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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VNT4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00797

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245329**

2.STATE VENDOR OR MEDICAID NO.
(L2) **974840700**

3. NAME AND ADDRESS OF FACILITY
(L3) **WARROAD CARE CENTER**
(L4) **1401 LAKE STREET NORTHWEST**
(L5) **WARROAD, MN** (L6) **56763**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/26/2018** (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)
09/30

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

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (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
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE - NE II 08/08//2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/08/2018 (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
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/26/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245329 August 8, 2018

Mr. Mark Bertilrud, Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

Dear Mr. Bertilrud:

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 July 31, 2018 the above facility is recommended for:

49 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 49 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

Electronically delivered

August 8, 2018

Mr. Mark Bertilrud, Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: Project Number H5329008 and S5329027

Dear Mr. Bertilrud:

On June 28, 2018, we informed you that the following enforcement remedies were being imposed:

- State Monitoring effective July 3, 2018. (42 CFR 488.422)

- Discretionary denial of payment for new Medicare and Medicaid admissions effective September 2, 2018. (42 CFR 488.417 (b))

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

- Civil money penalty (42 CFR 488.430 through 488.444)

Also, your were notified in our letter of June 28, 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 June 14, 2018.

This was based on the deficiencies cited by this Department for an extended survey completed on June 14, 2018. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted immediate jeopardy (Level L) whereby corrections were required.

We were able to verify, on June 13, 2018, that the conditions resulting in our notification of immediate jeopardy had been removed. Therefore, we notified the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

On July 26, 2018, the Minnesota Department of Health and Minnesota Department of Health, Office of Health Facility Complaints and on August 1, 2018 the Departement of Public Safety 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 14, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 31, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on July 26, 2018, as of July 31, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 31, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of June 28, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Discretionary denial of payment for new Medicare and Medicaid admissions, effective September 2, 2018, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective September 2, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective September 2, 2018, is to be rescinded.

In our letter of June 28, 2018, we advised you that, in accordance with 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, Warroad Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective June 14, 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.

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

- Civil money penalty (42 CFR 488.430 through 488.444)

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

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

August 8, 2018

Mr. Mark Bertilrud, Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

Re: Reinspection Results - Project Number S5329027 and H5329008

Dear Mr.. Bertilrud:

On July 26, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 26, 2018, with orders received by you on June 29, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

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: VNT4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00797

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245329**

2.STATE VENDOR OR MEDICAID NO.
(L2) **974840700**

3. NAME AND ADDRESS OF FACILITY
(L3) **WARROAD CARE CENTER**
(L4) **1401 LAKE STREET NORTHWEST**
(L5) **WARROAD, MN** (L6) **56763**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/14/2018** (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)
09/30

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

12.Total Facility Beds **49** (L18)
13.Total Certified Beds **49** (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
	49			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date:
Lisa Carey, HFE NE II 07/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 07/25/2018 (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
08/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically Submitted
June 28, 2018

Mr. Mark Bertilrud, Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

RE: Project Number S5329027 and H5329008
Dear Mr. Bertilrud:

On April 24, 2018, an abbreviated standard survey was completed at your facility by the Minnesota Department of Health, Office of Health Facility Complaints to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D). In addition, at the time of the June 14, 2018 abbreviated standard survey the Minnesota Department of Health, Office of Health Facility Complaints completed an investigation of complaint number H5329008.

On June 14, 2018, an extended survey was completed at your facility by the Minnesota Department of Health and on June 12, 2018, Minnesota Department of 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 **immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted immediate jeopardy (Level L) as evidence by the electronically attached CMS-2567, whereby corrections are required.

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;

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;

Appeal Rights – the facility rights to appeal imposed remedies; 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 June 13, 2018, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction from the extended survey completed on June 14, 2018 should be directed to:

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

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by an "F" tag), i.e., the plan of correction from the abbreviated standard survey completed on April 24, 2018 should be directed to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us
Phone: (651) 201-4204
Fax: (651) 281-9796

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 July 3, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition. The 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 September 2, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective September 2, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 2, 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.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for

two years effective June 14, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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

- Civil money penalty (42 CFR 488.430 through 488.444)

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you

have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division

P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

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

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

Feel free to contact me if you have questions.

