate sodium liquid from the other medication cup. LPN1 mixed the two liquid medications in one syringe, attached the syringe to the GT port and used the plunger to push the liquid medications down the tube.

On 4/10/18 at 10am, LPN1 was observed administering nasal spray to R55. LPN1 sprayed one spray instead of two sprays in each nostril.

On 4/10/18 at 10:20am, LPN1 was unable to find R55's face mask for his nebulizer treatment (a drug delivery device used to administer medication in the form of a mist inhaled into the lungs). LPN1 then use a mouth piece to administer R55's nebulizer treatment. R55's opened his mouth, then LPN1 put the mouth piece into R55s' mouth and turned on the nebulizer machine. Observation revealed that LPN1 did not provide R55 instructions to breathe in an out during the procedure. R55 fell asleep during the administration of the nebulizer treatment and was not able to adequately inhale the mist of the medication.

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F 759	Continued From page 134 On 4/10/18 at 5:15pm, the surveyor informed the Regional Director of Nursing (RDCS) and the Director of Nursing regarding the surveyor's observation with LPN1 during the medication pass. The RDCS stated there had performance issues and concerns with LPN1. During an interview on 4/11/18 at 10:30am, LPN1 stated that she did not have enough Lactulose to give R44. LPN1 also stated, "I only gave 20 ml." LPN1 further stated that she had to give R44's Miralax to supplement the missing dose of lactulose. When asked if R44 had asked for a Miralax, LPN1 stated no. When asked about the borrowing R207's (discharged resident) lactulose medication, LPN1 stated that it was R207's medication. When asked if it was appropriate to borrow other resident's medication, LPN1 stated, "No. We don't want to toss out discharged medications, so we keep them as our back up supplies." LPN1 was also asked about the amount of water mixed in with R44's Miralax powder. LPN1 stated, "Our cups can only be filled up to five oz. I should have used two medication cups, 4 oz per cup to dilute the Miralax powder." During an interview on 4/11/18 at 11am with LPN1, LPN1 stated that she tried to locate the dosing card of the Diclofenac Sodium gel for R55. LPN1 further stated that she never saw the dosing card in the box and had never used it at all. When asked if it was appropriate to crush R55's enteric coated aspirin, LPN1 stated, "No, it defeats the purpose of delayed release." When asked about the number of nasal spray she administered to R55, LPN1 stated, "I sprayed one for each nostril, I thought the order was one spray for each nostril." When asked about the nebulizer administration for R55, LPN1 stated, "I know I	F 759		

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didn't have a face mask to use but I used a mouth piece. When asked if she instructed R55 to breath in and out, LPN1 stated, "No, not really." When asked if R55 nebulizer treatment was administered appropriately, LPN1 stated, "I guess not."

On 4/11/18 at 11:10am LPN1 when asked about giving medications via GT tube, LPN1 stated to check the placement first. When asked if she checked R55's GT placement before she flushed the water, LPN1 asked herself if she did or not and stated, "I wasn't sure." When asked if crushing meds all at the same time, giving all the medications all at one time via R55's tube and using the plunger of the syringe to administer R55's medications were appropriate nursing practices, LPN1 remained silent and made no further comments.

Review of R55's physician's orders indicated no written orders to crush R55's medications. Further review of R55's medical record indicated no information regarding the risk and benefits of combining and giving R55's medications all at once via his GT.

Review of the facility's undated policy, "Administering Medication through an Enteral Tube" indicated, " Do not mix medications together prior to administering through an enteral tube. Administer each medication separately...Do not crush or split medications for administration through an enteral tube unless first checking with the pharmacy or facility approved 'Do Not Crush Medication List' ...Tablets that must be crushed prior to administration through an enteral tube require a specific order related to crushing...Do not crush enteric coated...Check gastric residual

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F 759	Continued From page 136 volume [GRV] to assess for tolerance of enteral feeding...When correct tube placement and acceptable GRV have been verified...Administer medication by gravity flow. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion...If administering more than one medication, flush with 15 mL (or prescribed amount) warm sterile or purified water between medications." Review of the facility's policy created on l2/27/2017 and reviewed on 4/3/2018, Medication Administration indicated, "Medications must be administered in accordance with the orders, including any required time fram...The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication."	F 759		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized	F 761		5/21/18

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F 761	Continued From page 137 personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure proper medication storage for eight residents (R35, R10, R19, R16, R40, R44, R55 and R207) and one of two observed medication carts, from a total of three facility medication carts and one medication storage room. 1. On 4/10/18 at 9:19am, LPN1 was observed preparing R44's medications. LPN1 took a Lactulose (laxative) solution from the medication cart that belonged to R207 for R44's use. During a medication pass observation on 4/10/18 at 9:50am, LPN1 prepared R55's medications, Aspirin EC (enteric-coated); Fluticasone Propionate Suspension (treat nasal symptoms such as congestion, sneezing and runny nose); Bumetanide (diuretic); Carvedilol (for high blood pressure); Finasteride (to reduce enlarged prostate); Escitalopram (antidepressant); Lisinopril (for high blood pressure); Acetaminophen (analgesic); Ferrous sulfate (iron) elixir; and, Docusate Sodium (stool softener). LPN1 was unable to find the medication for R55, Omeprazole. LPN1 left the nurse's station, left the	F 761	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to follow safely store and appropriately discard medications of discharged residents. Multiple residents were noted to have medication errors. Medications stored in med carts and storage room were not labeled correctly, discarded, med carts were left unlocked and unmonitored, medications were left on cart and medications left in cart dispensed but unlabeled. This was reviewed with staff immediately; medications must belong to the resident sharing medications is not allowed, med carts never to be left unlocked and unattended, medications must be labeled, and medications must be always stored in secured cart prior to	

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F 761	Continued From page 138 medication cart unlocked and left all R55's medications of top of the med cart unsupervised. During an interview on 4/11/19 at 10:45am, LPN1 stated R207 had been discharged and R207's lactulose should not be in the medication cart for other resident's use. When asked about the procedures on how to dispose medications when residents are discharged from the facility, LPN1 stated, "We don't want to toss out discharged medications, so we keep them as our back up supplies." When asked how to ensure residents medications were safely secured, LPN1 stated, "Always lock the medication cart." When asked if LPN1 left the cart locked shook her head and said, no. 2. On 4/13/18 at 10:16am, the surveyor observed an unlocked medication cart parked by the 400 hallway with the following medications found on top of the medication cart: R35's omeprazole; R10's Gabapentin and Lovenox; R19's Insulin pen and medication house stocks of Lactulose and Miralax medications. On top of the medication cart there were also several lancets. At 10:20am, LPN2 came out from a resident's room. During an interview on 4/13/18 at 10:20am with LPN2, when asked about the unlocked medication cart and the medications found on top of the medication cart, LPN2 stated, it was an oversight. When asked how to ensure resident's medications were safely secured, LPN2 stated to lock the cart and not to leave any medications on top of the medication cart unless attended. On 4/12/18 and 4/13/18, the surveyor had requested from the Regional Director of Clinical	F 761	giving. 2.Because all resident rely on facility to ensure proper medication administration and right to their own medications this citation has the potential to affect all residents. Resident medications were removed from med cart for discharged residents, any meds missing were ordered, and med carts monitored for being locked. The policy on medication storage was reviewed and updated. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff will be in-serviced on using residents medications, not substituting, locking med cart, labeling meds, removing meds from cart not in use and monitoring right route when reviewing the 5R's to medication administration. 4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the director of nurses to check all med carts and medication passes. The DON or designee will complete 2 med cart audits per week x 4 weeks, then 1 audit weekly x2 months to ensure compliance. All staff will do medication administration competency and then have med pass audits completed 3 staff per week x 4 weeks, then 1 staff weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective	

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F 761	Continued From page 139 Services the facility's policies and procedures on Dispositions of Medications. On 4/13/18 at 1pm, at the end of the survey, the surveyor had not received the requested information. 3. On 4/9/18 at 3:30pm a clear medication cup filled with approximately five pills was observed in an unsecured open drawer in R16's room. At the time of the observation, R16 had confirmed that the pills were his morning medications. Observation of the "Group 2" medication cart on 04/12/2018 at 6:56pm with TMA (trained medication aide) 1 and the MDS Coordinator revealed there were two clear medication cups filled with loose pills located in the top drawer of the medication cart. TMA1 had identified that the medications belonged to R40 and R44. TMA1 stated that both residents had refused their medications at the time of the evening medication pass and that she was "saving those for later." Further observation of the "Group 2" cart revealed a total of five loose pills located in the second drawer of the medication cart. On 4/13/18 at 10:18am the Director of Nursing (DON) was informed regarding the above findings. The DON stated the expectation was to encourage the resident to take the medications and if resident refused then the medications should be disposed. A medication storage policy was requested from the facility, however one was not provided upon survey exit.	F 761	action. 5.Pharmacy and DON will be responsible for this POC.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		5/21/18

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F 812	Continued From page 140 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure food past the storage date was not available for resident consumption. This had the potential to affect 51 of the 53 residents that received food from the kitchen. Findings Include: During the initial tour of the kitchen, an observation of the walk-in refrigerator on 04/09/2018 at 1:35pm, revealed a clear plastic food container of egg salad dated 04/02/2018, and a loaf of banana bread with a label of "prep date" of 04/04/2018. A review of the "drink and snack" (according to the sign on the door) refrigerator, at 1:45pm on	F 812	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to ensure healthy and safe meal service. Some of the many ways that this has been done is ensuring clean environment and safely preparing and serving food and beverages to residents. After the surveyor reported finding expired dates or undated items in kitchen it was determined staff not properly managing expired foods.	

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04/09/2018, revealed a gallon pitcher labeled as "Iced Tea" dated "04/03/18."

As the tour continued, at the dish washing room, it was noted the egg salad container and loaf pan (now empty) were on a cart with other dirty dish and cook ware.

In an interview on 04/09/2018 the acting Dietary Manager (DM) stated the items were past their use by date, and the banana bread had been thrown away. In an interview on 04/12/2018, the acting DM stated food "should have open and use by date - always an open date, but I know what has to be thrown out in 5 - 7 days." The DM was unable to provide a policy that addressed when to discard food.

A review of the facility provided, undated, "Refrigerated Food Storage Policy," revealed: "The Dining Services department will store refrigerated foods at 41o (degrees) F (Fahrenheit) or below and in such a manner as to avoid spoilage and contamination according to policy guidelines and federal, state, and local regulations."

A review of the FDA (Food and Drug Administration) website on 04/15/2018 at https://www.fda.gov/Food/ResourcesForYou/Consumers/ucm077342.htm revealed:
"Storing: Proper storage of eggs can affect both quality and safety.
-Use hard-cooked eggs (in the shell or peeled) within 1 week after cooking.
-Use frozen eggs within 1 year. Eggs should not be frozen in their shells. To freeze whole eggs, beat yolks and whites together. Egg whites can also be frozen by themselves.

Immediately the dietary manager threw out items and updated staff to monitor dates.
2.Because all residents receive their meals here in facility all are potentially affected by the cited deficiency, 4/17/2018, the dietary manager did deep clean of the fridge to remove all outdated items. Cleaning out fridge items that are expired is now done daily with kitchen cleaning schedule.
3.To enhance currently compliant operations and under the direction of the director of dietary, on 5/7/2018 dietary staff reviewed proper storage and dates with dietary manager to ensure all items are safe to serve.
4.Effective 4/28/2018, a quality-assurance program was implemented under the supervision of the director of dietary to monitor fridge for expired items. The director of dietary or designated quality-assurance representative will perform audits of fridge to be done 2x per week for 4 weeks then 1x per week for 2 months to ensure compliance via dietary manager or designee. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly QAPI meeting for further review or corrective action.
5.Dietary manager and maintenance will be responsible for this POC.

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F 812	Continued From page 142 -Refrigerate leftover cooked egg dishes and use within 3 to 4 days. When refrigerating a large amount of a hot egg-containing leftover, divide it into several shallow containers so it will cool quickly." In a telephone interview on 04/13/2018 at 10:18am, the consultant Registered Dietician stated that 51 of the 52 residents received food from the kitchen.	F 812		
F 865 SS=E	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to maintain a quality assessment and assurance (QAA) committee that was effective in identifying and responding to quality deficiencies. This deficient practice had the potential to affect	F 865	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that	5/21/18

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F 865	Continued From page 143 all 53 residents in the facility. Findings include: During an interview on 4/13/18 at 8:30am, the Executive Director provided information on specific problem areas that had been recently identified or performance improvement changes that had been made which only included the following: reduce the number of short stays successfully discharged to community, reduce short stay resident pain levels, increase the number short stay resident influenza vaccines, increase the number of short stay resident pneumococcal vaccines, decrease the number of short stay resident antipsychotics, and decrease the number of residents with pain in long stay residents. The facility's QAPI committee failed to identify potential quality issues as evidenced by the following: 1. The facility failed to develop an abuse policy that: a) included mistreatment and exploitation as types of alleged violations; b) ensured that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property are reported to the administrator and State Survey Agency within the required reporting timeframes; and) report the results of all investigations to the administrator or his or her designated representative and to the State Survey Agency within 5 working days of the incident. 2. The facility's staff failed to report an allegation of possible abuse immediately to the	F 865	one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to ensure that the Quality Assurance Performance Improvement committee identifies and develops appropriate action plans related to system failures. The facility failed to have appropriate action plans related to system failures including abuse program, investigations and reporting. Pressure ulcers, medication issues (errors, storage), and tracheostomy care. QAPI met on 4/30/18 where it was identified by Administrator that present system was not reviewing operations, identifying OFIs, prioritizing OFIs, determining the root cause and implementing PIPs. In discussion with Medical Director and QAPI members, it was determined and reviewed that QAPI had previously been ineffective. Administrator educated everyone on the QAPI program, the guidelines, processes and how to analyze data, etc. to begin to effectively address systemic failures to improve quality at facility. 2.Lack of appropriate action plans for system failures can affect all residents at the facility. After identifying system failures from survey, ad hocs were identified and implemented, and brought to QAPI on 4/30/2018. At this meeting, opportunities for improvement were identified, prioritized, root cause was determined, and performance improvement plans were initiated, reviewed and continue to be monitored.	

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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 865	Continued From page 144 administrator, and the facility failed to report this allegation to the State within the required time of two hours for one (R20) resident and failed to report allegations of resident-to-resident abuse immediately to the administrator affecting two residents (R22 and R258) reviewed for abuse. 3. The facility failed to thoroughly investigate and protect a resident in an allegation of possible abuse for one (R20) resident and failed to thoroughly investigate allegations of resident-to-resident abuse affecting two residents (R22 and R258) reviewed for abuse. 4. The facility failed to assess, monitor and provide timely interventions to prevent aspiration pneumonia for one (R55) resident reviewed for tube feeding. 5. The facility failed to ensure preventative measures were in place to prevent the development of pressure ulcer injury for one (R55) resident and to assess, document, and appropriately treat a pressure injury for one resident (R39)reviewed for pressure injuries. 6. The facility failed to ensure it was free of a medication error rate greater than 5% that affected three residents (R35, R44, and R55.) 7. The facility failed to perform tracheostomy care aseptically and put a process in place to monitor when the inner cannula was due to be changed for one (R35) of one resident reviewed for respiratory care. 8. The facility failed to ensure proper medication storage for eight residents (R35, R10, R19, R16, R40, R44, R55 and R207) and one of two	F 865	3.To enhance currently compliant operations and under the direction of the Administrator, education reviewed the elements and goals of the QAPI program, assistance and tools for accurate data review, and proper identification of root cause while assuring goals are SMART (specific, measurable, attainable, realistic and time oriented). All staff will receive in-service training regarding QAPI program, who is on the committee and their roles, what is discussed, frequency of meetings, who to report suggestions to bring to QAPI, where monthly posting of review of prior months QAPI are, etc. 4.The QA committee will meet monthly to discuss action plans related to deficiencies noted during survey, review and analyze audits and determine appropriate continued monitoring or system changes in addition to other items already identified on the QAPI plan agenda. The medical director will be present monthly and pharmacy consultant will be present at a minimum quarterly; if not present minutes will have submitted to them prior to meeting to allow for input during meeting, then will be reviewed and signed monthly. Audits are in place and reviewed monthly to assure that all supporting documentation from each department head is submitted to the Administrator the Monday prior to meeting for adequate time to review. After QAPI the minutes and supporting documentation will then be sent to RDCS and COO for review. This plan of correction will be monitored at the monthly QAPI meeting and audits to continue until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING ______ B. WING ______	04/13/2018

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MOORHEAD REHABILITATION & HEALTHCARE CENTER	**2810 SECOND AVENUE NORTH MOORHEAD, MN 56560**

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F 865	Continued From page 145 observed medication carts, from a total of three facility medication carts and one medication storage room. Review of the facility's "Quality Assurance and Performance Improvement plan," undated, indicated "...II. Program Feedback, Data Systems and Monitoring this is an ongoing process to monitor data based on assessment with having a goal of reducing areas that are flagging and resulting in overall improvement of performance, increasing star rating and resulting in higher resident satisfaction. The data is gathered and discussed quarterly with the QA committee..."	F 865	such a time that shows consistent substantial compliance with the regulations and the facilities' QAPI plan has been met, as determined by a representative of the regional executive team. 5.The Administrator or designee will be responsible for this POC.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880		5/21/18

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F 880	Continued From page 146 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 147 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow proper infection control practices related to the storage of nebulizer mask when not in use by one (R18) resident in the sample of 37. Findings include: R18 was admitted on 12/23/16 with a diagnoses that included cerebral infarction, hemiplegia, anxiety and pain. Review of R18's Medication Administration Record (MAR) dated 4/01/18 through 4/030/18 revealed an order for "DuoNebs (Dual Nebulizer) Solution 05.-2.5 (3) MG [milligrams].ML[milliliters] Ipratropium Albuterol 1 dose inhale orally four times a day..." An observation on 4/09/18 at 2pm revealed R18 had a nebulizer mask attached to his nebulizer, laying uncovered on his bedside table. The tubing on the nebulizer was undated. An observation on 4/10/18 at10am revealed the nebulizer mask laying uncovered on the bedside table. The tubing on the nebulizer was undated. An observation on 4/11/2018 at1pm revealed the nebulizer mask laying uncovered on the bedside table. The tubing on the nebulizer was undated. An observation on 4/12/2018 at10am revealed	F 880	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1It is the policy of the facility to provide infection prevention practices. Upon survey it was noted resident R18 had neb mask at bedside which was not cleaned and undated. Policy of dating and cleaning was not being followed. Immediately facemask changed out and dated. 2Because many resident's use face masks, many are potentially affected by the cited deficiency. All residents on who use oxygen or nebulizers were reviewed and supplies switched out and labeled. The policy on nebulizers has been reviewed. 3To enhance currently compliant operations and under the direction of the director of nurses, on 5/9/2018 all nursing staff will be in-serviced on nebulizer masks, cleaning and allowing air dry, dating all types of masks and tubing, and basic infection prevention policy. 4Effective 4/28/2018, a quality-assurance program was implemented under the	

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F 880	Continued From page 148 the nebulizer mask laying uncovered on the bedside table. The tubing on the nebulizer was undated. On 04/12/2018, at 1:45pm during an interview with the Director of Nursing (DON), who was also the facility's Infection Prevention, stated she expected all staff to follow the facility's infection control policies including proper sanitizing and storage of R18's nebulizer mask. An undated policy, titled "Administering Medication through a Small Volume (Handheld) Nebulizer" under the section "Steps in the Procedure: Step 29. When equipment (facemask) is completely dry, store in a plastic bag with the resident's name and the date on it. Step 30. Change equipment and tubing every seven days or according to company policy."	F 880	supervision of the DON to monitor nebulizer supplies. The DON or designated quality-assurance representative will perform the following systematic audits on residents with nebulizers; 3 residents per week x 4 weeks, then 1 resident weekly x2 months to ensure compliance in this area – dating, cleaning and changing weekly. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5The DON will be responsible for this POC.	
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff.	F 947		5/21/18

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F 947	Continued From page 149 §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide resident abuse prevention training for one nursing assistant whose personnel record was reviewed. This deficient practice had the potential to affect all 53 residents in the facility. Findings include: During an interview on 4/11/8 at 3:30pm, R20 stated that nursing assistant (NA)4 is "too rough...She told me that I'm mean and then she ignores me." R20 added that NA4 speaks harshly to her when NA4 asks R20 "What do you want?" and that she speaks this way to R20 often. On 4/12/18, at 7:45am NA4's transcripts from the facility's Relias (web-based training) site were reviewed. The transcript indicated resident abuse prevention training had not been completed by NA4 in 2017 or 2018. On 4/12/18, at 9am, E1 reviewed NA4's training transcript in the facility's Relias web based training system. E1 stated the transcript indicated NA4 had not completed the resident abuse prevention training within the last year. E1 stated that E4's last training was provided upon hire on December 2016. On 4/13/18 at 8:19am, the Executive Director was asked about the apparent lack of mandatory annual abuse training for NA4. No additional	F 947	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to ensure trainings for nursing aides is completed annually. The facility failed to provide resident abuse training to one NAR as required by the regulation. 2.The facility has determined that all residents have the potential to be affected by this deficient practice if staff are not adequately trained on abuse, neglect and exploitation upon hire and annually. Nursing aids out of compliance must complete training requirements through Relias of 12-hoour training by 5/20/2018. 3.Beginning 4/28/2018 staffing coordinator provided Relias training modules for all staff to complete abuse, neglect and exploitation requirements by May 20th, 2018. On 5/9/18 the DON (or designee) will provide all staff with the resident safety manual to reinforce information. A procedure has been implemented for staffing to set up all staff with new hires and annually to assure enrollment, monitoring and completion being	

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F 947	Continued From page 150 information was provided. Review of the facility's abuse policy titled "Vulnerable Adult," revised 12/23/17, under "Training," stated "All employees will be required to attend training through orientation and annual meetings on issues related to abuse prevention/intervention. This includes: 1. Appropriate interventions to deal with aggressive and/or catastrophic reactions of residents/patients. 2. How staff should report their knowledge of allegations without reprisal. 3. How to recognize signs of burnout, frustration and stress which may lead to abuse. 4. What constitutes abuse, neglect and misappropriation of resident/employee property."	F 947	reviewed. 4.Audits will be completed weekly on all staff to assure compliance, and with new employees during that time frame to assure compliance and any deficiencies noted will be corrected on the spot. The educational status of employees has been added to review indefinitely and ongoing at every QAPI to assure monthly the staffing coordinator or Designee is monitoring all staff nursing aides to complete annual 12-hour training. 5.The staffing coordinator (or designee) will be responsible for the POC.	

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: VNGR
Facility ID: 00938

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245052**

2. STATE VENDOR OR MEDICAID NO.
(L2) **154578700**

3. NAME AND ADDRESS OF FACILITY
(L3) **MOORHEAD REHABILITATION & HEALTHCARE CENTER**
(L4) **2810 SECOND AVENUE NORTH**
(L5) **MOORHEAD, MN** (L6) **56560**

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) **02/01/2017**

6. DATE OF SURVEY **03/13/2018** (L34)

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
IJ was cited at F 689 -- IJ removed March 13, 2018 but remained at the lower s/s of G
IJ of K cited at F812 - IJ removed March 9, 2018 but remained at the lower s/s of E
3 G's cited at F 676, F 686 and F 697

17. SURVEYOR SIGNATURE — Date :
Jonathan Anderson, HFE NE-II — 04/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Douglas S. Larson, Enforcement Specialist — 05/02/2018 (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
03/01/1979
(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.
01111
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Submitted
March 30, 2018

Mr. Jesse Doschadis, Administrator
Moorhead Rehabilitation & Healthcare Center
2810 Second Avenue North
Moorhead, MN 56560

RE: Project Number S5052027

Dear Mr. Doschadis:

On March 13, 2018, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on March 9, 2018, that the conditions, cited at F812, 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.

We also verified, on March 13, 2018, that the conditions, cited at F689, 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Gail Anderson, Unit Supervisor
Fergus Falls Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1505 Pebble Lake Road, Suite 300
Fergus Falls, Minnesota 56537-3858
Email: gail.anderson@state.mn.us
Phone: (218) 332-5140
Fax: (218) 332-5196

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 April 4, 2018. (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 deficiencies cited at F689, F812, F676, F686, F697. (42 CFR 488.430 through 488.444)

CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective June 1, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 1, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 1, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

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, Moorhead Rehabilitation & Healthcare Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 13, 2018. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

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

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

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

• Per day civil money penalty for the deficiencies cited at F689, F812, F676, F686, F697. (42 CFR 488.430 through 488.444)

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the

criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by June 1, 2018, the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 13, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900

St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING ______ B. WING ______	03/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD REHABILITATION & HEALTHCARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted March 6th, March 7th, March 8th, March 9th, March 12th and March 13th, 2018, during a recertification survey. The Condition of Participation 483.73: Establishment of the Emergency Program was found not met. 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	E 000		
E 001 SS=F	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness	E 001		4/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/09/2018

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

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E 001	Continued From page 1 program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to establish an emergency plan which meets the conditions of participation for emergency preparedness which included policies and procedures, communication, community based emergency drills, and staff training to meet the health, safety and security needs staff and patient population during an emergency or disaster. This deficient practice had the potential to affect all 59 residents residing in the facility. Findings include: A review of the emergency preparedness plan for the facility was conducted on 3/9/18 at 12:15 p.m., with the Director of Maintenance (DOM) present. The DOM indicated he had heard of appendix Z, was not aware of all the requirements and was unsure the status of the emergency plan for the facility. The DOM provided various documents for review: -A document titled Kaiser Permanente, Hazard and Vulnerability Assessment Tool, Naturally Occurring Events undated, which listed various events such as active shooter, bomb threat, mass casualty incident, suspicious odor, transportation failure, water disruption and zombies and	E 001	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because the provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1.All Golden Living stuff was removed from binder, and information was updated to reflect current facility name and policies. 2.An Emergency Plan will be developed by ED and DOM to address how the facility will coordinate with other healthcare facilities and the community as a whole during an emergency or a disaster. 3.ED set up meeting with Clay County Emergency Manager Bryan Green. The meeting will take place at Moorhead Rehab on 4-18-18. Nursing Homes in the community have been invited and staff	

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E 001	Continued From page 2 included the percent of risk for each category. However, the assessment did not include an assessment of the resident population and special needs of that population. -Disaster, Fire and Evacuation Plan, revised 10/17, which contained an organizational chart for the facility, and a list of telephone numbers for emergency services such as ambulance, city engineer, police department, transportation services and repair services and an employee telephone list. In addition, the manual contained a policy titled Golden living Center Moorhead, Emergency Management, updated 10/11/16, which addressed an emergency response such for fire, armed robbery, suspicious mail within the facility. - Emergency manual which contained policies for such emergency response as how to evacuate the building, Snow Emergency/Blizzard, Tornado Safety, Hurricane, Elopement, nuclear attack, Hot Work Operations, Fire Alarm System Impairment, General Evacuation,and Active Shooter. All the policies in the manual were titled Golden Living Center and had last been reviewed/revised on 10/16. Establishment of an Emergency Plan and policies and procedures for the emergency plan. The facility's various policy's did not address how the facility would coordinate with other healthcare facility's and the community as a whole during an emergency or disaster, nor had the policies and procedures that were provided been reviewed annually.	E 001	from FM Ambulance Services will be in attendance to go over emergency preparedness information. 4.ED will set up a full-scale evacuation drill with the help of community resources such as the Fire Department and Ambulance Services. 5.Full scale evacuation and table top exercise will be done annually with the participation of staff. 6.Transfer agreements have been signed by ED and sent to Essentia Health and Sanford Health on 4-3-18. They indicated they would sign but needed to send to legal team first. 7.A memo will be placed on the communication board and in the communication book notifying staff that the Emergency Preparedness Binder has been updated and they should familiarize themselves with it. 8.An all staff meeting will be conducted on 4-24-18 to discuss and train staff on the emergency preparedness information. 9.The Emergency Preparedness Binder will be revised and updated annually. 10.The ED and DOM are responsible for this POC.	

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E 001	Continued From page 3 Communication: the facility lacked documentation of a plan on communicating within the facility, with the community, and other agencies, to identify how the facility coordinates patient care within the facility, across healthcare providers, and with state and local public health. Training: Review of the training records provided by the facility revealed staff had been trained on a tornado warning response within the facilty. However, the records lacked documentation of any further training on a emergency plan for the facility which included policies and procedures had been developed from an all hazards approach assessment. Full Scale Exercise and or Table Top Exercise: review of documentation of Simulated Tornado Watch and Simulated Tornado warning, conducted on 6/15/17 revealed the facility had held a tornado watch and warning exercise within the facility and had moved residents into the hallways of the facilty. However, the exercises identified only facility staff were involved, and lacked documentation of coordination with the community and other agencies Further, the documentation lacked evidence the facility had participated in a community exercise, with various other agencies participating in the exercise. On 3/9/18, at 12:30 p.m. the DOM stated he had been hired in the facility approximately 6-8 weeks prior and was not sure what the status of the emergency plan was for the facility. He indicated there had been several other people that had worked on a emergency plan for the facility, and he was not sure what policies and procedures were in place at present and confirmed the policies provided had last been updated in 2016.	E 001		

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E 001	Continued From page 4 He indicated he was unsure when the vulnerability assessment tool had been completed, and stated "maybe last July" and was unsure if any analysis of the assessment had been done The DOM confirmed the training records, and stated he was unaware of any further training records nor had he conducted any training since he started in the facility.	E 001		
F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on March 6, 7, 8, 9, 12, and 13, 2018. The survey resulted in an Immediate Jeopardy (IJ) at F689 when R1 had not been comprehensively assessed for falls to determine effective interventions to prevent injury. Further, the facility inappropriately implemented the use of multiple floor mats for R1, which increased R1's risk for falls and injury. R1 continued to self transfer and sustain falls, which resulted in a risk for serious harm, injury or death due to his ongoing falls. The IJ began on 11/23/17, and was removed on March 13, 2018 at 2:00 p.m. In addition, the survey resulted in an IJ at F812 when R25 and R35 identified to consume unpasteurized, fried eggs on a routine basis; and for 27 of 27 additional residents R22, R7, R26, R108, R38, R37, R9, R45, R5, R44, R28, R42, R27, R55, R114, R56, R10, R29, R4, R208, R14, R209, R12, R20, R25, R52, and R30 identified by the facility to consume the unpasteurized, fried or undercooked eggs and who were at increased risk of contracting a potentially life-threatening Salmonella infection as a result. The IJ began on 10/10/17, and was removed on March 9, 2018 at 1:38 p.m..	F 000		

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F 000	Continued From page 5 As a result of identifying substandard quality of care, an extended survey was conducted on March 9, 2018. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess safety with self administration of medication for 2 of 2 residents (R31, R107) who stored medication in their room and were administering the medication. Findings include: R31's 30-day Minimum Data Set (MDS) dated 1/25/18, identified R31 had intact cognition. On 3/6/18, at 7:05 p.m. R31 was seated in a	F 554	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide adequate supervision and assistance with medication administration. One of the	4/23/18

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F 554	Continued From page 6 wheelchair in his room watching television. He had a bedside table immediately next to him on his left side which had two orange colored medication bottles sitting on top. R 31 stated he was self administering the medications in his room. R31 then moved a napkin which exposed two single pills placed on the table. R31 referred to these as his "white pill" and his "blue and dark blue" pills, and handed one bottle to the surveyor for review. The first orange colored bottle had a pharmacy label affixed to the side, which listed hydrocodone with acetaminophen (a narcotic) and filled on 11/29/17, with directions to administer one tablet every four hours as needed for pain. The bottle was approximately 1/2 full with oblong, white pills and R31 stated he took these pills "twice a day." The second orange colored bottle had a pharmacy label affixed to the side, which listed cephalexin (an antibiotic), however, R31's hand was covering the remainder of the label and he would not allow the surveyor to review. R31 stated this was his antibiotic for a foot infection he had and the pills were "hard to take" sometimes. When questioned on how many he was taking a day, R31 responded, "[I] think its six tablets." R31's Order Summary Report dated 1/4/18, identified an order for hydrocodone-acetaminophen 5/325 mg (milligrams) 1 tablet every 4 hours as needed; however lacked any physician order for cephalexin to be administered. Further, the physician orders lacked any dictation or input from the physician on R31 self administering medications.	F 554	many ways that this has been achieved for resident #31 is by reviewing medication policy and self-administration policy with resident and asking if R31 would like to have option of keeping meds at bedside which was determined to be nitroglycerin and tums. R31 was reviewed for knowledge of medications, safe use, dosages and administration. Order in place and care plan updated. R107 was noted to have orajel at bedside and reviewed medication use, safety and ability to use correctly. R107 can have gel at bedside, order in place and care plan updated. In this case, after the surveyor reported the medications found at bedside, the staff was reminded to report immediately to nursing to ensure self-administration assessment is completed, an order obtained, and care plan updated. The policy to be reviewed at next resident council meeting and with all new admits ensuring understanding of facility policy. 2.Because all residents receiving medications are potentially affected by the cited deficiency, 4/4/2018, the director of nursing along with ED in-serviced all staff to ensure understanding of reporting any medications including gels and OTC meds to nursing for review. The policy of self-administration was reviewed, and the assessment process was discussed so nursing staff understood importance of safely allowing residents the option of self-administering vs. allowing staff to do. The option of self-administration will be discussed at resident council and the rules of keeping medications at bedside.	

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F 554	Continued From page 7 R31's care plan dated 1/19/18, identified R31 had cellulitis (infection of soft tissue) is his foot and chronic pain and directed staff to administer medications associated with these including his antibiotic(s) and hydrocodone. The care plan lacked any dictation or interventions pertaining to R31 self administering his own medications. R31's progress note dated 2/26/18, identified R31 had complaints of chest pain and recorded R31 as saying, "I take Tums for it, I got it in my room for that purpose." On 3/7/18, at 9:58 a.m., R31 was again seated in his room in his wheelchair. There were no bottles or medications visible on his bedside table. R31 stated he put them in his dresser and showed them to the surveyor. R31 then closed his eyes mid sentence which lasted for several seconds before he awoke saying "[I] think I'm going to die." R31 did not elaborate further. R31 stated his foot infection and the associated pain, was the reason he took his "pain pill," however, his pain was never totally relieved. When questioned about his medication bottles he responded he "shouldn't be using them" and instructed the surveyor to not report them to staff. On 3/7/18, at 10:17 a.m. licensed practical nurse (LPN)-C and trained medication aide (TMA)-A were notified of R31's medications in his room. Neither were aware R31 was self administering medications, however, TMA-A reported staff had removed medications from his room on several occasions, mostly recently just a couple weeks prior. TMA-A explained she reported this to the nurses and it was "in their hands," and stated she was unaware of any follow up which had taken place since then.	F 554	All residents will be interviewed to see if they have meds in room and accordingly determine if they can be assessed and that they understand policy. Nursing staff and housekeeping will update DON immediately if after interviews with all residents completed and individual discussion any medications including OTC's are found in room. In addition, all new residents will be updated on policy of facility upon admission and random room audits will be completed on all residents to ensure no medications are found that are not administered by the facility without self-administration assessment and order. Any residents that choose to self-administer will store their medications in top drawer of nightstand and have a private key for that drawer for safe storage for resident to access self-administered medications safely. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all staff received in-service training regarding state and federal requirements for self-administration of medications and updated on the 2 residents, R31 and R107, to ensure staff aware of their meds at bedside. The training emphasizes the importance of safe medications, reporting any other medications found in room and the right residents have to self-administer. The staff reviewed the competency assessment residents need to demonstrate safe and accurate use, dose and dispensing of medications. Also, to remind resident to report to nursing when	

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F 554

Continued From page 8

R31's medical record was reviewed and lacked any assessment of R31's self administration of his own medications, including his sourcing of these medications, despite being found to have medications inside his room several times before.

When interviewed on 3/7/18, at 1:47 p.m. the director of nursing (DON) stated R31 had medications removed from his room when he first admitted and subsequent times since then. R31's physician was notified regarding him self medicating with narcotics and antibiotics as identified by the surveyor. DON stated staff needed to "talk to him about the self medicating" as he has been found to do so several times since his admission. R31 had never been assessed for self administration of medications, however, DON added this would be beneficial as he was looking to discharge the nursing home in the near future. She stated an assessment should be done "to make sure he's administered them correctly."

LACKED SELF ADMINISTRATION OF MEDICATION ASSESSMENT

R107's Diagnosis Report (print date of 3/9/18) indicated diagnoses of squamous cell carcinoma of skin, scalp and neck, with chronic pain. R107's Care Area Assessment (CAA) for pain dated 2/28/18, indicated R107 had pain related to cancer and gastrointestinal concerns. R107's initial care plan indicated resident was dependent on staff for activities of daily living (ADLs).

During an observation and interview on 3/08/18, at 12:23 p.m., registered nurse (RN)-A stated

F 554

they self-administered medication by asking if they have used to ensure nursing documenting use of the medication. The Policy and Procedure for self-administration of medication was reviewed.
4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor resident self-administering medication. The director of nurses or designated quality-assurance representative will perform the following systematic changes: randomly checking residents who are approved to self-administer. The DON or designee will complete 2 audits per week x 4 weeks, then 1 audit weekly x2 months Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting.
5.The DON will be responsible for this POC.

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R107 regularly requested oxycodone (form of morphine). RN-A stated recently, R107's physician changed the dosing time for the oxycodone from every 6 hours, to every 4 hours, for better pain relief. While observing care, it was noted that R107 had two (2) tubes or OralGel (an over the counter lidocaine gel used for oral pain) on resident's bedside stand. RN-A stated that R107's family brought the medication in for the resident.

During further observations on 3/09/18, at 12:32 p.m. it was observed R107 continued to have one (1) tube of OralGel on his bedside stand. When asked, R107 gesturing with hands and head nods, indicated he was getting relief with OralGel, compared to the gel the nurses provided. In a subsequent interview licensed practical nurse (LPN)-I stated she felt R107 was getting better relief with the medication dosing time change, but R107 still had family bring in OralGel for self-use.

In review of the medical record, there lacked evidence that a self-administration assessment had been completed by the facility.

During interview on 3/12/18, at 8:30 p.m. the director of nursing (DON) reviewed R107's medical record, confirmed he had not been assessed for self administration of medication and stated R107 should have been assessed for his ability to self administer OralGel.

An undated facility Self-Administration of Medications policy identified an assessment should be completed,"...to determine whether a resident is capable of self-administering medications." In addition, the policy directed staff shall identify and give the charge nurse any

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F 554	Continued From page 10 medications which are found at bedside, however, lacked any guidance or direction on self administration assessment after this occurs.	F 554		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance	F 578		4/4/18

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F 578	Continued From page 11 with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure conflicting directives for emergency care and treatment were clarified to ensure resident wishes would be implemented correctly in an emergent situation for 1 of 2 residents (R7) reviewed for advanced directives. Findings include: R7's most recent Provider Orders for Life Sustaining Treatment (POLST) signed 11/29/16, identified R7 as "CPR/ATTEMPT RESUSCITATION," along with, "PROVIDE LIFE SUSTAINING TREATMENT," which included intubation, cardioversion [shocking the heart to restore rhythm] and medical care to sustain life. Further, a transfer from the facility to the emergency department (ED) was presumed with these orders in place. There were no markings or dictation(s) on this form to demonstrate the signed document was not in-effect. R7's most recent Order Summary Report signed 9/29/17, identified R7 admitted to the facility on 9/20/17, and was listed as a "Do Not Resuscitate [DNR; allow to die a natural death should cardiac and/or respiratory arrest occur]." Further, R7's care plan dated 1/15/18, identified R7 as, "Do not Resuscitate," and listed interventions including to follow facility protocol for identification of code	F 578	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide adequate supervision and assistance with advance directives. One of the many ways that this has been achieved for resident #7 is by reviewing the advance directive on file and ensuring with resident and POA correct code status on file. R7 had a previous POLST in chart and a different order which was not determined to have been reviewed with resident. The current order in place for DNR is now clarified and noted in EMAR. The chart has been corrected and R7 profile updated. In this case, after the surveyor reported the contradictory advance directives on file, the staff was reminded to notify SW if they find any orders that are not clear and ensure resident and POA are actively involved in determining their wishes. The policy to be reviewed at next resident council meeting and with all new admits	

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F 578	Continued From page 12 status, and review a resident's code status "quarterly." R7's most recent Care Conference Summary dated 12/28/17, identified R7 as "DNR." The care conference had been attended by R7, his family member and several staff including the social worker (SW)-A. However, the summary lacked documentation R7's wishes for advance directives had been discussed. R7's medical record was reviewed and lacked any evidence the conflicting POLST and subsequent orders had been clarified to ensure the correct procedures would be implemented for R7 in an emergency situation. When interviewed on 3/7/18, at 3:00 p.m. licensed practical nurse (LPN)-K stated if R7 was found to be unresponsive and/or without a pulse, she would "look at his code" in the computer and implement treatment accordingly. LPN-K reviewed R7's computer record and stated he was listed as a DNR. Further, the SW-A was responsible to manage a resident's code status paperwork. On 3/7/18, at 3:06 p.m. SW-A and admission coordinator LPN-L were interviewed, and LPN-L explained the process for obtaining and implementing a residents' desired code status. The health care directives were received from the hospital and reviewed; then facility nursing staff were to complete a "code level sheet" form with them which would direct staff how to respond in an emergency situation. However, LPN-L and SW-A had reviewed R7's medical record and were unable to locate evidence a code level form had been completed. LPN-L stated the	F 578	ensuring understanding of facility policy. All hard charts have been reviewed as of 4/5/2018. 2.Because all residents are required to have advance directives on file all are potentially affected by the cited deficiency, 4/3/2018, the SW printed new POLST from MN.GOV and is initiating a plan to review to update over next quarter as well as ensure all are current up to date. Orders will be signed, reviewed and in chart. In addition, all new residents will be updated on policy and ensure current advance directives are admitted with resident and reviewed for accuracy. Charts immediately were audited for discrepancies of which 4 were not compliant and updated immediately. No other residents were affected. The Policy and Procedure for advanced directives was also reviewed and updated. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 in-service training for admissions, social service and nursing was completed regarding state and federal requirements for advance directives and ensuring consistent documentation in hard chart with order from physician and listed on profile. The training emphasized the importance of ensuring all residents come in with proper advance directives, POLST on hand or initiated for chart and reviewed with resident and POA to ensure right status is chosen. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the SW to ensure	

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F 578	Continued From page 13 conflicting orders should have been clarified in order to ensure the "patient wishes" were respected, and to "avoid any confusion if there is an emergent situation that comes up." A facility Advance Care Planning/POLST policy dated 12/23/17, identified guidelines which included the most current Health Care Directive and/or POLST being "located in the chart under the Advanced Directive tab." The provided policy lacked any direction or guidance on how to ensure changes and made or implemented to established order(s), nor any procedure to ensure unclear directions are clarified.	F 578	compliance of advance directives. The SW or designated quality-assurance representative will perform the following systematic changes: randomly checking resident charts for current and current advanced directives. The SW or designee will complete 2 audits per week x 4 weeks, then 1 audit weekly x2 months Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting. 5.Admissions and SW will be responsible for this POC.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 580		4/23/18

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(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.
(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-
(A) A change in room or roommate assignment as specified in §483.10(e)(6); or
(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.
(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

§483.10(g)(15)
Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review the facility failed to ensure the physician was notified of recurring, worsening pressure ulcers for 1 of 3 residents (R13) reviewed for worsening pressure ulcers, and for 1 of 1 resident (R41) reviewed with active yeast infection.