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
	245329	A. BUILDING _____ B. WING _____	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD CARE CENTER	**1401 LAKE STREET NORTHWEST WARROAD, MN 56763**

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E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 11, 12, 13, & 14, 2018, during a recertification survey. The facility is NOT in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
E 009 SS=C	Local, State, Tribal Collaboration Process CFR(s): 483.73(a)(4) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. * [For ESRD facilities only at §494.62(a)(4)]: (4) Include a process for cooperation and collaboration with local, tribal, regional, State, and Federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the dialysis facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts. The dialysis facility must contact the local emergency preparedness agency at least annually to confirm that the agency is aware of the dialysis facility's needs in the event of an	E 009		7/8/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/08/2018

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E 009	Continued From page 1 emergency. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts in their emergency plan. This had the potential to affect all 47 current residents in the facility. Findings include: A facility document, Emergency Management Program Description, revised 10/19/17, together with its complementary policies/procedures with various revision dates, as the facility's emergency preparedness plan (EPP) did not identify any process for collaboration with tribal, emergency preparedness officials. There were no efforts identified to maintain an integrated response during a disaster or emergency situation, including documentation of the facility's efforts to contact such officials, when applicable, of its participation in collaborative and cooperative planning efforts in their emergency plan. During interview on 6/14/18, at 12:15 p.m., the director of nursing and maintenance of the facility and safety, stated the facility was part of a health care coalition, and had no contact with tribal.	E 009	1. Tribal officials were contacted by the Director of Maintenance for their awareness and involvement in coordination of our emergency planning procedures. 2. Our emergency plan was updated to reference and include the coordination with tribal authority and we will maintain an ongoing discussion with them in our routine planning and updating of materials and emergency preparedness procedures.	
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6)	E 024		7/13/18

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E 024	Continued From page 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:] (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 document review and interview, the facility failed to develop in its emergency preparedness plan (EPP) policies and procedures addressing the screening and use of volunteers who may be used in emergency staffing strategies. This had the potential to affect all 47 current residents of the facility. Findings include: A facility document, Emergency Management Program Description, revised 10/19/17, together	E 024	Emergency Management Program revisions were completed by the Director of Nursing and the Director of Maintenance to include consideration for using and screening volunteers who may aide the facility in efforts surrounding an emergency situation. Program guidelines will continue to be reviewed and revised on an ongoing basis to consider opportunities to use volunteers in a safe and effective manner.	

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E 024	Continued From page 3 with its complementary policies/procedures with various revision dates, did not identify how the facility would screen and use volunteers in an emergency as part of the facility's EPP. During interview on 6/14/18, at 12:15 p.m., the director of nursing and maintenance manager of the facility and safety stated the policies and procedures, did not include anything about screening volunteers who may be helping out in an emergency situation. The director of nurses stated the use of volunteers were not included in an emergency plan.	E 024		
E 025 SS=C	Arrangement with Other Facilities CFR(s): 483.73(b)(7) [(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:] *[For Hospices at §418.113(b), PRFTs at §441.184,(b) Hospitals at §482.15(b), and LTC Facilities at §483.73(b):] Policies and procedures. (7) [or (5)] The development of arrangements with other [facilities] [and] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For PACE at §460.84(b), ICF/IIDs at §483.475(b), CAHs at §486.625(b), CMHCs at	E 025		7/3/18

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E 025	Continued From page 4 §485.920(b) and ESRD Facilities at §494.62(b):] Policies and procedures. (7) [or (6), (8)] The development of arrangements with other [facilities] [or] other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of services to facility patients. *[For RNHCIs at §403.748(b):] Policies and procedures. (7) The development of arrangements with other RNHCIs and other providers to receive patients in the event of limitations or cessation of operations to maintain the continuity of non-medical services to RNHCI patients. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop prearrangements transfer agreements, which include written agreements or contracted arrangements with other facilities to receive residents in the event of limitations or cessation of operations to maintain the continuity of services to facility residents. This had the potential to affect all 47 residents residing in the facility. Findings include: On 6/14/18, at 12:15 p.m. the facility's Emergency Preparedness Plan was reviewed with the director of nurses and maintenance manager. The director of nurses indicated the facility did not have any arrangements with other facilities to receive residents in the event of an emergency. The director of nurses stated the administrator had been in conversations with other facilities, but had not put any agreements into place.	E 025	Executive Director contacted LifeCare Medical Center upon notification of the deficient practice. Director has secured an agreement with LifeCare Medical Center dated 07-03-2018. The agreement includes language for mutual support in the event of situations requiring additional resources for continued safe operations. The agreement also specifies that transfers and temporary housing may be a part of that assistance.	