Findings include:

R13

F 580

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.
1.It is the policy of the facility to provide

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F 580	Continued From page 15 R13's annual Minimum Data Set (MDS) dated 12/26/17, identified R13 had severe cognitive impairment and had diagnoses which included dementia, anxiety, restless leg syndrome and psychosis. The MDS identified R13 required extensive assistance with activities of daily living (ADL's) including bed mobility, transfers and personal hygiene. The MDS identified R13 was at risk for pressure ulcer development, had no current or recently healed pressure ulcers. The MDS further identified the following skin treatments: pressure relieving devices for chair and bed. The MDS did not identify R13 was on a turning and repositioning program. Further, the MDS revealed R13 had no behaviors of rejection of care during the 14 day look back period. On 3/9/18, at 8:12 a.m. R13 was seated in a wheelchair in her room, her stocking clad feet/heels rested directly on the footrests of the wheelchair. At that time, the surveyor requested the director of nursing (DON) to come to R13's room, and DON entered R13's room with a measuring tape and pen and immediately indicated R13's heels should be offloaded at all times. DON stated R13 had a current pressure ulcer on her left heel. She removed R13's stocking from her left foot which revealed thick, hard black tissue which covered R13's heel. DON placed the measuring tape on R13's left heel, and immediately R13 stated, "God that hurts when you touch those!" DON reassured R13 she would be done shortly and measured the pressure ulcer on R13's left heel, revealing the following measurements: 2.5 centimeters (cm) in length and 2.0 cm in width. DON stated R13's heel was covered in eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or	F 580	notification of changes to providers and family. One of the many ways that this has been achieved for resident #13 is by reviewing wound and current documentation of wounds. R13 was noted to have L unstageable are to heel that increased in size and area now developed on previously healed area on R heel. Resident has prevalon boots which were not used appropriately - wound care and documentation did not address resident's heels and interventions were not followed. Care sheets and care plans updated, wound consult received for possible incision and drainage. Daughter updated on heels and treatment. R41 noted to have had yeast infection and staff did not respond timely to resident concern when they did notify MD took over 24 hours to get response then pharmacy didn't notify facility they would not fill the OTC suppositories. Resident has since had resolution of yeast infection and staff educated on timely follow up on medical symptoms and expecting no less than 8 hours to get response from MD or call again. If still no response update medical director. Pharmacy assumed OTC meds were ordered through different vendor. DON and regional director met with pharmacy and sent list of stocked OTC meds and agreed if order sent pharmacy will now always send OTC timely or touch base with DON if issue. 2.Because all residents count on staff for timely and appropriate care all are potentially affected by the cited deficiency, wound documentation has been reviewed, interventions for prevention are in place	

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F 580	Continued From page 16 tan in color, and may appear scab like) tissue. She confirmed R13 had an unstageable pressure ulcer on her left heel. The surveyor requested the DON visualize R13's right heel at that time. DON removed the stocking from R13's right foot, which revealed hard, thick, brown tissue covered R13's heel. She confirmed she had not assessed R13's right heel and measured the right heel pressure ulcers at that time as follows: 2.0 cm by 1.7 cm. DON confirmed R13's right heel also had an unstageable pressure ulcer. DON then donned R13's stockings and Prevalon boots, placed R13's feet back onto the footrests of the wheelchair. -At that time DON stated R13's unstageable left heel pressure ulcer had worsened since she last looked at it on 2/28/18. She indicated R13 had a history of unstageable (wound bed cannot be visualized due to the presence of slough or eschar. Slough; non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Eschar tissue; dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.) pressure ulcers on both heels. The DON stated she was aware R13 had an unstageable left heel pressure ulcer. She confirmed R13's 2/15/18, progress note and stated she was not aware R13 had pressure ulcers on both heels. She indicated she would contact a wound clinic nurse for recommendations and further stated she was unaware if R13's physician had been	F 580	and documented clearly on care sheets. All OTC medications have been reviewed along with staff interviews to ensure no orders have been incomplete and symptoms of acute concerns are followed up on immediately – if no return call from physician in 2 hours call back is warranted. All new orders have been second checked and skin monitoring reviewed with staff to report any bruises, skin tears, skin breakdown or rashes. All residents have been reviewed for a change in condition. No other residents were affected. The Policy and Procedure for change of condition was also reviewed and updated. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all staff received in-service training regarding state and federal requirements for monitoring for changes in condition and updated on the 2 residents, R13 to ensure staff always use Prevalon boots and understand offloading to prevent further alterations in skin integrity and R41 is resolved at this time however was noted to have yeast in skin folds and treatment was ordered timely and efficiently. The training emphasizes the importance of taking all resident concerns seriously, medication monitoring and follow up, following all interventions for effective maintenance and reporting of changes in skin conditions. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor new orders, change in condition,	

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F 580	Continued From page 17 notified of either of R13's unstageable pressure ulcers. DON stated she expected R13's heels to be off loaded at all times either with the Prevalon boots or a pillow. She further indicated she expected staff to document in R13's medical record anytime she refused to offload her heels. DON stated she was responsible for the facility's wound assessments and had completed weekly wound measurements when R13's left heel pressure ulcer re-occurred in February 2018. Review of R13's form titled, Wound Evaluation Flow Sheet, started on 12/15/17, the DON stored in her office, a hand written flow sheet with spaces for weekly wound measurements. The following was listed: -12/15/17, R13 had an unstageable ulcer of her left heel which measured 0.5 cm by 0.5 cm. The flow sheet identified R13's skin surrounding the pressure ulcer was intact and the wound margins were defined. The wound evaluation flow sheet revealed the current intervention was foam dressings to both feet. -12/29/17, revealed R13's left heel pressure ulcer measured 0.3 cm by 0.3 cm, wound margins were defined and the surrounding skin was intact. The form revealed the current intervention was to leave open to air. - 1/3/18, revealed R13's left heel pressure ulcer measured 0.3 cm by 0.3 cm, wound margins were defines and the surrounding skin was intact and was open to air. - 2/14/18, revealed R13's left heel pressure ulcer measured 1.8 cm by 2.0 cm, wound margins were defined, surrounding skin was intact and	F 580	and residents with impaired skin integrity. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will ensure audits done weekly to monitor change of condition and new orders for all residents for 1 week, then 6 residents a week for 2 weeks, then on 3 residents weekly for 4 weeks and residents with potential for altered skin integrity 6 residents for 2 weeks and 3 residents for 4 weeks to ensure compliance . Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON will be responsible for this POC.	

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F 580	Continued From page 18	F 580		

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purple. The form listed an intervention to leave the heel open to air.

-2/21/18, revealed R13's left heel pressure ulcer measured 1.8 cm by 2.0 cm, wound margins were defined, surrounding skin was intact. The form listed an intervention to leave the heel open to air.

-2/28/18, revealed R13's left heel pressure ulcer measured 1.8 cm by 2.0 cm, wound margins were defined, surrounding skin was intact. The form listed an intervention to leave the heel open to air.

R13's wound evaluation flow sheet did not include identification of R13's right heel ulcer, measurements and did not include any pressure relieving interventions for her heels.

Review of R13's wound evaluation flow sheet, found in the electronic record, 12/15/17, revealed R13 had an unstageable pressure ulcer on her right heel which was identified on 12/15/17. The wound evaluation flow sheet identified R13's right heel pressure ulcer measured 1 cm by 1 cm. The flow sheet further identified R13's pressure ulcer had the following characteristic: wound bed was 100% skin, periwound margins were defined, surrounding skin was intact. The flow sheet indicated the following treatments/interventions were in place; R13 was to have a foam dressing on both heels every 72 hours, pressure redistribution mattress and heel protectors. The electronic Wound Evaluation flow Sheet did not identify a pressure ulcer on R13's left heel.

R13's electronic wound sheet lacked documentation of any further monitoring of R13's

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F 580	Continued From page 19 right heel and lacked documentation of the presence of R13's left heel pressure ulcer. Review of R13's progress notes from 7/17/17, to 3/9/18, revealed the following: - 7/17/17, R13's heels were scabbed over and left open to air. -12/15/17, R13 was seen by her primary physician (MD)-A and new orders were obtained to apply foam dressing to both heels and change every 3 days and as needed. The note revealed R13 was to have pressure sore precautions in place. -12/29/17, R13's bilateral heels were to be left open to air. -1/18/18, a Braden assessment (tool used to identify risk for pressure ulcer development) listed R13 was at low risk for skin breakdown. - 2/15/18, R13's right heel had an intact tan scab, measured 2.3 centimeters (cm) by 1.5 cm and had no redness or drainage. The note further revealed R13's left heel had an intact scab with no redness or drainage and the surrounding skin was purple in color. The note lacked measurements of R13's left heel and indicated R13 had Prevalon boots (pressure relieving boots) on both of her feet. -3/9/18, R13's left heel measured 2.5 cm by 2 cm with scab intact with 20% eschar noted around the border of the wound, no redness or drainage noted, with surrounding skin intact and blanched to touch. Right heel measured 2 cm by 1.7 cm scab intact, no redness or drainage noted, and	F 580		

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surrounding skin intact. Call placed for recommendations for resident's heels and physician office contacted in regards to concerns with resident's heels. R13 agreed to allow Prevalon boots to be applied without difficulty.

On 3/9/18, at 9:03 a.m. R13's medical was reviewed with the DON. She confirmed R13's medical record had identified R13 had developed a reoccurring unstageable pressure ulcer on her right heel on 12/15/17. The DON confirmed R13's medical record had identified R13 had an unstageable pressure ulcer on her left heel. The DON stated she was not aware a wound evaluation had been completed on 12/1/5/17, for R13's right heel. The DON confirmed R13 had recurring pressure ulcers on both of her heels. The DON confirmed R13's medical record lacked documentation of when R13's bilateral unstageable pressure ulcers had healed. The DON confirmed R13's medical record lacked any comprehensive assessments of R13's bilateral unstageable pressure ulcers. She confirmed R13's medical record lacked a current assessment or any monitoring of R13' s right heel unstageable pressure ulcer. The DON stated she would have expected pressure relieving interventions to be put into place routinely for R13 to prevent worsening of both pressure ulcers.

Review of R13's current physician orders signed 2/16/18, included orders to leave bilateral heels open to air every shift, weekly skin check every Wednesday, and document findings/refusals. However, the orders lacked direction for pressure relieving interventions or treatments for R13's heels.

Review of R13's physician progress notes from

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8/30/17 to 12/15/17, revealed the following;

-8/30/17, skin heel pressure ulcer present on examination.

-10/24/17, R13 had a past history of decubitus (pressure) ulcer of the left heel.

-12/15/17, R13 was seen at the facility for a follow up visit. The note identified R13 had a current stage 3 decubitus ulcer of the left heel. The note directed facility staff to start dressing changes every 72 hours and to implement pressure ulcer precautions.

On 3/9/18, at 1:18 p.m. during a telephone interview with R13's primary physician (MD-A), MD-A stated she was last aware R13 continued to have current unstageable pressure ulcers on both of her heels in December 2017. MD-A stated R13 had recurring pressure ulcers on both of her heels and expected facility staff to provide pressure relief for R13's feet/heels. MD-A indicated she expected R13's heels to be offloaded, and if R13 refused to wear Prevalon boots she expected other methods of pressure relief to be attempted. MD-A stated she was not aware R13 had eschar tissue to both of her heels, nor was she aware the the size of R13's pressure ulcers had increased. MD-A stated she felt R13's unstageable pressure ulcers were likely stage 4, very deep and were very painful for R13.

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YEAST INFECTION:

R41's quarterly Minimum Data Set (MDS) dated 2/5/18, identified R41 had intact cognition and no current infections.

When interviewed on 3/6/18, at 2:23 p.m. R41 explained she had developed a yeast infection (fungal infection of the skin or mucous membranes) which was left untreated. R41 reported having redness and itching on her vagina to a nurse the week prior who told her they would "be back later" and then never returned. The following day, R41 reported it again to a different nurse, however, they also "never did anything about it." R41 stated a night nurse finally looked at it and stated "[I] think you have a yeast infection," however, again nothing was done about it. R41 was frustrated and expressed nothing still had been done to help her adding "[I] don't think they communicate with the doctor," as "I think it's because they don't care."

R41's progress note(s) identified the following dictations:

On 3/1/18, "[R41] had complained a few days ago about vaginal discomfort, felt it might have been the briefs ... could not see any redness or discharge of any kind ... will continue to monitor."

On 3/2/18, "[R41] c/o [complaints of] possible yeast infection. Labia is pink, swollen and nontender. Small bumps noted along inner labial fold. Scant yellow mucous noted in brief. [Patient] states area does not itch or burn. Will monitor." Further, on the same date, "[R41] complain that she has a [urinary tract infection] and a yeast infection. MD [medical doctor] has

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been notified via fax. awaiting [sic] response."

On 3/6/18 (four days later), "Received [telephone order] from [physician's nurse] for Monistat [an anti-fungal used to treat yeast infections] ... EMAR updated and order faxed to pharmacy. Resident made aware of new Rx [prescription]."

R41's Physician's Telephone Orders Audit sheet dated 3/6/18, identified a telephone order was obtained for Monistat vaginal suppositories. A diagnosis was listed for vaginal candidasis (a yeast infection of the vagina).

R41's medical record was reviewed and lacked any evidence R41's physician had reviewed the fax communication or been notified of R41's developed symptoms. Further, the record lacked evidence there had been ongoing attempts to notify R41's physician or consult with the medical director which resulted in R41 waiting four days for treatment order(s).

When interviewed on 3/8/18, at 1:15 p.m. licensed practical nurse (LPN)-I stated R41 had asked her "last week" to check for a yeast infection. R41 had reported she asked "a few nurses" to help her, however, did not feel anything had been done. LPN-I stated she was aware another nurse had faxed R41's physician about the developed symptoms, however, nobody had heard back so LPN-I then called the physician on 3/2/18, and the clinic nurse explained the physician may not address it without a clinic appointment. LPN-I verified the record lacked any evidence of follow-up since 3/2/18, adding "not all nurses like to badger doctors" for orders. Further, LPN-I stated staff should have at least notified the on-call physician

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F 580	Continued From page 24 to obtain treatment orders for R41's developed symptoms if they weren't able to immediately contact the primary physician. During interview on 3/8/18, at 1:39 p.m. the director of nursing (DON) stated she was aware the nurses had contacted R41's physician with the developed symptoms, however, "didn't get a response back." DON verified R41's medical record lacked any evidence of subsequent attempts to notify a physician of R41's developed infection. Further, DON stated she felt the "hiccups" with not getting orders timely would be addressed when the facility changed their medical director in the near future. A facility policy for notification of change was requested and none were provided.	F 580		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss	F 584		4/23/18

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F 584	Continued From page 25 or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure housekeeping services for a clean environment for 1 of 1 resident with odors in the sample (R9) who refused assistance with personal hygiene. Findings include: R9's Diagnosis Report print date of 3/12/18, indicated R9 had diagnoses of bipolar disease, dementia without behavioral disturbance, and anxiety. R9's urinary incontinence CAA, dated 12/20/17, listed R9 was occasionally incontinent of bladder, able to feel urge to void at times, went to the bathroom independently and was able to	F 584	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to promote a clean and comfortable environment to make it safe and homelike. Some of the many ways that this has been achieved for resident #9 is by working with resident family and ombudsman to assist with	

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obtain his own fluids. The CAA did not address his interventions for his incontinence and did not address his odors or personal hygiene. R9's care plan, revised 2/3/18, did not include interventions to address R9's incontinence or ongoing personal odor needs.

During supper observations, on 3/6/18 at 5:27 p.m., R9 was sitting at a dining room table, alone. R9 had a very strong urine odor, with the odor noticed approximately 5 feet away. At 9:40 a.m., R9 was served his evening meal, quickly consumed the meal, then returned to his room and laid on his back in bed. It was noted there was a very strong urine smell in the entire room. When asked R9 refused an interview at that time. On 3/07/18 at 2:44 p.m., R9 was observed walking the halls with a 4 wheeled walker, wearing clothes different than 3/7/18. However, R9 continued to have a noticeable urine odor. On 3/8/18 at 8:30 a.m., R9 was observed in the dining room having a strong urine smell eminating from self. After the meal, R9 returned to his room, and again a strong drafting of warm, very strong urine odor emminated from the room.

On an environmental tour on 3/12/18, 11:25 a.m. the environmental director (ED) and the facility administrator (ADM) stated they were both aware of R9's room having a strong urine odor. Both the ED and ADM stated R9 was incontinent of bladder, refused his clothing to be laundered, and would hang up soiled clothes to dry in his room. Neither staff members knew if the facility had reached out to family or the ombudsman for assistance with this concern. The ADM stated the previous administrator directed staff to go in and take R9's clothes to be laundered, which had upset resident.

F 584

working on resident refusal for cares. R9 was noted to have strong urine odor. Resident appears disheveled and dirty. Refuses to let staff clean his room. Care plan did not mention urinary incontinence nor behaviors regarding refusal of cares. In this case, after the surveyor reported the noticeable discrepancies in care and care plan, SW reached out to son who stated he is unable to get his dad to do anything either and when regional director approached resident he swore and said he doesn’t need to do anything. A couple staff have been able to get him to wash his groin and as soon as resident leaves room prior to lunch staff do as much cleaning as they can do including change and wash down bed and clean up bathroom. When staff try to wash clothing, resident becomes very hostile and aggressive. CP updated to describe behaviors and toileting. R9 has been uncooperative otherwise and staff work as a team to encourage cleanliness.
2.Because all residents that reside in the facility calling it their home, all are potentially affected by the cited deficiency. On 4/5/2018, under supervision of regional nurse 4 housekeeping staff and 2 nursing staff noted resident to leave room, immediately all items were removed and a deep clean was completed. Resident continues to refuse cares and gets very angry when asked to let others wash his clothes or mention showering. Given fresh wipes to use for peri-care after urination to assist with the urine smell after voiding. New washcloth put out every day in bathroom and staff will immediately do

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During an interview on 3/12/18, at 12:10 p.m. nursing assistant (NA)-I stated R9 did not like his room cleaned so she waited until he left for lunch, then stripped the bed, wiped down mattress, and attempted to remove soiled clothing. NA-I stated R9 got upset today, yelled at her, told her to leave and slammed the door. NA-I further stated that before she left R9's room, he grabbed a pair of soiled pants she was carrying and hung up the pants in his closet.

During an interview on 3/12/18, at 12:19 p.m. the social worker (SW) was aware of R9's room and personal odor, and attempted conversation with R9 had been refused by resident. SW further stated the facility has not reached out to family or ombudsman for assistance with R9's personal odors and room odors.

In a telephone interview on 3/12/18, at 12:49 p.m. family member (FM)-B verified the facility had not contacted him for assistance in helping with R9's room odor and refusal for clothes to be laundered. FM-B further stated, "It was awful the last time I was there (at the facility)."

The Facility's policy titled Deep Cleaning Rooms, reviewed 12/23/17, indicated residents rooms would be cleaned daily and a deep clean would be done monthly.

During an interview on 3/12/18, at 8:30 a.m. the director or nursing (DON) stated that the facility should have developed interventions to assist R9 in appropriate personal hygiene.

F 584

cleanup of room when resident leaves his room which he does prior to lunch every day. Encouraged to speak with SW regarding care issues. Son and daughter in law prefer resident go back to VA psychiatric unit again for inpatient services as they feel he is not reasonable and exhibiting an increase in PTSD and becoming too aggressive. When staff note any residents refusing cares they will refer to SW who will meet with resident to determine cause and plan. If resident continues to refuse will update family and ombudsman for support. Also, will try to have other staff approach resident to try as some have better connections with some residents. Current residents were audited by clothing and room smells and appearance to ensure no other residents had same issues with non-compliance. Housekeeping has been updating as well on any rooms that appear have strong odors or hoarding type appearance. No other residents were affected. The Policy and Procedure for comfortable environment was reviewed.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding clean homelike environment and addressing rooms with residents that refuse cares. The training emphasized the importance of understanding this facility is the residents home and often need to incorporate SW in working with residents with difficult behaviors. Staff also were educated on ways to work with residents that refuse cares and those that

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F 584	Continued From page 28	F 584	have extreme behaviors – handouts were given with options and staff role played refusal situations. If any resident exhibits the same pattern immediately interdisciplinary team will determine needs and how to address the situation before it gets out of control. Residents with high behavioral concerns that impact the entire facility will immediately get psych consult to assist with behavior management plan. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the SW to monitor resident requiring additional assistance with grooming, room cleaning and over all resistance to compliance. The SW or designee will complete 2 audits per week x 4 weeks on room order, odor and resident cleanliness, then 1 audit weekly for 4 weeks ensure staff able to work around resident refusal to keep odors at a minimum. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.SW and housekeeping will be responsible for this POC.	
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property,	F 607		4/23/18

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§483.12(b)(2) Establish policies and procedures to investigate any such allegations, and

§483.12(b)(3) Include training as required at paragraph §483.95,
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility to implement policies and procedures to ensure the State agency (SA) was notified in a timely manner for allegations of neglect with sustained bodily injury for 1 of 2 residents (R22) whose allegations were reviewed.

Findings include:

The facility Vulnerable Adult policy reviewed 12/23/17, identified a statement of providing a safe, comfortable environment for all residents which included supporting "Zero Tolerance" for patient abuse and/or neglect. The policy directed every employee of the care center was a mandated reporter and defined neglect as, "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." An "Internal Reporting Procedure" was listed which included the following steps:

- "During the shift that the alleged abuse/neglect or unexplained injury is first observed, a mandated reporter will immediately make an initial report to their Supervisor ... the Supervisor will immediately report to the House Supervisor who will then report it to the Director of Nursing/Administrator."

- "The Supervisor, Director of Nursing or Administrator will immediately institute an internal

Provider's Plan of Correction:

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.
1.It is the policy of this facility to report all incidents and do timely follow up on any incident that result in injury. In this case R22 was noted to have bumped butt on footboard during transfer by staff with Hoyer that resulted in a fracture. Resident complained of pain, staff did get an x-ray which confirmed the fracture. No incident report was filed nor follow up on transfer with Hoyer. In this case, after the surveyor reported the faulty system, the Hoyer lift was assessed on 4/4/2018 and staff educated on incident reporting and the policy regarding incidents and accidents. Nursing and SW were also educated on importance of reporting all vulnerable adult cases to the OHFC (office of health facility complaints). All incidents and accidents are to be reviewed immediately for any potential abuse or neglect. A resident protection manual was created, put at nursing

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investigation of the reported allegation or incident." This statement listed components of the investigations which may include interviews of the staff and resident.

- "The Director of Nursing or Administrator shall determine if the incident/allegation meets the criteria for 'Reportable Incident'. All incidents deemed reportable under MN statute are submitted to [SA] via the on-line Reporting System within the 2 hour period."

Further, the policy directed if the director of nursing (DON) or administrator determines the incident or allegation does not meet criteria for reporting under the State or Federal guidelines, "the [DON] of administrator will note that decision in writing on the Incident Report."

R22's quarterly Minimum Data Set (MDS) dated 12/22/17, identified R22 had intact cognition, required extensive assistance with transfers and bed mobility, and displayed no delusion, hallucinations, or rejection of care behaviors. R22's care plan revised 1/23/18, identified R22 was at risk for abuse due to his decreased mobility and directed staff to follow the facility vulnerable adult (VA) policy and file reports to the common entry point (CEP) as needed. Further, R22 required a hoyer lift (mechanical body lift) for transfers and staff should "care in pairs."

When interviewed on 3/6/18, at 7:16 p.m. R22 was questioned about his care and treatment in the facility. R22 stated he had a concern about how staff transfer him in the hoyer lift adding he was, "not sure if you'd call it abuse or not." R22 stated when staff had transferred him a week ago "or better," they hit him on the bed and were

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stations and educated to all staff to ensure the components of abuse and neglect are identified and immediately followed up on.
2.Because all residents receiving physical assistance are potentially affected by the cited deficiency and all residents are considered vulnerable all are potentially affected to potential for abuse/neglect. On 4/4/2018, the director of nursing reviewed transfers with staff and reviewed with therapy the need for Hoyer training. PT observed that all resident transfers involving Hoyer lifts were conducted safely. Since survey all incidents and accidents are reviewed, and any resident sustaining injury has been reviewed and reported immediately. No other residents were affected. The Policy and Procedure for abuse/neglect was reviewed and updated.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding minimizing accidents. The training will emphasize the importance of using all mechanical lifts safely. Also reviewed was abuse/neglect policy and safety. Staff educated on following plan of care, appropriate interventions, timeliness of reporting to OHFC. Nurses were reminded to chart once an order is taken, until the result of the order is in place and continue to follow up on resident condition, incident and where in process the follow up is until resolved. No other residents were affected.
4.Effective 4/4/2018, a quality-assurance

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	245052	A. BUILDING ______ B. WING ______	03/13/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD REHABILITATION & HEALTHCARE CENTER	2810 SECOND AVENUE NORTH MOORHEAD, MN 56560

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F 607	Continued From page 31 aware they had done so. The staff just "weren't careful" with him. Further, R22 stated no staff or management had followed up with him since this occurred. R22's progress notes were reviewed and identified the following entries: -10/10/17, at 2:05 p.m. R22 " ... wants an x-ray [due to] hitting buttocks, lower back on foot board of bed while being transferred in hoyer[.]" At 2:20 p.m. the nurse documented a call was out to PPX (professional portable x-ray) for an x-ray on R22's lumbar, sacral, spine and pelvis regions. There were no documentation regarding R22's pain or any potential injuries sustained which warranted requesting an x-ray, nor any indication if the administrator and/or director of nursing (DON) had been notified of R22 being potentially injured while transferred in the hoyer lift. -10/11/17, at 6:39 a.m. a late entry was recorded which identified, "ppx came at 6:30pm last night for resident's x-rays[.]" There was no further progress notes documented to ascertain the x-rays results, nor if any injury had been sustained during the provision of care as recorded on 10/10/17. R22's PPX Final Report signed 10/10/17, identified R22 had an x-ray obtained of his lumbar spine and pelvis related to "pain in butt area after hitting back on headboard during a lift." The report listed several findings when compared to his last CT scan which included, "Acute displaced fracture left 12th rib." A completed Incident Report Summary was submitted to the SA on 10/11/17, at 10:11 a.m.	F 607	program was implemented under the supervision of the director of nurses to monitor resident transfers requiring Hoyer lifts. PT will perform the following systematic changes: randomly checking all residents who require mechanical lift transfers to be completed immediately. Audits will be completed on 4 residents for 2 weeks then 2 residents for 2 months. Nursing has been educated on ensuring thorough documentation of all orders from initiation to completion to ensure adequate follow up. will be audited. All incidents will be immediately reported to DON and further discussed daily at stand up. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON and PT will be responsible for this POC.	

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(approximately 20 hours after the incident with injury occurred) which identified R22 as the resident involved with an allegation being reported as, "Physical Abuse," with defined text including, "Conduct intended to produce pain/injury or rough handling." R22 was identified as having sustained a rib fracture with a "date and time of incident" being recorded as 10/11/17, at 9:30 a.m. The summary did not identify R22's reported injury on 10/10/17.

When interviewed on 3/12/18, at 8:14 a.m. social worker (SW)-A stated neglect of care would be the failure to provide goods and services to avoid physical or mental harm adding "any harm that would be caused, we would report," if injury was sustained during the provision of care. R22's incident on 10/10/17, was reviewed with SW-A. The prior administrator and DON who reported and conducted the investigation for R22 were no longer present, and SW-A was unable to even locate an incident report regarding R22 being struck into the bed during care. SW-A stated she was unaware when the administrator had been notified of this allegation. SW-A stated potential allegations of neglect with injuries being sustained should be reported "within 2 hours." SW-A stated R22's potential allegation "should have been reported within 2 hours."

During interview on 3/12/18, at 8:47 a.m. the current DON stated she had "no clue" what actions were taken, or when, regarding R22's recorded allegation as it was handled by the previous administrator and DON. DON reviewed the record and stated no incident report could be located in their tracking systems. DON explained neglect of care would be considered leaving a resident unattended or "not providing cares

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F 607	Continued From page 33 appropriately," adding if staff were using proper procedures and protocol, an injury should not be obtained while using the hoyer lift to transfer someone. DON stated she was aware they had reported the incident, however, thought they did this as the situation "felt like it should of been reported." DON stated after reviewing the record and information related to R22's allegation, she felt it should have been reported to the SA within two hours and not the following day after it occurred.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in	F 609		4/23/18

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accordance with State law, including to the State Survey 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 recognize and ensure an allegation of neglect with sustained bodily injury was reported timely to the State agency (SA) for 1 of 2 residents (R22) whose allegations were reviewed.

Findings include:

R22's quarterly Minimum Data Set (MDS) dated 12/22/17, identified R22 had intact cognition, required extensive assistance with transfers and bed mobility, and displayed no delusion, hallucinations, or rejection of care behaviors.

R22's care plan revised 1/23/18, identified R22 was at risk for abuse due to his decreased mobility and directed staff to follow the facility vulnerable adult (VA) policy and file reports to the common entry point (CEP) as needed. Further, R22 required a hoyer lift (mechanical body lift) for transfers and staff should "care in pairs."

When interviewed on 3/6/18, at 7:16 p.m. R22 was questioned about his care and treatment in the facility. R22 stated he had a concern about how staff transfer him in the hoyer lift adding he was, "not sure if you'd call it abuse or not." R22 stated when staff had transferred him a week ago "or better," they hit him on the bed and were aware they had done so. The staff just "weren't careful" with him. Further, R22 stated no staff or management had followed up with him since this

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This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.
1.It is the policy of this facility to report all incidents and do timely follow up on any incident that results in injury. In this case R22 was noted to have bumped butt on footboard during transfer by staff with Hoyer that resulted in a fracture. Resident complained of pain, staff did get an x-ray which confirmed the fracture. No incident report was filed nor follow up on transfer with Hoyer. In this case, after the surveyor reported the faulty system, the Hoyer lift was assessed on 4/4/2018 and staff educated on incident reporting and the policy regarding incidents and accidents. Nursing and SW were also educated on importance of reporting all vulnerable adult cases to the OHFC (office of health facility complaints).
2.Because all residents are potentially affected by the cited deficiency and lack of follow through, on 4/4/2018, the director of nursing reviewed with all staff the importance of reporting suspected violations. A new resident protection

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F 609	Continued From page 35 occurred. R22's progress notes were reviewed and identified the following entries: -10/10/17, at 2:05 p.m. R22 " ... wants an x-ray [due to] hitting buttocks, lower back on foot board of bed while being transferred in hoyer[.]" At 2:20 p.m. the nurse recorded a call was out to PPX (professional portable x-ray) for an x-ray on R22's lumbar, sacral, spine and pelvis regions. There were no documentation regarding R22's pain or any potential injuries sustained which warranted requesting an x-ray, nor any indication if the administrator and/or director of nursing (DON) had been notified of R22 being potentially injured while transferred in the hoyer lift. -10/11/17, at 6:39 a.m. a late entry was recorded which identified, "ppx came at 6:30pm last night for resident's x-rays[.]" There was no further progress notes documented to ascertain the x-rays results, nor if any injury had been sustained during the provision of care as recorded on 10/10/17. R22's PPX Final Report signed 10/10/17, identified R22 had an x-ray obtained of his lumbar spine and pelvis related to "pain in butt area after hitting back on headboard during a lift." The report listed several findings when compared to his last CT scan which included, "Acute displaced fracture left 12th rib." A completed Incident Report Summary was submitted to the SA on 10/11/17, at 10:11 a.m. (approximately 20 hours after the incident with injury occurred) which identified R22 as the resident involved with an allegation being	F 609	manual was created to educate staff on components of the abuse program. The program further educates staff on when to report and what to report to ensure that this type of situation does not occur again. The program also has an incident report guide to assist staff to determine what is reportable and who to notify when. Further discussed was the proper procedure for incident and accidents and the notification process to ensure DON and SW are aware of any situation for immediate follow up. Policy and procedure for reportable events was reviewed. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding requirements for minimizing accidents. Staff were also advised with every incident regardless of how small or if no injury the DON needs to be informed immediately as well as doctor, family/POA and documented accordingly in point click care. Documentations must include follow up nurses notes and appropriate notification made to POA, MD, DON, ED and OHFC is necessary via DON or SW. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the SW to monitor all incidents to ensure anyone with injury or suspected abuse is reported immediately to OHFC. All incidents, accidents and injuries will be logged to ensure follow up completed per resident protection manual and investigation log. The SW or designated quality-assurance	

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F 609	Continued From page 36 reported as, "Physical Abuse," with defined text including, "Conduct intended to produce pain/injury or rough handling." R22 was identified as having sustained a rib fracture with a "date and time of incident" being recorded as 10/11/17, at 9:30 a.m. The summary did not identify R22's reported injury on 10/10/17. When interviewed on 3/12/18, at 8:14 a.m. social worker (SW)-A stated neglect of care would be the failure to provide goods and services to avoid physical or mental harm adding "any harm that would be caused, we would report," if injury was sustained during the provision of care. R22's incident on 10/10/17, was reviewed with SW-A. The prior administrator and DON who reported and conducted the investigation for R22 were no longer present, and SW-A was unable to even locate an incident report regarding R22 being struck into the bed during care. SW-A stated she was unaware when the administrator had been notified of this allegation. SW-A stated potential allegations of neglect with injuries being sustained should be reported "within 2 hours." SW-A stated R22's potential allegation "should have been reported within 2 hours." During interview on 3/12/18, at 8:47 a.m. the current DON stated she had "no clue" what actions were taken, or when, regarding R22's recorded allegation as it was handled by the previous administrator and DON. DON reviewed the record and stated no incident report could be located in their tracking systems. DON explained neglect of care would be considered leaving a resident unattended or "not providing cares appropriately," adding if staff were using proper procedures and protocol, an injury should not be obtained while using the hoyer lift to transfer	F 609	representative will perform the following systematic changes: the DON in conjunction with SW will make report immediately if any abuse/neglect or injury was suspected. All incidents/accidents or suspected abuse/neglect situations will be reviewed at stand up daily. The DON or designee will complete 6 audits per week x 2 weeks then 4 audits weekly x 2 weeks then 2 audits per month for 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON, ED and SW will be responsible for this POC.	

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F 609	Continued From page 37 someone. DON stated she was aware they had reported the incident, however, thought they did this as the situation "felt like it should of been reported." DON stated after reviewing the record and information related to R22's allegation, she felt it should have been reported to the SA within two hours and not the following day after it occurred. The facility Vulnerable Adult policy dated 12/23/17, identified the facility desired to provide a safe, comfortable environment for all residents and supported "zero tolerance" for abuse and/or neglect. Further, the policy directed all incidents determined to be reportable should be submitted to the SA "...within the 2 hour period."	F 609		
F 636 SS=E	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision.	F 636		4/23/18

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(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.

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F 636	Continued From page 39 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure resident Care Area Assessments (CAA) included a comprehensive analysis of a resident's needs, strengths, goals, history and preferences for 1 of 1 resident (R13) reviewed for worsening pressure ulcer, 1 of 1 resident (R17) reviewed for decline in ambulation, 1 of 1 resident (R207) reviewed for unmanaged pain and 1 of 1 resident (R28) reviewed for walk to dine and 1 of 1 resident (R1) reviewed for falls. R13 Findings include: R13's Annual Minimum Data Set (MDS) dated 12/26/17, identified R13 had severe cognitive impairment and had diagnoses which included dementia, anxiety, restless leg syndrome and psychosis. The MDS identified R13 required extensive assistance with activities of daily living (ADL's) including bed mobility, transfers, personal hygiene was continent of urine and frequently incontinent of bowel. The MDS identified R15 was at risk for pressure ulcer development, had no current or recently healed pressure ulcers. The MDS further identified R13 received antipsychotic medication and had frequent pain rated at a 9 out of 10 on a numeric scale. Further the MDS revealed R13 had no behaviors of rejection of care during the 14 day look back period. R13's Annual Care Area Assessment (CAA) dated 12/26/17, identified ten care areas had triggered from the data entered into the MDS requiring analysis, the following areas were	F 636	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to ensure all residents are assessed correctly via assessments and MDS to coordinate appropriate care plans. Some of the many ways that this has been achieved for R1 is by ensuring mats off floor unless bed in low position and next to bed, activates of distraction are available when needed, and daily walks to stretch legs and strengthen gait. R13 had wound assessed, interventions correctly placed on care plan and sheet and referred to wound specialist to further evaluate heels. R17 has been seen by prosthetic clinic and is having it sized, therapy will work on using prosthetic and staff aware of importance of following plan of care. R 28 listed on walk to dine program; staff encouraged to walk regularly, follow care sheet and update nursing or therapy for any noticeable declines. R207 had unmonitored pain and pain assessment not clear nor documentation. In this case, after the surveyor reported all residents listed above the care area assessments were inaccurate based on documentation and MDS. All care plans have been reviewed and updated, MDS nurse has	

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F 636	Continued From page 40 triggered; Cogitative Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling Catheter, Mood State, Falls, Nutritional Status, Pressure Ulcer, Psychotropic Drug Use and Pain. -Cognitive Loss/Dementia CAA, revealed the care area was an actual problem for R13 related to cognitive impairment and a diagnosis of non-Alzheimers dementia. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS,) which included; neurological factors and ADL function, requiring additional assessment/analysis of R13's cognition. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R13's cognitive functioning. The CAA further lacked any other considerations that could affect R13's cognitive functioning from resident observation and resident and/or family input for care planning considerations. -ADL Functional/Rehabilitation Potential CAA revealed the care area was an actual problem for R13 related to requiring extensive assistance from facility staff for ADL's. The CAA revealed multiple pre-populated check marked areas which included; pain, incontinence and depression. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R13's ADL's. The CAA further lacked any other considerations that could affect R13's ADL functioning from resident observation and resident and/or family input for care planning considerations. -Urinary Incontinence and Indwelling Catheter CAA revealed the care area was an actual	F 636	taken a CAA training and is aware of how to properly document on CAA's. 2.Because all residents are assessed to determine their appropriate plan of care based on their assessments all are potentially affected by the cited deficiency, on 4/4/2018, the MDS nurse reviewed accuracy of CAA's and MDS that surveyors noted to be inaccurate. All other resident CAA's will be reviewed for timeliness and accuracy. Furthermore, all CAA's being created as of 4/5/2018 will be double checked by regional reimbursement coordinator prior to submission to ensure compliance. Policy on MDS/CAA was reviewed. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all staff received in-service training regarding state and federal requirements for documentation, assessments and proper follow up on all missing information to ensure clear and correct care plans. The training also emphasized the importance of the MDS nurse to follow up on items that are not being addressed during assessment period and ensuring care areas are complete. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the MDS nurse to that all residents will be reviewed at time of admission or annual to ensure CAA's are being completed thoroughly and completely. All triggers will be care planned and communicated to staff via care sheets and communication book if	

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F 636	Continued From page 41 problem for R13 related to incontinence and need for assist with toileting. The CAA revealed multiple pre-populated check marked areas which included pain, environment, urinary urgency and need for assistance with toileting. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R13's incontinence. The CAA further lacked any other considerations that could affect R13's urinary incontinence from resident observation and resident and/or family input for care planning considerations. -Mood State CAA revealed the care area was an actual problem for R13 related to diagnosis of dementia, psychotic disorder and routine use of an antipsychotic. The CAA revealed multiple pre-populated check marked areas which included dementia, pain and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R13's mood. The CAA further lacked any other considerations that could affect R13's mood from resident observation and resident and/or family input for care planning considerations. -Falls CAA revealed the care area was an actual problem for R13 related to required assistance with transfers, bed mobility and toileting. The CAA revealed multiple pre-populated check marked areas which included difficulty with balance, medications and incontinence. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R13's risk for falls. The CAA further lacked any other considerations that could affect R13's fall risk from resident observation and resident and/or family input for care planning considerations.	F 636	new interventions in place. Audits of CAA's will be completed for accuracy and timeliness; they will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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-Nutritional Status CAA revealed the care area was an actual problem for R13, though did not indicated the reason. The CAA revealed multiple pre-populated check marked areas which included arthritis, dementia, anxiety and poor memory. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R13's nutrition. The CAA further lacked any other considerations that could affect R13's nutrition from resident observation and resident and/or family input for care planning considerations

-Pressure Ulcer CAA revealed the care area was an actual problem for R13 related to need for assist with bed mobility and incontinence. The CAA revealed multiple pre-populated check marked areas which included; altered mental status, extrinsic and intrinsic risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R13's risk of pressure ulcers. The CAA further lacked any other considerations that could affect R13's risk for pressure ulcers from resident observation and resident and/or family input for care planning considerations.

- Psychotropic Drug Use CAA revealed the care area was an actual problem for R13 related to diagnosis of anxiety, depression and psychotic disorder. The CAA identified R13 received psychotropic medications. The CAA revealed multiple pre-populated check marked areas which included medication classes, adverse consequences of psychotropic medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R13's risk of using psychotropic

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F 636	Continued From page 43 medications. . The CAA further lacked any other considerations that could affect R13's risk of using psychotropic medications from resident observation and resident and/or family input for care planning considerations. - Pain CAA revealed the care area was an actual problem for R13 related to complaints of leg pain and routine use of medications. The CAA revealed multiple pre-populated check marked areas which included disease and conditions that may cause pain such as arthritis and osteoporosis. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R13's pain. The CAA further lacked any other considerations that could affect R13's pain from resident observation and resident and/or family input for care planning considerations. On 3/12/18, at 12:20 p.m. the facility MDS coordinator (MDSC)-A confirmed she had completed R13's MDS and CAA dated 12/26/17. MDSC-A confirmed R13's CAA lacked a comprehensive analysis of each care area and did not address any considerations which may affect R13's affected care area. RAI manual dated 10/17, identified Care Areas were triggered by the MDS items in responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning. The RAI manual identified the CAA process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directed facility staff to evaluate triggered care areas. Further the RAI	F 636		

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manual identified whereas the MDS identified actual or potential problems, the CAA process provides for further assessment of the triggered areas by guiding staff to look for causal or confounding factors and was important the CAA documentation included the causal or unique risk factors for decline or lack of improvement. In addition the RAI manual indicated facilities were instructed to identify and use tools that were current and grounded in current clinical standards of practice and when applied to practice, the use of sound clinical problem solving and decision making skills were imperative in completing the CAA process.

R17

R17's Admission Minimum Data Set (MDS) dated 10/13/17, identified R17 had moderate cognitive impairment and had diagnosis which included pneumonia, below the knee amputation (BKA,) chronic obstructive pulmonary disease (COPD,) and diabetes. The MDS identified R17 was independent with activities of daily living (ADL's) including transfers, bed mobility and was occasionally incontinent of urine. The MDS revealed R17 did not ambulate, had one sided limited range of motion of the lower extremity. The MDS identified R17 had received physical therapy (PT,) occupational therapy (OT,) services. The MDS identified R17 received anti-anxiety medication and had frequent pain.

R 17's Care Area Assessment (CAA)dated 10/13/17, identified eight had triggered from the data entered into the MDS requiring analysis, the following areas were triggered; Cognitive Loss/Dementia, ADL Functional/Rehabilitation Potential, Urinary Incontinence and Indwelling

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Catheter, Falls, Nutritional Status, Dehydration/Fluid Maintenance, Pain and Psychotropic Drug Use.

-Cognitive Loss/Dementia revealed the care area was an actual problem for R17 related to moderate cognitive impairment and an inability to recall 1 of 3 objects. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS,) which included; neurological factors, diabetes and ADL function, requiring additional assessment/analysis of R17's cognition. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R17's cognitive functioning. The CAA further lacked any other considerations that could affect R17's cognitive functioning from resident observation and resident and/or family input for care planning considerations.

-ADL Functional/Rehabilitation Potential CAA revealed the care area was an actual problem for R17 related to right below the knee amputation and prosthesis. The CAA revealed multiple pre-populated check marked areas which included; pneumonia, recent hospitalization, pain and underlying conditions requiring additional assessment of R17's ADL function. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R17's ADL's. The CAA further lacked any other considerations that could affect R17's ADL function from resident observation and resident and/or family input for care planning considerations.

-Urinary Incontinence and Indwelling Catheter CAA revealed the care area was an actual

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problem for R17 related to diagnosis of benign prostate hypertrophy (BPH,) and R17's inability to always know when he needed to void. The CAA revealed multiple pre-populated check marked areas which included pain, diabetes, depression and medications. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R17's continence. The CAA further lacked any other considerations that could affect R17's urinary function from resident observation and resident and/or family input for care planning considerations.

-Falls CAA revealed the care area was an actual problem for R17 related to antianxiety medication and a right prosthesis. The CAA revealed multiple pre-populated check marked areas which included medications and internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R17's risk for falls. The CAA further lacked any other considerations that could affect R17's risk for falls from resident observation and resident and/or family input for care planning considerations.

-Nutritional Status CAA revealed the care area was an actual problem, though did not indicate the nature of the problem. The CAA revealed several pre-populated check marked areas which included functional problems, poor memory, diabetes and respiratory disease. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R17's nutrition. The CAA further lacked any other considerations that could affect R17's nutrition from resident observation and resident and/or family input for care planning

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F 636	Continued From page 47 considerations. -Dehydration/Fluid Maintenance CAA revealed the care area was a potential problem and did not indicated the nature of the problem. The CAA revealed several pre-populated check marked areas which included depression, diabetes and medication use. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R17's risk for dehydration. The CAA further lacked any other considerations that could affect R17's risk for dehydration from resident observation and resident and/or family input for care planning considerations. Psychotropic Drug Use CAA revealed the care area was an actual problem related to anxiety, depression and antianxiety medication use (Xanax.) The CAA revealed several pre-populated check marked areas which included anti-anxiety medication and adverse consequences of psychotropic drug use. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R17's risk of psychotropic drug use The CAA further lacked any other considerations that could affect R17's risk of psychotropic drug use from resident observation and resident and/or family input for care planning considerations. -Pain CAA revealed the care area was an actual problem related to complaints of back pain. The CAA revealed several pre-populated check marked areas which included pneumonia, contractures and pain affect on function. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which	F 636		

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F 636	Continued From page 48 impacted R17's pain The CAA further lacked any other considerations that could affect R17's pain from resident observation and resident and/or family input for care planning considerations On 3/12/18, at 12:26 p.m. the MDSC-A confirmed she had completed R17's admission MDS and CAA dated 10/13/17. MDSC-A confirmed R17's CAA lacked a comprehensive analysis of each care area and did not address any considerations which may affect R17's affected care area. RAI manual dated 10/17, identified Care Areas were triggered by the MDS items in responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning. The RAI manual identified the CAA process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directed facility staff to evaluate triggered care areas. Further the RAI manual identified whereas the MDS identified actual or potential problems, the CAA process provides for further assessment of the triggered areas by guiding staff to look for causal or confounding factors and was important the CAA documentation included the causal or unique risk factors for decline or lack of improvement. In addition the RAI manual indicated facilities were instructed to identify and use tools that were current and grounded in current clinical standards of practice and when applied to practice, the use of sound clinical problem solving and decision making skills were imperative in completing the CAA process. R207	F 636		

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R207's Admission Minimum Data Set (MDS) dated 2/27/18, identified R207 was cognitively intact and had diagnosis which included recent surgical past of a right knee arthroscopy (TKA) (surgical procedure to repair knee damage,) depression, anxiety and schizophrenia. The MDS identified R207 was independent in all activities of daily living and was receiving both skilled physical therapy (PT) and occupation therapy (OT,) services. The MDS further identified R207 had constant pain and had received as needed medication for pain. The MDS identified R207 received psychotropic medications.

R207's Care Area Assessment (CAA)dated 2/27/18, identified six had triggered from the data entered into the MDS requiring analysis, the following areas were triggered; ADL Functional/Rehabilitation Potential, Falls, Nutritional Status, Pressure Ulcer and Pain and Psychotropic Drug Use.

-ADL Functional/Rehabilitation Potential CAA revealed the care area was an actual problem for R207 related to recent right TKA, cellulitis (infection/inflammation of skin,) bipolar disorder and had a history of substances abuse. The CAA revealed several pre-populated checked marked areas which included recent hospitalization, depression and complications of immobility. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R207's ADL's. The CAA further lacked any other considerations that could affect R207's ADL function from resident observation and resident and/or family input for care planning considerations.

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F 636	Continued From page 50 -Falls CAA revealed the care area was an actual problem for R207 related to supervision with bed mobility and toileting and receipt of psychotropic medications. The CAA revealed several pre-populated check marked areas which included medications, anxiety, depression, and pain. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R207's risk for falls. The CAA further lacked any other considerations that could affect R207's risk for falls from resident observation and resident and/or family input for care planning considerations. -Nutritional Status CAA revealed the care area was an actual problem, though did not indicate the nature of the problem. The CAA revealed several pre-populated check marked areas which included functional problems, poor memory, depression and pain. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R207's nutrition. The CAA further lacked any other considerations that could affect R207's nutrition from resident observation and resident and/or family input for care planning considerations. -Pressure Ulcer CAA revealed the care area was an actual problem related to supervision with bed mobility. The CAA revealed several pre-populated check marked areas which included extrinsic risk factors, medications and newly admitted. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R207's risk for pressure ulcers. The CAA further lacked any other considerations that could affect R207's risk for pressure ulcers from resident observation and resident and/or family	F 636		

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F 636	Continued From page 51 input for care planning considerations. -Psychotropic Drug Use CAA revealed the care area was an actual problem related to anxiety, depression, bipolar disorder and schizophrenia. The CAA revealed several pre-populated check marked areas which included anti-anxiety medication and adverse consequences of psychotropic drug use. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R207's risk of psychotropic drug use. The CAA further lacked any other considerations that could affect R207's risk of psychotropic drug use from resident observation and resident and/or family input for care planning considerations. -Pain CAA revealed the care area was an actual problem related to R207's frequent complaints of pain rated 6/10 on a numeric pain scale and use of pain medication. The CAA revealed several pre-populated check marked areas which included arthritis and contractures. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R207's pain. The CAA further lacked any other considerations that could affect R207's pain from resident observation and resident and/or family input for care planning considerations. On 3/12/18, at 12:34 p.m. MDSC-A confirmed she had completed R207's admission MDS and CAA's dated 2/27/18. MDSC-A confirmed R207's CAA lacked a comprehensive analysis of each care area and did not address any considerations which may affect R207's affected care area. R28	F 636		

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R28's Annual MDS dated 1/16/18, identified R28 had severe cognitive impairment and had diagnoses which included dementia, restlessness and agitation. The MDS identified R28 required extensive assistance with activities of daily living (ADL's) including locomotion and was always incontinent of both bowel and bladder. The MDS identified R28 had a significant weight loss of 5% or more in the last month. The MDS further identified R28 had no falls within the last quarter and was at risk for pressure ulcer development.

R28's Care Area Assessment (CAA)dated 1/16/18, identified five had triggered from the data entered into the MDS requiring analysis, the following areas were triggered; Cognitive Loss/Dementia, Urinary Incontinence and Indwelling Catheter, Falls, Nutritional Status and Pressure Ulcer.

-Cognitive Loss/Dementia CAA, revealed the care area was an actual problem for R28 related to severe cognitive impairment and a diagnosis of non-Alzheimers dementia. The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS,) which included; neurological factors and ADL function, requiring additional assessment/analysis of R28's cognition. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R28's cognitive functioning. The CAA further lacked any other considerations that could affect R28's cognitive functioning from resident observation and resident and/or family input for care planning considerations.

-Urinary Incontinence and Indwelling Catheter

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F 636	Continued From page 53	F 636		

CAA revealed the care area was an actual problem for R28 related to incontinence and need for assist with toileting. The CAA revealed multiple pre-populated check marked areas which included environment, urinary urgency and need for assistance with toileting. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R28's incontinence. The CAA further lacked any other considerations that could affect R28's urinary incontinence from resident observation and resident and/or family input for care planning considerations.

-Falls CAA revealed the care area was an actual problem for R28 related to required assistance with transfers, bed mobility and toileting. The CAA revealed multiple pre-populated check marked areas which included difficulty with balance, medications and incontinence. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R28's risk for falls. The CAA further lacked any other considerations that could affect R28's fall risk from resident observation and resident and/or family input for care planning considerations.

-Nutritional Status CAA revealed the care area was an actual problem for R28, though did not indicated the reason. The CAA revealed multiple pre-populated check marked areas which included physical limitations, dementia and poor memory. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R28's nutrition.

-Pressure Ulcer CAA revealed the care area was an actual problem for R28 related to need for assist with bed mobility and incontinence. The

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CAA revealed multiple pre-populated check marked areas which included; altered mental status, extrinsic and intrinsic risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R28's risk of pressure ulcers. The CAA further lacked any other considerations that could affect R28's risk for pressure ulcers from resident observation and resident and/or family input for care planning considerations.

On 3/12/18, at 12:38 p.m. the MDSC-A confirmed she had completed R28's annual MDS and CAA dated 1/16/18. MDSC-A confirmed R28's CAA lacked a comprehensive analysis of each care area and did not address any considerations which may affect R28's affected care area.

RAI manual dated 10/17, identified Care Areas were triggered by the MDS items in responses that indicate the need for additional assessment based on problem identification, known as "triggered care areas," which form a critical link between the MDS and decisions about care planning. The RAI manual identified the CAA process provides guidance on how to focus on key issues identified during a comprehensive MDS assessment and directed facility staff to evaluate triggered care areas. Further the RAI manual identified whereas the MDS identified actual or potential problems, the CAA process provides for further assessment of the triggered areas by guiding staff to look for causal or confounding factors and was important the CAA documentation included the causal or unique risk factors for decline or lack of improvement. In addition the RAI manual indicated facilities were instructed to identify and use tools that were current and grounded in current clinical standards

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F 636	Continued From page 55 of practice and when applied to practice, the use of sound clinical problem solving and decision making skills were imperative in completing the CAA process.	F 636		

R1's admission Minimum Data Set (MDS) dated 11/11/17, identified R1 had intact cognition, and had diagnoses which included Parkinson's disease, dementia, anxiety, glaucoma, weakness, restlessness and agitation. The MDS identified R1 required total assistance for eating, extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, and did not walk. The MDS also identified R1 had a fall in the last month prior to admission, a fall in the last 2-6 months prior to admission, and no falls since admission. The MDS did not identify R1's fall on 11/8/17, that R1 was ambulating, refused assistance with an activity of daily living (ADL) or that R1 was combative with staff on 11/8/17.

R1's admission Care Area Assessment (CAA) dated 11/14/17, identified eight care areas had triggered from the data entered into the MDS requiring analysis, the following areas were triggered: Visual Function, ADL Functional/Rehabilitation Potential, Urinary

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F 636	Continued From page 56 Incontinence and Indwelling Catheter, Falls, Nutrition, Pressure Ulcer, Psychotropic Drug Use and Pain. -Visual Function CAA revealed the care area was an actual problem for R1 related to a diagnosis of glaucoma. R1 stated as of that moment his vision was "ok". The CAA revealed multiple pre-populated check marked areas (from data entered on the MDS), which included: diseases and conditions of the eye marked as glaucoma and diabetic retinopathy, diseases and conditions that could cause visual disturbances marked as dementia. and medications that could impair vision marked for antidepressant and antipsychotics. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R1's visual functioning. The CAA further lacked R1's use of glasses, input from resident observation and resident or family input for care planning consideration. -ADL Functional/Rehabilitation Potential CAA revealed the care area was an actual problem for R1 related to severe tremors at times which would cause R1 to require assistance with dressing, bathing, grooming, transfers, toileting and eating. The CAA revealed multiple pre-populated check marked areas which included: recent hospitalization, vision problems, incontinence, depression. The CAA lacked ADL problem evaluation, R1's locomotion considerations, and a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R1's ADL functioning. The CAA further lacked any other considerations that could affect R1's ADL functioning from resident observation and resident and/or family input for	F 636		

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F 636	Continued From page 57 care planning considerations. -Urinary Incontinence and Indwelling Catheter CAA was requested, however not provided. -Falls CAA revealed the care area was an actual problem for R1 related to a diagnoses of Parkinson's disease and glaucoma, was currently receiving psychotropic medications and had numerous falls at previous living facility. The CAA revealed multiple pre-populated check marked areas which included: difficulty maintaining seated balance, impaired balance during transitions, medications including anti-psychotics, anti-depressants and anti-anxiety agents and pre-populated internal risk factors. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R1's risk for falls. The CAA further lacked any other considerations that could affect R1's fall risk from resident observation and resident and/or family input for care planning considerations. -Nutritional Status CAA revealed the care area was an actual problem for R1. The CAA revealed multiple pre-populated check marked areas which included dementia and Parkinson's disease. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R1's nutrition. The CAA further lacked any other considerations that could affect R1's nutrition from resident observation and resident and/or family input for care planning considerations. -Pressure ulcer CAA revealed the care area was an actual problem for R1 related to requiring assistance with ADLs, urinary incontinence and	F 636		

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was at risk for developing pressure ulcers. The CAA revealed multiple pre-populated check marked areas which included; altered mental status, immobility, diabetes, dementia and that R1 was newly admitted. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R1's risk of pressure ulcers. The CAA further lacked any other considerations that could affect R1's risk for pressure ulcers from resident observations and resident and/or family input for care planning considerations.

-Psychotropic Drug Use CAA revealed the care area was an actual problem for R1 related to diagnoses of depression, anxiety, dementia and R1 was currently receiving Remeron (anti-depressant), Seroquel (anti-psychotic) and Ativan (anti-anxiety) medication. The CAA revealed multiple pre-populated check marked areas which included; medication classes R1 was taking, adverse consequences of depression, anxiety, sedation, disturbance of gait. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R1's risk of using psychotropic medications. The CAA further lacked any other considerations that could affect R1's risk of using psychotropic medications from resident observation and resident and/or family input for care planning considerations.

-Pain CAA revealed the care area was an actual problem for R1 related to occasional back pain rated 4 out of 10 on a 10 point scale that occasionally made it hard for R1 to sleep at night. The CAA revealed multiple pre-populated check marked areas which included; diseases and conditions that may cause pain. pain effect on

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F 636	Continued From page 59 function and immobility. The CAA lacked a comprehensive analysis of the aforementioned pre-populated checkmarks which impacted R1's pain. The CAA further lacked any other considerations that could affect R1's pain from resident observation and resident and/or family input for care planning considerations. On 3/12/18, at 11:26 a.m. registered nurse MDS coordinator (MDSC)-A conmpleted R1's admission MDS and CAA dated 11/14/17. MDSC-A confirmed R1's CAA lacked a comprehensive analysis of the pre-populated checkmarks from the MDS data.	F 636		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a Significant Change in Status Assessment (SCSA) when two or more areas of change in resident status were noted on the Minimum Data Set (MDS) for 1 of 2 (R28) residents reviewed for a decline activities of daily	F 637	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of	4/23/18

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F 637	Continued From page 60 living (ADL's). Findings include: R28's quarterly Minimum Data Set (MDS) dated 10/25/17, identified R28 had severe cognitive impairment and had diagnoses which included dementia, restlessness and agitation. The MDS identified R28 required extensive assistance with activities of daily living (ADL's,) of bed mobility, transfers and toileting. The MDS identified R28 was independent in locomotion, eating and did not ambulate. The MDS revealed R28's weight at the time of the MDS was 135 pounds (lbs.) Further the MDS identified R28 was frequently incontinent of both bowel and bladder. R28's annual MDS dated 1/16/18, identified R28 had severe cognitive impairment and had diagnoses which included dementia, restlessness and agitation. The MDS identified R28 required extensive assistance with activities of daily living (ADL's) including locomotion and required limited assistance with eating. The MDS identified R28 ambulated with physical assistance. The MDS revealed R28's weight at the time of the MDS was 125 lbs, a 10 lb weight loss since R28's last MDS. The MDS futher identified R28 was always incontinent of both bowel and bladder. Review of the above assessments indicated a 10 lb weight loss, increase need for staff assistance in ADL's of eating, locomotion and ambulation and a decline in bowel and bladder incontinence. On 3/12/18, at 12:51 p.m. the facility MDS coordinator (MDSC)-A confirmed she had completed both of R28's aforementioned MDS's. MDSC-A stated she usually only completed SCSA	F 637	Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide consistent quality care to ensure residents with significant changes are appropriately assessed and necessary interventions put in place and that care plan is accurate. Some of the many ways that this has been achieved for R28 is to get PT/OT ordered, dietary consult and update care sheets to ensure staff adequately caring for resident to prevent further decline. In this case, after the survey determined R28 showed a decline in status on 4/6/2016 such as needing more assistance with cares, is incontinent and has been having less of appetite. a significant change was initiated. Assessments done and care plan to be created based on needs after assessment has closed. 2.Because all residents have constantly changing needs all are potentially affected by the cited deficiency, on 4/4/2018, the MDS nurse reviewed criteria for significant changes. All residents were audited to determine others needing sig change. Other residents determined to have changes have been identified and significant change assessments have been initiated. Policy and procedure on significant change was reviewed and updated. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding changes in resident’s condition. The	

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when a resident was admitted or discharged from hospice services. She stated she did not have a current process in place for monitoring changes in residents status.

On 3/12/18, at 3:04 p.m. the director of nursing (DON) stated she would expect a SCSA to be completed when when two or more areas of decline were observed with a resident. She confirmed the facility did not have a current process in place for capturing resident decline except when in a resident was admitted or discharged from Hospice services.

A facility policy was requested for recognition and completion of resident SCSA MDS's, none were provided.

The Resident Assessment Instrument manual dated 10/17, included the definition of a significant change as a decline or improvement in a resident's status that:

1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered "self-limiting";
2. Impacts more than one area of the resident's health status; and
3. Requires interdisciplinary review and/or revision of the care plan.

The manual further directed when the interdisciplinary team (IDT) determined that a significant change occurred, the nursing home should document the initial identification of the significant change in the clinical record. The final decision regarding what constitutes a significant change in status must be based upon the

F 637

training emphasized the importance of monitoring ADL's both improvement and decline.
4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the DON and MDS to monitor residents having changes in their care. The MDS nurse or designated quality-assurance representative will perform the following systematic changes: MDS nurse will pull the ADL significant change analysis report and review data to see who has had changes in status and full audit will be done by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area and initiate sig change if needed. All residents will be reviewed at time of quarterly or annual to ensure not a significant change. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.MDS nurse will be responsible for this POC.

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F 637	Continued From page 62 judgment of the IDT. The manual clarified that MDS assessments are not required for minor or temporary variations in resident status.	F 637		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete required quarterly Minimum Data Set(s) (MDS) at least every 92 days for 2 of 2 (R23 , R1) residents reviewed for late quarterly MDS. Findings include: "Quarterly Review Assessment" is an OBRA '87-required, non-comprehensive assessment that must be completed at least every 92 days following the previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. R 23's annual MDS dated 11/7/17, identified R23 was cognitively intact and had diagnoses which included congestive heart failure, atrial fibrillation, depression and anxiety. The MDS identifed R23 was independent in all activities of daily living (ADL's) and had a tracheostomy which required suctioning.	F 638	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide quarterly assessments every quarter to ensure correctly assessed and appropriate care plan is developed. In this case, after the surveyor reported that R23 and R1 did not have timely quarterly assessments it was determined it was due to being dropped off the scheduler. These residents had a hospital stay and upon returning did not get correctly added to the census. Both have been assessed and are currently up to date on their assessments. The census is reviewed every day in stand up and scheduler double checked to ensure any residents back from a leave are back into schedule.	4/23/18

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F 638	Continued From page 63 Review of R23's record lacked documentation of a quarterly MDS completed after the annual MDS on 11/7/17. On 3/12/18, at 12:39 p.m. R23's medical record was reviewed with the facility MDS coordinator. She confirmed R23's quartely MDS had been missed and was not completed timely. The MDS coordinator stated her usual practice was to schedule residents MDS's 90 days apart. She stated a Quarterly MDS was currently in progress for R23 with an assessment reference date set of 3/7/18. The MDS coordinator confirmed there were over 120 days between assessment reference dates. R1's admission MDS dated 11/11/17, identified R1 had intact cognition, and had diagnoses which included Parkinson's disease, dementia, anxiety, glaucoma, weakness, restlessness and agitation. The MDS identified R1 required total assistance for eating, extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, and did not walk. Review of R1's clinical record revealed R1 had a quarterly MDS assessment with an assessment reference date (ARD) of 3/7/18, which is a total of 116 days between R1's admission ARD of 11/11/17, and current ARD of 3/7/18. On 3/13/18, at 10:37 a.m. registered nurse Minimum Data Set coordinator (MDSC)-A stated MDS assessments should have no more than 90	F 638	2.Because all residents are reviewed quarterly all are potentially affected by the cited deficiency, on 4/5/2018, the MDS nurse reviewed process of ensuring accurate census with admissions and business office manager. Policy and procedure on quarterly assessments has been reviewed. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding importance of quarterly and annual assessments. All residents will be reviewed at time of admission or readmission to ensure are they do not fall off the scheduler and are assessed thoroughly and completely. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the MDS nurse to assure all residents are assessed quarterly and annually. The MDS nurse will audit census with point click care tracker to ensure no resident is out of compliance over next 3 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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F 638	Continued From page 64 days between assessments. MDSC-A stated she depended on an electronic scheduler, built in to the electronic health record, for tracking when residents' MDS assessments were due so the assessments could be scheudled. MDSC-A reviewed R1's MDS assessments and confirmed R1 had 116 days between scheduled assessments.	F 638		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure resident status was accurately reflected in the Minimum Data Set (MDS) for 1 of 1 residents (R13) reviewed for worsening pressure ulcers. In addition, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 resident (R38) reviewed for dental care, and 1 of 1 resident (R9) with incontinence. Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2017, identified Section M: Skin Conditions to be completed with an intent to "document the risk, presence, appearance, and change of pressure ulcers." Further, the manual provided several coding instructions, including completing question M0100A and M0210A and M0300A, directing staff to, "Review the medical record,	F 641	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide accurate assessments on all residents. R13 MDS did not note any pressure areas, R38 MDS did not properly indicate dental issues, and R9 did not properly state incontinence. In this case, after the survey indicated the incorrect information immediately the documentation was reviewed on these residents. R13 has had wound information updated, care plan updated and interventions in place. R38 was noted to have poor oral hygiene and multiple broken teeth and care plan has	4/23/18

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	245052	A. BUILDING ______ B. WING ______	03/13/2018

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MOORHEAD REHABILITATION & HEALTHCARE CENTER	**2810 SECOND AVENUE NORTH MOORHEAD, MN 56560**

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Continued From page 65

including skin care flow sheets or other skin tracking forms, nurses' notes, and pressure ulcer risk assessments. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident."

R13's annual Minimum Data Set (MDS) dated 12/26/17, identified R13 was at risk for pressure ulcer development, had no current or recently healed pressure ulcers. The MDS further identified the following skin treatments: pressure relieving devices for chair and bed. The MDS did not identify R13 was on a turning and repositioning program.

Review of R13's form titled, Wound Evaluation Flow Sheet, started on 12/15/17, the DON stored in her office, a hand written flow sheet with spaces for weekly wound measurements. The following was listed:

-12/15/17, R13 had an unstageable ulcer of her left heel which measured 0.5 cm by 0.5 cm. The flow sheet identified R13's skin surrounding the pressure ulcer was intact and the wound margins were defined. The wound evaluation flow sheet revealed the current intervention was foam dressings to both feet.

-12/29/17, revealed R13's left heel pressure ulcer measured 0.3 cm by 0.3 cm, wound margins were defined and the surrounding skin was intact. The form revealed the current intervention was to leave open to air.

- 1/3/18, revealed R13's left heel pressure ulcer measured 0.3 cm by 0.3 cm, wound margins were defines and the surrounding skin was intact

F 641

been updated. R9 had new bowel and bladder assessment completed and care plan updated.
2.Because all residents receive their level of care based on their assessments all are potentially affected by the cited deficiency, on 4/5/2018, the MDS nurse reviewed how information is gathered and importance of doing hands on review with residents to ensure accurate information. In addition, nursing staff were educated on importance of documenting appropriately on residents and reviewing care sheets to ensure staff providing correct cares. All current resident MDS's were reviewed for accuracy and resubmitted when necessary or if determined to need significant change. Through this process 3 discrepancies were noted and addressed immediately to ensure proper documentation; MDS corrected. No other residents were affected.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff were in-serviced training requirements for assessments and MDS/care plans. MDS nurse was educated on importance of seeing residents they assess and ensure accuracy. All residents will be reviewed quarterly and annually, and staff interviews will be critical piece in gathering data. All triggers will be care planned and communicated to staff via care sheets and communication book if new interventions in place.
4.Effective 4/4/2018, a quality-assurance

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F 641	Continued From page 66 and was open to air. Review of R13's wound evaluation flow sheet, found in the electronic record, 12/15/17, revealed R13 had an unstageable pressure ulcer on her right heel which was identified on 12/15/17. The wound evaluation flow sheet identified R13's right heel pressure ulcer measured 1 cm by 1 cm. The flow sheet further identified R13's pressure ulcer had the following characteristic: wound bed was 100% skin, periwound margins were defined, surrounding skin was intact. The flow sheet indicated the following treatments/interventions were in place; R13 was to have a foam dressing on both heels every 72 hours, pressure redistribution mattress and heel protectors. The electronic Wound Evaluation flow Sheet did not identify a pressure ulcer on R13's left heel. On 3/12/18, at 12:32 p.m. the facility MDS coordinator confirmed R13's MDS dated 12/26/17, did not identify R13 had any pressure ulcers. The MDS coordinator stated her usual process for obtaining data to enter into the MDS included; reviewing R13's electronic medical record and paper chart, going back 7 days from the assessment reference date. She stated she was unaware R13 had any pressure ulcers at the time of the assessment. The Centers for Medicare and Medicaid (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/17, identified Section L: Dental was to be completed with an intent to record any dental problems present during the look-back period. The manual indicated "assessing dental status can help	F 641	program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic changes: after corrections determined, audit of all MDS's for accuracy will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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F 641	Continued From page 67 identify residents who may be at risk for aspiration, malnutrition, pneumonia, endocarditis, and poor control of diabetes". Further, the manual provided several assessment steps including: "Conduct exam of the resident's lips and oral cavity. Visually observe and feel all oral surfaces including lips, gums, tongue, palate, mouth floor, and cheek lining. Check for abnormal mouth tissue, abnormal teeth, or inflamed or bleeding gums. Oral examination of residents who are uncooperative and do not allow for a thorough oral exam may result in medical conditions being missed. Referral for dental evaluation should be considered for these residents." R38's annual MDS dated 1/17/18, identified R38 was severely cognitively impaired and had diagnoses which included Diabetes Mellitus, dementia and anxiety. The MDS indicated R38 required total assistance with personal hygiene which included brushing teeth. R38's MDS Oral/Dental Status, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth was seen, was unmarked. Inflamed or bleeding gums: if gums appear irritated, red, swollen, or bleeding, was unmarked. Unable to examine: if the resident's mouth cannot be examined, was unmarked. None of the above, was marked yes. Review of R38's clinical record revealed a provider note from Apple Tree Dental dated 8/11/16, indicating R38 had many broken teeth and areas of likely decay. No other dental provider notes were received from the facility. On 3/6/18, at 6: 42 p.m. R38 smiled revealing multiple broken teeth on the top, right front of mouth. The right front tooth was half decayed with white/cream colored matter attached to the	F 641		

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F 641	Continued From page 68	F 641		

teeth at the gumline. R38's gums around the upper right side teeth were reddened and inflamed with multiple other teeth showing decay.

On 3/8/18, at 6:59 a.m. nursing assistant (NA)-A stated R38 was combative with cares which included brushing teeth. NA-A stated staff was unable to complete oral cares often, due to the behavior and reported it to the nurse.

On 3/12/18, at 10:57 a.m. NA-I stated R38 was very combative with cares which included brushing teeth. NA-I stated R38 had not let anyone brush his teeth in a long time, but staff attempted after meals, reported refusals to the nurse, and placed a behavior note in the electronic record.

On 3/12/18, at 10:58 a.m. licensed practical nurse (LPN)-G stated R38 was combative with cares and staff had to reapproach often. LPN-G stated R38 refused oral cares often and confirmed R38 had some broken and decaying teeth.

On 3/12/18, at 11:28 a.m. registered nurse MDS coordinator (MDSC)-A stated, to complete the section on Oral/Dental Status she would check the resident's clinical record, review progress notes, and review activity of daily living (ADL) charting completed by nursing assistants. MDSC-A stated if she had any follow up questions she would go out to the floor and ask staff. MDSC-A stated she did not usually physically assess residents. MDSC-A confirmed she completed R38's MDS dated 1/17/18, including the Oral/Dental status. She could not recall if she physically assessed R38 at the time of the assessment. MDSC-A reviewed the Apple Tree Dental provider note dated 8/11/16, and

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F 641	Continued From page 69 stated "none of the above" would not be an accurate assessment of R38's dental status at the time of the assessment. MDSC-A stated coding R38's dental section "none of the above" would cause the dental Care Area Assessment (CAA) to not trigger and a comprehensive assessment of his dental status would not have been completed. On 3/12/18 at 12:32 p.m. director of nursing (DON) stated she would expect resident MDS data to be accurate and the MDS assessment was what drove the residents care plan and care for the resident. DON stated she would expect R38's current dental status to be reflected on the MDS. An MDS policy was requested from the facility and one was not provided. The facility stated staff utlized the instructions in the Resident Assessment Instrument (RAI) Manual for MDS assessments. The Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual for Version 3.0 dated 10/17, was published by the Centers for Medicare & Medicaid Services (CMS). CMS's goal was to disseminate information broadly to facilitate accurate and effective resident assessment practices in long-term care facilities. R9's Diagnosis Report print date of 3/12/18, indicated R9 had diagnoses of bipolar disease, dementia without behavioral disturbance, and anxiety. R9's quarterly MDS dated 12/20/17, indicated R9 did not exhibit any behavior and indicated R9 was always continent of bladder. During supper observations, on 3/06/18 at 5:27	F 641		

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F 641	Continued From page 70 p.m., R9 was sitting at a dining room table, alone. R9 had a very strong urine odor, with the odor noticed approximately 5 feet away. At 9:40 a.m., R9 was served his evening meal, quickly consumed the meal, then returned to his room and laid on his back in bed. It was noted there was a very strong urine smell in entire room. When asked R9 refused an interview at that time. On 3/07/18 at 2:44 p.m., R9 was observed walking the halls with a 4 wheeled walker, wearing clothes different than 3/7/18. However, R9 continued to have a noticeable urine odor. On 3/08/18 at 8:30 a.m., R9 was observed in the dining room having a strong urine smell emminating from self. After the meal, R9 returned to his room, and again a strong drafting of warm, very strong urine odor emminated from the room. During an interview on 3/12/18, at 12:10 p.m. nursing assistant (NA)-I indicated she was aware R9 was incontinent of urine and stated R9 did not like his room cleaned so she waited until he left for lunch, then stripped the bed, wiped down mattress, and attempted to remove soiled clothing. NA-I stated R9 got upset today, yelled at her, told her to leave and slammed the door. NA-I further stated that before she left R9's room, he grabbed a pair of soiled pants she was carrying and hung up the pants in his closet. During an interview on 3/12/18, at 8:30 a.m. the director or nursing (DON) confirmed R9 was incontinent and stated R9's quarterly MDS, dated 12/20/17, had been incorrectly coded for his bladder function.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)	F 656		4/23/18

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F 656	Continued From page 71 §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the	F 656		

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F 656	Continued From page 72 requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop an accurate comprehensive care plan for 1 of 1 resident (R17) reviewed for prosthesis. In addition, the facilty failed to ensure a comprehensive care plan was developed for activities of daily living (ADL) for 1 of 1 resident (R1) reviewed for falls. Findings Include: R17's Admission Minimum Data Set (MDS) dated 10/13/17, identified R17 had moderate cognitive impairment and had diagnosis which included pneumonia, below the knee amputation (BKA,) chronic obstructive pulmonary disease (COPD,) and diabetes. The MDS identified R17 was independent with activities of daily living (ADL's) including transfers, bed mobility. The MDS revealed R17 did not ambulate, had one sided limited range of motion of the lower extremity. The MDS further identified R17 had received physical therapy (PT,) occupational therapy (OT,) services. R 17's quarterly MDS dated 1/10/18, identified R17 was cognitively intact, independent in ADL's and had one sided limited range of motion of the lower extremity. The MDS revealed R17 did not ambulate and did not receive PT or OT services. Review of R17's care plan dated 1/19/18, identified R17 had a right BKA with a prosthesis and indicated he was independent with all ADL's including transfers. R17's care plan lacked indications for staff assistance with R17's	F 656	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide consistent quality care to ensure residents have comprehensive care plans. Some of the many ways that this has been achieved for R1 is therapy completed, staff educated on managing resident episodes, mats off floor, and offer walks throughout the day. R17 has determined he would like to try prosthetic again, company sizing correctly, therapy ready to start with re-training when it is completed and staff aware to follow care sheets and encourage walking with training from therapy regarding prosthetic application. In this case, after the survey determined R1 MDS was not correct nor was R17 both were revised and updated including care sheets for staff. 2.Because all residents are have changing levels of care all are potentially affected by the cited deficiency, on 4/5/2018, the MDS nurse reviewed process of ensuring accurate MDS's to formulate comprehensive care plans. All other resident care plans have been reviewed and updated for accuracy, MDS	

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F 656	Continued From page 73 prosthesis or ambulation. On 3/9/18, at 4:01 p.m. R17 was seated in an electric scooter in his room. R17's prosthesis was on the floor against the wall, between his closet and the end of his bed. R17 stated when he first arrived at the facility in October 2017, he had received both OT and PT services for approximately 2-3 weeks and had been able to walk with his prosthesis and the therapist. He indicated since he had stopped working with therapy, no other staff member had offered or assisted him to ambulate in the facility. He indicated his prosthesis was too big for him and felt his stump had shrunk. R17 stated at that time he did not feel he would be able to walk. R17 further indicated he had voiced his concerns about losing his ability to walk and to wear his prosthesis to his primary medical doctor as he did not feel his concerns would be addressed by the facility staff. On 3/12/18, at 9:33 a.m. physical therapy director (PT)-A confirmed R17 had received skilled therapy services when he arrived at the facility. She stated R17's payor source was from North Dakota and only allowed for 15 skilled therapy visits a calendar year, therefore R17 was discharged from skilled therapy within a few weeks from his admission. PT-A stated she felt R17 made improvements with his mobility in areas of ambulation and transfers while working with therapy. She stated R17's prosthesis was fitting and felt it had worked well with R17. On 3/12/18, at 9:20 a.m. certified occupational therapist (OT)-A confirmed R17 had received skilled therapy services when he arrived at the facility and had received 8 skilled OT visits. She	F 656	nurse has taken a CAA training and is aware of how to properly document on CAA's as well as ensure all assessments completed during look back period are completed, and correct information is gathered. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding changes in resident's condition and reviewed documentation of ADL's. The training emphasized the importance of monitoring ADL's both improvement and decline and ensuring information on care sheet follows the actual care performed. MDS nurse to visualize residents and ask staff through interview to confirm data. The education included development of care plan after assessment of resident individual needs. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the MDS and DON to monitor residents MDS and ensure data accurate and correct. The MDS nurse or designated quality-assurance representative will perform the following systematic audits of assessments that formulate the care plan based on individual resident needs. They will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for	

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F 656	Continued From page 74 stated she felt R17 had made significant progress with therapy and had improved in his ability to donn and doff his prosthesis, balance, transfers and ambulation. OT-A stated R17 had been able to ambulate up to 100 feet with CGA when he was discharged from therapy services. OT-A confirmed she had recommended facility nursing staff continue to work with R17 with his prosthesis and ambulation in order to maintain and potentially improve his modified independence. She further stated she had concerns with the facility not providing residents with any type of formal or informal ADL maintenance/restorative services. On 3/12/18, at 9:52 a.m. the director of nursing (DON) confirmed R17's care plan lacked any direction to assist R17 with ambulation and to monitor and assist R17 with his prosthesis. The DON stated the facility currently did not have any type of restorative or maintenance program to prevent decline in residents ADL's. She stated implementing a restorative program was one of the areas she was working to develop and indicated she did not have a current plan in place. The DON stated she would have expected R17 to maintain his ability to ambulate and further stated she was unaware OT had recommended nursing staff to assist R17 with ambulation. She further indicated nursing and the contracted therapy department had communication problems and were currently working on improving communication for recommendations. R1's admission Minimum Data Set (MDS) dated 11/11/17, identified R1 had intact cognition, and	F 656	further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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F 656	Continued From page 75	F 656		

had diagnoses which included Parkinson's disease, dementia, anxiety, glaucoma, weakness, restlessness and agitation. The MDS identified R1 required extensive assistance with bed mobility, transfers and did not walk.

R1's Care Area Assessment (CAA) dated 11/14/17, indicated R1 had a history of numerous falls at previous living facility and had been admitted from an acute hospital after multiple falls and worsening of Parkinson's disease. The CAA indicated R1 required assistance with dressing, bathing, grooming, transfers, bed mobility, eating and toileting at times due to severe tremors and was at risk for an increase in assistance with ADLs.

Review of R1's current care plan printed on 3/8/18, last revised 3/6/18, identified R1 had an ADL self-care performance deficit related to impaired balance, Parkinson's disease and tremors. However, R1's care plan lacked instructions for staff regarding R1's self performance and assistance needed for bed mobility, transfers and ambulation.

Review of R1's progress notes from 11/1/17, to 11/11/17, revealed:

-11/10/17, R1 had frequent muscle movement this shift and had been up and down from bed and noted to walk to the bathroom.

-11/8/17, R1 was very agitated that day and refused to wait for staff to walk around room and out of room.

Review of R1's Physical Therapist (PT) Progress and Discharge Summary with start of care dated

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11/7/17, and end of care date 12/4/17, revealed R1 had diagnoses of muscle weakness, difficulty in walking and unsteadiness in feet. R1 had had been discharged from therapy due to significant variability in his mobility depending on medication doses. The summary included recommendations for assist of 1 for all mobility tasks and general supervision while R1 mobilized on the unit in his wheelchair due to history of attempting to self transfer.

Review of R1's Occupational Therapist (OT) Progress and Discharge Summary with start date of 11/7/17, and end date of 12/1/17, revealed the summary identified R1 was a fall risk, had significant weakness/balance concerns without the use of Parkinson's disease medications, required supervision/assist with standing ADLs and functional transfers/ambulation to ensure safety and level of assist dependent on medication schedule.

On 3/7/18, at 9:30 a.m. R1 was observed to walk in his room alone, over the fall mat to the closet and on to the bathroom.

On 3/8/18, at 8:57 a.m. R1 abruptly stood up from the chair, with uncontrolled arm movements, shuffled feet and an unsteady gait, walked across the uneven surface of the fall mats,, transitioning to the regular floor over to his closet.

On 3/8/18, at 10:15 a.m. PT-A stated R1 received therapy after admission, but was no longer in therapy. PT-A stated R1 was a fall risk and due to R1's balance and judgement he should never transfer or ambulate on his own.

On 3/8/18, at 10:37 a.m. NA-A stated when R1

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F 656	Continued From page 77 was not having involuntary movements, he could transfer, walk in his room and go to the bathroom independently or with supervision. On 3/8/18, at 10:54 a.m. LPN-C stated she felt R1 could transfer and ambulate independently. On 3/8/18, at 12:25 p.m. director of nursing (DON) stated R1 had Parkinson's disease, so his fall risk was "really high." The DON stated R1 self transferred a lot and R1 was not safe to transfer or walk independently. DON reviewed R1's current care plan and confirmed R1's care plan lacked transfer and ambulation instructions for staff. A policy was requested for comprehensive care plans, however none were provided.	F 656		
F 676 SS=G	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living.	F 676		5/7/18

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The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living:

§483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care,

§483.24(b)(2) Mobility-transfer and ambulation, including walking,

§483.24(b)(3) Elimination-toileting,

§483.24(b)(4) Dining-eating, including meals and snacks,

§483.24(b)(5) Communication, including
(i) Speech,
(ii) Language,
(iii) Other functional communication systems.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide restorative/maintenance services to prevent the loss of ambulation ability for 1 of 1 resident (R17) who was reviewed for a decline in ambulation. R17 sustained actual harm when the facility failed to assess for and implement a restorative/maintenance services and can no longer ambulate.

Findings Include:

R17's Admission Minimum Data Set (MDS) dated 10/13/17, identified R17 had moderate cognitive impairment and had diagnosis which included pneumonia, below the knee amputation (BKA), chronic obstructive pulmonary disease (COPD) and diabetes mellitus. The MDS identified R17

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This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.
1.It is the policy of this facility to provide maintenance with ADL's to prevent unnecessary decline. Some of the many ways that this has been achieved for R17 is to have prosthetic scheduled for re-fit and when in place get PT/OT ordered. In this case, after the survey determined R17 showed a decline in ambulation ability and was not using prosthesis,

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was independent with activities of daily living (ADL's) including transfers and bed mobility. The MDS revealed R17 did not ambulate, and had one sided limited range of motion of the lower extremity. The MDS further identified R17 had received physical therapy (PT) and occupational therapy (OT) services.

R17's quarterly MDS dated 1/10/18, identified R17 was cognitively intact, independent in ADL's and had one sided limited range of motion of the lower extremity. The MDS revealed R17 did not ambulate and did not receive PT or OT services.

R17's Care Area Assessment (CAA) dated 10/13/17, identified R17 had been admitted to the facility from an acute care hospital and had diagnoses which included pneumonia, depression and anxiety. The CAA identified R17 had a right BKA and had a prosthesis. The CAA identified R17 was working with PT and OT services for strengthening, endurance and prosthetic training, however, did not identify ambulation or locomotion. The CAA identified R17 was independent in ADL's and indicated R17 did not ambulate at the time of the assessment. Further, the CAA identified R17 was at risk of injury due to cognitive impairment.

Review of R17's care plan identified R17 had a right BKA with a prosthesis and indicated he was independent with all ADL's including transfers. R17's care plan identified R17 did not ambulate.

Review of a nursing assistant (NA) care guide dated 3/6/18, revealed R17 required one assist with transfers with a front wheeled walker, had a right prosthesis and utilized a scooter. The care

immediate referral sent to get sized and re-evaluated for fit. 4/5/2016 R17 went to clinic and will need another visit which is being worked on as resident is on restrictions with many providers and needs release. Assessments done and care plan to be created based on needs after prosthetic is in place.
2.Because many residents have prosthetic devices many are potentially affected by the cited deficiency, on 4/4/2018, the DON reviewed all residents with prosthetic devices to ensure utilization is in place and care plan accurate also reviewed all residents that need to be walked during the day. Policy and procedure on ADL's has been reviewed including ambulation. All residents with decline according to CASPER and those with walking on care plans have been reviewed and evaluated to ensure compliance or determine needs. No other residents were affected.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding decline in ADL's and importance of ambulating residents with care sheets that indicate they should be walked with staff for maintenance. The training emphasized the importance of monitoring ADL's both improvement and decline. Care sheets have been updated to include all assistive devices and staff aware they must report items omitted, refused or not effective
4.Effective 4/4/2018, a quality-assurance program was implemented under the

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F 676	Continued From page 80 guide lacked any direction for use of R17's prosthesis. On 3/7/18, R17 was seated in a wheelchair in his room, he indicated he had received therapy services for a couple of weeks when he arrived at the facility last fall. R17 stated therapy services had stopped because of his insurance. He further stated he had not received any type of exercises or walking with the facility staff. R17 stated he had a new prosthesis and was unsure if he would be able to walk if he tried. He indicated his new prosthesis was now too big for his right stump. On 3/8/18, at 6:21 a.m. nursing assistant (NA)-C stated R17 was usually independent in all of his ADL's. She stated he had a right BKA and had a prosthesis. She indicated R17 was independent in donning and doffing the prosthesis and stated he did not always wear the prosthesis. NA-C stated R17 did not ambulate and was unaware if he was able to ambulate. NA-C further indicated the facility did not have a restorative or maintenance program for range of motion or walking residents. She indicated residents would usually be seen by therapy for any exercise or walking programs. On 3/9/18, at 4:01 p.m. R17 was seated in an electric scooter in his room. R17's prosthesis was on the floor against the wall, between his closet and the end of his bed. R17 stated when he first arrived at the facility in October 2017, he had received both OT and PT services for approximately 2-3 weeks and had been able to walk with his prosthesis and the therapist. He indicated since he had stopped working with therapy, no other staff member had offered or assisted him to ambulate in the facility. He	F 676	supervision of the DON and MDS to monitor residents having changes in their care leading to decline in ADL's. The MDS nurse or designated quality-assurance representative will perform the following systematic audits of residents ADL's to ensure no decline based on ADL significant change analysis report audits and that any resident listed having ambulation with staff ordered will be monitored to ensure activity is being done and documented accordingly. The audits will be completed by MDS nurse 2 audits per week x 4 weeks then 1 audit weekly x 2 months to ensure compliance in this area. All residents will be reviewed at time of quarterly or annual to ensure not a significant change. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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indicated his prosthesis was too big for him and felt his stump had shrunk. R17 stated at that time he did not feel he would be able to walk. R17 further indicated he had voiced his concerns about losing his ability to walk and to wear his prosthesis to his primary medical doctor as he did not feel his concerns would be addressed by the facility staff.

Review R17's PT progress and discharge summary, start date 10/11/17, and end of care dated 11/3/17, identified R17's progress since his start of care was significant and he had participated well in all five PT sessions. The summary revealed R17 made consistent gains with lower extremity strength, balance and endurance. R17 had received gait training for appropriate gait pattern with prosthesis limb and on safe assistive devices to reduce risk for falls and improve efficiency of ambulation. The PT discharge summary revealed R17 had ongoing balance and endurance deficits, was at high risk for falls with independent mobility, was able to ambulate with PT and required contact guard assist (CGA) and front wheeled walker (FWW). The summary identified R17 would benefit from further therapy, however, due to payor source, R17 was discharged from skilled therapy services. Further the summary revealed R17 was a candidate for living in an assisted living facility with a potential to progress to a handicap accessible independent living setting and was provided education and a home exercise program.

Review of R17's OT progress and discharge summary, start of care date 10/9/17, and end date 11/9/17, identified R17 had made good progress since his start of care and had

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participated in all eight therapy sessions. The summary revealed R17 made gains with ADL performance with transfers and ambulation. The summary revealed R17 required supervision to assist with standing ADL's and functional transfers and ambulation with FWW to ensure safety. Further the OT discharge summary identified R17 was at risk for falls, and had been educated on a home exercise program to maintain gains made in OT.

R17's current physician orders signed 3/6/18, revealed an order dated 1/16/18, for PT and OT evaluation and treat as indicated.

On 3/12/18, at 9:33 a.m. physical therapy director (PT)-A confirmed R17 had received skilled therapy services when he arrived at the facility. She stated R17's payor source was from North Dakota and only allowed for 15 skilled therapy visits a calendar year, therefore R17 was discharged from skilled therapy within a few weeks from his admission. PT-A stated she felt R17 made improvements with his mobility in areas of ambulation and transfers while working with therapy. She stated R17's prosthesis was fitting and felt it had worked well with R17.

On 3/12/18, at 9:20 a.m. certified occupational therapist (OT)-A confirmed R17 had received skilled therapy services when he arrived at the facility and had received 8 skilled OT visits. She stated she felt R17 had made significant progress with therapy and had improved in his ability to donn and doff his prosthesis, balance, transfers and ambulation. OT-A stated R17 had been able to ambulate up to 100 feet with CGA when he

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was discharged from therapy services. OT-A confirmed she had recommended facility nursing staff continue to work with R17 with his prosthesis and ambulation in order to maintain and potentially improve his modified independence. She further stated she had concerns with the facility not providing residents with any type of formal or informal ADL maintenance/restorative services.

On 3/12/18, at 9:52 a.m. the director of nursing (DON) confirmed R17's care plan lacked any direction to facility staff to assist R17 with ambulation and to monitor and assist R17 with his prosthesis. The DON stated the facility currently did not have any type of restorative or maintenance program to prevent decline in residents ADL's. She stated implementing a restorative program was one of the areas she was working on to develop and indicated she did not have a current plan in place. The DON stated she would have expected R17 to maintain his ability to ambulate and further stated she was unaware OT had recommended nursing staff to assist R17 with ambulation. She further indicated nursing and the contracted therapy department had communication problems and were currently working on improving communication for recommendations.

On 3/12/18, at 10:59 a.m. licensed practical nurse (LPN)-C stated R17 was independent with mobility with a motorized scooter. She stated R 17 had a prosthesis and indicated R17 was independent with the prosthesis and occasionally wore his prosthesis. LPN-C stated she did not recall R17 ever ambulating since his admission.

On 3/12/18, at 11:46 a.m. NA-E stated R17 was

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overall independent with his ADL's, though she felt he could use some more assistance with grooming. She stated R17 had a prosthesis and would wear it when he chose. NA-E indicated R17 was independent with his prosthesis and was also independent with his mobility with his motorized scooter. She further indicated she had never ambulated with R17.

On 3/12/18, at 12:07 p.m. LPN-D stated R17 was independent in his mobility with a motorized scooter and had a prosthesis for a right BKA. She indicated R17 had received therapy services when he arrived at the facility and was unaware of any therapy recommendations. LPN-D stated she was not aware if R17 could ambulate and indicated she had not seen him ambulate since his admission.

On 3/12/18, at 2:06 p.m. PT-A stated R17 had been able to walk with the use of his prosthesis, walker and CGA to moderate assistance, 4 wheeled walker (WW) and a gait belt up to approximately 100 feet. PT-A stated she had not received any recent referrals for R17 and was unaware of any decline in his ambulation ability. PT-A indicated R17 was given a home exercise program to maintain his strength. She indicated she felt R17 would have benefited from continued assistance with ambulating, however, she stated the facility did not have a formal or informal restorative/maintenance program to prevent decline in ADL's, such as ambulation. A request was made for PT-A to assess R17's current ability to ambulate.

On 3/12/18, at 2:12 p.m. R17 was seated in a motorized scooter wearing a tee shirt and dark jeans, his prosthesis rested on the floor between

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his closet and the end of the bed. R17 stated he had not walked since he had received skilled therapy services. PT-A entered R17's room, moved to gather his prosthesis and 4 WW, which was also rested against the wall by his prosthesis. PT-A indicated she had to obtain another 4 WW as R17's was missing one of the two tennis balls that were on the back two legs of the 4 WW. PT-A immediately left the room and returned with another 4 WW. R17 indicated he did not routinely complete the home exercise program and indicated he would donn the prosthesis a few times a week. R17 stated he felt the prosthesis no longer fit him as it had when he first arrived at the facility. R17 stated he had to use a stocking cap over his gel liner PLY sock (a sock used to cover an amputated limb [stump] when using a prosthesis.) in order for his prosthesis to fit. R17 made several attempts to donn the Gel liner PLY sock, however, he would hold his breath, his face would turn red and he had to stop. PT-A cued R17 to breath and he donned the Gel liner PLY sock. R17 placed the prosthesis onto R17's right stump. PT-A donned a gait belt around R17's torso and cued him to stand. R17 stood from his bed, in an attempt to secure his prosthesis onto his stump, and indicated his prosthesis would not set into place. PT-A confirmed R17's prosthesis no longer fit and stated the prosthesis was too loose. R 17 indicated he had requested to see his prosthetics company but had been told his insurance would not cover an adjustment. PT-A stated she would follow up with R17's prosthetics company.

On 3/12/18, at 2:47 p.m. PT-A stated she felt R17 had experienced muscle wasting in his stump from his prosthesis not being used routinely. She confirmed R17 would not be able to ambulate at

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that time. She further indicated she felt R17's endurance had declined and he was not safe to ambulate or transfer independently. PT-A stated the facility's usual practice was to screen residents annually and quarterly, however, confirmed R 17 had not recently been screened. She indicated she was unaware of R17's decline.

Review of R17's progress notes from 10/5/17, to 3/8/18, revealed the following;

-10/5/17, R17 was admitted from the hospital with pneumonia. The note revealed R17 had a right BKA and was at the facility to receive PT and OT services for strengthening and endurance. A later note revealed R17 was alert and oriented, was able to make his needs known. The note revealed R17 was independent with transfers, bed mobility and self care ADL's and had no behavioral issues.

-12/28/17, R17 had reported to a facility RN his prosthesis was no longer fitting him properly. The note indicated the writer would set up an appointment for R17's prosthesis. R17's medical record lacked any further documentation of R17's aforementioned concern.

-1/17/18, R17 was very active throughout the facility on his motorized scooter, however, did not address R17's ambulation.

R17's medical record lacked any documentation of R17's ability to ambulate following his discharge from skilled therapy services and lacked documentation of evaluation of R17's prosthesis.

On 3/12/18, at 2:59 p.m. during a follow up

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F 676	Continued From page 87 interview, the DON stated she would expect facility staff to monitor R17's use of his stump and indicated she felt he was independent with donning and doffing his prosthesis. She stated she was unaware R17's prosthesis no longer fit. On 3/13/18, at 10:30 a.m. during a telephone interview with R17's primary physician (PA)-A, she stated R17 had recently reported to her he had not been walking and stated she had ongoing concerns with the facility's communication. She stated she had not been notified by the facility R17 was no longer able to ambulate or R17's prosthesis no longer fit. PA-A stated she would not have expected R17 to decline in his ambulation and stated she would have expected facility staff to assist R 17 to maintain the progress he had made with skilled therapy. PA-A stated she felt at times R17 was not always compliant, however, she stated she felt that did not negate R17's needs. She further indicated she was very disappointed R17 had declined so significantly. The Facility Assessment, revised 2/19/18, identified restorative nursing, transfers and ambulation would be offered based on residents needs. A policy was requested for prevention of ADL decline and ambulation, none were provided.	F 676		
F 677 SS=E	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;	F 677		4/23/18

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide assistance with grooming and bathing for 3 of 5 residents (R7, R22, R13) reviewed for activities of daily living (ADLs) and who were dependent on staff for their care. In addition the facility failed to provide assistance with ambulation for 1 of 1 resident (R28) reviewed for ambulating to meals.

Findings include:

LACK OF BATHING:

R22's quarterly Minimum Data Set (MDS) dated 12/22/17, identified R22 had intact cognition and required extensive assistance with transfers and personal hygiene. Further, a section labeled "Bathing" was used to record the amount of assistance provided during baths and/or showers, however, this section was completed as "Activity itself did not occur during the entire period."

During interview on 3/6/18, at 7:14 p.m. R22 stated he wanted to be bathed "once a week for sure," however, it was not consistently being done as "sometime[s] they [staff] overlook it."

A Bath Schedule Hall 4 listing dated 3/9/18, identified R22 was scheduled for a weekly bath on Friday evening.

R22's ADL - Bathing tracking sheet dated 2/12/18 to 3/9/18, identified columns for staff to record how much assistance was provided to complete R22's baths. A total of 11 entries were completed, however, eight of these were recorded as "Not Applicable." There was no

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This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.
1.It is the policy of this facility to provide consistent quality care to residents needing assistance with their ADL's. Some of the ways this is done is by gathering data through assessments to ensure all residents needing assistance with ADL's such as ambulating, grooming, dressing, and bathing are identified and assisted appropriately. In this case, after the survey determined multiple residents didn't get the assistance they needed a review of residents was completed. R13 had facial hair and needed to have removed. Staff were able to coax after multiple attempts but only some of facial hair was removed due to R13 refusing rest of the care. Staff will continue to attempt. R7 is diabetic and needs nails clipped it is to be done weekly with bath and nursing was advised this is a care need and needs to be completed every week. At this time nails are trimmed. R22 needs assistance with bathing. It is identified that he needs assistance with baths, he often refuses and will accept bed baths, so care plan and sheets updated and staff educated on documenting refusals vs not completed

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documentation provided to support these entries, nor their meaning in the recorded answers.

When interviewed on 3/9/18, at 10:48 a.m. nursing assistant (NA)-K stated the NA staff were responsible to complete their own baths and R22 was a scheduled, evening "bed bath." When questioned about what 'Not Applicable' meant on the charting, NA-K responded it was an example of "the PM staff for you," adding she did not think they did their job(s) consistently. Further, NA-K stated residents have reported to her before about not getting their baths done on the evenings, however, she never followed up or reported these concerns as it was not her task to do.

During interview on 3/12/18, at 8:59 a.m. the director of nursing (DON) stated completed baths should be recorded in the electronic charting (ADL - Bathing). DON reviewed the charting for R22 and stated she knew "no reason" why they were charting 'Not Applicable' as a response. Further, the last recorded bath(s) R22 was charted as having in the past 30 days were on 3/9/18, 3/2/18, and 2/12/18.

LACK OF GROOMING:

R7's quarterly Minimum Data Set (MDS) dated 12/18/17, identified R7 had intact cognition and required extensive assistance with personal hygiene.

During observation on 3/6/18, at 1:46 p.m. R7 was laying in bed in his room. R7 had visibly long fingernails on both hands, with several nails

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and R22 stated he doesn't want a different bath day he will take one when he chooses. R28 is assist of 1 with walking. Some staff prefer 2 to have w/c to follow. Although it was stated she will walk to meals it is noted she hasn't been. Since survey staff have been educated on walking and will do short daily walks in hall to continue with strengthening. PT will assess for further goals. Assessments done and care plan to be created based on needs after assessment has closed.
2.Because all residents have constantly changing needs all are potentially affected by the cited deficiency, on 4/4/2018, the MDS nurse reviewed residents needing assistance with grooming and bathing or ambulation. MDS nurse will review each quarter if resident goals being met and ensure staff follow through with cares. A current review was completed of all residents with similar ADL needs. Policy and procedure on AD's has been reviewed. No other residents were affected.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding changes in resident's condition, dignity in cares and following care sheets. The training emphasized the importance of monitoring ADL's both improvement and decline and reporting said changes. Staff were evaluated on ADL's and reviewed ADL competencies. Reviewed staff expectations regarding following care sheets and performing ADL's according to resident cares and staff expectations of

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F 677	Continued From page 90 having a dark colored substance underneath. R7 stated "the nurses" help him clip his nails as he was diabetic adding it had been "two or three weeks," since anyone last helped him clip them. R7 added he would like his nails kept shorter and cleaner as they get "dirty from the food," however, not all of the staff are always willing to help him. R7's care plan dated 1/15/18, identified R7 had an activities of daily living (ADL) self care deficit and he required extensive assist of one staff to complete personal hygiene. Further, a provided Bath Schedule Hall 3 listing dated 3/2/18, identified R7 to receive a bath every Sunday and Wednesday on the evening shift. During subsequent observation on 3/8/18, at 2:12 p.m. R7 was laying in bed and continued to have long fingernails with visible black substance underneath several of them. R7 expressed he did receive a bath last evening, however, staff did not trim or clean his nails. R7's electronic Treatment Administration Record (eTAR) dated 3/2018, lacked any identified treatments to be completed by the nursing staff related to R7's nail care. When interviewed on 3/8/18, at 2:30 p.m. licensed practical nurse (LPN)-I stated R7 needed "extensive" assistance with his cares due to his weakness. LPN-I explained nail care should be completed for all residents when they have their weekly skin check done as every resident has their own nail kit and staff are available to help them. If someone was diabetic, the nurse was then responsible to cut and clean the nails, however, LPN-I added there was nothing in the computer which would trigger or	F 677	job performance. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the DON and MDS to monitor residents needing assistance with ADL's. The MDS nurse or designated quality-assurance representative will perform the following systematic changes: random audits will be completed by MDS nurse on overall personal appearance and separate audit for individuals with walking for maintenance during assessments. DON or designee will audit staff cares with ADL's 6 audits per week x 4 weeks then 3 audit weekly x 2 months to ensure compliance in this area. All residents will be reviewed at time of quarterly or annual to ensure not a significant change. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.MDS nurse will be responsible for this POC.	

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directed them to do so. LPN-I observed R7's nails and stated R7 "looks like he hasn't washed his hands in a week!" Further, LPN-I stated R7 was a person who "likes to look nice" and his nails should have been trimmed when staff noticed they were long and "full of crud."

During interview on 3/9/18, at 8:40 a.m. the director of nursing (DON) stated she expected staff to assist with grooming as they required which included keeping nails clean and trimmed.

R13's Annual Minimum Data Set (MDS) dated 12/26/17, identified R13 had severe cognitive impairment and had diagnoses which included dementia, depression, anxiety and restless leg syndrome. The MDS identified R13 required extensive assistance with activities of daily living (ADL's) including dressing, grooming and personal hygiene. The MDS revealed R13 had no behaviors including rejection of care.

R13's Annual Care Area Assessment (CAA) dated 12/26/17, identified R13 had severe cognitive impairment, required extensive assistance from facility staff with ADL's including grooming. The CAA indicated R13 was able to make her needs known and direct her cares.

R13's care plan revised 2/26/18, revealed R13 had a self care deficit and required extensive

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F 677	Continued From page 92 assistance from facility staff for dressing, personal hygiene and nail care. R13's care plan did not identify facial hair removal or shaving needs. Further the care plan revealed R13 required extensive assistance of two staff with toileting, however did not identify urinary continence. A group one nursing assistant care guide updated 3/6/18, revealed R13 required extensive to total assistance of one to two facility staff with ADL's. On 3/7/18, at 8:40 a.m. a telephone interview with R13's family member (FM)-A, indicated R13 was dependent on facility staff for her grooming and personal hygiene. FM-A stated R13's cognition had continued to decline in the last few years. She stated R13 used to pay meticulous attention to her grooming, which included painting her nails and removal of any facial hair on her chin and above her lips. FM-A stated she had voiced concerns to the facility social worker and director of nursing (DON) as recently as one month ago regarding R13's facial hair and the cleanliness of her finger nails. FM-A stated R13 was no longer able to remove her facial hairs, or independently clean or paint her fingernails. She further indicated R13 continued to have facial hair and dirty fingernails when she visited. On 3/6/18, at 1:18 p.m. R13 was seated in a wheelchair in her room, her fingernails were painted pink, however the polish was chipped and uneven on multiple nails. R13's fingernails had grown out approximately 6-7 millimeters in length from the tops of her fingers. R13's fingernails had a brown substance underneath all of her nails. R13 had several chin hairs varying in length from 5-7 mm and were dark in color. R13 also had	F 677		

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several black whiskers above and on the sides of her lip.

On 3/7/18, at 2:03 p.m. R13 was seated in a wheelchair in her room, facing the window. R13's fingernails continued to have chipped polish and a brown substance underneath. R13 continued to have several chin hairs varying in length and dark in color. R13's facial hair above her lip also remained unchanged.

On 3/7/18, at 2:25 p.m. licensed practical nurse (LPN)-E stated R13 required extensive assistance from facility staff for all of her ADL's needs including dressing and grooming.

On 3/8/18, at 4:48 a.m. NA-J stated R13 required staff assistance with all cares.

On 3/8/18, at 4:48 a.m. R13 was lying in bed on her back with a blanket covering her from chin to ankles. R13's facial hair remained on her chin and above her lip. R13's fingernails continued to have chipped nail polish, with a brown substance underneath.

On 3/8/18, at 6:58 a.m. LPN-C stated R13 required extensive assistance from facility staff with ADL's which included grooming and personal hygiene. She stated R13 was usually compliant with personal cares.

On 3/8/18, at 11:34 a.m. R13 was seated in a wheelchair in her room. R13 continued to have several chin hairs varying in length from 5-7 mm in length and dark in color. Further R13's facial hair above her lip also remained. She continued to have chipped pink nail polish on all of her fingernails with a brown substance underneath.

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On 3/8/18, at 2:41 p.m. R13 was seated in a wheelchair in her room, and her facial hair and fingernails were unchanged/

On 3/9/18, at 8:40 a.m. the director of nursing (DON) confirmed R13's care plan directed facility staff to assist R13 with grooming and incontinence cares. She confirmed R13's care plan did not address her facial hair. The DON confirmed R13's long fingernails had a brown substance underneath them, and R13's facial hair. The DON stated she expected staff to assist R13 with grooming, which included removal of her facial hair and ensuring R13's nails were clean. She stated she was unaware FM-A had reported concerns with R13's assistance with grooming.

On 3/9/18, at 12:39 p.m. R13 was seated in a wheelchair in the doorway of her room. R13 continued to have several dark chin and lip hairs varying in length from 5-7 mm. She continued to have chipped nail polish and a brown substance underneath the nail length.

On 3/9/18, at 1:09 p.m. NA-C stated R13 required extensive assistance with ADL's including grooming. She further indicated R13 was overall cooperative when assisting with cares.

R28's Annual Minimum Data Set (MDS) dated 1/16/18, identified R28 had severe cognitive impairment and had diagnoses which included dementia, restlessness and agitation. The MDS identified R28 required extensive assistance with activities of daily living (ADL's) including locomotion. The MDS indicated R28 was assisted to ambulate during the seven day look back

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R28's annual Care Area Assessment (CAA) dated 1/16/18, identified R28 had severe cognitive impairment and required extensive assistance of one with ADL's including transfers and bed mobility. R28's CAA's lacked any documentation of R28's ambulation.

Review of R28's care plan revised 2/9/18, revealed R28 had a self care deficit and staff was to assist R28 to ambulate to and from meals.

Review of a facility nursing assistant (NA) care guide sheet updated 3/6/18, revealed R28 required extensive assistance with ADL's including transfers with 1-2 assist and a gait belt. The care guide did not indicate an ambulation status for R28.

On 3/6/18, at 5:26 p.m. R28 was seated in a wheelchair while nursing assistant (NA)-G wheeled her to the dining room. NA-G then wheeled R28 to a circular table in the back of the dining room, placed a clothing protector on R28 and left the dining room. NA-G did not offer to ambulate with R28 to the dining room.

On 3/6/18, at 6:00 p.m. R28 remained seated in a wheelchair in the dining room. Licensed practical nurse (LPN)-K sat next to R28 and assisted her to eat.

On 3/6/18, at 6:30 p.m. R28 was seated in her wheelchair, finished with her evening meal and was wheeled back to her room by LPN-K. She did not offer to ambulate with R28 from the dining room back to her room.

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On 3/7/18, at 9:30 a.m. R28 was seated in her wheelchair in her room. NA-O indicated she had recently wheeled R28 back to her room from breakfast. R28 stated she was tired and requested to lie down. NA-O assisted R28 into her bed with a gait belt.

On 3/7/18, at 9:36 a.m. NA-O stated R28 required extensive assistance from facility staff for all ADL's. She stated R28 used a wheelchair for locomotion and was dependent on staff for mobility. NA-O stated she was unaware of R28's ability to ambulate.

On 3/8/18, at 4:27 a.m. NA-J stated R28 required extensive assistance with ADL's, including mobility. NA-J stated she assisted R28 with checking and changing every two hours during the night and indicated R28 was compliant with cares. NA-J was unsure if R28 ambulated and indicated R28 had a four wheeled walker (4 WW) in her room.

On 3/8/18, at 8:10 a.m. R28 was seated in a wheelchair in her room, at that time NA-E wheeled R28 to the dining room. NA-E was not observed to offer R28 assistance with ambulating to the dining room.

On 3/12/18, at 10:55 a.m. LPN-C stated R28 required extensive assistance with all ADL's and required a wheelchair for locomotion. LPN-C stated she was not aware of R28's ambulation status and indicated she had not observed R28 to ambulate with staff. LPN-C further indicated she had not noticed any decline in R28's ADL's.

On 3/12/18, at 11:46 a.m. NA-E stated R28 required extensive assistance with all ADL's

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including mobility. She stated R28 used a wheelchair for locomotion and was able to wheel herself short distances. NA-E indicated she was unaware of R28's ability to ambulate and stated staff assisted R28 to transfer with a gait belt.

On 3/12/18, at 11:51 a.m. R28 was seated in a wheelchair, at that time, NA-E approached R28 and wheeled her to the dining room for the noon meal. R28 was not offered assistance to ambulate.

On 3/12/18, at 12:23 p.m. NA-C stated R28 required assistance with all ADL's including mobility. NA-C stated R28 was supposed to be walked to the dining room and was unsure why R28 had not been assisted to ambulate. However, NA-C stated R28 was not on a walk to dine program.

On 3/12/18, at 3:04 p.m. the director of nursing (DON) confirmed R28's care plan directed facility staff to assist R28 to ambulate to all meals. She stated she would expect R28's care plan to be followed. The DON stated she felt R28 needed to be assisted with ambulation to prevent decline.

Review of R28's progress notes from 5/5/17, to 3/8/18, revealed the following:

-a note dated 5/15/17, revealed R28 used a wheelchair and would slowly move herself around the facility.

-a note dated 8/5/17, revealed R28 was wheeling herself around the facility and was totally dependent on facility staff for ADL's. The progress note did not address R28's ambulation.

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F 677	Continued From page 98 -a note dated 8/23/17, revealed R28 routinely used a wheelchair to get around the facility. The note did not address any ambulation for R28. -a note dated 9/14/17, revealed R28 required extensive assistance from staff for transfers using a gait belt. The note revealed R28 used a wheelchair and further revealed R28 could walk with assistance of one, gait belt and walker. R28's medical record lacked any further documentation of R28's ambulation. An undated facility Giving A Bedbath policy identified a procedure to complete the baths which included documenting the bath "...on the resident's ADL record and/or in the resident's medical record." Further, the policy directed to document and notify the supervisor(s) if the resident refuses. An undated facility Care of Fingernails/Toenails policy identified guidelines such as nail care included daily cleaning and "regular trimming." Having trimmed, smooth nails helps prevent the resident from accidentally scratching or injuring themselves. In addition, a guideline was listed which indicated, "Unless otherwise permitted, do not trim the nails of diabetic residents or residents with circulatory impairments." A procedure was listed which directed to soak the nail(s), clean under them using an orange stick and trim them. Documentation should be completed in the medical record and refusal(s) should be reported to the supervisor. However, the policy lacked any information on how to complete or ensure diabetic residents' nail care would be completed, or by whom.	F 677		

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	245052	A. BUILDING ______ B. WING ______	03/13/2018

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F 677	Continued From page 99 A facility policy was requested for following care plan and providing assistance with ambulation, none was provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to routinely monitor and implement physican orders for notification of primary physician of elevated blood sugars for 1 of 1 resident (R17) reviewed with uncontrolled Diabetes Mellitius. Findings Include: R17's admission Minimum Data Set (MDS) dated 10/13/17, identified R17 had moderate cognitive impairment and had diagnoses which included diabetes, pneumonia, below the knee amputation (BKA,) and hypertension (HTN.) The MDS identified R17 was independent with activities of daily living (ADL's) including transfers, bed mobility. The MDS identified R17 received insulin 7 out of 7 days during the assessment period. R17's quarterly MDS dated 1/10/18, identified R17 was cognitively intact, independent in ADL's	F 684	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to assist with monitoring residents with chronic diseases. Some of the many ways that this has been accomplished by monitoring BG levels in diabetics, having specific parameters in place and ensuring appropriate follow up with physician if interventions are not successful. R17 was noted to have uncontrolled DM II with elevated BG levels and inadequate follow up regarding inconsistent results. In reviewing current treatments noted	4/23/18

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F 684 Continued From page 100

and received insulin 7 out of 7 days during the assessment period.

R17's Care Area Assessment (CAA)dated 10/13/17, identified R17 had been admitted to the facility from an acute care hospital and had diagnoses which included pneumonia,diabetes, HTN and received routine daily doses of insulin. The CAA's did not identify the results of R17's blood sugars.

Review of R17's current physican orders signed 3/6/18, revealed the following orders:

- accu checks (method of checking blood sugars for diabetics) dated 1/16/18, three times a day, contact MD (medical doctor) if blood sugar is greater then 350 or less than 90, DO NOT FAX BS (blood sugar) READING.

- insulin aspart (Novolog) solution 100 unit/ml (milliliter,) dated 2/5/18, inject 23 units subcutaneously (sq) with meals for type 2 diabetes.

- insulin glargine (Lantus) solution 100 unit/ml, dated 2/5/18, inject 70 units sq at bedtime for type 2 diabetes.

- Metformin HCL extended release 24 hour, dated 2/1/18, give 500 milligram (mg) by mouth in the morning for type 2 diabetes.

Review of R17's Medication Administration Records (MAR) from 1/17/18, to 3/12/18, revealed the following:

- January 2018, MAR identified R17's blood sugar reading was greater than 350 on 15 out of

F 684

multiple changes to medications for diabetic management and results remain varied. Physician off site and resident unable to physically see as often as necessary for the complexity of blood glucose monitoring. Reviewed with resident option for in house physician to assist with more structured monitoring. Resident was not interested in changing. Resident states he feels his BG levels are better with a regular diet and prefers to eat things he buys from the outside of building. Care plan and progress note updated.

2.Because many residents have diabetes many are potentially affected by the cited deficiency, on 4/5/2018, the DON reviewed all residents with BG monitoring to ensure levels are with desired range of ordering physician. Staff educated on consistent implementation of MD orders. Ensure following up on any resident orders that indicate an acute change in disease process. No other residents were affected.

3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding normal monitoring, reporting data to physicians and follow up with BG results. It was determined through this in-service that often R17 has BG levels >450 in evening and the regular provider is out of the office. The on call staff are not supportive in being proactive and only give small coverages without following up with primary who also has currently refused a process for faxing results. After

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F 684	Continued From page 101 46 documented readings. The MAR revealed R17's blood sugar was not checked 4 times as ordered. The MAR identified R17's blood sugar had reached 512 on 1/21/18. - February 2018, MAR identified R17's blood sugar reading was greater than 350 on 21 out of 65 documented readings. The MAR revealed R17's blood sugar was not checked 9 times as ordered. The MAR identified R17's blood sugars had reached 565 on 2/5/18, and had 9 readings over 400. - March 2018, 3/1/18 through 3/12/18- identified R17's blood sugar reading was greater than 350 on 9 out of 31 documented readings. The MAR revealed R17's blood sugar was not checked 3 times as ordered. The MAR identified R17's blood sugars had reached 526 on 3/5/18, and had 4 readings over 400. Review of a facility form titled, report of consultation dated 2/8/18, revealed report to R17's primary physician which indicated R17's blood sugars had been running high, greater than 250, and on that date, his blood sugar was 409. The form revealed R17's primary physician listed a diagnosis of uncontrolled type II Diabetes Mellitus, and ordered the following: start metformin 500 mg extended release, one tablet daily, check fasting blood sugars every morning, two hours post (lunch and dinner,) as well. The form further revealed R17 was to have a recheck of his diabetes in April. Review of a report of consultation, dated 3/6/18, revealed a report to R17's physician which indicated R17 had refused to be awoken to have his blood sugar checked. The form revealed	F 684	further follow up with physician she agreed to routine faxes to monitor BG levels and be able to track trends. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the DON to monitor residents with DMII. The DON or designated quality-assurance representative will perform the following systematic changes: audits done weekly to monitor BG results on 5 residents with DMII for 2 weeks then on 2 residents weekly for 4 weeks to ensure compliance. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON will be responsible for this POC.	

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F 684	Continued From page 102 R17's physician listed diagnosis of uncontrolled type II Diabetes Mellitus, wait to check fasting blood sugars until R17 woke, and started Victoza 0.6 mg for one week, increase to 1.2 mg week two and increase to 1.8 mg week three, stop metformin. Review of R17's progress notes from 1/17/18, to 3/6/18, revealed the following regarding R17's elevated blood sugars: -1/17/18, dietician note which indicated R17's blood sugars had ranged from 99-489 in the last month. The note revealed R17's diet was changed to a consistent carbohydrate diet (limited carbs.) -1/20/18, R17's blood sugar was 499 at 5:00 p.m. and indicated R17 had received his scheduled insulin. The note revealed R17's blood sugar had decreased to 473 at 5:30 and indicated R17 had instructed the licensed nurse to contact his primary physician. Further, the note revealed an on call MD ordered R17 to receive an additional 10 extra units of insulin and recheck his blood sugar in an hour. -2/2/18, R17's blood sugar was 433, his primary physician was contacted and were waiting for a response. - 2/5/18, R17's blood sugar was 565 at 6:40 a.m., on call MD was notified. The note revealed R17 was to receive his scheduled 20 units of insulin and if R17's blood sugar did not decrease, send to the emergency department. A later note revealed R17's blood sugar at 8:50 was 406, R17's primary physician was contacted and increased R17's Lantus and Novolog insulins.	F 684		

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F 684	Continued From page 103 -2/11/8, R17's blood sugars were above 350 twice on that date and indicated R17's primary physican was faxed R17's blood sugar results from 2/11/18 and 2/9/18. - 2/12/18, R17's primary physician directed not to fax high blood sugars, and requested to be notified via telephone when any of R17's blood sugars were greater than 350. The note listed to call and notify the on call on weekends and after hours. -2/27/18, R17's primary physician had been notified his last two blood sugars had been 448 and 400. R17's medical record lacked documentation R17's primary physician was notified of an elevated blood sugar (above 350) 14 times in January, 16 times in February and 9 times in March, including a blood sugar of 526 on 3/5/18. On 3/9/18, at 4:01 p.m. R17 was seated in a electric scooter in his room. He stated he was a diabetic and indicated his blood sugars were to be checked three times daily. R17 stated he had a history of elevated blood sugars and indicated his blood sugars had routinely been elevated since his return from the hospital in January. R17 stated his primary physician was supposed to be notified when his blood sugars were elevated and indicated he did not feel the staff notified her routinely. On 3/12/18, at 9:52 a.m. the director of nursing (DON) confirmed R17's MAR revealed numerous blood sugar readings over 350 and confirmed R17's medical record lacked documentation	F 684		

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F 684	Continued From page 104 R17's primary physician was routinely contacted. She stated she would expect licensed staff to contact R17's physician via telephone when his blood sugars were above 350. The DON stated she felt it was important for R17's physician to be notified due to possible medication adjustments. She stated she felt it was hard on R17's body to have routinely high blood sugars. On 3/12/18, at 10:59 a.m. LPN-C stated R17 was a diabetic and routinely had his blood sugar checked. LPN-C stated R17 was non-compliant with any type of diet and often had elevated blood sugars. She stated R17's primary physician was supposed to be contacted if his blood sugar was above 350. LPN-C stated she was not sure if R17's physician was routinely notified of blood sugars above 350. On 3/13/18, at 10:30 a.m. during a telephone interview with R17's primary physician (PA)-A, she stated she had ongoing concerns with the facility's communication. She stated she had not been notified by the facility of R17's elevated blood sugars on a routine basis's. PA-A stated she had resorted to having her nurse contact the facility twice a week to obtain R17's blood sugars. She stated she would still expect the facility to notify her anytime R17's blood sugars were above 350. PA-A stated she felt at times R17 was not always compliant, however, she stated she felt that did not negate R17's needs. A policy was requested for monitoring blood sugars and notification to physician, none were provided.	F 684		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		4/23/18

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F 686	Continued From page 105 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, failed to conduct adequate monitoring, and failed to implement interventions to promote healing and prevent worsening for 1 of 1 resident (R13) reviewed with current, recurring, unstageable pressure ulcers on both heels. R13 sustained actual harm when the facility failed to assess her pressure ulcers and implement pressure relieving interventions, which resulted in a worsening of unstageable bilateral heel ulcers. Findings Include: R13's annual Minimum Data Set (MDS) dated 12/26/17, identified R13 had severe cognitive impairment and had diagnoses which included dementia, anxiety, restless leg syndrome and psychosis. The MDS identified R13 required extensive assistance with activities of daily living (ADL's) including bed mobility, transfers and personal hygiene. The MDS identified R13 was at	F 686	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide treatment and services to prevent pressure ulcers. One of the many ways that this has been achieved for resident #13 is by reviewing wound and current documentation of wounds. R13 was noted to have L unstageable are to heel that increased in size and area now developed on previously healed area on R heel. After survey noted the R heel and that prevalon boots were not used appropriately - wound care and documentation did not address resident’s heels and interventions	

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F 686	Continued From page 106 risk for pressure ulcer development, had no current or recently healed pressure ulcers. The MDS further identified the following skin treatments: pressure relieving devices for chair and bed. The MDS did not identify R13 was on a turning and repositioning program. Further, the MDS revealed R13 had no behaviors of rejection of care during the 14 day look back period. R13's annual Care Area Assessment (CAA) dated 12/26/17, identified R13 had diagnoses of non-Alzheimer's dementia, depression and psychotic disorder, had severe cognitive impairment, required extensive assistance with ADL's including bed mobility, toileting and transfers. The CAA identified R13 was able to make her needs known and direct her cares. The CAA revealed R13 was at risk for pressure ulcers, deep tissue injuries and infection. The CAA did not identify R13 had a current unstageable pressure ulcer and failed to address interventions for pressure relief for R13's heels. Review of R13's Braden Scale of Predicting Pressure Sore Risk form, dated 1/18/18, identified R13 was chairfast, had very limited mobility, had a problem with friction and shear and probably inadequate nutrition, and listed R13 was at low risk for developing pressure ulcers. Review of R13's Norton Scale for Predicting Risk of Pressure Ulcer form, dated 1/18/18, identified R13 was chairbound, had slightly limited mobility, usually incontinent of urine, was in fair physical condition, and was listed at moderate risk for the development of pressure ulcers No further skin assessments were found in R13's clinical record.	F 686	were not followed all interventions re-evaluated and put in place and orders for R heel were initiated. Care sheets and care plans updated, wound consult received for possible incision and drainage of bilateral heels d/t non-healing and unstageable. Daughter updated on heels and treatment. 2.Because all residents have diagnoses which could lead to alteration in skin integrity or due to illness have potential for skin breakdown all are potentially affected by the cited deficiency, wound documentation has been reviewed, interventions for prevention are in place and documented clearly on care sheets. Weekly skin audits are completed, and staff update DON on any new areas noted immediately including reporting of any bruises, skin tears, skin breakdown or rashes. All current resident with pressure ulcers were assessed for comprehensive assessment along with appropriate interventions. Implementation of those interventions is reviewed on rounds weekly. Staff to alert DON is resident refuses otherwise. Staff educated on importance of offloading, repositioning, care plan updated, care sheets updated. No other residents were affected. The policy on wound care has been updated. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all staff received in-service training for monitoring skin and pressure areas, to ensure staff always use Prevalon boots and understand offloading to prevent further alterations in skin integrity. The training	

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F 686	Continued From page 107 R13's care plan revised 2/26/18, revealed R13 had a self care deficit and required extensive assistance from facility staff for ADL's, transfers and toileting. R13's care plan revealed R13 had scabs on both heels related to a history of pressure ulcers and immobility. R13's care plan listed various interventions which included to educate R13 and family on causes of skin breakdown including transfer/positioning requirements, importance of taking care during ambulating/mobility and frequent positioning, teach R13 and family the importance of changing position for prevention of pressure ulcers, encourage small frequent position changes, instruct/assist to shift weight in wheelchair every 15 minutes. However, R13's care plan did not address any interventions for pressure relief for R13's heels. The facility's group one NA care guide updated 3/8/18, revealed R13 required extensive to total assistance of one to two facility staff with ADL's, repositioning every two hours and as needed. The care guide directed facility staff to float heels, Prevalon boots and indicated R13 was confused. The care guide further indicated R13 had behaviors resisting cares at times. On 3/6/18, at 1:20 p.m. R13 was seated in a wheelchair in her room, both of her stocking covered feet, including her heels, rested directly on the footrest of her wheelchair. R13's wheelchair footrests were covered with a thin black stretchy fabric. Two Prevalon boots (pressure relieving devices used for heels,) were observed on the floor at the end of R13's bed. On 3/7/18, at 8:44 a.m. during a telephone	F 686	emphasizes the importance of following all interventions for effective skin maintenance and reporting of changes in skin conditions. Education done on importance of comprehensive assessment of skin, pressure ulcers and implementation of appropriate interventions. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents with impaired skin integrity and updating MD, family and care plans with any changes to ensure appropriate follow through. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will ensure audit all residents with pressure ulcers or those at risk weekly x 4 weeks then on 6 residents weekly for 4 weeks to ensure compliance than 2 residents weekly x 2 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON will be responsible for this POC.	

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F 686	Continued From page 108	F 686		

interview with R13's family member (FM)-A she indicated R13 had a history of bilateral heel pressure ulcers. FM-A stated R13 used to go to a wound clinic weekly for routine pressure ulcer treatment and indicated she had thought R13's bilateral heel pressure ulcers had healed approximately a month ago. FM-A stated R13 had a history of not wearing the Prevalon boots for pressure ulcer and indicated she was unaware of any other pressure relieving interventions. She further stated she was unsure if the facility routinely checked R13's heels.

On 3/7/18, at 2:03 p.m. R13 was seated in a wheelchair in her room, both of her stocking covered feet, including her heels, rested directly on the footrests of the wheelchair. Two Prevalon boots were observed on the floor at the end of R13's bed.

On 3/7/18, at 2:12 p.m. R13 remained seated in a wheelchair in her room, both of her feet/heels continued to rest on the footrests of the wheelchair. Licensed practical nurse (LPN)-E entered R13's room and R13 complained of pain to both of her feet and her left leg. LPN-E spoke with R13 regarding her pain and immediately left R13's room. R13's heels remained on the footrests of the wheelchair, LPN-E did not offer to reposition or float R13's heels.

On 3/7/18, at 2:14 p.m. LPN-E re-entered R13's room and spoke with R13 about her complaints of pain. R13 stated loudly to LPN-E her feet hurt and she thought they were dying. R13's stocking covered feet/heels remained on the footrests of the wheelchair. LPN-E did not visualize R13's feet or heels. LPN-E again left R13's room, she did not offer any pressure relief for R13's feet.

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F 686	Continued From page 109	F 686		

On 3/7/18, 2:20 p.m. LPN-E re-entered R13's room and gave her two Tylenol, indicated the medication was for R13's complaints of pain. R13's feet/heels remained resting directly on the footrests of the wheelchair. LPN-E proceeded to leave R13's room without providing pressure relief. Two Prevalon boots remained on the floor towards the end of R13's bed.

On 3/7/18, at 2:25 p.m. LPN-E stated R13 was dependent on staff for ADL's. She stated she was not aware of any current treatments or interventions for R13's feet/heels. LPN-E stated R13 had a history of pressure ulcers on her heels and was unsure if the pressure ulcers were still there. She stated R13 did not use the Prevalon boots anymore due to refusals and was unaware of any other pressure relieving interventions.

On 3/8/18, at 4:48 a.m. NA-J stated R13 wore the Prevalon boots for leg pain and indicated R13 had no current skin issues. She stated she felt R13 had chronic pain and indicated she had to be very careful when providing cares to R13. NA-J further indicated she felt once she had completed cares R13's discomfort passed.

On 3/8/18, at 6:48 a.m. NA-E stated R13 required extensive assistance with ADL's including bed mobility. She stated R13 used to wear Prevalon boots and would still occasionally at night. NA-E indicated she was not aware of why R17 had the Prevalon boots.

On 3/8/18, at 6:58 a.m. LPN-C stated R13 would refuse cares at times, did not usually wear Prevalon boots and was not sure why R13 had them on. She indicated R13 used to have pretty

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bad ulcers on both of her heels and further stated she was not one hundred percent sure if they were still there. LPN-C stated she was unsure who was responsible for R13's skin assessments and further indicated it could be the facility's director of nursing (DON.)

On 3/9/18, at 8:12 a.m. R13 was seated in a wheelchair in her room, her stocking clad feet/heels rested directly on the footrests of the wheelchair. At that time, the surveyor requested the director of nursing (DON) to come to R13's room, and DON entered R13's room with a measuring tape and pen and immediately indicated R13's heels should be offloaded at all times. DON stated R13 had a current pressure ulcer on her left heel. She removed R13's stocking from her left foot which revealed thick, hard black tissue which covered R13's heel. DON placed the measuring tape on R13's left heel, and immediately R13 stated, "God that hurts when you touch those!" DON reassured R13 she would be done shortly and measured the pressure ulcer on R13's left heel, revealing the following measurements: 2.5 centimeters (cm) in length and 2.0 cm in width. DON stated R13's heel was covered in eschar (dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab like) tissue. She confirmed R13 had an unstageable pressure ulcer on her left heel. The surveyor requested the DON visualize R13's right heel at that time. DON removed the stocking from R13's right foot, which revealed hard, thick, brown tissue covered R13's heel. She confirmed she had not assessed R13's right heel and measured the right heel pressure ulcers at that time as follows: 2.0 cm by 1.7 cm. DON confirmed R13's right heel also had an unstageable pressure ulcer. DON then donned

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R13's stockings and Prevalon boots, placed R13's feet back onto the footrests of the wheelchair.

- At that time DON stated R13's unstageable left heel pressure ulcer had worsened since she last looked at it on 2/28/18. She indicated R13 had a history of unstageable (wound bed cannot be visualized due to the presence of slough or eschar. Slough; non-viable yellow, tan, gray, green or brown tissue; usually moist, can be soft, stringy and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed. Eschar tissue; dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.) pressure ulcers on both heels. The DON stated she was aware R13 had an unstageable left heel pressure ulcer. She confirmed R13's 2/15/18, progress note and stated she was not aware R13 had pressure ulcers on both heels.

She indicated she would contact a wound clinic nurse for recommendations and further stated she was unaware if R13's physician had been notified of either of R13's unstageable pressure ulcers. DON stated she expected R13's heels to be off loaded at all times either with the Prevalon boots or a pillow. She further indicated she expected staff to document in R13's medical record anytime she refused to offload her heels. DON stated she was responsible for the facility's wound assessments and had completed weekly wound measurements when R13's left heel pressure ulcer re-occurred in February 2018.

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F 686	Continued From page 112 Review of R13's form titled, Wound Evaluation Flow Sheet, started on 12/15/17, the DON stored in her office, a hand written flow sheet with spaces for weekly wound measurements. The following was listed: -12/15/17, R13 had an unstageable ulcer of her left heel which measured 0.5 cm by 0.5 cm. The flow sheet identified R13's skin surrounding the pressure ulcer was intact and the wound margins were defined. The wound evaluation flow sheet revealed the current intervention was foam dressings to both feet. -12/29/17, revealed R13's left heel pressure ulcer measured 0.3 cm by 0.3 cm, wound margins were defined and the surrounding skin was intact. The form revealed the current intervention was to leave open to air. - 1/3/18, revealed R13's left heel pressure ulcer measured 0.3 cm by 0.3 cm, wound margins were defines and the surrounding skin was intact and was open to air. - 2/14/18, revealed R13's left heel pressure ulcer measured 1.8 cm by 2.0 cm, wound margins were defined, surrounding skin was intact and purple. The form listed an intervention to leave the heel open to air. -2/21/18, revealed R13's left heel pressure ulcer measured 1.8 cm by 2.0 cm, wound margins were defined, surrounding skin was intact. The form listed an intervention to leave the heel open to air. -2/28/18, revealed R13's left heel pressure ulcer measured 1.8 cm by 2.0 cm, wound margins	F 686		

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were defined, surrounding skin was intact. The form listed an intervention to leave the heel open to air.

R13's wound evaluation flow sheet did not include identification of R13's right heel ulcer, measurements and did not include any pressure relieving interventions for her heels.

Review of R13's wound evaluation flow sheet, found in the electronic record, 12/15/17, revealed R13 had an unstageable pressure ulcer on her right heel which was identified on 12/15/17. The wound evaluation flow sheet identified R13's right heel pressure ulcer measured 1 cm by 1 cm. The flow sheet further identified R13's pressure ulcer had the following characteristic: wound bed was 100% skin, periwound margins were defined, surrounding skin was intact. The flow sheet indicated the following treatments/interventions were in place; R13 was to have a foam dressing on both heels every 72 hours, pressure redistribution mattress and heel protectors. The electronic Wound Evaluation flow Sheet did not identify a pressure ulcer on R13's left heel.

R13's electronic wound sheet lacked documentation of any further monitoring of R13's right heel and lacked documentation of the presence of R13's left heel pressure ulcer.

Review of R13's progress notes from 7/17/17, to 3/9/18, revealed the following:

- 7/17/17, R13's heels were scabbed over and left open to air.

-12/15/17, R13 was seen by her primary physician (MD)-A and new orders were obtained

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to apply foam dressing to both heels and change every 3 days and as needed. The note revealed R13 was to have pressure sore precautions in place.

-12/29/17, R13's bilateral heels were to be left open to air.

-1/18/18, a Braden assessment (tool used to identify risk for pressure ulcer development) listed R13 was at low risk for skin breakdown.

- 2/15/18, R13's right heel had an intact tan scab, measured 2.3 centimeters (cm) by 1.5 cm and had no redness or drainage. The note further revealed R13's left heel had an intact scab with no redness or drainage and the surrounding skin was purple in color. The note lacked measurements of R13's left heel and indicated R13 had Prevalon boots (pressure relieving boots) on both of her feet.

-3/9/18, R13's left heel measured 2.5 cm by 2 cm with scab intact with 20% eschar noted around the border of the wound, no redness or drainage noted, with surrounding skin intact and blanched to touch. Right heel measured 2 cm by 1.7 cm scab intact, no redness or drainage noted, and surrounding skin intact. Call placed for recommendations for resident's heels and physician office contacted in regards to concerns with resident's heels. R13 agreed to allow Prevalon boots to be applied without difficulty.

On 3/9/18, at 9:03 a.m. R13's medical was reviewed with the DON. She confirmed R13's medical record had identified R13 had developed a reoccurring unstageable pressure ulcer on her right heel on 12/15/17. The DON confirmed R13's

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F 686	Continued From page 115 medical record had identified R13 had an unstageable pressure ulcer on her left heel. The DON stated she was not aware a wound evaluation had been completed on 12/1/5/17, for R13's right heel. The DON confirmed R13 had recurring pressure ulcers on both of her heels. The DON confirmed R13's medical record lacked documentation of when R13's bilateral unstageable pressure ulcers had healed. The DON confirmed R13's medical record lacked any comprehensive assessments of R13's bilateral unstageable pressure ulcers. She confirmed R13's medical record lacked a current assessment or any monitoring of R13' s right heel unstageable pressure ulcer. The DON stated she would have expected pressure relieving interventions to be put into place routinely for R13 to prevent worsening of both pressure ulcers. Review of R13's current physician orders signed 2/16/18, included orders to leave bilateral heels open to air every shift, weekly skin check every Wednesday, and document findings/refusals. However, the orders lacked direction for pressure relieving interventions or treatments for R13's heels. Review of R13's physician progress notes from 8/30/17 to 12/15/17, revealed the following; -8/30/17, skin heel pressure ulcer present on examination. -10/24/17, R13 had a past history of decubitus (pressure) ulcer of the left heel. -12/15/17, R13 was seen at the facility for a follow up visit. The note identified R13 had a current stage 3 decubitus ulcer of the left heel.	F 686		

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The note directed facility staff to start dressing changes every 72 hours and to implement pressure ulcer precautions.

On 3/9/18, at 1:18 p.m. during a telephone interview with R13's primary physician (MD-A), MD-A stated she was last aware R13 continued to have current unstageable pressure ulcers on both of her heels in December 2017. MD-A stated R13 had recurring pressure ulcers on both of her heels and expected facility staff to provide pressure relief for R13's feet/heels. MD-A indicated she expected R13's heels to be offloaded, and if R13 refused to wear Prevalon boots she expected other methods of pressure relief to be attempted. MD-A stated she was not aware R13 had eschar tissue to both of her heels, nor was she aware the the size of R13's pressure ulcers had increased. MD-A stated she felt R13's unstageable pressure ulcers were likely stage 4, very deep and were very painful for R13.

An undated facility policy titled Pressure Ulcer Treatment, revealed the purpose of the policy was to provide guidelines for the care of existing pressure ulcers and the prevention of additional pressure ulcers. The policy identified general guidelines for assessment of current pressure ulcers, pressure ulcer care, interventions, treatment and infection control. The policy listed definitions and descriptions of all stages of pressure ulcers, interventions and care strategies, documentation and reporting to supervisor any worsening a pressure ulcer or refusals of interventions.
The policy directed facility staff to provide ongoing assessment, monitoring and implement interventions and analyze interventions in order to aid in the healing of active pressure ulcers to

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F 686	Continued From page 117 prevent the worsening and/or new development of.	F 686		
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct a comprehensive falls assessment to determine effective interventions, and failed to consistently implement interventions for 1 of 1 resident (R1) who had a history of multiple falls which resulted in laceration and required medical treatment. Further, the facility implemented an inappropriate intervention which increased R1's safety risk and resulted in further falls for R1. This deficient practice resulted in immediate jeopardy for R1. The immediate jeopardy began on 11/23/17, when R1 had not been comprehensively assessed for the root cause of repeated attempts of self transfer and appropriate interventions implemented and was identified on 3/9/18. The regional director of clinical Services (RDCS) and director of nursing (DON) were notified of the immediate jeopardy at 3:20 p.m. on 3/9/18. The immediate jeopardy was removed at 2:00 p.m. on 3/13/18, but noncompliance remained at the lower G scope and severity level, which indicated	F 689	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to ensure an environment that remains free of accident hazards. Some of the many ways that this has been done is by identifying hazard(s) and risk(s), monitoring for safe environment and implementing immediate interventions when necessary. 2.When the surveyor noted R1 to have multiple floor mats covering floor surface it was determined that they were not used correctly. Immediate action was taken to remove floor mats. It was noted resident had 3 falls 3/8/18 and none were addressed by nursing staff. It was	4/23/18

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actual harm that is not immediate Jeopardy.

Findings include:

R1's admission Minimum Data Set (MDS) dated 11/11/17, identified R1 had intact cognition, and had diagnoses which included Parkinson's disease, dementia, anxiety, glaucoma, weakness, restlessness and agitation. The MDS identified R1 required total assistance for eating, extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, and did not walk. The MDS also identified R1 had a fall in the last month prior to admission, a fall in the last 2-6 months prior to admission, and no falls since admission. The MDS did not identify R1's fall on 11/8/17.

R1's Care Area Assessment (CAA) dated 11/14/17, indicated R1 had a history of numerous falls at previous living facility and had been admitted from an acute hospital after multiple falls and worsening of Parkinson's disease. The CAA indicated R1 received an anti-psychotic and anti-anxiety medication, exhibited sedation, disturbances in balance, depression, was at risk for falls and injury. R1's CAA did not identify he had fallen since admission to the facility (11/8/17).

R1's Risk For Falls assessment, undated, identified as completed on admission, indicated R1 had a total risk score of 11. The assessment indicated a total score of 10 or above deemed resident at risk.

No further fall assessments were found in R1's clinical record nor provided by the facility.

Review of R1's current care plan printed on

F 689

determined R1 is high fall risk and interventions not in place to prevent further falls. Also noted no post fall follow up to previous falls.
3.Fall assessment was completed immediately and follow up process put into place 3/9/18
4.The director of nursing along with therapy reviewed the need for assistive devices by R1 and determined floor mats were not safe on floor in resident room and agreed based on completion of fall risk assessment by DON on 3/9/2018; PT and OT would re-evaluate R1 for other therapy goals and/or interventions to ensure safety.
5.Immediately 1:1 put in place until further evaluation could determine best plan of care. A fall analysis was completed and noted most falls between 8:30-10:00 am. Resident states often feels like he needs to do something. Also noted that his behaviors increase as do his tremors during this time. Both are believed after conversation with resident that he gets tired of sitting.
6.Staff will be encouraging short walks to dining table 3x/day to meals and have resident sit in regular chair as his disease process allows and until therapy completes working with him to formally update safe walking guidelines. Activities also will encourage after breakfast activities to increase focused stimulation as resident will allow.
7.Falls, bowel and bladder, aims, activity and ADL assessments update 3/12/18.
8.To enhance currently compliant operations and under the direction of the

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F 689	Continued From page 119 3/8/18, last revised 3/6/18, identified R1 was a high risk for falls related to confusion, deconditioning, gait/balance problems and unaware of safety needs, had Parkinson's and monitor for risk of falls. R1's care plan listed various interventions which included: encourage R1 to call for assistance before getting up, encourage R1 to stay in his room when he is unsteady and flailing all over the place, have staff sit with R1 when having involuntary muscle movement and non-compliant, monitor R1 while up in wheelchair, ensure R1's call light was within reach and encourage R1 to use it for assistance as needed, provide prompt response to all requests for assistance. R1's care plan lacked transfer and ambulation instructions. In addition, R1's care plan also indicated R1 had self movement to floor from wheelchair and bed, had expressed suicidal ideations, and directed to provide mats to facilitate R1's comfort and safety while sitting and lying on floor. R1's care plan directed to utilize a low bed with mats placed on the floor on either side, remove head and foot board and place padding on the wall at head of the bed. Further, R1's care plan identified he utilized an anti-anxiety medication, and directed staff to monitor R1 every shift for safety due to the use of the anti-anxiety medication, which was associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment which looked like dementia and increased risk of falls, broken hips and legs. The care plan directed to monitor for adverse reactions to the anti-anxiety medications which included clumsiness, slow reflexes, confusion, disorientation, dizziness, impaired thinking and judgement, aggression or	F 689	DON, in-servicing to nursing staff was started immediately started on 3/9/18 on use of mats and fall potential/accident hazards. The training also emphasized risk for falls, what constitutes a fall, where to find interventions and importance of always reporting incidents and accidents. On 4/4/2018 an all staff in-service was completed to educate on education staff of comprehensive assessments, analysis of falls, and appropriate interventions. All residents with falls are reviewed, ensured a comprehensive assessment has been completed, appropriate interventions put in place and staff are implementing them appropriately 9.A new post fall assessment was developed for facility and completed on R1 on 3/12/18. This assessment reviewed root causes of the latest fall. It was determined by interview resident just wanted to stretch legs and move around. A new log system is set in place for better tracking on repetitive falls. All falls will be discussed after morning standup for full interdisciplinary review. 10.All incident reports will be reviewed by DON or designee. Care plan on R1 updated and current. PT moved bigger bed into room to ensure resident able to see it better and moved to middle of room. Working on therapeutic goals for next 30 days. Care sheet was updated appropriately. 11.Effective 3/9/2018, a quality-assurance program was implemented under the supervision of the director of nursing to monitor use of floor mats or other accident hazards.	

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impulsive behavior.

Review of untitled form, identified as the facility nursing assistant care sheet, updated 3/6/18, directed staff R1 required one to two staff assistance and gait belt for transfers, one to two staff for activities of daily living (ADL), at fall risk and R1 was alert with periods of confusion. However, the form lacked directions for use of floor mats, and lacked directions for ambulation.

On 3/6/18, at 3:17 p.m. R1 was observed lying on his back in bed. R1's mattress was without a head or footboard and was positioned into the corner of the room with the head end against one wall and the entire side of the bed against another wall. On the wall next to the side of R1's low bed was a tan, beveled edge foam fall mat that started just below the mattress and went up the wall approximately two feet . On the wall above the attached fall mat was eight pieces of gray duct tape that had been rolled onto itself and attached to the wall in various spots. Next to R1's bed a second tan, beveled edge foam fall mat was observed on the floor. Directly next to the tan fall mat on the floor was another maroon colored, beveled edge fall mat. Directly next to the maroon fall mat on the floor was another black fall mat that had a second maroon fall mat stacked on top of it, that continued under a metal heat register to touch the wall, leaving no part of R1's floor visible from the bed to the opposite wall. R1's call light was clipped onto a pull string cord for the wall mounted light approximately two feet higher than R1's bed and three feet away from R1.

During interview at that time, R1 stated he had fallen recently but could not recall how long ago. He stated he had to go to the bathroom, tried to

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12.The director of nursing or designate will audit R1 environment and safety, all fall reports, ensure post fall completed and care plan up to date; daily on AM and PM shift for 2 weeks, 3x/week for 2 weeks, weekly for 2 weeks and then monthly for 6 months to ensure compliance. R1 has been audited for cares, falls and interventions for safety per previous plan of correction. Logs have been in place to ensure ongoing compliance and correction has been sustained
13.Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly QAPI meeting for further review or corrective action. Policy on fall assessments, use of floor mats and safety have been updated.
14.The DON is responsible for this POC.

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go himself and fell. He stated he landed on his knee when he fell, lifted his right leg and pulled up his pant leg to reveal a golf ball sized dry, brown scab to just below the right knee.

On 3/6/18, at 3:42 p.m. licensed practical nurse (LPN)-E confirmed that R1's call light clipped to the wall light pull string was not in reach for R1. LPN-E stated R1 did use call light at times, but staff also positioned the medication cart outside of R1's room for increased supervision.

On 3/7/18, at 9:30 a.m. R1 was observed to be seated in the wheelchair in his room. R1's wheelchair was positioned with wheels next to fall mats facing the television. R1's call light was clipped to a pillow on his bed, not within reach. R1 stood up from wheelchair and walked to his closet and then walked into his bathroom. At 9:35 a.m. R1 walked out of the bathroom to his wheelchair and sat down abruptly. He then propelled his wheelchair using his feet, out of his room and down the hallway.

On 3/8/18, at 6:13 a.m. R1 was observed using his feet to propel his wheelchair down the hall back to his room after a shower. R1 stood up from his wheelchair and walked over the corner of the fall mat that was closest to his bed. He sat down on the edge of the foot end of his bed, immediately stood back up, and walked over the tan fall mat and then the maroon fall mats to a wooden arm chair that was positioned on the maroon fall mat and stood holding onto the back of the wooden chair. At 6:17 a.m. nursing assistant (NA)-I entered R1's room and proceeded to change the linen on R1's bed. NA-I did not attempt, nor offer assistance with R1's ambulation. R1 walked on top of the maroon fall

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F 689	Continued From page 122 mat to his closet, and then walked to the bathroom. NA-I left R1's room and returned at 6:19 a.m. R1 remained standing in the bathroom. At 6:24 a.m. R1 walked out of the bathroom to his wheelchair and sat down. NA-I exited R1's room. At 6:26 a.m. R1 self transferred from his wheelchair and walked to his closet, and walked into the bathroom. At 6:30 a.m. R1 walked out of the bathroom, between his wheelchair and the corner of his bed, onto the fall mats to the corner of his room where an over-the-bed type table was positioned on top of a fall mat. R1 grabbed his water mug off of the table and walked over the fall mats around the left side of his wheelchair and sat down. At 7:21 a.m. R1 stood up from his wheelchair, walked over the fall mats to the over-the-bed table and then starting walking back to his wheelchair. R1's left foot caught on the edge of the maroon floor mat and R1 stumbled forward two steps and then caught his balance using his right arm to brace on the back of his wheelchair. R1 walked around the side of the wheelchair and sat down. On 3/8/18, at 8:24 a.m. NA-I stated R1 required supervision for transferring. NA-I stated he could toilet independently, but she stood in the bathroom with R1, because he could get "jittery." NA-I stated R1's ambulation depended on what kind of day R1 was having and indicated if it was a good day he could walk on his own and if it was a bad day he required extensive assistance. NA-I stated she felt R1 was having a good day. NA-I stated the fall mats were on the floor in R1's room to prevent injury when R1 fell, and the looped gray duct tape attached to the wall above R1's bed used to hold another fall mat to the wall. She stated when R1 had a bad day he would be on the bed and would throw himself onto the floor	F 689		

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with uncontrollable movements and flop around on the mats. NA-I stated R1 had "bad days" about once a week. NA-I confirmed R1's NA care sheet instructed staff to transfer R1 with one to two staff and a gait belt. NA-I stated R1's floor mats had been on the floor "all the time."

Continual observations was conducted on 3/8/18, from 8:42 a.m. to 9:20 a.m.:

-At 8:42 a.m. R1 was seated on the foot end edge of his low bed with his arms flailing up and down along side his body. R1 abruptly threw himself backwards onto the bed, and arms were moving up an down uncontrollably. NA-I and trained medication aide (TMA)-A stood outside R1's doorway by the medication cart and did not enter R1's room or offer assistance. NA-I stated she had offered R1 a massage to help calm him and he refused. TMA-A stated she gave R1 an as needed Ativan (antianxiety medication) just prior.

-At 8:47 a.m. R1 remained on his back and his arms continued to move uncontrollably. NA-A walked past R1's room towards a wall mounted kiosk. NA-A briefly stepped back from kiosk, turned and looked into R1's room and immediately returned to using the kiosk. NA-A continued to enter data into the kiosk, and sporadically turn and look at R1, and then using the kiosk.

-At 8:49 a.m. R1 continued in the same position with the same uncontrollable movements. NA-A stopped charting, turned and looked into R1's room again. TMA-A pushed the medication cart past R1's room, looked into R1's room as she passed but, neither NA-A or TMA-A entered R1's room nor offer assistance.

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F 689	Continued From page 124 -At 8:51 a.m. R1 sat on the edge of mattress, leaned back with legs straight, with his feet flat on the floor, as his arms continued to move uncontrollably. NA-A left the wall kiosk, entered R1's room, briefly visualized him and immediately exited the room without offering or providing assistance and returned to wall kiosk. -At 8:52 a.m. R1 stood himself up, walked on top of the uneven fall mats, towards the wooden chair on the floor mats, turned and lost his balance. He reached out with both arms for the back of the wooden arm chair to steady himself, but fell onto the floor onto his right side holding onto the wooden chair. NA-A was immediately informed of R1's fall. NA-A walked to R1's doorway, looked in, stated R1 fell often and stated, "that's why the mats are there." NA-A immediately walked back to the wall kiosk. R1 sat up and continued to have uncontrollable movements of upper arms as he rocked his trunk back and forth. R1 grabbed the wooden chair and tipped it back upright with jerky arm movements and with an unsteady gait proceeded to stand up and walk over the uneven fall mats to the foot end of his bed and sat down. -At 8:54 a.m. R1 continued to have uncontrollable movements in his arms and rocked his trunk back and forth on his bed. NA-A left wall kiosk and briefly entered R1's room and exited the room. R1 stood up again, and with an unsteady gait, walked back to the wooden chair on the fall mats. -At 8:57 a.m. R1 abruptly stood up from the chair, with uncontrolled arm movements, shuffled feet and an unsteady gait, walked on the uneven surface of the fall mats, then onto the floor to his closet. NA-I was informed R1 was standing	F 689		

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F 689	Continued From page 125 independently. NA-I entered R1's room and asked if he was alright. R1 walked towards his bed, and threw himself onto his bed, bounced on the mattress, and ended up lying on his left side. NA-I walked out of R1's room and stated R1 did not like it if he thought she was watching him. NA-I then entered another resident's room. -At 9:01 a.m. R1 sat himself up in bed and moved down to the foot end of his bed. He remained seated at the foot end and rocked back and forth with arms moving up and down. The fall mat closest to R1's bed had slid away from the bed at an angle, leaving a gap of approximately 6 inches. R1 rolled his hips to the right and sat down onto the fall mat next to his bed. R1 then laid down on his right side and rolled side to side on the floor mats and then sat up, seated on the floor mats. At 9:02 a.m. NA-I exited another resident's room and surveyor notified her R1 self transferred to the floor mats. NA-I looked at R1 from his door way, but did not go into his room. R1 remained seated on the floor on the fall mats, with his shoulders rocking side to side. -At 9:17 a.m. R1 stood up from the wooden arm chair, took two steps forward towards his bed and then fell forward, landing abruptly onto his bed. NA-I was present in the doorway of R1's room. NA-A entered R1's doorway and stood next to NA-I. R1 kicked his legs to get enough momentum to get to a seated position on the side edge of his bed. R1 then stood up on the floor mat next to his bed, started to walk towards the wooden arm chair, turned around, and started to fall backwards towards the metal heat register. R1 fell to a seated position, as NA-I ran up to him. NA-I braced R1's back to keep him from falling backwards in his seated position and NA-A exited	F 689		

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the room to update TMA-A. At 9:20 a.m. R1 was seated on the floor next to his wheelchair with his back facing the closet. He braced himself in the seated position with his arms stretched out behind him. NA-I was next to R1 on the floor supporting his upper back.

During interview on 3/08/18, at 9:27 a.m. TMA-A stated she felt R1's involuntary movements did not have a set pattern, R1 would have a couple of tired days where he required assistance with everything. She stated some days R1's involuntary movements were worse than other days. TMA-A stated if R1's involuntary movements got really bad they would have a NA sit with him one on one. TMA-A stated when staff were to "one to one" (1:1) R1, there were not specific directions as to what specific things to do for him. TMA-A stated R1's various fall mats had always been on the floor, covering the corner his room. She stated she was aware R1 was unsteady when walking and braced himself on things in an attempt to prevent falling. TMA-A stated she felt R1 transferred himself on the floor purposefully to be more comfortable.

On 3/08/18, at 9:55 a.m. NA-L stated R1 was a fall risk and she was aware R1 had fallen a few times in the past. NA-L stated R1 had good days and bad (referring to his involuntary movements). She stated R1 had involuntary movements every 2-3 days, and stated she felt R1 got frustrated when staff tried to supervise him. She indicated if R1's movements were not "dangerously bad" then he would sit alone in his wheelchair, chair or bed in his room.

On 3/08/18, at 10:15 a.m. physical therapist (PT)-A stated R1 had received therapy after

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admission, but was no longer in therapy. PT-A stated R1 had a lot of limitations due to his Parkinson's disease and was having more abnormal movements and impulsivity so he was discharged from therapy. PT-A stated R1 was a fall risk and due to R1's balance and judgement he should never transfer or ambulate on his own. PT-A stated R1 could walk independently one day, and require maximum assistance of two staff to stand the next day. PT-A stated she was aware R1 self transferred quite frequently, especially if he was having a good day and thought he could do things on his own.

On 3/08/18, at 10:37 a.m. NA-A stated R1 had involuntary movements almost daily, with some days the movements were constant and other days the movements were off and on. NA-A stated when R1 was not having involuntary movements, he could transfer, walk in his room and go to the bathroom independently or with supervision. NA-A stated R1 "almost" falls a lot, but he would catch himself on objects. NA-A stated the fall mats in R1's room had "always" been down on the floor.

On 3/08/18, at 10:54 a.m. LPN-C stated she felt R1 could transfer and ambulate independently. R1 had fall mats on the floor and wall next to bed for safety. LPN-C stated if R1 was noted to have a lot of involuntary movement, he was administered the as needed Ativan and if the Ativan did not control the movements, a staff person would sit with him. LPN-C stated she was not aware R1 had fell today.

On 3/08/18, at 11:00 a.m. LPN-I stated she felt R1's Parkinson's disease had been getting worse, and had experienced a lot of falls at home

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F 689	Continued From page 128 before he transferred to the facility. She stated R1 had "good days" and "bad days." She indicated on R1's "bad days" he had a lot of involuntary movements. LPN-I stated she felt R1 preferred to be by himself and would get angry if staff tried to assist him. She stated when R1 had involuntary movements staff try to get him to his room. LPN-I stated R1 utilized as needed Ativan which was not always effective and used the fall mats because he would crawl out of bed. LPN-I confirmed she was not aware R1 had fell today. On 3/8/18, at 12:25 p.m. director of nursing (DON) stated R1 had Parkinson's disease, so his fall risk was "really high." The DON stated she was aware R1 had involuntary movements sometimes once a week, and staff provided 1:1 supervision with R1. She stated she would expect the 1:1 supervision to start when R1's involuntary movements began and would expect staff being within arms reach of R1 so he did not fall and hurt himself. The DON stated R1 self transferred a lot and R1 was not safe to transfer or walk independently. DON reviewed R1's fall incident reports, the first report completed on 12/13/17, and confirmed a report should of been completed after each of R1's falls. She confirmed no fall incident reports had been completed for 3/8/18. On 03/08/18, 2:47 p.m., during a follow up interview, DON confirmed R1's incident reports and clinical record did not include a post fall analysis, to determine the root cause of his falls, and assess R1's whole situation all together. She indicated R1 had denied falling this a.m. and felt R1's fall with the chair "concerning." She stated she would expect staff to initiate 1:1 supervision for R1 right at the start of his involuntary movements, and continue the entire time he had	F 689		

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F 689	Continued From page 129 the episodes. DON indicated she understood there were to be one fall mat on R1's wall, and 3 more on his floor. She indicated the fall mats could be considered an added fall risk and stated she maybe would consider securing the fall mats to the floor in the future. Review of R1's Incident Reports from 11/1/17, to 3/8/18, revealed the following: The reports lacked documentation or analysis of R1's two falls on 11/8/17, a fall on 11/23/17 with laceration requiring sutures, and 2 falls on 11/29/17, as documented in R1's progress notes. -12/13/17, at 8:30 a.m. in his room throwing stuff from one place to another, moved his bed to another position, very agitated and uncontrollable and did not allow staff to go near him. R1 started to run in the hall as staff ran behind him with the wheelchair and later he fell on the floor x 3. The report identified R1 as unable to explain what went on, alert to self and place, confused to situation and condition. The report stated R1 was usually in that uncontrollable mood, most of the time. The report indicated R1 had no injuries, R1 was not following the care plan, and R1 was difficult to redirect. The report further identified R1 was wheelchair bound and needed to be in the wheelchair at all times for locomotion. The report indicated R1 was confused and had gait imbalance, was occasionally confused when he is in that mood, and uncontrollable body movement occurred very rapidly. R1 was a very high risk for injuring self and others when attempting/offering assistance within that time frame. The report lacked an analysis of the falls, or how to address R1's behaviors.	F 689		

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-12/17/17, at 8:45 a.m. seated on wheelchair cushion edge in the dining room, when R1 had a very sudden, strong involuntary muscle movement and fell off his wheelchair and landed on his knees. R1 denied pain and had a large purple/brown bruise to right knee. The report lacked any further information, or an analysis of the fall.

-12/29/17, at 10:46 a.m. R1 exited his room pushing his empty wheelchair, stumbled forward and hit his chest on a medication cart and fell to the floor. The report identified R1 received an as needed Ativan at 8:00 a.m. R1 had no pain and no injuries observed post incident, but a chest x-ray was ordered related to the fall. The report indicated R1 was oriented and was encouraged to walk with staff. The report further indicated rugs/carpet, gait imbalance and ambulating without assistance pushing an empty wheelchair were predisposing factors to R1's fall. The report lacked an analysis of the fall.

-12/29/17, at 11:50 a.m. NA was attempting to walk with R1 in hallway with wheelchair following as R1 would not allow staff to assist. R1 was having frequent involuntary muscle movements and would not sit down in wheelchair or walk with four wheeled walker. R1 attempted to grab a hold of fire door, the door closed and R1 fell. The report indicated R1 sustained an abrasion to his right knee, right fifth finger, right knee and left side by hip. The report indicated R1 was alert, incontinent, had gait imbalance, impaired memory and Parkinson's disease. The report listed R1 had improper footwear and ambulating without assistance. The report lacked an analysis of the fall, or how to address R1's behaviors.

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F 689	Continued From page 131 -1/1/18, at 8:30 a.m. un-witnessed fall in his room, fell into the corner of the register attached to the wall. R1 had a red mark on the left side of his forehead and a scratch to his left knee. The report indicated R1 was alert and oriented, had as needed Ativan prior to fall because he was agitated and unable to control involuntary movement in his arms and legs. The report indicated predisposing environmental factors of mats on R1's floor, R1 was unable to control involuntary movements and gait imbalance. The report lacked an analysis of the fall. -1/6/18, at 10:37 a.m. R1 slide on his buttock from the wheelchair. The report indicated no injury occurred, and R1 was unable to state what happened as he was confused most often, did not recall and not able to explain accurately. The report indicated R1 was able to propel himself in his wheelchair to and from dining room and walk short distances from room to bathroom. The report indicated R1 was confused, had gait impairment and memory impairment. The report lacked an analysis of the fall. -1/12/18, at 3:48 p.m. an un-witnessed fall out of his wheelchair onto the floor in hall way. The report indicated no injury, was oriented only to person and ambulatory without assistance and had gait imbalance. The report lacked any further information or an analysis of the fall. -1/17/18, at 9:27 a.m. frequent involuntary muscle movements while ambulating per self with no assistive devices. Became very agitated and swung himself around, causing himself to fall onto his buttocks. R1 was assisted back into his wheelchair and denied being hurt. The report indicated R1 had gait impairment, impaired	F 689		

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memory and Parkinson's disease and was experiencing frequent involuntary muscle movements. The report lacked an analysis of the fall.

Review of R1's progress notes from 11/1/17 to 3/8/18 revealed the following:

-11/1/17, admitted to facility with diagnoses which included Parkinson's disease, anxiety and dementia with behavioral disturbances, mood swings and history of falls.

-11/8/17, 12:25 a.m. heard a loud sound, found R1 on floor behind door thrashing around. No injury noted, 1:1 supervision initiated. 12:50 a.m., out of bed on floor again, 1:23 a.m., R1 became combative towards staff, 911 called, thrashing in bed, and sent to ER for evaluation. The note indicated a previous incident of thrashing the previous day with the same symptoms.

-11/23/17, 3:00 a.m. heard loud sound from room, found on floor, sustained a small (sic) 1.5 centimeter (cm) cut on forehead, resident uncooperative, thrashing about with uncontrolled movements. Order received to transfer to hospital for evaluation. At 10:45 a.m. R1 returned to the facility with 4 sutures to area above eye.

-11/29/17, 2:00 p.m. very frequent involuntary muscle movements this morning, attempted to self transfer multiple times to and from wheelchair to bed and/or other chairs around the facility. Almost fell 2 times but was successfully assisted by staff back to wheelchair without falls occurring. Education given regarding use of call light and waiting for assistance for transfers until muscle movements were less frequent. R1 verbalized

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understanding but did not follow through.

-12/5/17, 4:50 a.m. exaggerated movement of extremities noted, bouncing off of bed onto padded floor, back to bouncing on bed, hitting body against padded walls. R1 sent to hospital for evaluation. The notes indicated R1 returned to facility at 10:00 a.m. with no new orders.

-12/12/17, 9:13 a.m. very agitated this morning, self ambulating with front wheeled walker (FWW) while having frequent involuntary movements making it very unsafe. NA attempted to ambulate with R1, became very angry and started to bang FWW on the ground and attempting to strike staff. R1 sat down on his bed and was able to calm himself down., staff educated him on the staff's job to keep him safe and staff needed to assist with ambulation when his is having frequent involuntary movements. R1 verbalized understanding.

-12/13/17, 10:33 a.m. R1 in room throwing stuff from one place to another, moved bed to another position, did not allow staff to go near him, left room and ran in hall as staff ran behind him with wheelchair and he fell on floor 3 times. No injuries or bruises noted.

-12/21/17, 5:30 a.m. extreme Parkinson shakes of large extremities, bouncing on matted floor and against padded wall, instructed NA to watch closely and keep R1 safe. At 12:38 p.m. frequent involuntary muscle movements, combative with staff, threw himself on bed and kicked staff. Redirection attempted but became more agitated, staff left room.

-12/29/17, 8:00 a.m. exited room, stumbled

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forward with chair hitting chest and fell to floor, chest x-ray ordered, negative for fracture.

-1/17/18, 9:47 a.m., ambulating per self with no assistive devices while having frequent, involuntary muscle moments. Staff attempted to assist to sit in wheelchair, became very agitated and swung self around and fell on buttocks, no injury noted. R1 educated on importance of not ambulating per self until muscle movements under control so he does not fall and hit his head.

-2/17/18, 12:40 p.m. agitated, moves his body here and there, unable to concentrate or focus on given direction, as needed anti-anxiety medication given, seemed helpful for an hour and resumed agitation again.

-3/8/18, 2:18 p.m. reported to writer when R1 was in room he started to fall and staff caught him and lowered him to ground with butt touching floor first, R1 had been anxious this a.m. with lots of uncontrolled movements, received as needed anti-anxiety medication and 1:1 done .

Review of R1's PT Therapist Progress and Discharge Summary with start of care dated 11/7/17 and end of care date 12/4/17, revealed R1 had diagnoses of muscle weakness, difficulty in walking and unsteadiness in feet. R1 had had been discharged from therapy due to significant variability in his mobility depending on medication doses, at times tardive dyskinesia limits any functional movements, while other times bradykinesia limits any functional movements, and at times R1 could complete mobility tasks including walking up to 350 feet with a front wheeled walker without assistance. Progress with safety education has been limited by R1

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presenting with dementia. The summary included recommendations for assist of 1 for all mobility tasks and general supervision while R1 mobilized on the unit in his wheelchair due to history of attempting to self transfer.

Review of R1's OT Therapist Progress and Discharge Summary with start date of 11/7/17 and end date of 12/1/17, listed diagnoses which included Parkinson's disease and repeated falls. The summary listed R1 was a fall risk, had significant weakness/balance concerns without the use of Parkinson's disease medications, required supervision/assist with standing ADLs and functional transfers/ambulation to ensure safety and level of assist dependent on medication schedule.

On 03/09/18, at 08:59 a.m. the regional director of clinical services (RDCS) indicated she was unsure when the floor mats were placed, but felt the 5 fall mats were placed on his wall and were not to be used on R1's floor. She indicated she felt R1's family was making a lot of the choices with previous nursing home administration instead of nursing and therapy trying to prevent the "unpreventable."

On 03/09/18 at 10:26 a.m. the therapy program manager (TPM) stated R1 had been discharged from therapy on 12/5/17, and indicated in a stand up meeting for falls right after that, the floor mats on the wall, removal of head board and foot board and dycem in the wheelchair were placed for R1. She confirmed there were no typed recommendations for therapy for safety after the stand up meeting, and stated therapy would not recommend anyone walking on floor mats.

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On 3/9/18, at 10:36 a.m. NA-N stated R1's fall mats on the floor had been present since admission, and stated staff sometimes find R1 on the mats and tell the nurse, and the nurse tell staff "that is not a fall." She stated she was not sure if finding a resident on a fall matt on the floor would be considered a fall for the resident.

On 03/09/18, at 11:08 a.m. maintenance worker (MW)-A confirmed he was aware when the floor mats had been placed on R1's wall and stated he remembered the second MW-A standing on a mat on R1's floor when he had placed 2 mats on the wall in R1's room, "sometime before Christmas."

On 03/09/18, at 12:03 p.m. per telephone interview, nurse practitioner (NP)-A stated R1 had Parkinson's disease, gait disturbance and had "fairly significant autism" and indicated she felt R1 had Aspergers (brain development disorder that leads to problems with social skills, behavior, and coordination). She indicated R1 had a hard time verbalizing his needs and his interpersonal communication was difficult. NP-A indicated 1:1 could be helpful for R1, but it depended on the staff's approach with him. She indicated she felt staff needed to know how to interpret R1 and when to back off. NP-A stated she felt the mats could be a fall risk if he was not in lying in bed, and the facility should not have a mat on the floor when he had increased involuntary movements (dyskensia).

On 03/09/18, at 12:50 p.m. a group interview was conducted with the DON and RDCS. The confirmed R1 had Parkinson's disease and lewy body dementia, however, denied R1 had a diagnosis of autism. DON indicated there was no

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pattern for R1's falls, and stated he fell "all over the building" and was impulsive. They verified R1's cognition and mobility varied frequently, and felt this was consistent with his lewy body dementia diagnosis. The indicated they were unsure when the fall mats had been placed in R1's room, but felt that therapy had brought them to R1's room to protect him from the walls. The DON and RDCS confirmed R1's record lacked documentation of any analysis of his falls and lacked documentation of any further falls assessments since admission. They indicated the facility's computer system made it difficult for staff to remember to complete a falls assessment due to a 2 step procedure to access the electronic form. The DON stated she would expect an analysis of R1's fall after each fall and complete fall assessments on admission, quarterly and after each fall. The RDCS confirmed R1 did not report his falls consistently and confirmed R1's clinical record could not be accurate to include all of his falls. The DON and RDCS confirmed the lack of fall assessments, completion of post fall analysis after each and the fall mats increased the risk for falls for R1.

On 03/09/18 at 01:52 p.m. family member (FM)-C stated he came to the facility 1-3 times per week to visit R1. He stated he knew the fall mats had been on the floor, covering the area from his bed to the windows "pretty much" since he was admitted to the facility.

The IJ which began on 11/23/17, was removed on 3/13/18, at 2:00 p.m. when the facility implemented a removal plan which included:

- Conducting a comprehensive fall assessment for R1 which included analysis of patterns for falls

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and causative factors;

- Removing the multiple floor mats from R1's room and floor to be free of clutter and adequate lighting;

-Developing individualized fall interventions for R1 which included PT evaluation, the use of 1:1 supervision with specific directions for how to conduct the supervision, use of as needed medication for agitated episodes, identification of R1's individual behaviors as related to his falls, and use of a bariatric bed in center of room, working, reachable call light, and bed in low position at night;

-Education of staff on what a fall was, on R1 specific care plan interventions, and how to conduct an appropriate 1:1 session for R1;

- Implementing audits to ensure R1's fall interventions were consistently implemented by staff.

On 3/13/18, from 12:44 p.m. to 1:29 p.m. nursing staff were interviewed and verified they had received education regarding R1's new care plan interventions which included removal of floor mats from R1's room, how and when to conduct 1:1 supervision for R1, use of as needed medications, the definition of a fall and who to report a fall to, and changes to R1's bed. Observations were conducted to verify the implementation of appropriate interventions for R1.

A facility provided policy titled Fall Assessment, dated 12/23/17, indicated nursing staff, in conjunction with the attending physician,

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F 689	Continued From page 139 consultant pharmacist, therapy staff, and others will seek to identify and document resident risk factors for falls. The policy indicated a resident's record would be reviewed for history of falls, especially falls in the last 90 days and recurrent or periodic bouts of falling over time and the fall assessment would determine the resident plan of care. The policy further indicated a resident's medication or combination of medication would be reviewed that could relate to falls or fall risk, staff will look for evidence of a possible link between the onset of falling and recent changes in medication, evaluate vital signs, medical conditions or sensory impairments that may predispose to falls. The assessment data would be used to identify underlying medical conditions that may increase the risk of injury from falls. The staff would evaluate functional and psychological factors that may increase fall risk, including ambulation, mobility, gait, balance, excessive motor activity, ADL capabilities, activity tolerance, continence and cognition. The staff would seek to identify environmental factors that may contribute to falling and identify and address modifiable fall risk factors and interventions to minimize the consequences of risk factors that are not modifiable.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		4/23/18

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F 690	Continued From page 140 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately conduct a bladder assessment in order to develop a toileting plan to maintain continence for 1 of 1 resident (R13) reviewed for incontinence. Findings include: R13's annual MDS dated 12/26/17, identified R13 had severe cognitive impairment and had diagnoses which included dementia, anxiety,	F 690	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide incontinence care to all residents who	

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F 690	Continued From page 141 restless leg syndrome and psychosis. The MDS identified R13 required extensive assistance with activities of daily living (ADL) including bed mobility, transfers and toileting. The MDS identified R13 was continent of urine and was not on a toileting program. R13's annual Care Area Assessment (CAA) dated 12/26/17, identified R13 had diagnoses of non-Alzheimer's dementia, depression and psychotic disorder, had severe cognitive impairment, required extensive assistance with ADL's including bed mobility, toileting and transfers. The CAA identified R13 was able to make her needs known and direct her cares. The CAA revealed R13 was incontinent of urine, however did not indicate whether R13 was on a toileting program or had a change in continence. Review of R13's medical record revealed no comprehensive bladder assessments had been completed within the last year for R13. R13's care plan revised 2/26/18, revealed R13 had a self care deficit, required extensive assistance from facility staff for dressing, personal hygiene and extensive assistance of two staff with toileting. R13's care plan did not identify R13's urinary continence needs. A group one nursing assistant care guide updated 3/6/18, revealed R13 required extensive to total assistance of one to two facility staff with ADL's. The care guide directed staff to assist R13 with toileting every two hours and as needed with one to two assist. On 3/7/18, at 2:25 p.m. licensed practical nurse (LPN)-E stated R13 required extensive	F 690	need it based on bowel and bladder assessment and offer option of toileting program or continence program if resident is able. One of the many ways that this has been achieved for resident #13 is by reviewing bowel and bladder patterns, cognitive ability to cue or toilet and overall functional ability. After survey noted the R13 was confused and consistently wet it was determined a new process needed to be developed to prevent increased moisture to resident with impaired skin integrity and to meet basic need to be clean and dry. R13 noted needing extensive A2 with toileting and transfers. No toileting program was in place and no bowel and bladder assessment had been completed to determine resident needs. On 4/4/2018 bowel and bladder assessment completed, and resident and staff interview completed. Resident noted to have incontinence. Can verbalize need at times to use bedpan due to cognition fluctuations staff to check and change every am, after meals and before bed and check at midnight and determined appropriate check and change program. Care sheets and care plans updated. 2.Because all residents are required to have toileting assessments and re-evaluated regularly, and many have changes in overall condition all are potentially affected by the cited deficiency. DON reviewed with staff appropriate programs for residents they consistently find saturated in bed or wheelchair. All current residents assessed for continence via bowel and bladder assessments and appropriate interventions for toileting or	

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F 690	Continued From page 142 assistance from facility staff for all of her ADL's needs including dressing and grooming. LPN-E indicated R13 was consistently incontinent and she thought R13 was on a routine check and change program for incontinence and should be checked every 2-3 hours. On 3/8/18, at 4:36 a.m. R13 laid in bed on her back with a blanket covering her from chin to her ankles. Nursing assistant (NA)-J entered R13's room, removed the blanket over R13 and proceeded to assist R13 to remove her pajama pants at that time NA-J stated she was surprised R13 had pajama pants on, as she usually did not sleep with pants on. R13's pajama pants and incontinent brief were both saturated with wetness, which NA-J confirmed was urine. NA-J assisted R13 to turn to her left side, which revealed two urine soaked disposable blue chux pads on top of a bath blanket. R13's buttocks skin was wet, pinkish white and had deep ridges from the incontinent pad. NA-J then proceeded to cleanse R13's buttocks and peri-area, applied a barrier ointment to R13's buttocks, donned a clean brief, removed the two blue urine soaked chux pads and replaced them with three clean disposable blue chux pads. NA-J covered R13's body with a blanket and exited R13's room. On 3/8/18, at 4:48 a.m. NA-J stated R13 required staff assistance with all cares, including grooming, and checking and changed every two hours for incontinence. NA-J stated she was unable to recall when R13 was last checked and changed. NA-J stated R13 was usually incontinent of urine and indicated R13 did not usually soak through the incontinent brief and the chux pads.	F 690	check and changing have been put in place. Care sheets updated and care plan. No other residents were affected. The policy on toileting – bowel and bladder assessments has been reviewed. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all staff received in-service training for appropriate toileting, incontinent care, check and change and importance of clean dry skin to prevent alterations in skin integrity The training emphasizes the importance of following all a plan to encourage residents to be as independent as they can with their care but ensure staff intervene when resident unable to complete basic ADL on their own. Educated on appropriately assessing toileting needs and appropriate interventions. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents with impaired skin integrity and updating MD, family and care plans with any changes to ensure appropriate follow through. The director of nurses or designated quality-assurance representative will perform the following systematic changes: the DON or designee will audit 5 residents bowel and bladder program in conjunction with assessment and interventions 2x per week for 3 weeks than 3 residents 2x per week for 3 weeks to ensure toileting plan or check and change program appropriate for the residents. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be	

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F 690	Continued From page 143 On 3/8/18, at 6:58 a.m. LPN-C stated R13 required extensive assistance from facility staff with ADL's which included grooming and personal hygiene and check and changed for incontinence. She indicated she thought R13 was assisted to check and change every 2-3 hours but was unsure if R13 was ever continent. She stated R13 was usually compliant with personal cares. On 3/9/18, at 8:40 a.m. the director of nursing (DON) confirmed R13's care plan directed facility staff to assist R13 with grooming and toileting. She confirmed R13's care plan did not address R13's continence or identify R13's toileting needs to maintain continence. The DON stated she expected staff to assist R13 with grooming, which included incontinence cares. She stated she felt it was unlikely R13 would have soaked through her brief or her chux pads if she had been routinely checked and changed. The DON further indicated she did not routinely complete resident bladder assessments and was unsure of when R13 was last assessed. On 3/9/18, at 1:09 p.m. NA-C stated R13 required extensive assistance with ADL's including grooming and toileting. NA-C indicated R13 required checking and changing for incontinence every 2-3 hours. She further indicated R13 was overall cooperative when assisting with cares. On 3/12/18, at 12:20 p.m. the MDS coordinator confirmed she had completed R13's most recent MDS and confirmed R13 had been identified as being continent of urine and was not on a toileting program. MDS coordinator stated she was responsible for completing facility residents quarterly and annual assessments which would include bladder assessments. MDS coordinator	F 690	documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON will be responsible for this POC.	

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F 690	Continued From page 144 confirmed R13's medical record lacked a recent bladder assessment. She further confirmed she was unaware of how facility staff assisted R13 with toileting and/or checking and changing.	F 690		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure physician ordered protein supplements was provided for 1 of 1 residents (R50) who was identified with a low albumin level. Findings include:	F 692	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and	4/23/18

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F 692	Continued From page 145 R50's Admission Record (print date 3/9/18) indicated the diagnoses of peritonitis (inflammation of the abdominal lining), and post surgical colostomy placement. R50's admission Minimum Data Set (MDS), dated 2/6/2018, indicated R50 was cognitively intact. During a resident group meeting, on 3/8/18 at 12:58 p.m., R50 stated that he was to be receiving a protein drink daily since admission. R50 stated he finally started receiving it about 2 days ago. On 2/8/18, the previous registered dietician (PRD) assessed R50's nutritional needs, making recommendations to R50's primary physician the request for "1 oz Liquacel qd (everyday)." This recommendation was made by PRD due to R50's post-surgical colostomy, and a low range albumin (protein). R50 had follow-up lab on 1/25/18, still indicated R50 was still considered by PRD to be on the low end of the acceptable albumin range. R9's primary physican signed the recommendations into orders the following on 2/9/18: "1 oz Liquacel qd (everyday)." The order was entered into R50's electronic medical record with an order date of 2/09/18, and a start date of 2/10/18. On 3/8/18, a review of R50's electronic medication administration record (eMAR), dated February 2018, revealed the protein supplement had been initiated and all days on 2/10/18 through 2/28/18, 18 days were blank, not given. The eMAR for March 2018 for R50, indicated R50 received his protein supplement only on 6 of the first 8 days of March.	F 692	federal law. 1.It is the policy of the facility to ensure all residents receive proper nutrition to ensure overall health. One of the many ways that this has been achieved for resident #50 was to initially order extra protein supplementation for his borderline low albumin levels. After survey noted the R50 had initial orders for increased protein supplement for low albumin levels and it had never been given immediately albumin lab was ordered, dietician notified, and point click care documentation for supplements was reviewed to ensure put on MAR and followed up appropriately to nursing. Medication error was completed on 4/4/2018, albumin level was ordered and determined to be 4.0 and dietician updated. At the time correction being completed resident went to hospital for back surgery and at this time will re-evaluate need for supplementation when returns. 2.Because many residents receive supplementation or dietary orders for enhanced nutrition or hydration many are potentially affected by the cited deficiency. DON reviewed all residents that had supplements to ensure that all supplements are being given. Reviewed with dietician the report for supplements and ensuring coded properly under dietary. The Policy and Procedure for supplements was reviewed and updated. No other residents were affected. The policy on nutritional supplements has been reviewed. 3.To enhance currently compliant	

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F 692	Continued From page 146 In an interview on 3/12/18 at 8:23 a.m., the director of nursing (DON), after reviewing R50's February and March 2018 eMAR's, was uncertain why resident had not received his physician ordered protein supplement. No further information was provided.	F 692	operations and under the direction of the director of nursing, on 4/4/2018 all staff received in-service training for monitoring nutrition, hydration, supplements and labs. The training emphasizes the importance of following all orders and ensuring all nutritional needs be met and the importance of following up on supplementation and notification of updated labs to evaluate necessity of supplements for people with abnormal labs. Dietary will also ensure all new admits with supplements get listed under supplements, so they can easily monitor with orders and appropriate labs ordered as necessary. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the dietary manager or designated quality-assurance representative will complete 2 audits on all residents receiving supplements per week x 4 weeks, then 1 audit weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.The Dietary manager, dietician and DON will be responsible for this POC.	
F 696 SS=D	Prostheses CFR(s): 483.25(j) §483.25(j) Prostheses The facility must ensure that a resident who has a prosthesis is provided care and assistance,	F 696		5/7/18

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F 696	Continued From page 147 consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary services and assistance with the use of a prosthesis for 1 of 1 resident (R17) reviewed with an amputation. This deficient practice resulted in the inability to wear the prosthesis due to muscle wasting of R17's right below the knee amputation (BKA.) Findings include: R 17's admission Minimum Data Set (MDS) dated 10/13/17, identified R17 had moderate cognitive impairment and had diagnosis which included pneumonia, below the knee amputation (BKA,) chronic obstructive pulmonary disease (COPD,) and diabetes. The MDS identified R17 was independent with activities of daily living (ADL's) including transfers, bed mobility. The MDS revealed R17 did not ambulate, had one sided limited range of motion of the lower extremity. The MDS further identified R17 had received physical therapy (PT,) occupational therapy (OT,) services. R 17's quarterly MDS dated 1/10/18, identified R17 was cognitively intact, independent in ADL's and had one sided limited range of motion of the lower extremity. The MDS revealed R17 did not ambulate and did not receive PT or OT services. R 17's Care Area Assessment (CAA)dated 10/13/17, identified R17 had been admitted to the	F 696	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of this facility to provide maintenance with prosthetic devices to prevent unnecessary decline and ensure normal quality of life. Some of the many ways that this has been achieved for R17 is to have prosthetic re-fit and when in place get PT/OT ordered. In this case, after the survey determined R17 showed a decline in ambulation ability and was not using prosthesis, immediate referral sent to get sized and re-evaluated for fit. 4/5/2018 R17 went to clinic which determined unable to get appointment with current orthotic clinic due to restriction now needs approval for provider to approve prosthetic. Therapy also assisting with this process. Assessments will be done and care plan to be created based on needs after prosthetic is in place, currently all other assessments are current and care plan correct. Resident stated will use when he feels like it and often prefers scooter, as far as cognition can exaggerate thoughts	

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Continued From page 148

facility from an acute care hospital and had diagnoses which included pneumonia, depression and anxiety. The CAA identified R17 had a right BKA and had a prosthesis. The CAA identified R17 was working with PT and OT services for strengthening, endurance and prosthetic training, however, did not identify ambulation or locomotion. The CAA identified R17 was independent in ADL's and indicated R17 did not ambulate at the time of the assessment. Further, the CAA identified R17 was at risk of injury due to cognitive impairment.

Review of R17's care plan identified R17 had a right BKA with a prosthesis and indicated he was independent with all ADL's including transfers. R17's care plan identified R17 did not ambulate.

Review of a nursing assistant (NA) care guide dated 3/6/18, revealed R17 required one assist with transfers with a front wheeled walker, had a right prosthesis and utilized a scooter. The care guide lacked any direction for use of or assistance with R17's prosthesis.

On 3/7/18, R17 was seated in a wheelchair in his room, he indicated he had received therapy services for a couple of weeks when he arrived at the facility in the fall. R17 stated therapy services had stopped because of his insurance. He further stated he had not received any type of exercises or walking with the facility staff. R17 stated he had a new prosthesis and was unsure if he would be able to walk if he tried. He indicated his new prosthesis was now too big for his right stump.

On 3/8/8/18, at 6:21 a.m. NA-C stated R17 was usually independent in all of his ADL's. She stated he had a right BKA and had a prosthesis. She

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but is alert and oriented current BIMS 14/15.
2.Because many residents have prosthetic devices some are potentially affected by the cited deficiency, on 4/4/2018, the DON reviewed all residents with prosthetic devices to ensure utilization is in place and care plan accurate. Other residents determined to have declines have been identified and significant change assessments have been initiated. No other residents were affected.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training regarding changes in resident’s condition. The training emphasized the importance of monitoring ADL’s both improvement and decline. Care In conjunction with therapy all staff will be in -serviced on prosthetic donning and doffing and walking protocols when prosthesis in place and importance of residents need for exercise, walking and maintaining independence with their cares. Fitting with dignity and quality of life staff were educated on importance of ensuring all residents live in a home like environment and can live at their highest functional status.
4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of therapy to monitor residents having prosthetics to ensure being utilized correctly and allowing resident utmost autonomy in self-cares. Therapy or designated quality-assurance representative will perform the following

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F 696	Continued From page 149 indicated R17 was independent in donning and doffing the prosthesis and stated he did not always wear the prosthesis. NA-C stated R17 did not ambulate and was unaware if he was able to ambulate. NA-C further indicated the facility did not have a restorative or maintenance program for range of motion or walking residents. She indicated residents would usually be seen by therapy for any exercise or walking programs. On 3/9/18, at 4:01 p.m. R17 was seated in an electric scooter in his room. R17's prosthesis was on the floor against the wall, between his closet and the end of his bed. R17 stated when he first arrived at the facility in October 2017, he had received both OT and PT services for approximately 2-3 weeks and had been able to walk with his prosthesis and the therapist. He indicated since he had stopped working with therapy, no other staff member had offered or assisted him to ambulate in the facility. He indicated his prosthesis was too big for him and felt his stump had shrunk. R17 stated at that time he did not feel he would be able to walk. R17 further indicated he had voiced his concerns about losing his ability to walk and to wear his prosthesis to his primary medical doctor as he did not feel his concerns would be addressed by the facility staff. Review R17's PT progress and discharge summary, start date 10/11/17, and end of care dated 11/3/17, identified R17's progress since his start of care was significant and he had participated well in all five PT sessions. The summary revealed R17 made consistent gains with lower extremity strength, balance and endurance. R17 had received gait training for appropriate gait pattern with prosthesis limb and	F 696	systematic audit of all residents with prosthetics 3 per week x 4 weeks, then 1audits weekly x2 months to ensure compliance in this area to ensure all residents with prosthetics are in the sample and assessment will include, fit of prosthetic, proper donning/doffing, actual use and resident satisfaction. All residents will be reviewed at time of quarterly or annual to ensure not a significant change. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.The ED, DON and therapy will be responsible for this POC.	

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F 696	Continued From page 150 on safe assistive devices to reduce risk for falls and improve efficiency of ambulation. The PT discharge summary revealed R17 had ongoing balance and endurance deficits, was at high risk for falls with independent mobility, was able to ambulate with PT required CGA and FWW. The summary identified R17 would benefit from further therapy, however due to payor source, R17 was discharged from skilled therapy services. Further the summary revealed R17 was a candidate for living in an assisted living facility with a potential to progress to a handicap accessible independent living setting and was provided education and a home exercise program. Review of R17's OT progress and discharge summary, start of care date 10/9/17, and end date 11/9/17, identified R17 had made good progress since his start of care and had participated in all eight therapy sessions. The summary revealed R17 made gains with ADL performance with transfers and ambulation. The summary revealed R17 required supervision to assist with standing ADL's and functional transfers and ambulation with front wheeled walker (FWW) to ensure safety. Further the OT discharge summary identified R17 was at risk for falls, and had been educated on a home exercise program to maintain gains made in OT. On 3/12/18, at 9:33 a.m. physical therapy director (PT)-A confirmed R17 had received skilled therapy services when he arrived at the facility. She stated R17's payor source was from North Dakota and only allowed for 15 skilled therapy visits a calendar year, therefore R17 was discharged from skilled therapy within a few weeks from his admission. PT-A stated she felt	F 696		

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R17 made improvements with his mobility in areas of ambulation and transfers while working with therapy. She stated R17's prosthesis was fitting and felt it had worked well with R17.

On 3/12/18, at 9:20 a.m. certified occupational therapist (OT)-A confirmed R17 had received skilled therapy services when he arrived at the facility and had received 8 skilled OT visits. She stated she felt R17 had made significant progress with therapy and had improved in his ability to donn and doff his prosthesis, balance, transfers and ambulation. OT-A stated R17 had been able to ambulate up to 100 feet with CGA when he was discharged from therapy services. OT-A confirmed she had recommended facility nursing staff continue to work with R17 with his prosthesis and ambulation in order to maintain and potentially improve his modified independence. She further stated she had concerns with the facility not providing residents with any type of formal or informal ADL maintenance/restorative services.

On 3/12/18, at 9:52 a.m. the director of nursing (DON) confirmed R17's care plan directed facility staff assist R17 with ambulation and to monitor and assist R17 with his prosthesis. The DON stated the facility currently did not have any type of restorative or maintenance program to prevent decline in residents ADL's. She stated implementing a restorative program was one of the areas she was working to develop and indicated she did not have a current plan in place. The DON stated she would have expected R17 to maintain his ability to ambulate and further stated she was unaware OT had recommended nursing staff to assist R17 with his prosthesis. She further indicated nursing and the contracted

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F 696	Continued From page 152 therapy department had communication problems and were currently working on improving communication for recommendations. On 3/12/18, at 10:59 a.m. licensed practical nurse (LPN)-C stated R17 was independent with mobility with a motorized scooter. She stated R 17 had a prosthesis and indicated R17 was independent with the prosthesis and occasionally wore his prosthesis. LPN-C stated she did not recall R17 ever ambulating since his admission. On 3/12/18, at 11:46 a.m. NA-E stated R17 was overall independent with his ADL's, though she felt he could use some more assistance with grooming. She stated R17 had a prosthesis and would wear it when he chose. NA-E indicated R17 was independent with his prosthesis and was also independent with his mobility with his motorized scooter. She further indicated she had never ambulated with R17. On 3/12/18, at 12:07 p.m. LPN-D stated R17 was independent in his mobility with a motorized scooter and had a prosthesis for a right BKA. She indicated R17 had received therapy services when he arrived at the facility and was unaware of any therapy recommendations. LPN-D stated she was not aware if R17 could ambulate and indicated she had not seen him ambulate since his admission. On 3/12/18, at 2:06 p.m. PT-A stated R17 had been able to walk with the use of his prosthesis, walker and CGA to moderate assistance, 4 WW and a gait belt up to approximately 100 feet. PT-A stated she had not received any recent referrals for R17 and was unaware of any decline in his ambulation ability. PT-A indicated R17 was given	F 696		

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a home exercise program to maintain his strength. She indicated she felt R17 would have benefited from continued assistance with ambulating, however she stated the facility did not have a formal or informal restorative/maintenance program to prevent decline in ADL's, such as ambulation. A request was made for PT-A to assess R17's current ability to ambulate.

On 3/12/18, at 2:12 p.m. R17 was seated in a motorized scooter wearing a tee shirt and dark jeans, his prosthesis rested on the floor between his closet and the end of the bed. R17 stated he had not walked since he had received skilled therapy services. PT-A entered R17's room, moved to gather his prosthesis and 4 wheeled walker (WW), which was also rested against the wall by his prosthesis. PT-A indicated she had to obtain another 4 WW as R17's was missing one of the two tennis balls that were on the back two legs of the 4 WW. PT-A immediately left the room and returned with another 4 WW. R17 indicated he did not routinely complete the home exercise program and indicated he would donn the prosthesis a few times a week. R17 stated he felt the prosthesis no longer fit him as it had when he first arrived at the facility. R17 stated he had to use a stocking cap over his gel liner PLY sock (a sock used to cover an amputated limb (stump) when using a prosthesis.) in order for his prosthesis to fit. R17 made several attempts to donn the Gel liner PLY sock, however he would hold his breath, his face would turn red and he had to stop. PT-A cued R17 to breath and he donned the Gel liner PLY sock. R17 placed the prosthesis onto R17's right stump. PT-A donned a gait belt around R17's torso and cued him to stand. R17 stood from his bed, in an attempt to secure his prosthesis onto his stump, and

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F 696	Continued From page 154 indicated his prosthesis would not set into place. PT-A confirmed R17's prosthesis no longer fit and stated she the prosthesis was too loose. R 17 indicated he had requested to see his prosthetics company but had been told his insurance would not cover an adjustment. PT-A stated she would follow up with R 17's prosthetics company. On 3/12/18, at 2:47 p.m. PT-A stated she felt R17 had experienced muscle wasting in his stump from his prosthesis not being used routinely. She confirmed R17 would not be able to ambulate at that time. She further indicated she felt R17's endurance had declined and he was not safe to ambulate or transfer independently. PT-A stated the facility's usual practice was to screen residents annually and quarterly, however, confirmed R 17 had not recently been screened. She indicated she was unaware of R17's decline. R17's current physician orders signed 3/6/18, revealed an order, dated 1/16/18, for PT and OT evaluation and treat as indicated. R17's physical orders did not address R17's prosthesis. Review of R17's progress notes from 10/5/17, to 3/8/18, revealed the following; -10/5/17, R17 was admitted from the hospital with pneumonia. The note revealed R17 had a right BKA and was at the facility to receive PT and OT services for strengthening and endurance. A later note revealed R17 was alert and oriented, was able to make his needs known. The note revealed R17 was independent with transfers, bed mobility and self care ADL's and had no behavioral issues. -12/28/17, R17 had reported to a facility RN his	F 696		

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prosthesis was no longer fitting him properly. The note indicated the writer would set up an appointment for R17's prosthesis. R17's medical record lacked any further documentation of R17's aforementioned concern.

-1/17/18, R17 was very active throughout the facility on his motorized scooter, however, did not address R17's ambulation.

R17's medical record lacked any documentation of R17's ability to ambulate following his discharge from skilled therapy services and lacked documentation of evaluation of R17's prosthesis.

On 3/12/18, at 2:59 p.m. during a follow up interview, the DON stated she would expect facility staff to monitor R17's use of his stump and indicated she felt he was independent with donning and doffing his prosthesis. She stated she was unaware R17's prosthesis no longer fit.

On 3/13/18, at 10:30 a.m. during a telephone interview with R17's primary physician (PA)-A, she stated R17 had recently reported to her he had not been walking and stated she had ongoing concerns with the facility's communication. She stated she had not been notified by the facility R17 was no longer able to ambulate or R17's prosthesis no longer fit. PA-A stated she would not have expected R17 to decline in his ambulation and stated she would have expected facility staff to assist R 17 to maintain the progress he had made with skilled therapy. PA-A stated she felt at times R17 was not always compliant, however, she stated she felt that did not negate R17's needs. She further indicated she was very disappointed R17 had declined so

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F 696	Continued From page 156 significantly. The Facility Assessment, dated August 2017, identified restorative nursing, transfers and ambulation would be offered based on residents needs. A policy was requested for prosthesis, none were provided.	F 696		
F 697 SS=G	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, failed to develop non-pharmacological interventions to manage acute pain for 1 of 1 resident (R207) status post surgery with ongoing pain. This deficient practice caused actual harm for R207, who experienced unmanaged pain, disturbed sleep patterns and reports of depressed mood with pain. Findings include: R207's Admission Record form, printed 3/9/18, identified R207's had been admittted to the facility on 2/20/18, and had diagnoses which included pain, osteoarthritis knee, bipolar disorder and schizophrenia.	F 697	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide adequate supervision and assistance with pain management. R207 had been in facility for therapy r/t TKA. R207 complained of pain on numerous occasions. Staff were not consistent on documenting or administering pain medication. The therapy department did try e-stim for pain and heat without	4/23/18

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R207's admission Minimum Data Set (MDS) dated 2/27/18, identified R207 was cognitively intact and had diagnoses which included recent surgical past of a right knee arthroscopy, depression, anxiety and schizophrenia. The MDS identified R207 was independent in all activities of daily living and was receiving both skilled physical therapy (PT) and occupation therapy (OT) services. The MDS further identified R207 had constant pain and had received as needed (PRN) medication for pain. The MDS did not identify R207 received non-pharmacological interventions for pain.

R207's Admission ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) dated 2/27/18, identified R207 had a recent right knee arthroscopy in addition to right lower extremity cellulitis (infection and inflammation of the skin). The CAAs identified R207 was cognitively intact and was working with therapies on strengthening and mobility. The CAA further indicated R207 was expected to return to her own apartment.

R207's Admission Pain CAA dated 2/27/18, identified R207 complained of frequent pain rating 6/10 on a numeric pain scale (0 being no pain and 10 being the worst pain imaginable) and received Gabapentin (medication for nerve pain), Tylenol, and Oxycontin (extended release opioid analgesic) for pain. The CAA lacked documentation of the location or any characteristics of R207's pain. Further, the CAA did not identify what was a tolerable level of pain for R17.

Review of R207's electronic and paper record lacked any further pain assessments completed by the facilty.

F 697

success. The short-term goal was pain at 7/10 since R207 rated it 9/10 upon admission - as strengthening improved and swelling reduced long-term pain control would be within more appropriate range. MD also reduced scheduled meds upon resident visit and felt pain management was appropriate. Pain is subjective, and documentation must be defined by the resident it is imperative all staff understand that documentation is critical for appropriate medical interventions. Based on findings medications were available for PRN use and breakthrough pain. The pain assessment was not accurate to detail amount of pain and documentations was not complete enough to state other non-pharmacological approaches. Reviewed with MDS nurse accuracy in data pertaining to side of pain documented when coding and ensuring if pain not managed based on review importance of follow up with floor staff to get control of pain to acceptable level.
2.Because many residents receive pain medications, come to facility with deconditioning and often increased pain all are potentially affected by the cited deficiency, 4/4/2018, the director of nursing along with MDS nurse reviewed residents that trigger for pain .All residents have been assessed for pain, comprehensive assessment completed and appropriate interventions in place. No other residents were affected.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all staff

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F 697	Continued From page 158 R207's hospital total knee replacement discharge instructions dated 2/20/18, revealed the following: -Pain Assessment completed at the hospital on 2/20/18, listed R207 had acute pain in right knee after surgery. Her current pain level had been rated at a 9 out of 10, with a mutual pain goal for pain relief to be a pain level of 2. The discharge instructions listed for pain management included: - ice knee and elevate your leg periodically. - take pain medications approximately 45-60 minutes prior to therapy/activity. - stay on top of the pain, may help to take pain medications before therapy. - never place a pillow under the knee. R207's current unsigned physician orders identified the following orders: - an order dated 2/20/18, acetaminophen 650 milligrams (mg) by mouth every 4 hours as needed for mild pain. - an order dated 2/20/18, Tramadol (non-opioid analgesic) 50 mg by mouth every 6 hours as needed for moderate pain. - an order dated 2/21/18, Gabapentin 600 mg by mouth three times a day for dorsalgia (nerve pain in the extremities). - an order dated 3/1/18,	F 697	received in-service training regarding pain management. The training emphasizes the importance of listening to the resident, adequate pain control and other interventions according to care plan. Staff educated on accurate pain assessment, non-pharmacological pain interventions, and pain monitoring to ensure adequate pain control. The Policy and Procedure for pain management was reviewed and updated. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor resident self-administering medication. The director of nurses or designated quality-assurance representative will perform the following systematic changes: MDS nurse and DON will audit 5 residents that trigger for pain based on their assessment and interview 2x per week for 3 weeks than 3 residents 2x per week for 6 weeks to ensure residents with pain are appropriately treated. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting. 5.The DON and MDS will be responsible for this corrective action.	

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oxycodone-acetaminophen (Percocet, combination opioid analgesic) 5-325 mg, give one tablet by mouth every 6 hours as needed related to pain, if Tramadol only does not help then try Percocet, maximum of two tablets in 24 hours.

R207's current care plan revised 3/6/18, revealed R207 had acute and chronic pain related arthritis, and incorrectly identified the location of pain as the left knee and incorrectly listed the recent left knee arthroscopy (versus right knee). The care plan revealed R207 received pain medication therapy. The care plan directed facility staff to monitor R207 for pain, administer analgesics, hot or cold therapy as tolerated and indicated R207 was able to verbalize pain to staff. The care plan identified R207's goal was to verbalize adequate relief of pain.

On 3/7/18, at 8:02 a.m. R207 was lying in bed on her back with a pillow under her right leg. She stated she recently had surgery on her right knee due to severe arthritis. R207 stated she had frequent pain of her right knee and indicated the pain felt like a burning ache that started at the top of her right knee and moved down her leg. She indicated her pain would often start when she moved her right leg around. R207 stated the medication would not last long enough and felt her pain was not managed with her current medications. She indicated she had spoken with facility nursing staff and had been told to speak to her orthopedic physician, which had not addressed her concerns. R207 indicated she felt angry and often times depressed when she felt pain. She stated her pain would wake her up approximately 5 out of 7 days a week. R207 stated at those times, she would be told she could not receive any pain medication until the

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F 697	Continued From page 160 morning. R207 stated as recently as last night she had requested pain medication at approximately 11:00 p.m. and did not receive any pain medication until 12:30 a..m.. She further stated her pain had reached a level of 9 before she had received any medication and felt she had been neglected by staff. R207 stated staff had not offered ice packs or warm packs to aid in pain management. R207 stated she received both PT and OT daily and indicated she did not always receive pain medication prior to therapy. She further indicated she had not been seen by her primary physician since she arrived at the facility on 2/20/18, and stated her primary physician was not in the area. Review of R207's PT evaluation and Plan of Treatment form dated 2/21/18, revealed R27 was receiving skilled physical therapy. The plan of treatment identified R207 had right knee pain due to a recent right total knee arthroplasty (TKA). The form revealed R207 had identified her pain as a sharp ache and limited her functional activities. The form indicated R207 received as need pain medications for pain and had rated the her right knee pain at an 8 out of 10 at rest and a 9 out of 10 with movement. The plan of treatment revealed a short term goal to have R207's pain average 7 out of 10 with activity. On 3/8/18, at 4:44 a.m. licensed practical nurse (LPN)-D stated she felt R207 was reliable and felt she would be able to appropriately verbalize if she was having pain. LPN-D stated she had observed R207 grimacing while she walked with a cane and indicated she felt R207 should have more pain coverage. LPN-D stated R207 would often wake at night and request pain medication for right knee pain. She further indicated she had not	F 697		

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offered R207 the use of ice or heat therapy.

On 3/8/18, at 5:14 a.m. LPN-B stated she felt R207 was reliable and indicated R207 had reported to her she had felt her pain was not managed. LPN-B stated R207 had two PRN pain medications and she often complained of pain at a level between 7-8 on a numeric scale. LPN-B indicated R207 would frequently awaken at night and walk to the nurse's station and would be grimacing in pain. LPN-B further indicated she would often use distraction until she could administer pain medications for R207. She stated she did not feel R207's pain was adequately managed and had encouraged R207 to speak to her physician. LPN-B stated she was unable to routinely administer pain medication prior to therapy for R207.

On 3/8/18, at 5:22 a.m. R207's call light was activated at that time, NA-I entered R207's room. R207 was lying in bed on her back, her brow was furrowed, jaw was tight and stated she had pain in her right knee. NA-I then left R207's room and reported R207's pain to LPN-B. At that time NA-I stated she felt R207 often had pain. She stated R207 had cried in the past from the pain in her right knee and stated she felt bad for her. NA-I stated she would encourage R207 to elevate her leg with a pillow and used to offer ice, but R207 no longer used ice packs.

On 3/8/18, at 8:21 a.m. R207 was seated in a chair in the dining room, with a cane propped against the table on her right side. She stated she had received pain medication promptly the night before, however, she had been told that morning at approximately 5:30 a.m., she could not receive any further pain medication at the time. R207

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would periodically rub her right knee with her right hand and would grimace. R207 stated she was not offered any non-pharmacological pain interventions such as ice or heat therapy, range of motion exercises or positioning changes. R207 further stated she felt the facility thought she was a "drug seeker" and indicated she felt like one when she asked for pain medication. She stated she wished she had better coverage and duration of pain relief with her current medication, so she did not have to ask staff.

On 3/8/18, at 8:35 a.m. R207 stood from her chair in the dining room, used a cane on her right hand when she stood, R207's brow furrowed and her lips tightened. She indicated she was going to walk to therapy. R207's right knee was stiff and her gait was shuffled, R207 did not bear full weight to her right lower extremity. R207 ambulated down the hallway to the therapy department. R207 sat on a chair in the therapy room and the director of physical therapy (PT)-A indicated it was R207's last day of therapy and proceeded to complete R207's discharge evaluation.

On 3/8/18, at 8:47 a.m. PT-A stated she felt R207 was a reliable source of information. PT-A stated R207 had continued to report pain to her in therapy and had hoped R207's pain would decrease with medicinal pain management. PT-A stated she had not met with nursing to discuss R207's pain management and felt R207 was able to verbalize her pain to facility nursing staff. She was aware R207 did not receive pain medications prior to therapy sessions, and indicated she had encouraged R207 to request pain medications prior to therapy.

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-At 8:58 a.m. R207 indicated her pain was an 8 out of 10 and she tightened her jaw when she stood from the chair when cued by PT-A. R207 stated she had never been asked what a tolerable level of pain was for her or what her pain goal was. She indicated a level of less than 5 would be tolerable for her.

On 3/8/18, at 9:27 a.m. during a follow up interview with PT-A she indicated she had recently discussed R207's complaints of pain with LPN-C. She indicated R207 often reported a high level of pain and stated she felt R207's non-verbal expressions did not match what R207 was verbally reporting. PT-A stated R207 had mental health issues and a history of addiction and indicated she was not sure how to manage R207's pain.

On 3/8/18, at 3:16 p.m. LPN-C stated she felt R207 was a reliable source of information and felt R207 did not fabricate stories. LPN-C stated R207 routinely complained of pain and she had encouraged R207 to talk to her orthopedic doctor. She stated R207's orthopedic doctor did not make any changes to R207's pain medications and further indicated R207 had not been seen by a practitioner since her arrival at the facility. LPN-C stated R207 had recently reported to her she had to wait over an hour and half for pain medications on the night shift. LPN-C stated she had not informed the director of nursing (DON) of R207's report.

Review of R207's Medication Administration Record (MAR) from 2/20/18, to 3/8/18, revealed the following:

- R207's February MAR revealed R207's pain

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level was documented each shift and identified R207 had reported pain 15 out of 26 times. The MAR revealed R207's pain rating was not documented 2 out of 26 times. The MAR identified R207 had received Tylenol 650 mg three times and had been effective two out of the three times. The MAR revealed R207 had received Percocet 11 out of 18 opportunities and R207 had rated her pain from 0-9 out of 10. The MAR further revealed R207 had received Tramadol 12 out of 24 opportunities and R207 had rated her pain from a 5-9 out of 10.

- R207's March MAR revealed R207's pain level was documented each shift and identified R207 had reported pain 9 out of 21 times. The MAR revealed R207's rating was not documented 3 out of 21 times. The MAR identified R207 had received Percocet 14 out of a a possible 20 times and Tramadol 10 out of 22 opportunities.

Review of R207's PT discharge summary dated 3/8/18, identified R207 had met her PT goal of reporting an average level of pain a 7 out of 10 with activity.

Review of R207's progress notes from 2/20/18, to 3/9/18, revealed the following:

- a note dated 2/20/18, revealed R207 was recently hospitalized with sepsis (severe, often fatal systemic blood infection usually caused by an untreated localized infection), pneumonia, cellulitis of right lower extremity, a recent right knee arthroscopy, osteoarthritis of the right knee. The note revealed R207 had a current incision to her right knee following a recent knee replacement on 2/12/18. The note further revealed R207 was to be followed by a facility

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F 697	Continued From page 165 rounding physician during her stay at the facility. The note listed R207 had a past medical history of various diagnoses which included longterm (current) use of opiate analgesic, history of methamphetamine addiction, and cellulitis of right lower extremity, status post right knee arthroscopy. - a note dated 2/21/18, revealed R207 had been in bed most of the day and had a pain medication once during the shift. The note lacked any characteristics of R207's pain, relief of pain or any non-pharmacological interventions offered to R207. -a note dated 2/22/18, revealed R207 was working with therapy, was independent with a walker and received PRN pain medications. A later note revealed R207 requested a PRN pain medication. The notes did not reveal any characteristics of R207's pain. -a note dated 2/23/18, revealed R207 was able to make her needs known, was receiving therapy and was independent in ADL's. -a note dated 2/26/18, revealed R207 remained independent with ADL's, received therapy and was on PRN pain medication. -a note dated 2/27/18, revealed R207 utilized PRN pain medications and continued to work with therapies. A later note revealed a nurse had been called to the therapy department due to R207's right knee was warm and tender to touch. The note indicated R207 was to be sent to the walk in clinic for an evaluation. The note did not reveal any characteristics of R207's pain, relief of pain or any non-pharmacological interventions offered	F 697		

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F 697	Continued From page 166 to R207 -a note dated 2/28/18, revealed R207 had received a PRN pain medication and R207 had requested to establish a routine schedule for pain medications. The note revealed R207 was instructed her pain medications were as needed and further instructed R207 to speak to her Orthopedic doctor during her follow up appointment. There was no further documentation of R207's Orthopedic doctors response. The note lacked any characteristics of R207's pain, relief of pain or any non-pharmacological interventions offered to R207. -a note dated 3/1/18, revealed R207's facility provided primary physician was contacted regarding her concerns with pain management. The note revealed an order was obtained to change the frequency of Percocet from every 12 hours to every 6 with a maximum of two doses daily. -a note dated 3/2/18, revealed R207 had requested pain medications once. The note lacked any characteristics of R207's pain, relief of pain or any non-pharmacological interventions offered to R207. -a note dated 3/4/18, revealed R207 had received pain medication twice. The note lacked any characteristics of R207's pain, relief of pain or any non-pharmacological interventions offered to R207. -a note dated 3/9/18, revealed R207 had reported ineffective pain management with her current regimen. The note further indicated R207's facility	F 697		

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F 697	Continued From page 167 appointed practitioner had been contacted and did not wish to make any changes. On 3/9/18, at 1:12 p.m. LPN-I stated she felt R207 was reliable and indicated she felt R207's pain was not well managed with her current medication regimen. LPN-I stated she had discussed R207's pain management with her in order to attempt to establish some type of routine to increase the duration of R207's pain relief. LPN-I stated she felt bad for R207 and indicated she had spoken with R207's primary physician's nurse practioner regarding R207's pain. LPN-I stated the nurse practioner decreased the amount of time R207 had to wait between doses of Percocet. She further indicated she felt R207 would benefit from a face to face visit with the practitioner. LPN-I indicated a face to face visit had not been scheduled for R207 and indicated R207 was to be discharged from the facility in the near future. On 3/9/18, at 3:58 p.m. R207 was ambulating down the hall towards her room with a cane in her right hand. R207 had tight lips, furrowed brow, she did not bear full weight on her right leg. On 3/12/18, at 9:17 a.m. R207's primary physician stated he was not aware of R207's continued complaints of pain. He stated he had not met with R207 since her admission to the facility and indicated he had been on vacation for the past couple weeks. He indicated he would expect the facility to contact R207's orthopedic surgeon first regarding her pain. He indicated if R207's orthopedic surgeon did not address her pain, then he would have expected to be notified. He further stated he would expect facility nursing staff to comprehensively assess R207's pain in	F 697		

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F 697	Continued From page 168 order to monitor for changes in pain, due to her history of infection. On 3/12/18, at 3:01 p.m. R207's medical record was reviewed with the DON. She confirmed R207's medical record lacked a comprehensive pain assessment and lacked monitoring of R207's pain. The DON confirmed R207's reports of ineffective pain management should have been reported to her primary physician and indicated R207 should have been seen by a physician for ongoing reports of pain. The DON confirmed R207's medical record lacked any documentation of non-pharmacological interventions attempted for pain. Review of an undated facility policy titled Pain Assessment and Management, revealed it was the purpose of the policy to help staff identify pain with residents and develop interventions that were consistent with the residents goals. The policy defined general guidelines which included defining pain management was a process of alleviating the residents pain to a level that was acceptable to the resident based on his or her clinical condition and established treatment goals. The policy identified the following steps of the procedure; recognizing pain, assessing pain, identifying cause of pain, defining goals and appropriate interventions, implementing pain management strategies, monitoring and modifying approached, documentation and reporting.	F 697		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the	F 744		4/23/18

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F 744	Continued From page 169	F 744		

appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review the facility failed to provide appropriate interventions for behaviors for person centered dementia care to 1 of 1 resident (R1) reviewed for falls.

Findings include:

R1's admission Minimum Data Set (MDS) dated 11/11/17, identified R1 had intact cognition, and had diagnoses which included Parkinson's disease, dementia, anxiety, weakness, restlessness and agitation. The MDS identified R1 required total assistance for eating, extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, and did not walk. The MDS further identified R1 had no behaivors, received a daily anti-psychotic medication, daily anti-depressant medication and had received a PRN anti-anxiety medication twice during the seven day look-back period.

R1's Care Area Assessment (CAA) dated 11/14/17, identified R1 was recently admitted from acute hospital after multiple falls and worsening of Parkinson's disease. R1 was alert and oriented and able to make needs known. The CAA indicated R1 received Seroquel (anti-psychotic medication), Ativan and Remeron (anti-depressant medication) for diagnoses which included depression, anxiety and dementia and R1 exhibited sedation, disturbances in balance, depression, was at risk for falls and injury.

This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.
1.It is the policy of the facility to provide treatment and services to residents with dementia. R1 was noted to have uncontrolled movements and had floor mats on floor so staff weren't concerned about R1 actions as they felt the floor mats for him to fall safely.
Documentations of care plan and care sheets did not indicate how to deal the cognitive changes resident had. Care plan was updated to ensure resident safety by mats only next to bed when resident in bed in low position, if resident becomes agitated staff sit with on 1:1 and offer walking with resident who is 1 person assist with ambulation. Resident also encouraged to participate in activities after breakfast which appeared to be most common time for episodes.
2.Because many residents have diagnosis of dementia, signs of cognitive impairments or intermittent confusion many are potentially affected by the cited deficiency, staff were reminded to ensure safe environments and necessary

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Review of R1's care plan printed on 3/8/18, last updated 3/6/18, identified R1 had impaired cognitive function related to dementia with behavioral disturbance. R1's care plan listed various interventions which included: administer medications as ordered, provide R1 with necessary cues-stop and return if agitated, cue, reorient and supervise as needed, monitor and document for physical/non-verbal indicators of discomfort or distress and follow up as needed. R1's care plan indicated R1 may get anxious and agitated with his lack of mobility and this increased anxiety, offer calm environment and redirect. R1 was likely frustrated with disease not intentionally aggressive with staff-therefore give extra time and understanding. However, the care plan lacked R1 physical behaivors, or what individualized interventions staff would try when refusing needed assistance for safety such as ambulating independently or refusing one to one assistance.

Review of untitled form, identified as the facility nursing assistant care sheet, updated 3/6/18, directed staff R1 required one to two staff assistance and gait belt for transfers, one to two staff for activities of daily living (ADL), at fall risk and R1 was alert with periods of confusion. However, the form lacked directions for behaviors.

On 3/8/18, at 8:42 a.m. R1 was seated on the foot end edge of his low bed with his arms flailing up
and down along side his body. R1 abruptly threw himself backwards onto the bed, and arms were moving up an down uncontrollably. Nursing assistant (NA)-I and trained medication aide (TMA)-A stood outside R1's doorway by the

F 744

interventions to redirect behaviors. SW reviewed importance of BIM score in conjunction with cares and interventions. All current residents with dementia reviewed and behaviors, appropriate interventions
No other residents were affected. The policy on dementia has been reviewed.
3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all staff received in-service training reminding staff of immediate 1:1 need for behaviors that could potentially lead to negative outcome. Staff were educated on assessment of dementia and behaviors, and appropriate interventions A fall analysis was completed and noted most falls between 8:30-10:00 am activities notified to actively engage resident after breakfast. Resident states often feel like he needs to do something. Also noted that his behaviors increase as do his tremors during this time. Formulating care by looking possible triggers that might indicate resident is uncomfortable or needing some stimulation.
4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor resident's dementia and risk for increasing behaviors and/or fall risk was completed. The director of nurses or designated quality-assurance representative will perform audits done weekly to monitor results on treatments and services to residents with dementia for 2 weeks then on 3 residents weekly for 4 weeks to ensure compliance. Any

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F 744	Continued From page 171 medication cart and did not enter R1's room or offer assistance. NA-I stated she had offered R1 a massage to help calm him and he refused. TMA-A stated she gave R1 an as needed Ativan (antianxiety medication) just prior. -At 8:49 a.m. R1 continued in the same position with the same uncontrollable movements. NA-A stopped charting, turned and looked into R1's room again. TMA-A pushed the medication cart past R1's room, looked into R1's room as she passed but, neither NA-A or TMA-A entered R1's room nor offer assistance. -At 8:51 a.m. R1 sat on the edge of mattress, leaned back with legs straight, with his feet flat on the floor, as his arms continued to move uncontrollably. NA-A left the wall kiosk, entered R1's room, briefly visualized him and immediately exited the room without offering or providing assistance and returned to wall kiosk. -At 8:52 a.m. R1 stood himself up, walked on top of the uneven fall mats, towards the wooden chair on the floor mats, turned and lost his balance. He reached out with both arms for the back of the wooden arm chair to steady himself, but fell onto the floor onto his right side holding onto the wooden chair. NA-A was immediately informed of R1's fall. NA-A walked to R1's doorway, looked in, stated R1 fell often and stated"that's why the mats are there." NA-A immediately walked back to the wall kiosk. R1 sat up and continued to have uncontrollable movements of upper arms as he rocked his trunk back and forth. R1 grabbed the wooden chair and tipped it back upright with jerky arm movements and and with an unsteady gait proceeded to stand up and walk over the uneven	F 744	deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.DON will be responsible for this POC.	

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fall mats to the foot end of his bed and sat down.

-At 8:57 a.m. R1 abruptly stood up from the chair, with uncontrolled arm movements, shuffled feet and an unsteady gait, walked on the uneven surface of the fall mats, then onto the floor to his closet. NA-I was informed R1 was standing independently. NA-I entered R1's room and asked if he was alright. R1 walked towards his bed, and threw himself onto his bed, bounced on the mattress, and ended up lying on his left side. NA-I walked out of R1's room and stated R1 did not like it if he thought she was watching him. NA-I then entered another resident's room.

During interview on 3/08/18, at 9:27 a.m. TMA-A stated she felt R1's involuntary movements did not have a set pattern, R1 would have a couple of tired days where he required assistance with everything. She stated some days R1's involuntary movements were worse than other days. TMA-A stated if R1's involuntary movements got really bad they would have a NA sit with him one on one. TMA-A stated when staff were to "one to one" (1:1) R1, there were not specific directions as to what specific things to do for him.

On 3/08/18, at 9:55 a.m. NA-L stated R1 was a fall risk and she was aware R1 had fallen a few times in the past. NA-L stated R1 had good days and bad (referring to his involuntary movements). She stated R1 had involuntary movements every 2-3 days, and stated she felt R1 got frustrated when staff tried to supervise him. She indicated if R1's movements were not "dangerously bad" then he would sit alone in his wheelchair, chair or bed in his room.

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On 3/08/18, at 11:00 a.m. LPN-I stated she felt R1's Parkinson's disease had been getting worse, and had experienced a lot of falls at home before he transferred to the facility. She stated R1 had "good days" and "bad days." She indicated on R1's "bad days" he had a lot of involuntary movements. LPN-I stated she felt R1 preferred to be by himself and would get angry if staff tried to assist him. She stated when R1 had involuntary movements staff try to get him to his room. LPN-I stated R1 utilized as
needed Ativan which was not always effective and used the fall mats because he would crawl out of bed.

On 3/8/18, at 12:25 p.m. director of nursing (DON) stated R1 had Parkinson's disease, so his fall risk was "really high." The DON stated she was aware R1 had involuntary movements sometimes once a week, and staff provided 1:1 supervision with R1. She stated she would expect the 1:1 supervision to start when R1's involuntary movements began and would expect staff being within arms reach of R1 so he did not fall and hurt himself.

Review of R1's progress notes from 11/1/17 to 3/8/18 revealed the following:

-11/1/17, admitted to facility with diagnoses which included Parkinson's disease, anxiety and dementia with behavioral disturbances, mood swings and history of falls.

-11/8/17, 12:25 a.m., heard a loud sound, found R1 on floor behind door thrashing around. No injury noted, 1:1 supervision initiated. 12:50 a.m., out of bed on floor again, 1:23 a.m., R1 became combative towards staff, 911 called, thrashing in

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F 744	Continued From page 174 bed, and sent to ER for evaluation. The note indicated a previous incident of thrashing the previous day with the same symptoms. -11/23/17, 3:00 a.m., heard loud sound from room, found on floor, sustained a small (sic) 1.5 centimeter (cm) cut on forehead, resident uncooperative, thrashing about with uncontrolled movements. Order received to transfer to hospital for evaluation. at 10:45 a.m. R1 returned to the facility with 4 sutures to area above eye. -11/29/17, 2:00 p.m., very frequent involuntary muscle movements this morning, attempted to self transfer multiple times to and from wheelchair to bed and/or other chairs around the facility. Almost fell 2 times but was successfully assisted by staff back to wheelchair without falls occurring. Education given regarding use of call light and waiting for assistance for transfers until muscle movements were less frequent. R1 verbalized understanding but did not follow through. -12/5/17, 4:50 a.m., exaggerated movement of extremities noted, bouncing off of bed onto padded floor, back to bouncing on bed, hitting body against padded walls. R1 sent to hospital for evaluation. The notes indicated R1 returned to facility at 10:00 a.m. with no new orders. -12/12/17, 9:13 a.m., very agitated this morning, self ambulating with front wheeled walker (FWW) while having frequent involuntary movements making it very unsafe, NA attempted to ambulate with R1, became very angry and started to bang FWW on the ground and attempting to strike staff. R1 sat down on his bed and was able to calm himself down., staff educated him on the staff's job to keep him safe and staff needed to	F 744		

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assist with ambulation when his is having frequent involuntary movements. R1 verbalized understanding.

-12/13/17, 10:33 a.m. R1 in room throwing stuff from one place to another, moved bed to another position, did not allow staff to go near him, left room and ran in hall as staff ran behind him with wheelchair and he fell on floor 3 times. No injuries or bruises noted.

-12/21/17, 5:30 a.m. extreme Parkinson shakes of large extremities, bouncing on matted floor and against padded wall, instructed NA to watch closely and keep R1 safe. At 12:38 p.m. frequent involuntary muscle movements, combative with staff, threw himself on bed and kicked staff. Redirection attempted but became more agitated, staff left room.

-12/29/17, 8:00 a.m. exited room, stumbled forward with chair hitting chest and fell to floor, chest x-ray ordered, negative for fracture.

-1/17/18, 9:47 a.m., ambulating per self with no assistive devices while having frequent, involuntary muscle moments. Staff attempted to assist to sit in wheelchair, became very agitated and swung self around and fell on buttocks, no injury noted. R1 educated on importance of not ambulating per self until muscle movements under control so he does not fall and hit his head.

-2/17/18, 12:40 p.m. agitated, moves his body here and there, unable to concentrate or focus on given direction, as needed anti-anxiety medication given, seemed helpful for an hour and resumed agitation again.

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-3/8/18, 2:18 p.m., reported to writer when R1 was in room he started to fall and staff caught him and lowered him to ground with butt touching floor first, R1 had been anxious this a.m. with lots of uncontrolled movements, received as needed anti-anxiety medication and 1:1 done .

On 3/9/18, at 8:43 a.m. registered nurse (RN)-A stated R1 was pleasant when he was and not when he is not. RN-A stated when R1 had involuntary movements secondary to his Parkinson's disease he would get frustrated at staff when they try and assist him. R1 will get mad and would hit out. RN-A stated when R1 started having bad days he would refuse any kind of assistance, we can sometimes get a gait belt around him when he was trying to self ambulate, but sometimes staff cannot because he gets physical.

On 03/09/18, at 12:03 p.m., during a phone interview nurse practitioner (NP)-A stated R1 had Parkinson's disease, gait disturbance and had "fairly significant Autism" and indicated she felt R1 had
Aspergers(brain development disorder that leads to problems with social skills, behavior, and coordination). She indicated R1 had a hard time verbalizing his needs and his interpersonal communication was difficult. NP-A indicated 1:1 could be helpful for R1, but it depended on the staff's approach with him. She indicated she felt needed to know how to interpret R1 and when to back off.

On 03/09/18, at 12:50 p.m. a group interview was conducted with the DON and regional director of clinical services (RDCS). They confirmed R1 had Parkinson's disease and Lewy Body dementia,

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F 744	Continued From page 177 however, denied R1 had a diagnosis of Autism. They verified R1's cognitive and mobility varied frequently, and felt this was consistent with his lewy body dementia diagnosis. A policy regarding dementia care was requested, however none were provided.	F 744		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to address behaviors impacting care and environmental concerns for 1 of 1 residents (R9) reviewed for behaviors impacting the resident environment. Findings include: R9's annual MDS dated 4/24/17, listed R9 was cognitively intact and had diagnoses which included dementia, bipolar disease and atrial fibrillation. The MDS indicated R9 had not been evaluated with a Level II PASRR, had no behaviors, and did not receive psychological therapy. This was the same as the previous assessment. R9's quarterly Minimum Data Set (MDS) dated 12/20/17, indicated R9 had diagnoses which included dementia, anxiety disorder and bipolar disease. The MDS indicated R9 was able to make independent decisions regarding tasks of	F 745	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide treatment and services to all residents and follow up on any recommendations sent upon admission on PASARR. One of the many ways that this has been achieved for resident # is by initiating the psych services, involving ombudsman and family in care. After survey noted level II PASARR had not been followed and did not mesh with level I PASARR a referral was made immediately to have resident seen for psych services. The determination was made by not following	4/23/18

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F 745	Continued From page 178 daily life. R9 did not exhibit any behavior, which was the same as the prior assessment and did not receive psychological therapy. Review of R9's Care Area Assessments (CAA) dated 5/1/17, revealed assessments regarding activities of daily living, urinary incontinence, nutritional status and dental care. However, R9's CAAs lacked assessment of mood, behavioral symptoms, psychosocial well-being or dementia. R9's care plan, revised 2/3/18, listed R9 had behaviors which included cursing or screaming at staff to leave the room and refusal of cares due to diagnoses of dementia, bipolar disorder and anxiety disorder. The care plan identified interventions which included helping R9 avoid situations or people that were upsetting, refer R9 to a psychologist/psychiatrist as needed, telling R9 what staff are going to do before staff began, cue/reorient/supervise as needed, must dine in dining room and avoid things that cause anxiety. Review of an untitled form, identified as the facility nursing assistant care sheet, indicated R9 was independent in activities of daily living and was alert and oriented. R9 refused cares and staff were to reapproach and chart, encourage to change clothes daily and report behaviors to nurse. Review of R9's Quarterly Interdisciplinary Resident Review dated 10/26/17, indicated R9 was verbally abusive, socially inappropriate/disruptive, and resisted cares. On 3/6/18, at 5:27 p.m., R9 was seated at a dining room table, alone. R9 had a very strong urine odor, with the odor noticed approximately 5	F 745	the PASARR appropriate care was also likely not followed as R9 has bipolar disorder and can become aggressive and anxious. Needs extra assistance to be able to do basic ADL's. Care plan and behavior assessment also updated 4/5/2018. 2.Because all residents must have a PASARR on admission all are potentially affected by the cited deficiency, a protocol has been developed to ensure no PASARR's are missed upon admission. All current residents were assessed with dementia and behaviors to develop other interventions to assist with appropriate cares. No other residents were affected. The policy on PASARR's has been updated. 3.To enhance currently compliant operations and under the direction of the SW, on 4/4/2018 a review was done with SW, admission, medical records, and MDS regarding PASARR's. Medical records will ensure the residents from North Dakota get a PASARR as they often are not done in the hospital. The SW will ensure all admissions have PASARR upon admission. The admissions director will ensure all admission packs are copied immediately and copy given to SW to save for 6 months to ensure all recommendations are in place based on level II PASARR's and the MDS coordinator in doing admission review will also ensure it is on file. All staff were educated on the need for social services need for monitoring and assisting with dementia and behavior needs. 4.Effective 4/4/2018, a quality-assurance	

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F 745 Continued From page 179

feet away. At 5:40 p.m., R9 was served his evening meal, quickly consumed the meal, returned to his room and laid on his back in bed.

On 3/7/18 at 2:44 p.m., R9 was observed walking the halls with a 4 wheeled walker, wearing clothes different than 3/7/18. However, R9 continued to have a noticeable urine odor.

On 3/7/18, at 3:26 p.m., R9's PASRR Level I was reviewed with the social worker (SW). The SW stated the PASRR Level I was completed on 4/14/16, and a Level II assessment was indicated due to mental illness of Bipolar I disorder, current episode depressed without psychosis. R9's Level II assessment was completed 4/25/16 with a recommendation for "Outpatient Psychiatry-It was recommended that he have a psychological test to clarify if he has dementia or not". The SW stated she was unaware if the recommendation was followed up on, or who follows up on and tracks PASRR recommendations.

On 3/7/18, at 3:39 p.m. the SW confirmed that the outpatient psychiatry referral was not completed for R9 and that the facility would be calling to set up an appointment soon.

Review of R9's psychiatry history and physical note dated 3/31/16, indicated R9 had a history of inpatient psychiatry for a severe depressive episode with psychosis. R9 was admitted to the psychiatric unit for violence toward staff when he had a disagreement with a nursing home aid and slapped her. R9 was currently not in a manic or depressive episode, however, R9's cognitive function was concerning as he confabulated during the interview. R9 would need a psychological test to clarify if he had a dementia

F 745

program was implemented under the supervision of the SW to monitor residents PASARR's on admission and review current residents. The SW will perform the following systematic audits on 3 residents with behavior and dementia weekly for 3 months to ensure appropriate services in place and on admissions to ensure admitted with PASSAR. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.SW, MDS, Admissions and Medical Records will be responsible for this POC.

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F 745	Continued From page 180 diagnosis. Review of R9's physician note dated 1/30/18, indicated R9 had a history of bipolar disorder and R9 was initially admitted secondary to violence related to the same and evaluated by mental health physician. R9 remained non-agitated, non-violent, and required a lot of cues to finish his activities of daily living. R9 had a history of depression with anxiety, but mood was stable. R9 was alert and not very cooperative during examination. R9's bipolar I disorder presently more stable, continue with nursing care and physical therapy. R9 was presently being followed by psychiatry. Review of R9's progress notes from 3/1/17, to 3/8/18, revealed the following: -3/1/17, at 12:10 p.m., R9 was noted to have on clean pants and shirt and was praised for it. R9 later changed back into usual soiled shirt again. When asked why he changed his clothes, he yelled and slammed the door to his room. R9 had aggressive posture and appeared to want to throw his shirt. R9 was reminded to be nice and responded to a calm, slow voice. -3/12/17, at 6:35 p.m. R9 refused bath. -5/5/17, at 3:36 p.m. R9 refused to be weighed and clothing change. -6/6/17, at 5:07 p.m. R9 complied with clothing change after much encouragement over the past week. -7/27/17, at 7:08 p.m. R9 got to his room that evening and noticed that his bedding was	F 745		

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F 745	Continued From page 181 changed and clothes were missing with room cleaned and organized. R9 got upset and began to curse and yell and slammed the door very violently. Later R9 came up to the licensed practical nurse (LPN) as if he was going to hit the LPN. R9 wanted to know who cleaned his room and who told them to do it. -9/5/17, at 10:11 a.m. R9 continued to refuse changing his clothes despite continued encouragement to do so. R9's response was "yep...we'll see" while walking away. -12/20/17, at 8:04 a.m. R9 was approached times three about completing cognition, mood and pain assessment. Resident continued to refuse. -1/14/18, at 2:55 p.m. R9 was noted to have urine covered back of shirt and pants. R9 refused to allow staff to assist him getting cleaned. -1/31/18, at 9:16 p.m. R9 refused bath. -2/18/18, at 9:03 a.m. R9 refused bath. -3/6/18, at 3:24 p.m. R9 refused shower offered by nursing times two. He yelled at nursing assistant when she attempted to change bedding and chased her out to his room. On 3/12/18, at 11:25 a.m. the environmental director (ED) and the facility administrator stated they were both aware of R9's room having a strong urine odor. Both the ED and administrator stated R9 was incontinent of bladder, refused his clothing to be laundered, and would hang up soiled clothes to dry in his room. Neither staff members knew if the facility had reached out to family or the ombudsman for assistance with this	F 745		

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F 745	Continued From page 182 concern. The administrator stated the previous administrator directed staff to go in and take R9's clothes to be laundered, which had upset R9. On 3/12/18, at 12:10 p.m. nursing assistant (NA)-I stated R9 did not like his room cleaned, so she waited until he left for lunch, then stripped the bed, wiped down mattress, and attempted to remove soiled clothing. NA-I stated while cleaning R9's room today, he returned while she was cleaning and he got upset, yelled at her, told her to leave and slammed the door. NA-I further stated that before she left R9's room, he grabbed a pair of soiled pants she was carrying and hung up the pants in his closet. On 3/12/18, at 12:19 p.m. during a follow up interview the SW stated she was aware of R9's room and personal odor, but unaware staff were entering R9's room and doing things without his permission. She stated she had attempted conversations with R9, but had been refused by R9. On 3/12/18, at 12:49 p.m. during a telephone interview family member (FM)-B verified the facility had not contacted him for assistance in helping with R9's room odor and refusal for clothes to be laundered. FM-B further stated, "It was awful the last time I was there [at the facility]." On 3/12/18, at 1:26 p.m. during follow up interview with SW, she confirmed no behavioral assessments had been completed for R9 and that R9 had not received psychiatric services while a resident of the facility. The SW stated she had attempted some other assessments for R9 and he had refused them as well. The SW stated	F 745		

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F 745	Continued From page 183 she was unaware of any behavioral assessments available to complete for R9, or if R9's physician was aware of R9's refusal of cares. She stated she had not attempted to reach out to the family or Ombudsman for assistance with behavioral interventions. The SW stated the facility is working on getting behavioral tracking set up so that data would be available for assessments. She stated the last administrator had been successful implementing interventions for R9's behaviors of not showering, changing his clothes and not getting hair cuts, but nothing had been successful since the last administrator left about two months ago. The SW stated she was hopeful the psychiatry evaluation would help the facility to be successful in getting R9 more compliant with cares. On 3/12/18, at 2:01 p.m. the director of nursing (DON) stated she was unaware of the facility process for PASRR, as the admissions nurse would handle it on admission. The DON stated the admission nurse was out today, but the admission and marketing director (AMD) was learning the role to take over and she would be able to answer that question. She stated she would expect the PASRR recommendation be followed up on. The DON stated R9 had no behavioral assessment that she was aware of, and R9's refusals of care was something the staff continued to work on. She stated the smell from R9's room was a "foul" urea smell and that staff encouraged him to be compliant and the facility might reach out to the family to see if they could assist with compliance. The DON stated the facility had to work on building a relationship with R9 to get a rapport with him to do his cares. She stated the old administrator had a good rapport with R9 and no one else has been successful.	F 745		

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F 745	Continued From page 184	F 745		

On 3/12/18, at 2:16 p.m. the AMD stated she was not aware of the current PASRR process and was still learning the role. AMD stated to talk with the health information manager (HIM).

On 3/12/18, at 2:19 p.m. HIM stated she was only responsible for the North Dakota PASRR and stated the SW would be the one to follow up on Minnesota PASRR Level I and II.

On 3/12/18, at 2:25 p.m. during a follow up interview the SW stated, tracking any PASRR Level I or II was "news to her". At 2:37 p.m. the SW stated from this point on she would be responsible for PASRR in Minnesota.

Review of the undated facility policy titled, The Behavioral Assessment, Intervention and Monitoring, included as part of the comprehensive assessment, staff would evaluate the resident's usual patterns of cognition, mood and behavior. Interventions and approaches would be based on detailed assessment of physical, psychological and behavioral symptoms and underlying causes, as well as potential situational and environmental reasons for the behavior.

Review of the undated facility policy titled, Pre-Admission Screening, indicated the policy was to provide all residents with the appropriate services available to them to reach their highest level of physical and psychosocial functioning. The policy indicated that the social service director would be informed if a potential resident meets level of care requirements and if a Level II screening was necessary.

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F 755	Continued From page 185	F 755		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain and provide physician ordered antifungal cream in a timely manner to 1	F 755	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission	4/23/18

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F 755	Continued From page 186 of 1 residents (R41) who developed a yeast infection which was left untreated as a result. In addition, the facility failed to ensure medications were given per manufacturer instructions for 1 of 1 residents (108) observed to receive K-Dur (a potassium supplement) during observations of medication pass in the facility. Findings include: ANTIFUNGAL CREAM: R41's quarterly Minimum Data Set (MDS) dated 2/5/18, identified R41 had intact cognition and no active infections. When interviewed on 3/6/18, at 2:23 p.m. R41 stated she felt staff ignored her. R41 indicated the week prior she had developed a yeast infection (a fungal infection on the skin or mucous membranes) which she felt had not been acted upon timely, despite R41 reporting it several times to the staff. R41 stated nothing still had been done to help her resolve it. R41's progress note(s) were reviewed and identified the following entries: On 3/2/18, R41 had complaints of having a UTI and a yeast infection. The note dictated, "MD [medical doctor] has been notified via fax. awaiting [sic] response." On 3/6/18, staff received a telephone order from the MD for Monistat vaginal suppositories [an antifungal] to be completed for seven (7) days. The note described, "EMAR updated and order faxed to pharmacy ... Nursing will start tomorrow morning at [8:00 a.m.] as well as continuing to	F 755	of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide pharmacy services timely and efficiently. R41 had yeast infection and after getting order from physician the pharmacy failed to send medication. In reviewing with pharmacy consultant, it was noted old policy was in place not to send over the counter medications as they would be supplied by other supply company and this cream was considered OTC so was not sent then on second call stated need prior authorization. R41 which facility did not receive. R108 had received her K pill by nurse and it was crushed – the medication is not allowed to be crushed and given. After survey noted these concerns immediately DON met with pharmacy to ensure all OTC meds would be sent when ordered or nurse would be notified immediately if there are questions and all medications to be labeled appropriately if unable to be crushed. 2.Because all residents receive their medications from our facility pharmacy and staff administer most of medications it has potential to affect all residents. A list of appropriate meds to crush has been added to med books on cart as well as on shared drive with a link to look up medications on. All staff dispensing meds will be reviewed to ensure proper medication procedures are enforced and medications ordered are available by next	

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F 755	Continued From page 187 monitor vaginal area until resolved." On 3/8/18, R41's medical record was reviewed and lacked any evidence this ordered treatment had been implemented. When interviewed on 3/8/18, at 1:15 p.m. licensed practical nurse (LPN)-I stated R41's Monistat was ordered by the physician on 3/6/18, however, the facility still had not received it from the pharmacy, and stated she was aware R41 was frustrated with the lack of timely care. LPN-I stated she had called the pharmacy just that day (3/8/18) and they reported to her they had never been notified it was needed as it was considered an over-the-counter medication, which the facility provides through another pharmacy source. LPN-I stated it was an "oversight" by the staff, and stated she had seen situations like this happen before. During interview on 3/8/18, at 1:39 p.m. the director of nursing (DON) stated she was unaware R41's medication still had not been obtained or implemented as "nobody reported that to me." The DON stated the staff should have ensured the medication was ordered, delivered and implemented timely so R41 did not have to "lay in bed with a yeast infection." When interviewed on 3/12/18, at 9:51 a.m. the dispensing pharmacist (DP) stated the facility had a different "preference" for obtaining their over-the-counter medications and used an outside source. DP stated if the nurses obtained an order for these medications they "need to call us" so it can be filled and delivered. DP stated he reviewed R41's record in their system and they had not been notified in any capacity of the need	F 755	shift. The policy on crushed meds has been updated along with pharmacy policy book provided at nursing station. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training on pharmacy expectations, follow up on omitted medications and appropriate meds to crush. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor resident medications and pharmacy follow up. The DON or designee will complete 2 audits per week x 4 weeks, then 1 audit weekly x2 months to ensure compliance with OTC delivery of medications timely and 3 med audits per week x 4 weeks then 1x 2 months. Including 3 med pass audits per week over next 3 months. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action. 5.Pharmacy and DON will be responsible for this POC.	

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for a Monistat prescription until 3/8/18, when called by a nurse. DP stated it was the facility's responsibility to obtain and provide the medications to their residents and if they had been notified on 3/6/18, the medication could have been delivered that same day. DP felt issues like these were "all about the communication."

A facility Medication Ordering and Receiving From Pharmacy policy dated 5/2012, identified each physician order should be written on a medication order form, in the resident's chart or on a transfer order form "... and transmitted to the pharmacy." Further, the policy gave procedures how to obtain emergency medications, however, lacked any direction or procedure to order and/or obtain over-the-counter prescriptions.

CRUSHED POTASSIUM:

R108's Diagnoses Report printed 3/12/18, indicated R108 had essential hypertension, congestive heart failure (CHF), and received both a diuretic (water reduction medication) and a potassium supplement which was documented in resident's current Order Summary Report.

During a medication pass observation on 3/07/18, at 8:20 a.m. licensed practical nurse (LPN)-J was observed dishing R108's potassium supplement (two 20 mEq tablets into a medication cup. LPN-B then crushed both tablets and placed them in chocolate pudding. When asked, LPN-J stated she crushed R108's potassium because she was unable to swallow them whole.

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F 755	Continued From page 189 R108's current Order Summary Report printed 3/12/18, physician orders included: Potassium Chloride Crystals - Give 40 milliequivalents (mEq) by mouth two times a day for low amount of potassium in blood, start date of 2/22/18. The order did not direct to crush the medication. Review of potassium manufacturer's instructions (via www.Drugs.Com) included: Take K-Dur with a full glass of water. Take the medicine with food or just after a meal. Do not crush, chew, or suck a K-Dur tablet. Sucking on the tablet will irritate your mouth or throat. During an interview on 3/12/18, at 1:06 p.m. the director of nursing (DON) stated supplements formulated the same as K-Dur should not be crushed, because it was extended release crystals. The DON stated staff should either be dissolving the tablets in water or ask R108's physician for a liquid potassium supplement. The Medication Therapy undated policy included: All medication orders will be supported by appropriate care processes and practices. The policy directed staff medications that need to be mixed with other medications or crushed need to have an order from MD (physician), and if residents unable to swallow meds (medications) safely or need in other format it will be discussed with physician.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5)	F 758		4/23/18

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F 758	Continued From page 190	F 758		

§483.45(e) Psychotropic Drugs.
§483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
(i) Anti-psychotic;
(ii) Anti-depressant;
(iii) Anti-anxiety; and
(iv) Hypnotic

Based on a comprehensive assessment of a resident, the facility must ensure that---

§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

§483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;

§483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and

§483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their

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F 758	Continued From page 191 rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure a resident was reassessed for continued use of an as needed (PRN) psychotropic medication, Ativan (anti-anxiety), beyond the allotted 14 days for 1 of 1 residents (R1) reviewed for falls. Findings include: R1's admission Minimum Data Set (MDS) dated 11/11/17, identified R1 had intact cognition, and had diagnoses which included Parkinson's disease, dementia, anxiety, weakness, restlessness and agitation. The MDS identified R1 required total assistance for eating, extensive assistance with bed mobility, transfers, dressing, toileting, personal hygiene, and did not walk. The MDS further identified R1 had no behaviors, received a daily anti-psychotic medication, daily anti-depressant medication and had received a PRN anti-anxiety medication twice during the seven day look-back period. R1's Care Area Assessment (CAA) dated 11/14/17, identified R1 was recently admitted from acute hospital after multiple falls and worsening of Parkinson's disease. R1 was alert and oriented and able to make needs known. The CAA indicated R1 received Seroquel	F 758	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to follow guidelines regarding use of PRN psychotropic medications. R1 has Lewy body dementia with anxious outbursts. Ativan was ordered PRN and has been utilized multiple days in consecutive months. On 4/5/2018 MD ordered scheduled Ativan and removed prn order as resident is determined to have anxiousness. Ativan order updated in the MAR staff aware to watch for adverse reactions and monitor target behaviors as stated in care plan. 2.Because many residents have orders for PRN psychotropics, many are potentially affected by the cited deficiency, staff were reminded to ensure safe environments and necessary interventions to redirect behaviors before utilizing medications if medications are needed	

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F 758	Continued From page 192 (anti-psychotic medication), Ativan and Remeron (anti-depressant medication) for diagnoses which included depression, anxiety and dementia and R1 exhibited sedation, disturbances in balance, depression, was at risk for falls and injury. Review of R1's care plan printed on 3/8/18, last updated 3/6/18, identified R1 utilized an anti-anxiety medication, and directed staff to monitor R1 every shift for safety due to the use of the anti-anxiety medication, which was associated with an increased risk of confusion, amnesia, loss of balance, and cognitive impairment which looked like dementia and increased risk of falls, broken hips and legs. The care plan directed to monitor for adverse reactions to the anti-anxiety medications which included clumsiness, slow reflexes, confusion, disorientation, dizziness, impaired thinking and judgement, aggression or impulsive behavior. R1's physician Orders Summary Report, signed 1/30/18, indicated R1 received Ativan 1.0 milligram (mg) by mouth every four hours as needed for anxiety with an ordered date of 12/29/17, and Ativan 1.0 mg inject intramuscularly (IM) every four hours as needed for anxiety related to Parkinson's disease with an order date of 12/29/17. However, R1's PRN Ativan orders lacked a stop date of 14 days after the order start date as required. Additionally, there had been no physician assessment for ongoing use of the PRN Ativan. Review of R1's electronic medication administration record from 3/1/18, to 3/12/18, indicated R1 had received PRN Ativan 6 times.	F 758	consistently MD to schedule if medications not utilized discontinued. This will occur every 14 days. All residents have been reviewed for current as needed psychotropic meds for appropriate use. No other residents were affected. The policy on PRN psychotropics has been reviewed and revised. 3.To enhance currently compliant operations and under the direction of the director of nurses, on 4/4/2018 all nursing staff received in-service training on utilizing PRN psychotropic medications that are ordered PRN for more than 14 days and the importance of physician doing visit to order continued use or schedule if needed consistently, indicating target behaviors noted in documentation, and non-pharmacological approaches. Psychotropic medications will be reviewed at quarterly and annual review to determine need, effectiveness or dose reduction. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the director of nurses to monitor residents with prn orders for psychotropic meds. The director of nurses or designated quality-assurance representative will perform the following systematic audits on residents with orders for prn psychotropics 5 residents per week x 4 weeks, then 3 residents weekly x2 months to ensure compliance in this area of PRN use. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for	

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F 758	Continued From page 193 Review of R1's progress notes from 1/12/18, to 3/8/18, revealed: R1 received PRN Ativan 31 times from 1/12/18 (14 days after PRN Ativan start date), to 3/8/18, without documented reassessment for appropriateness of R1's as needed anti-anxiety medication. Review of pharmacy recommendation signed by R1's physician on 12/18/17, indicated PRN anti-anxiety medication Ativan orders are to be written for no more than 14 days unless deemed necessary beyond that time. R1's physician responded with "stop after 14 days for reassessment". No further pharmacy recommendations were received from the facility. Review of physician note dated 1/30/18, indicated R1 had a history of depression with anxiety, had no depression or anxiety, mood was stable and no behaviors. Current medication list included Ativan 1 mg tablet and Ativan 2 mg per 1 milliliter injection. On 3/8/18, at 10:54 a.m. licensed practical nurse (LPN)-C stated she felt R1 could transfer and ambulate independently. R1 had fall mats on the floor and wall next to bed for safety. LPN-C stated if R1 was noted to have a lot of involuntary movement, he was administered the PRN Ativan and if the Ativan did not control the movements, a staff person would sit with him. On 3/8/18, at 11:00 a.m. LPN-I stated she felt R1's Parkinson's disease had been getting worse, and had experienced a lot of falls at home before he transferred to the facility. She stated R1 had "good days" and "bad days." She indicated on	F 758	further review or corrective action. 5.The Pharmacy, SW and DON will be responsible for this POC.	

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F 758	Continued From page 194 R1's "bad days" he had a lot of involuntary movements. LPN-I stated she felt R1 preferred to be by himself and would get angry if staff tried to assist him. She stated when R1 had involuntary movements staff try to get him to his room. LPN-I stated R1 utilized as needed Ativan which was not always effective and used the fall mats because he would crawl out of bed. On 3/13/18, at 2:07 p.m. director of nursing (DON) stated R1's medications were reviewed monthly by the consultant pharmacist and R1's provider on routine rounds. DON confirmed R1's order for PRN oral and IM Ativan was from 12/29/17 and was used for anxiety related to Parkinson's disease. The DON stated she was aware of the 14 day requirement for PRN psychotropic medication. A facility policy titled Medication Therapy, undated, indicated all decisions related to medications shall include appropriate elements of the care process including adequately detailed assessment and review of causes of symptoms. The policy indicated individual's current medication regimen would be reviewed to identify a clear indication for use, appropriate dose, frequency of administration and duration of use are appropriate and potential side effects present.	F 758		
F 803 SS=C	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national	F 803		4/23/18

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F 803	Continued From page 195 guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure menu items were prepared and served as written to the resident population. This had potential to affect all 57 residents residing in the facility who were identified to consume meals from the main production kitchen. Findings include: A provided Weekly Menu dated 3/4/18, to 3/10/18, identified a weeks' period of posted meals. The menu identified a dinner (evening) meal for 3/6/18, which was listed as baked tilapia (fish), wild rice, sliced zucchini, whole wheat breadstick, and banana split dessert.	F 803	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide meal service to all residents with an alternative option available. These menus will be posted in advance for resident's review. During survey noted that residents felt that often communication is lacking in serving what is posted.	

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F 803 Continued From page 196

During observation of the evening meal service on 3/6/18, at 5:19 p.m. cook (CK)-A removed a large pan of apple crisp from the oven and placed it on the counter. Immediately following, dietary aide (DA)-A began to scoop the crisp into smaller bowls. DA-A stated these were going to be served tonight for the dessert as the banana split dessert did not get made. At 5:38 p.m. CK-C began to remove foil from the covered metallic pans which had been placed on the steam table for service during the meal. CK-C exposed a pan of baked squash along with a separate pain which had whole wheat toast inside. CK-C stated they did not have any breadsticks to serve for the meal, and the supplier did not deliver any zucchini so they prepared squash instead. This meal was served to residents gathered in the dining room.

When interviewed on 3/6/18, at 6:19 p.m. CK-A read the posted menu and stated the meal was not served as it was supposed to be adding, "we have nothing up." CK-A indicated the food service supplier did not deliver zucchini as they were supposed to, so the cooks switched to squash. CK-A expressed frustration with some of the dietary staff as they did not consistently follow direction and one cook was always serving items which weren't supposed to be served. CK-A stated he asked dietary staff the previous evening to make the advertised banana split bars, however, the dietary staff did not make the banana split bars. CK-A stated, "They refuse to do what you ask them." CK-A explained if the menu was being changed it should be posted up on the front station so residents know it changed, however, this had not been done.

R29's quarterly Minimum Data Set (MDS) dated

F 803

2.Because all residents eat at the facility for at least 2 meals all are potentially affected by the cited deficiency. This was discussed with dietary manager and dietician and it is agreed that if meals are planned out there is ample time to get ingredients from vendor to ensure menus are followed. The dietary team will ensure if not available changes to menu will be posted to alert residents of changes. The policy on following a following menus was reviewed with department.
3.To enhance currently compliant operations and under the direction of the dietician and dietary manager, on 4/4/2018 all staff received in-service training for menus, meal choices, and options for residents.
4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the dietary manager to monitor menus and ensure what is posted is served. The dietary manager or designated quality-assurance representative will perform the following systematic audits 8 residents for 6 weeks to ensure menu is followed by asking residents if their meals were as requested. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.Dietary manager & Dietitian will be responsible for this POC.

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F 803	Continued From page 197 12/29/17, identified R29 had intact cognition. On 3/6/18, at 6:49 p.m. R29 stated the posted menu of food items was not being served "quite often." R29 stated having the menu changed was frustrating at times. On 3/8/18, at 12:58 p.m. a resident meeting was held with 11 residents in attendance. The food service was discussed including its presentation and appearance. The resident group expressed the meals being served were different than the posted menu adding the posted menu was rarely correct. When interviewed on 3/8/18, at 8:34 a.m. the corporate registered dietician (RD)-A stated the facility had been "kinda lacking" with ensuring all residents were aware of the posted menus and any changes being made. If the menu was changed, it should be posted "right away" so the residents are "aware of what's going on." A facility policy on menu service and food preparation was not provided.	F 803		
F 807 SS=D	Drinks Avail to Meet Needs/Prefs/Hydration CFR(s): 483.60(d)(6) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(6) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to honor and implement	F 807	This Plan of Correction constitutes my written allegation of compliance for the	4/23/18

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F 807

Continued From page 198

identified preferences of meal beverages for 1 of 1 residents (R41) who desired to drink less juice to help her lose weight.

Findings include:

R41's quarterly Minimum Data Set (MDS) dated 2/5/18, identified R41 had intact cognition and required set up assistance with eating.

During interview on 3/6/18, at 2:17 p.m. R41 stated she just wanted water during the lunch and dinner meal as she was trying to cut back on her calories, and indicated she was frustrated with it not being done and staff continuing to serve her juices and milk at meals. R41 showed the surveyor a menu slip from the lunch meal she had just been given a couple hours prior which identified her preference to only be served water for the lunch and dinner meal, however, R41 added, "they don't pay attention."

R41's undated, unlabeled white menu slip identified R41 consumed a regular diet and texture. A section labeled Special Notes directed, "Provide only water at L & D [lunch and dinner]."

R41's nutritional care plan dated 2/8/18, identified R41 to be morbidly obese "related to excessive calorie intake," and listed several goals including to have no significant weight changes or, "...gradual weight loss towards [ideal body weight]." The plan listed interventions to help R41 meet this goal including, "Obtain and update food/beverage preferences," and, "Provide resident beverages with all meals and meal passes."

During observation of the evening meal on

F 807

deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

1.It is the policy of the facility to provide meal service to all residents and serve items per resident choice. R41 stated wanted water with meals. During survey noted resident did not get water was often given juice which was not wanted. R41 stated staff don't read diet card and offer choices or give what is requested.

2.Because all residents eat at the facility for at least 2 meals all are potentially affected by the cited deficiency. This was discussed with dietary manager and dietician and it is agreed resident's preferences should be followed and indicated on meal ticket, as well staff should honor those choices. Diet slips have been updated to ensure properly list preferences of food and drink. Main menu and alternate menu will be listed, and staff will ensure they follow the slip to give residents the food or drink they choose. All residents have been interviewed to determine their preferences and diet slips have been updated.

3.To enhance currently compliant operations and under the direction of the dietician and dietary manager, on 4/4/2018 all staff received in-service training for menus, meal choices, and options for residents. All staff were in-serviced on diet choices, diet orders and importance of giving resident what

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3/6/18, at 6:13 p.m. R41 was delivered a room tray by nursing assistant (NA)-M. However, the tray only had a glass of milk on it; with no water provided. R41 stated with a abrupt tone, "Well there you are, no water, again!" No staff was observed to ask R41 about her choice or preference for beverages with the meal, despite her menu slip identifying she only desired water.

When interviewed on 3/6/18, at 6:26 p.m. NA-M explained the process for room tray delivery. The tray(s) were passed around, then staff go back after approximately 30 minutes and pick them up. A separate mobile cart followed the room trays with various beverages which were passed immediately following the trays. NA-M stated residents were given beverages from the cart and "get what is given" to them. NA-M was unaware how staff ensure choices for beverages are provided or honored using this process.

When interviewed on 3/8/18, at 3:27 p.m. corporate registered dietician (RD)-A stated the process being used to deliver beverages with room trays was "not the way it should go," and staff should be asking each resident for their choice of beverages with each meal. RD-A added "some education" may be needed as food choice was "probably one of the only things they [residents] have control over" while living in the nursing home.

A facility Resident Food Preferences policy dated 12/23/17, identified a direct interview would be completed with each resident for their meal preferences upon admission and these would be documented in the clinical record. Further, a resident "...should be offered choices and allowed to make their own decisions regarding meal

they are asking for not choosing for them. Reviewed respect and dignity with meals and personal choices vs mandatory choices.
4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the dietary manager to monitor menus and ensure what is posted is served. The dietary manager or designated quality-assurance representative will perform the following systematic audits of 8 residents reviewing resident preferences weekly for 6 weeks to ensure residents choices are being honored. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly quality-assurance committee meeting for further review or corrective action.
5.The ED, Dietitian, Dietary staff, and Nursing staff will be responsible for this POC.

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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 807	Continued From page 200 preferences if options are safe and follow their dietary guidelines."	F 807		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adaptive equipment to promote independence with drinking for 1 of 1 residents (R7) reviewed for nutrition and who expressed difficulty with drinking from a glass. Findings include: R7's quarterly Minimum Data Set (MDS) dated 12/18/17, identified R7 had intact cognition and was independent with eating after setup assistance. When interviewed on 3/6/18, at 2:03 p.m. R7 stated he was being served his juices at meals on a regular glass, however, wished he could use the mugs with handles he used to have as he was fearful of spilling it. R7 stated he had poor hand and finger dexterity and was "eventually going to spill one [beverages]." Further, R7 stated he had repeatedly asked for his mugs with handles back, however, nobody had followed up with him about it.	F 810	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.It is the policy of the facility to provide adaptive equipment to all residents in conjunction with OT to ensure resident remains as independent and high functioning as they can. R7 was noted to have a sippy cup on his diet card and appeared to have very difficult time drinking with regular cup due to shaking. However sippy cup was not available. Staff stated resident preferred regular cup, OT to evaluation for more appropriate cup and one resident agrees with. 2.Because all many residents need adaptive devices many are potentially affected by the cited deficiency. This was	4/23/18

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F 810	Continued From page 201 R7's Quarterly Nutrition Note dated 3/1/18, identified R7 required approximately 2010 milliliters (ml) of fluid a day to maintain good nutritional status. R7 uses " ... built-up silverware, a sippy cup and inner-lip plate to assist him in feeding himself." In addition, R7's nutritional care plan dated 11/8/17, identified R7 was at risk for dehydration and impaired nutrition related to his mobility and age. The plan listed several interventions to help meet his identified nutrition goals including having occupational therapy (OT) screen and provide adaptive equipment as needed along with, "Use ordered adaptive equipment: built-up silverware, blue inner-lip plate." The care plan lacked any identified need or intervention to use a cup with handles or "sippy cup." During observation of the breakfast meal service on 3/9/18, at 8:11 a.m. R7 was seated at a table in the main dining room in his wheelchair. At 8:16 a.m. dietary aide (DA)-A approached R7 and served him a regular 240 ml glass of apple juice and a cup of coffee filled with chocolate milk. R7 reached for the glass of apple juice and pulled it towards him on the table, then used both hands around the glass, picked it up and brought it to his lips. R7 was visibly shaky as he picked up the glass from the table despite using two hands around the regular glass. At 8:24 a.m. nursing assistant (NA)-K approached R7 with his breakfast meal and placed it on the table in front of him along with a white colored slip of paper. The slip of paper identified R7's name along with his current diet. Further, the slip identified a section labeled, "Adaptive Equipment," which included, "Sippy Cup." At 8:28 a.m. R7 again picked up the regular glass of apple juice using both hands to hold it while he brought it to his	F 810	discussed with dietary manager and dietician and it is agreed the diet slip will be updated when appropriate cup is determined and in meantime staff to encourage sippy cup if R7 does not agree offer cup and fill half way, refill as needed. All staff update at in-service 4/4/2018 about adaptive equipment and importance of offering it or alerting charge nurse if further follow up is needed to find another option. All residents with adaptive devices have been reviewed for use and appropriateness. No other residents were affected. 3.To enhance currently compliant operations and under the direction of the director of nursing, on 4/4/2018 all staff received in-service training for adaptive equipment. Reviewed respect and dignity with and importance of giving residents the tools they need to be successful in their ADL's. 4.Effective 4/4/2018, a quality-assurance program was implemented under the supervision of the dietary manager to monitor menus and ensure what is posted is served. The dietary manager or designated quality-assurance representative will perform the following systematic changes: the dietary manager or OT will complete residents with adaptive devices or needing devices 2 audits 3x per week x 4 weeks, then 2 audits 2x week x 4 weeks then weekly x2 months to ensure compliance in this area. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly	

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F 810	Continued From page 202	F 810		

mouth, visibly shaky as he lifted it from the table. R7 consumed 100% of the provided juice without spilling it.

When interviewed on 3/9/18, at 8:45 a.m. NA-K stated R7 used to use a sippy cup for his beverages, however, NA-K thought this was stopped. NA-K stated the kitchen struggled to be "updated" with information at times and stated " they don't update those tickets [white slip]." NA-K observed R7's white menu slip on the table and verified it directed to use a sippy cup at meals, however, felt it wasn't an issue because he "never complained."

When interviewed on 3/9/18, at 8:50 a.m. DA-A stated R7 used a "regular glass" for his meals, not a sippy cup despite his menu slip directing to do so. DA-A stated she would check with the cook to make sure. At 8:53 a.m. cook (CK)-B stated staff should be serving his juices to him using a sippy cup as he struggled and was "not capable of using the regular cups" consistently. CK-B added she had witnessed R7 to shake and struggle with drinking before.

During interview on 3/9/18, at 9:01 a.m. licensed practical nurse (LPN)-I stated she had observed R7 have "some difficulty" with drinking fluids adding R7 was not someone who would verbalize if he needed help, despite maybe needing it sometimes. LPN-I stated a resident using adaptive equipment would have it listed on the "meal card [white slip]" and staff should be using the items which are listed. LPN-I stated the staff maybe required some "education" on using adaptive equipment, and added it was important to use those things for residents who need them so they can be "as independent as they can be."

Plan of correction (F 810):

quality-assurance committee meeting for further review or corrective action.
5.All staff will be responsible for this POC.

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F 810	Continued From page 203 When interviewed on 3/12/18, at 9:02 a.m. the director of nursing (DON) stated she was aware R7 had used sippy cups in the past and to her knowledge they had not been discontinued. DON added, "he needs to be served them," to be able to feed himself. A facility policy on use of adaptive equipment at meal(s) was requested, however, none was provided.	F 810		
F 812 SS=K	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unpasteurized shell eggs were fully cooked and prepared in a	F 812	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission	4/23/18

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F 812 Continued From page 204

manner to prevent foodborne illness with potential Salmonella poisoning (a bacterial infection which can cause diarrhea, fever and abdominal cramps and can lead to hospitalization or death). This resulted in an immediate jeopardy (IJ) situation for 2 of 2 residents (R25, R35) identified to consume unpasteurized, fried eggs on a routine basis; and for 27 of 27 additional residents (R22, R7, R26, R108, R38, R37, R9, R45, R5, R44, R28, R42, R27, R55, R114, R56, R10, R29, R4, R208, R14, R209, R12, R20, R25, R52, R30) identified by the facility to consume the unpasteurized, fried or undercooked eggs and who were at increased risk of contracting a potentially life-threatening Salmonella infection as a result.

The IJ began on 10/10/17, when the facility began to receive, prepare and serve unpasteurized shell eggs on a made-to-order basis which included having a runny yolk which was not fully cooked resulting in an increased potential for foodborne illness. On 3/8/18, at 12:38 p.m. the corporate registered dietician (RD)-A and Vice President of Clinical Reimbursement were notified of the IJ. The IJ was removed on 3/9/18, at 1:38 p.m., however, non-compliance remained at the lower scope and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E).

In addition, the facility failed to ensure meal items and re-heated food was prepared and served hot enough to reduce or prevent foodborne illness for 7 of 7 residents identified to consume a reheated meal. Further, the facility failed to ensure cleaned dishes were allowed to air dry and not stacked away for re-use while wet; and ensure 1 of 1 production mixers were kept in a clean and

F 812

of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.

1.It is the policy of this facility to ensure healthy and safe meal service. Some of the many ways that this has been done is ensuring fresh food, properly cooked food, and making sure there are no signs or symptoms of gastroenteritis or salmonella. After the surveyor reported finding non-pasteurized eggs in kitchen and learning 2-3 residents ate eggs lightly cooked the were non-pasteurized and eggs were immediately removed, and pasteurized ones ordered; residents were reviewed for any signs or symptom of illness. It also ensures food temps are safe, kitchen equipment is clean and dishes are dried appropriately to reduce infection.

2.Because all residents receive their meals here in facility all are potentially affected by the cited deficiency, 3/8/2018, the director of dietary reviewed which eggs were ordered, and which residents preferred sunny side up or over easy. All orders now only contain pasteurized shell eggs. Vendor was notified, and order changed within their system to only supply shell eggs that are pasteurized. Dietary and nursing staff aware of current policy for eggs, food temps, kitchen equipment, dish drying protocols.

3.To enhance currently compliant operations and under the direction of the director of dietary, on 3/8/2018, all dietary

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F 812	Continued From page 205 sanitary manner to reduce the risk of contamination and associated foodborne illness. These practices had potential to affect 57 of 57 residents identified to receive food and/or meals prepared and served by the main production kitchen. Findings include: UNPASTEURIZED EGGS: A United States (US) Food and Drug Administration (FDA) Egg Safety: What You Need To Know feature dated January 2016, identified fresh eggs may contain bacteria called, "Salmonella," with an estimated 79,000 case(s) and 30 deaths from associated foodborne illness being reported each year from eating these contaminated eggs. The feature explained certain group(s) of people were at higher risk of having "severe illness," as a result of contracting Salmonella and listed these people to be, " ... children, older adults, pregnant women, and people with weakened immune systems (such as transplant patients and individuals with HIV/AIDS, cancer, and diabetes)." There were several steps listed to help reduce and/or eliminate the risk of Salmonella including, "Cook eggs until both the yolk and the white are firm. Scrambled eggs should not be runny." In addition, a Centers for Disease Control and Prevention (CDC) Feature dated 5/24/17, identified the inside of shell eggs which appear normal may contain the bacteria Salmonella which, " ... can make you sick, especially if you eat raw or lightly cooked eggs." The article listed several steps which could reduce this risk including, "Consider buying and using pasteurized	F 812	staff that cook will receive in-service training regarding state and federal requirements for safe egg handling and cooking. The training will emphasize cooking eggs safely and using pasteurized eggs for serving. 4.Effective 3/8/2018, a quality-assurance program was implemented under the supervision of the director of dietary to monitor cooking of eggs. The director of dietary or designated quality-assurance representative will perform the following systematic changes: randomly checking, or weekly checking residents who prefer eggs not fully cooked. Any deficiencies will be corrected on the spot, and the findings of the quality-assurance checks will be documented and submitted at the monthly QAPI meeting for further review or corrective action. 4/4/2018 all staff meeting reviewed food temps, pasteurized eggs and made to order changes, drying dishes to air and cleanliness of kitchen equipment. 5.Audits of kitchen eggs, equipment, food temps and kitchen cleanliness are being done 3x per week for 4 weeks then 1x per week for 2 months to ensure compliance via dietary manager or designee. 6.Dietary Manager and Dietitian are responsible for this POC.	

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F 812	Continued From page 206 eggs and egg products, which are widely available," and, "Cook eggs until both the yolk and white are firm." Further, the article identified Salmonella infections, "can be serious and is more dangerous for certain people," which included older adults and people with weakened immune systems dictating these affected people, " ... may get a more serious illness that can even be life-threatening." On 3/6/18, at 12:32 p.m. an initial tour of the main production kitchen was completed with cook (CK)-A. The kitchen had a single walk-in refrigerator in use which was opened and inspected. This revealed two separate cardboard boxes with additional flats of eggs placed on top of them. There were several open holes in these flats, along with some additional broken and replaced empty egg shells placed inside. The boxes were labeled as "Grade AA Shell Eggs," and neither of the boxes, nor the broken shell(s) or visible eggs placed on top or inside had visible markings or any evidence present to identify they had been pasteurized (a process used to reduce the risk of food-borne illness in items that are not cooked or are only lightly cooked; typically done with shell eggs and marked with a visible stamping on the eggs). CK-A stated these eggs were used on a "near daily basis" to make made-to-order "fried eggs." CK-A explained the staff prepare and serve "a lot of eggs," during the week for the breakfast and lunch meals. During observation of the morning meal service on 3/8/18, at 7:25 a.m. CK-B was in the kitchen making scrambled eggs on the griddle stove-top using a pasteurized, liquid egg mix. In the trash can next to the griddle top, there were several visible broken egg shells. None of these shells	F 812		

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F 812	Continued From page 207 had visible markings to demonstrate they had been pasteurized. CK-B was questioned about the egg shells in the trash and stated she made "over easy" eggs with them describing the made-to-order eggs as, "like over easy fried." CK-B explained she made these eggs using the shell eggs stored in the walk-in refrigerator, and showed the surveyor the same boxes and flats of unpasteurized shell eggs observed on 3/6/18, adding she prepared and then placed these fried eggs on the steam table out in the dining room for service during the morning meal. At 7:48 a.m. CK-B removed the lids from the serving pans contained in the steam table and stated she was ready to begin the meal service. There were several fried eggs contained in a single container on the steam table, and CK-B verified all the food visible on the steam table was ready and able to be served to the residents gathered in the dining room. The surveyor requested her to obtain a temperature reading of the fried eggs. CK-B inserted a thermometer into the stacked fried eggs and stated they were 120 degrees (F) now, however, explained they had been 145 degrees when she checked them before placing them in the steam table prior to 7:25 a.m.. The eggs had visible yellow yolk run out of the egg when the thermometer spike was removed. RD-A, who was present at the steam table when the egg temperatures were checked, stated the eggs should be warmed up in the oven to ensure they are cooked and hot enough to be served. RD-A immediately removed the eggs from service, removed them from the steam table and returned the eggs into the kitchen. Immediately following, CK-B stated fried and undercooked eggs are served "by request"	F 812		

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F 812	Continued From page 208 routinely unless they were listed on the menu for the meal service (every Tuesday). CK-B stated the cooks serve "about sixty" fried and/or undercooked eggs when they were listed on the menu. When questioned about using unpasteurized eggs for made-to-order cooking, CK-B was unaware the shell eggs being used were unpasteurized, further adding CK-A was responsible to order all food items from the vendors. RD-A observed the eggs, which were removed from the steam table just prior, with the surveyor in the kitchen and verified the eggs were undercooked with a visibly runny yolk. RD-A explained made-to-order eggs, including "sunny side up" and "over easy", were frequently prepared for residents to consume, however, she thought the facility only used pasteurized eggs when making them. RD-A proceeded to visualize the supply of shell eggs in the facility's walk-in refrigerator and verified the eggs being used to cook made-to-order eggs were unpasteurized. The prepared eggs removed from the steam table were disposed of by the RD-A at that time. RD-A indicated she was unaware how long the unpasteurized eggs had been in use nor how the unpasteurized eggs had even been obtained as the facility was only supposed to using pasteurized eggs when preparing fried or undercooked eggs. A four (4) week menu rotation dated 2/11/18 through 3/10/18, was provided by the facility. These menus identified each day of the week (Sunday - Saturday) along with each of the three separate meals being provided on each day. On every Tuesday, for the first meal of the day, "Fried Egg," was listed as being offered and/or served.	F 812		

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F 812	Continued From page 209	F 812		

On 3/8/18, at 8:16 a.m. during a follow up interview with RD-A, she stated nearly all the residents of the facility were served fried eggs when it was listed on the menu (every Tuesday), in addition other residents were served them "if they request it," on other days. RD-A verified there were no pasteurized eggs in the facility which could have been used to make undercooked or made-to-order fried eggs. RD-A expressed using unpasteurized eggs for undercooked, made-to-order service was "not good," because people who are elderly or have compromised health were "more at risk of getting sick" with Salmonella poisoning. She stated a call had been placed to the food service vendor and informed them they could no longer send unpasteurized eggs to the facility. RD-A stated she "would assume" the unpasteurized eggs had just been delivered within the past week as two cases of eggs had just come in "last Thursday." Further, RD-A stated CK-A had been in charge or managing the kitchen, however, was no longer with the facility so there was nobody else employed in their dietary department who was FoodSafe certified.

The past four (4) weeks of temperature records were requested for the meal services, and RD-A provided the following HACCP Recording Charts which contained the recorded temperatures of food items served for each meal. These were dated and identified the following:

- On 3/6/18, fried eggs were written as being served for breakfast with a recorded temperature of 168 degrees.

- On 2/27/18, the chart identified "Egg" was

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F 812	Continued From page 210	F 812		

served for breakfast, however, did not specify if these were scrambled eggs, fried eggs, or another cooked egg dish. The recorded temperature was 165 degrees.

- On 2/20/18, fried eggs were served for breakfast with a recorded temperature of 155 degrees.

- On 2/13/18, fried eggs were served for breakfast with a recorded temperature of 182 degrees.

No other days in the four week period were provided to demonstrate what items had been prepared, cooked and temperature checked for the resident population despite it being identified by CK-A and RD-A the facility routinely made fried, undercooked eggs for residents on a weekly and "by request" basis. No further documentation was provided to determine if or when "by request" fried eggs had been served or if they had been checked for proper serving temperature.

A listing of residents who routinely consumed the fried, made-to-order eggs was requested. The facility provided an undated List of Resident at High Risk for Salmonella which identified a total of 27 current residents (R22, R7, R26, R108, R38, R37, R9, R45, R5, R44, R28, R42, R27, R55, R114, R56, R10, R29, R4, R208, R14, R209, R12, R20, R25, R52, R30) as being at higher risk for a potential Salmonella bacterial infection and consuming the eggs. This listing identified residents over 65 years of age, along with an additional 8 residents having either diabetes mellitus (diseases resulting in higher than normal blood sugar levels), HIV (human immunodeficiency virus; causes AIDS and

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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 812	Continued From page 211 interferes with the body's ability to fight infections) and/or to be receiving chemotherapy (cancer treatment drugs which can weaken the body's immune system). Further, the listing identified a section labeled, "Resident that will request Fried Eggs 2 - 3 x [times] per week," with R25 and R35 being identified under this heading. R25's quarterly Minimum Data Set (MDS) dated 1/10/18, identified R25 had diagnosis of diabetes mellitus and had intact cognition. During interview on 3/8/18, at 11:13 a.m. R25 stated he was provided and consumed fried eggs a "couple times a week." These eggs were typically served "sunny side up [fried on just one side and never flipped with the yolk being completely liquid and the whites on the surface being barely set]" and the yolk was liquid and runny when consumed. R25 explained he sees "a lot," of other residents eating these, too, when they were served by the kitchen. R35's annual MDS dated 1/31/18, identified R35 had moderate cognitive impairment. During interview on 3/8/18, at 11:19 a.m. R35 stated he had been served fried eggs with a "runny" yolk from the kitchen in the past couple weeks. R35 described these eggs as being served "over easy [fried on both sides so the egg whites are firm while the yolk remains runny]." R7's quarterly MDS dated 12/18/17, identified R7 had intact cognition. During interview on 3/6/18, at 1:51 p.m. R7 voiced he desired more choices with his meals at the nursing home. R7 explained he saw another resident ask for "sunny side up" eggs the week prior and was served sunny side up eggs. R7 stated the eggs were "like runny," when the other resident consumed them.	F 812		

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	245052	A. BUILDING ______ B. WING ______	03/13/2018

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F 812 Continued From page 212 F 812

When interviewed on 3/8/18, at 8:41 a.m. registered nurse regional director of clinical services (DCS)-A stated the administrator was off-campus and not available for interview. When questioned about using unpasteurized eggs for made-to-order service, DCS-A stated she would "go with the old school theory" and provided an example of people eating "fresh" eggs from the farm and having less infections and illness. DCS-A explained she did not feel the facility had any higher risk population for potential foodborne illness when consuming undercooked eggs than anywhere else adding there was "very little potential risk," from consuming the undercooked eggs as if someone was "used to that," they would likely not become ill. Further, DCS-A stated RD-A was the acting kitchen manager and in charge of the "oversight of what's happening in there."

A facility provided Sysco (food supply vendor) invoice dated 8/29/17, identified the facility received pasteurized egg shells. On 10/10/17, a different food vendor company, Reinhart, was used and delivered the ordered items for the kitchen. These invoices, dated 10/10/17 to 3/2/18 (most recent delivery), identified the facility began receiving unpasteurized egg shells on 10/10/17, and continued to present day. A total of 23 cases (each with 15 dozen) of unpasteurized eggs were delivered over 21 separate deliveries during these weeks.

During subsequent interview on 3/12/18, at 9:12 a.m. RD-A stated the facility was currently using Reinhart as their main food vendor; switching from Sysco in October 2017. The invoices from both vendors were reviewed, and RD-A verified

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F 812	Continued From page 213 the unpasteurized shell eggs started being delivered in October 2017, when the facility switched vendors. RD-A explained a cook was in charge of ordering the food items, however, all ordered items should have been reviewed by the (previous) RD to make sure the items were correct and within budget. RD-A expressed any unpasteurized eggs being prepared undercooked should be "155 [degrees] at least," when being served as this was "per regulation" and food code. Further, RD-A reiterated serving unpasteurized eggs which were prepared undercooked or with runny yolk(s) was not acceptable as the elderly population and people with compromised immune systems or disease processes were "so vulnerable" to a potential bacterial infection and associated illness. A facility Safe Egg Handling policy dated 12/23/17, identified the dietary service "...must follow safe handling of eggs, as recommended by the FDA and American Egg Board to avoid the spread of salmonella and other potential foodborne illnesses." The director of dietary or designee was responsible to ensure eggs were properly received, stored and cooked prior to being served. Further, it was "...preferred to use pasteurized shell eggs per stated by FDA due to concerns of Salmonella Enteritidis [SE] for residents at risk," and dictated, if used, all raw egg shells "...must be cooked to 155 [degrees F] - with whites solid and yoke firm." Although, the risk for Salmonella infection is relatively small statistically speaking, elderly patients and people with compromised immune systems or disease processes have a higher risk and are more likely to experience a severe illness from an acquired Salmonella bacterial infection.	F 812		

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F 812	Continued From page 214	F 812		

This unnecessary risk resulted in a need for immediate correction as it had a high potential for serious harm, injury or death should any infection be acquired from eating the unpasteurized, fried eggs which were prepared undercooked and consumed.

The IJ which began on 10/10/17, was removed on 3/9/18, at 1:38 p.m. when the facility implemented a removal plan which included:

- Removing the unpasteurized eggs from made-to-order service and ordering new, pasteurized eggs to use when preparing undercooked, fried eggs;

- Providing education to the dietary and nursing staff regarding State and Federal requirements for safe egg handling and preparation and;

- Implementing audits to ensure the correct eggs are being ordered, delivered and prepared.

On 3/9/18, from 12:51 p.m. to 1:06 p.m. direct dietary and nursing staff were interviewed and verified they had received education regarding the safe preparation of made-to-order, undercooked eggs; and the kitchen was toured to ensure no unpasteurized eggs were available to use for made-to-order cooking.

NOT CHECKING FOOD TEMPERATURE:

On 3/6/18, at 12:32 p.m. an initial kitchen tour was completed with cook (CK)-A. A steam table was in use outside the kitchen, and adjacent to this was a mobile cart with several metallic serving plans placed on top. These pan(s)

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F 812	Continued From page 215 contained various items, identified by CK-A as from the lunch meal including mashed potatoes, brown gravy, rice and hamburger patties. During observation of the evening meal service on 3/6/18, at 5:19 p.m. CK-C prepared food in the main production kitchen including baked fish, mashed potatoes with gravy, baked squash and toast. A single Seco steam table was plugged into the wall in the dining room, just outside the kitchen. CK-A loaded the steam table with various sized, covered, metallic containers of the prepared items. The foil covering(s) did not have any visible holes or marks to identify the food items inside the containers had been checked for proper serving temperature prior to placing them inside the steam table. CK-A removed the foil covering(s) and began to plate food for the residents. There was no observed food temperatures obtained prior to the service of the meal. When questioned about checking the temperature of the food items, CK-C stated she checked them at "4 pm" when she removed them from the oven and covered them with aluminum foil adding she was "a little busy" and just "didn't write them down" on the flowsheet. CK-C recited the temperatures of each item aloud stating the baked fish was 180 degrees (F) when removed, the squash was 175 F and the toast was 120 F. Further, inside the steam table were containers containing hamburger patties, mashed potatoes with gravy, and rice just as was observed during the end of the lunch meal service at 12:32 p.m.. When questioned about using these items for the evening meal service, CK-C stated these were the same food items used at the lunch meal	F 812		

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F 812	Continued From page 216 earlier, she just had reheated them. However, CK-C was unaware how hot these items had reached in the oven before she placed them in the steam table for service as she did not check the temperature of them. CK-C stated she served about seven (7) people these items during the service and verified they should have been checked for temperature prior to serving. An HACCP Recording Chart dated 3/6/18, was provided and reviewed. The flowsheet provided spacing to record each meals' dishes served along with a cooking and service temperature. However, under the heading of "Supper:" was left blank with no food items or temperatures being recorded for either a cooking temperature or service temperature. When interviewed on 3/6/18, at 6:19 p.m. CK-A stated the served food items should have been checked for proper temperature just prior to placing it on the steam table for service. However, the evening shift staff do not listen to his direction adding they will sometimes serve meals even if the temperature(s) of the food items are too low. CK-A added he asked CK-C "four times" to check it and record the temperatures that evening before the meal service began. During interview on 3/8/18, at 8:28 a.m. the corporate registered dietician (RD)-A stated kitchen staff should be checking the temperature "right before they put [the food items] in the steam table," so they have an opportunity to re-heat the items should the food items be too cool. She stated the staff should ensure a correct serving temperature to reduce the risk of foodborne illness. Further, RD-A stated the staff	F 812		

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F 812	Continued From page 217	F 812		

should not be re-using food items from the previous meals and should be "making new product," for each service.

A facility policy on food temperature(s) and associated monitoring was not provided.

WET DISHES:

On 3/6/18, at 12:32 p.m. an initial kitchen tour was completed with cook (CK)-A. A single metallic, free standing cabinet was opened which contained several stacks of metallic serving pans. A stack of four (4) "2/8ths" pans had visible water droplets inside and stuck together when attempted to be separated. In addition, two stacked "six inch" pans also contained visible water droplets inside. These pans dripped water from the bottom when they were removed from the cabinet and physically separated.

When interviewed immediately following, CK-A stated the pans should have been left on the rack to air dry before being put away in the shelving unit, however, the staff were "in a hurry" and just put them away, instead.

During interview on 3/8/18, at 8:28 a.m. the corporate registered dietician (RD)-A stated there were some concerns with "good follow up" in the kitchen amongst the staff at times, and the dishes should have been allowed to air dry before being stacked and put away for use. RD-A explained this should be done to reduce the chance of bacterial growth in the wet, stacked dishes.

A facility Kitchen Sanitation policy dated 12/23/17, identified staff "will ensure all pots, pans utensils [sic] and other items are air dried prior to use."

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F 812	Continued From page 218	F 812		

SOILED MIXER:

An undated Univex Operators Manual identified a section labeled, "Cleaning Your Mixer," and directed to wash the body of the mixer, the bowl support and the beater shaft with warm water and mild soap. Further, "Wash the bowl and beater immediately after use."

On 3/6/18, at 12:32 p.m. an initial kitchen tour was completed with cook (CK)-A. A single, uncovered Univex commercial mixer was positioned along the wall with a large mixing bowl attached at the base of the machine. Inside the bowel, a large wire whip was placed inside and detached from the mixer shaft. The mixer shaft (point where the whip attached to the machine) had several chunks and small, visible, white colored speckling of debris present. Further, the face of the mixing machine and inside of the mixing bowl contained the same crusted, white colored substance and chunks. CK-A observed this and stated nobody from the kitchen had used the mixer that day (3/6/18), adding the white colored chunks were likely from making mashed potatoes. CK-A stated the device was considered 'ready for use', however, it should be cleaned prior to the use.

When interviewed on 3/8/18, at 8:28 a.m. the corporate registered dietician (RD)-A stated she had observed and cleaned the mixer. RD-A thought the white, crusted substance was possible cake batter which had dried. RD-A stated the mixer should be cleaned daily and "stored clean" to prevent bacterial growth on the device.

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F 812	Continued From page 219 A facility Cleaning Kitchen Mixer Protocol dated 12/23/17, identified a procedure to disassemble and clean the device, however, lacked any guidance or dictation on how often this should be completed.	F 812		
F 843 SS=C	Transfer Agreement CFR(s): 483.70(j)(1)(2) §483.70(j) Transfer agreement. §483.70(j)(1) In accordance with section 1861(l) of the Act, the facility (other than a nursing facility which is located in a State on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that- (i) Residents will be transferred from the facility to the hospital, and ensured of timely admission to the hospital when transfer is medically appropriate as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law; and (ii) Medical and other information needed for care and treatment of residents and, when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or reintegrated into the community will be exchanged between the providers, including but not limited to the information required under §483.15(c)(2)(iii). §483.70(j)(2) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the	F 843		4/23/18

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F 843	Continued From page 220 facility to make transfer feasible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and/or have evidence of an in-effect transfer agreement with a local Medicare participating hospital entity. This had potential to affect all 58 residents in the facility who could require hospitalization on an emergent basis. Findings include: During the extended survey from 3/5/18 to 3/13/18, evidence was requested to demonstrate the facility had a transfer agreement in place with a local Medicare participating hospital entity. However, no information or evidence was provided. When interviewed on 3/12/18, at 1:28 p.m. the administrator stated they were unable to locate a transfer agreement with a local hospital, however, were going to call Sanford Health and see if they had a copy of one. Further, if someone required emergency transfer to a hospital, the staff would just call 911 and have the ambulance bring them to West Fargo Sanford hospital for care. No further information was provided.	F 843	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. 1.Transfer agreement has been developed and signed by ED and sent to Essentia Health and Sanford Health on 4-3-18. 2.The agreement is to ensure that residents will be transferred from the facility to the hospital when transfer is medically appropriate as determined by the attending physician, or in an emergency situation. 3.Both hospitals indicated they would sign the agreement but needed to send it to legal their legal team first to review. They indicated that it typically takes two to four weeks to get back from their legal team. 4.The ED will discuss this deficiency at the QAPI meeting on 4-30-18 and will make sure the agreement always gets renewed prior to expiration. 5.The ED is responsible for this POC.	
F 844 SS=C	Disclosure of Ownership Requirements CFR(s): 483.70(k)(1)-(3) §483.70(k) Disclosure of ownership. §483.70(k)(1) The facility must comply with the disclosure requirements of §420.206 and 455.104	F 844		4/23/18

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F 844	Continued From page 221 of this chapter. §483.70(k)(2) The facility must provide written notice to the State agency responsible for licensing the facility at the time of change, if a change occurs in- (i) Persons with an ownership or control interest, as defined in §§420.201 and 455.101 of this chapter; (ii) The officers, directors, agents, or managing employees; (iii) The corporation, association, or other company responsible for the management of the facility; or (iv) The facility's administrator or director of nursing. §483.70(k)(3) The notice specified in paragraph (k)(2) of this section must include the identity of each new individual or company. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the State agency (SA) was notified as required when the current director of nursing (DON) was appointed to their position. This had potential to affect all 58 residents in the facility. Findings include: During the extended survey from 3/5/18 to 3/13/18, evidence was requested to demonstrate the SA had been notified when the DON was hired to her position. A facility letterhead signed 3/12/18, identified the letter was, " ... to notify the Minnesota Department of Health of a change in key staff."	F 844	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because the provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1.On 3-12-18 a letter was typed on facility letterhead and sent to the SA via email notifying them of a change in key staff. 2.The letter stated that there had been a change in the Director of Nursing position	

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F 844	Continued From page 222 The DON was changed to the current person on 1/23/18. When interviewed on 3/12/18, at 1:28 p.m. the administrator stated the current DON was hired on 1/23/18, and verified the SA was not notified until today with the provided letterhead. Further, the administrator stated he was "unaware" the SA had to be notified when the DON position was changed. No further information was provided.	F 844	and was signed and dated by the ED. 3.The ED is now fully aware of this requirement and will discuss this deficiency at the QAPI meeting on 4-30-18. 4.The ED is responsible for this POC.	

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

F5052027

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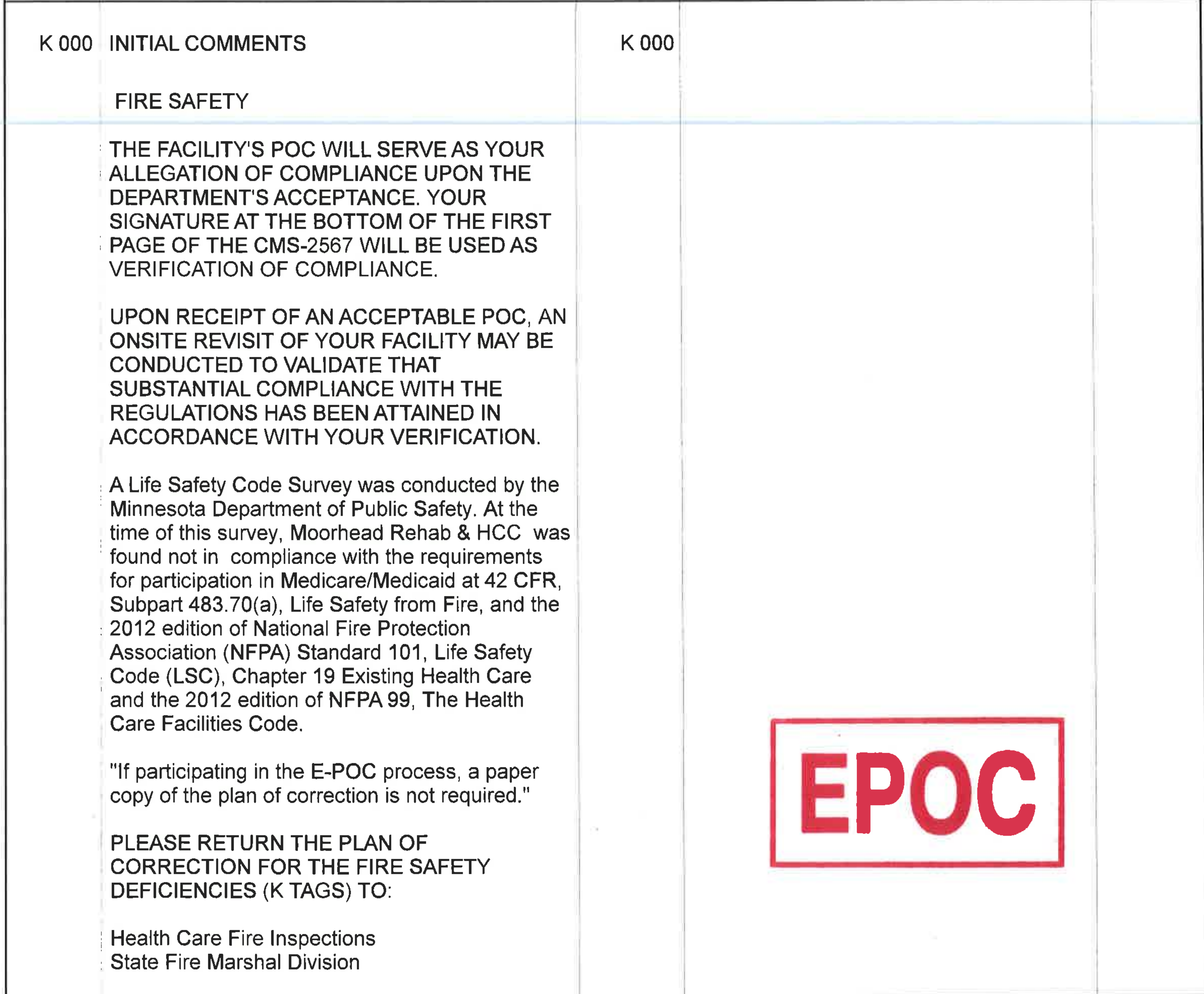

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Moorhead Rehab & HCC was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, The Health Care Facilities Code. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/09/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**03/07/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOORHEAD REHABILITATION & HEALTHCARE CENTER	**2810 SECOND AVENUE NORTH** **MOORHEAD, MN 56560**

(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	K 000		

445 Minnesota Street, Suite 145
St. Paul, MN 55101

Or by e-mail to:
Marian.Whitney@state.mn.us
and
Angela.kappenman@state.mn.us

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

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

2. The actual, or proposed, completion date.

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

Moorhead Rehab & HCC was built in three stages. In 1963 the original 1-story building was constructed without a basement and was determined to be Type II (111) construction. In 1998 a 1-story addition was constructed to the north east of the east wing of the original building and was determined to be Type V (111) construction. In 2009 a dayroom addition was constructed to the north east corner of the original building and a dining room addition to the south east of the original dining room was constructed. These additions are Type II (000), 1-story without a basement.

The entire building is sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition.

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING ____	**03/07/2018**

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K 000	Continued From page 2 As of November 1, 2016 this was surveyed as one building, existing, with the construction type as the least fire resistive construction type per NFPA 101 section 8.2.1.3 (3) The facility has a capacity of 78 beds and had a census of 58 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain the smoke detection system as required by the Life Safety Code,(LSC) 2012 edition, section 9.6.2.10.1.1 and NFPA 72, The National Fire Alarm and Signaling Code, 2010 edition, section 29.10. This deficient condition could delay alarm notification in case of a fire and affect all 78 residents and an undetermined amount of staff and visitors. Findings include:	K 345	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because the provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to:	4/2/18

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	245052	A. BUILDING **01 - MAIN BUILDING 01** B. WING _______	**03/07/2018**

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K 345	Continued From page 3 On the facility tour between 12:00 pm to 3:30 pm on 03/07/2018 review of the records revealed a smoke detector next to room 410 failed and was not replaced. This deficient condition was confirmed by the Executive Director and the Maintenance Director	K 345	1.Protection Systems was contacted, and a new smoke detector has been installed in hallway next to room 410 in accordance with NFPA 72. 2.Fire Alarm System will continue to be inspected on an annual basis and will have a sensitivity test completed. 3.The DOM is responsible for this POC.	
K 346 SS=C	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This REQUIREMENT is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the Fire Alarm system has to be placed out-of-service for four or more hours in a 24 hour period as per NFPA 101 2012 edition section 9.6.1.6. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 78 residents as well as an undetermined number of staff, and visitors. Findings include: On the facility tour between 12:00 pm and 3:30 pm on 03/07/2018 review of the records revealed	K 346	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because the provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: -Fire Watch Policy was created and includes the following procedures: 1.Staff will notify Administration and Maintenance the moment a disruption in	4/4/18

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K 346	Continued From page 4 the Fire Alarm System out of service policy did not contain the verbiage when out of service for more than 4 hours in a 24 hour period and it did not contain current contact information. This deficient condition was confirmed by the Executive Director and the Maintenance Director	K 346	the fire alarm system is identified. 2.If the Fire alarm is off line for more than 4 hours in a 24-hour period, the Maintenance Director or Administrator will notify the State Fire Marshal (Robert Baumann 612-215-0525) and a Fire Watch will be in effect. 3.If the Sprinkler system is offline for more than 10 hours in a 24-hour period, the State Fire Marshal will be notified, and a Fire Watch will be implemented. 4.Maintenance Director will immediately notify local fire department and fire alarm service vendor. 5.The Maintenance Director or Administrator will notify all staff and announce over the PA system that the facility will operate on fire watch. 6.Administrator and/or Maintenance Director will designate one staff member to be the Watch Inspector. This person will have no other duties and maintain the facility Fire Watch Log. 7.Facility will maintain Fire Watch protocol until repairs are complete. 8.Policy was posted on communication board and put in both communication books. 9.The DOM and ED are responsible for this POC.	
K 354 SS=C	Sprinkler System - Out of Service CFR(s): NFPA 101 Sprinkler System - Out of Service Where the sprinkler system is impaired, the extent and duration of the impairment has been determined, areas or buildings involved are inspected and risks are determined,	K 354		4/4/18

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K 354	Continued From page 5 recommendations are submitted to management or designated representative, and the fire department and other authorities having jurisdiction have been notified. Where the sprinkler system is out of service for more than 10 hours in a 24-hour period, the building or portion of the building affected are evacuated or an approved fire watch is provided until the sprinkler system has been returned to service. 18.3.5.1, 19.3.5.1, 9.7.5, 15.5.2 (NFPA 25) This REQUIREMENT is not met as evidenced by: Based on a record review and staff interview, the facility has failed to provide a complete and acceptable written policy containing procedures to be followed in the event that the automatic fire sprinkler system has to be placed out-of-service for ten or more hours in a 24 hour period as per NFPA 25. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 78 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On the facility tour between 12:00 pm and 3:30 pm on 03/07/2018 review of the records revealed the Fire Sprinkler System out of service policy did not contain the verbiage when out of service for more than 10 hours in a 24 hour period and it did not contain current contact information. This deficient condition was confirmed by the Executive Director and the Maintenance Director	K 354	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because the provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: -Fire Watch Policy was created and includes the following procedures: 1.Staff will notify Administration and Maintenance the moment a disruption in the fire alarm system is identified. 2.If the Fire alarm is off line for more than 4 hours in a 24-hour period, the Maintenance Director or Administrator will notify the State Fire Marshal (Robert Baumann 612-215-0525) and a Fire Watch will be in effect. 3.If the Sprinkler system is offline for more than 10 hours in a 24-hour period, the State Fire Marshal will be notified, and a Fire Watch will be implemented.	

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K 354	Continued From page 6	K 354	4.Maintenance Director will immediately notify local fire department and fire alarm service vendor. 5.The Maintenance Director or Administrator will notify all staff and announce over the PA system that the facility will operate on fire watch. 6.Administrator and/or Maintenance Director will designate one staff member to be the Watch Inspector. This person will have no other duties and maintain the facility Fire Watch Log. 7.Facility will maintain Fire Watch protocol until repairs are complete. 8.Policy was posted on communication board and put in both communication books. 9.The DOM and ED are responsible for this POC.	
K 754 SS=F	Soiled Linen and Trash Containers CFR(s): NFPA 101 Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting	K 754		4/4/18

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K 754	Continued From page 7 FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to properly store soiled linen and trash containers in a protected hazardous room as stated in the Life Safety Code NFPA 101 2012 edition section 19.7.5.7. This deficient practice could affect the safety of all 78 residents and an undetermined amount of staff and visitors if smoke or fire from one of these containers made the corridors non-useable. Findings include: On the facility tour between 12:00 pm and 3:30 pm on 03/07/2018 observations revealed trash and linen containers were being stored in the corridor at all 4 corners of the center section of rooms that surrounded the courtyard. This deficient condition was confirmed by the Executive Director and the Maintenance Director	K 754	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because the provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1.Staff were educated on 4-4-18 at an all staff meeting about the importance of storing the trash and linen bins in the corridor. 2.They were informed that both bins cannot be stored in one hallway and must store one 32-gallon bin in each alcove. 3.By having one 32-gallon bin per alcove this has reduced the capacity to 32 gallons in a 64 square foot area which will not reduce the required width of less than 7ft. 4.The DOM and ED will complete a Trash/Linen audit x3 a week for 4 weeks and then monthly for 3 months. 5.DOM and ED are responsible for this POC.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category	K 901		3/15/18

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K 901	Continued From page 8 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility has failed to provide a complete and current facility Risk Assessment in accordance with the NFPA 99 "Health Care Facilities Code" 2012 edition section 4.1. This deficient practice could affect all patients, as well as an undetermined number of staff, and visitors. Findings include: On the facility tour between 12:00 pm and 3:30 pm on 03/07/2018 during record review the facility was not able to provide a risk assessment document based on NFPA 99. This deficient condition was confirmed by the Executive Director and the Maintenance Director	K 901	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because the provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1.NFPA 99-2012 Utility Risk Assessment was developed on an Excel Spreadsheet 2.The risk assessment categories are based on harm to the residents due to loss of utility - Medical Gas, Electrical Systems, and HVAC 3.On the assessment there are four categories: Death or serious injury, Minor injury, Discomfort, & No harm. 4.The risk assessment will be revised annually and as needed by the DOM. 5.The DOM is responsible for this POC	
K 920 SS=F	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101	K 920		4/13/18

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K 920	Continued From page 9 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to ensure multiple outlet adapters are in accordance with the 2012 edition of NFPA 99 section 10.2..4.2.1 and the use of power strips comply with 10.2.3.6. This deficient practice could affect all 78 residents and an undetermined amount of patients, staff and visitors. Findings include: On the facility tour between 12:00 pm and 3:30 pm on 03/07/2018 observations revealed power strips not listed for resident rooms were being	K 920	The preparation of the following plan of correction for this deficiency does not constitute and should not be interpreted as an admission nor an agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction prepared for this deficiency was executed solely because the provisions of state and federal law require it. Without waiving the foregoing statement, the facility states with respect to: 1.ED and DOM went around the facility	

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K 920	Continued From page 10 used in resident rooms. 104, 204, 212, 306, 403 and 405. In addition, an oxygen concentrator was plugged into a power strip and not directly into a wall receptacle. This deficient condition was confirmed by the Executive Director and the Maintenance Director	K 920	and took away all the power strips in resident rooms and made sure all concentrators were plugged directly into the wall. They also informed residents that these are considered a fire hazard and are not allowed in rooms. 2.Old power strips were confiscated and put out of commission and replaced with UL 1363 power strips. 3.The two-way outlets in resident rooms will slowly be changed into four-way outlets to eliminate the use of power strips. 4.DOM will label all UL 1363 power strips, so staff are aware they can be used. 5.A memo will be put in the communication book and communication board notifying staff that all power strips not labeled are prohibited. 6.ED and DOM will discuss this issue at next resident council meeting on (4-16-18). 7.Power strip audit will be done x2 a week for 4 weeks and then monthly for 3 months. 8.DOM & ED are responsible for this POC.	