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F 000	Continued From page 5	F 000		
F 000	INITIAL COMMENTS On June 11, 12, 13 & 14, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ) at F812. An IJ was called at F812 on 6/11/18, at 8:26 p.m. related to the improper cooling of foods in order to prevent and/or reduce the risk of food borne illness. The IJ was removed on 6/13/18, at 11:08 a.m. after verification of a removal plan. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC 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 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.	F 565		7/24/18

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F 565	Continued From page 6 (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to address the resident council's concerns related to food temperature, quantity and quality, during a survey initiated resident council meeting with 8 of 15 residents (R36, R40, R26, R6, R34, R38, R41 and R8) active members of the facility resident council. Findings include:	F 565	1. The Dining Service Director spoke to each resident about their specific concerns and their specific preferences for food temperature and type. These residents will also be a part of follow up auditing procedures. The facility established a resident food group and held an initial meeting to discuss the ongoing function of the group	

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F 565	Continued From page 7 On 6/12/18, at 3:55 p.m., a co-chair of the resident council (R43) gave permission for the survey team to review previous minutes of resident council meetings. Review of Resident Council minutes from 8/2017 to 6/2018 revealed the following: -8/7/17: Still having a problem with food not being warm enough and the quantity of alternative menu items was not enough. -9/11/17: Still have a problem with food not being warm enough. A staff person came and said they ordered some parts for the steam tables. -10/2/17: Food was cool, cafe choices could be crispy (shrimp and fries). There was a request to have buns heated for hamburgers so that they might stay warm longer. -11/6/17: Food was cool on the Angle unit. Requests were made for more variety in salads and for soup to be offered more often as the alternate choice for the evening meal. -12/4/17: A resident from the BB unit said the food could be warmer. -1/8/18: Food could be warmer and more soup was requested. -2/5/18: Too many repeats on the menu. -3/12/18: They were running out of certain alternative menu items. -4/9/18: Better -5/7/18: Dietary needs work and there was still cold food, and some of the meat was tough and hard to chew. There was a request to peel cucumbers, as the peel was too hard to eat. There was no toaster in the BB unit. -6/11/18: There were still issues with the temperature of the food, they were running out of food more frequently (especially mashed potatoes). Potatoes in the potato salad were not fully cooked. Residents were tired of chicken so	F 565	and desired outcomes. The group has now met for a second time and will meet on an ongoing basis in approximately 2 week intervals until it is determined that the food concerns have been resolved. At that time frequency may be altered or the group may be discontinued based on resident interest. The Committee may then be reinstated in the future at either the request of the Council or the suggestion of management based on dining service satisfaction. 2. The facility has created a Resident Council policy and a Council Action Plan form that will be used to document resident concerns and facility responses. These items will become a regular part of all Council meetings and will be documented in the meeting minutes. 07/05/2018 3. The facility Activity Director will work with the Council to make sure that their concerns are accurately documented in the minutes and via the Action Forms. She will serve as the liaison between the Council and any department or individual that needs to respond to an Action Plan either in writing or in person as a method of follow up and closure. She will continue to facilitate until the matter is satisfactorily resolved. She will communicate with the administrator as necessary to seek assistance with any matters that are either unresolved or that are recurring in nature. 4. Audits will be performed for 3 days	

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F 565	Continued From page 8 frequently on the menu and the french fries were never good--they are cold or soggy. There was no evidence of follow-up to the concerns listed in the minutes. No action forms were available for review. On 6/13/18 at 12:30 p.m., a resident council meeting was held and the following residents attended: R36, R40, R26, R6, R34, R38, R41 and R8. At the resident council meeting, R36 stated he had concerns about the quality of the food, as some was not cooked through. R36 also stated when he has asked for "two eggs over easy and hash browns", the staff just laugh. In addition, R38 stated the food was not hot enough. On 6/13/18, at 1:33 p.m., the activities director (AD) stated she takes minutes at the resident council meetings and the Activity Aide (AA)-A runs the meeting. The AD stated she informs the administrator and appropriate staff of concerns that are raised and then lets the resident council know what they say. The AD stated she has no log or written documentation of any follow-up on concerns raised at the resident council. The AD confirmed there was no evidence in the minutes of follow-up to the resident council. Finally, the AD stated she feels for the residents and the facility was doing the best they could in regards to food. On 6/13/18, at 2:19 p.m., the administrator stated there had not been good follow-up regarding food concerns, stating food had been a challenging issue for the facility for months, with turnover in	F 565	out each week on resident meal satisfaction under the direction of the Director of Dining Services. They will be conducted in a random dining room and at random meal times as chosen by the Director. Sampling will be reviewed to make sure we are covering all dining rooms and each of the three main meal times. Audits will be reported to the Food Committee and at QAPI meetings until goal of 85% appropriate responses is met for 2 consecutive months. At that time the Committee will change audit frequency and number until they are comfortable that the problem has been resolved on an ongoing basis. Food temperatures will be logged daily at time of service. Weekly audits will be conducted by kitchen manager and will be reports at QAPI meetings. 4. Items in Action Plans will be a part of the Activity Directors report and the Dining Service Directors report to the facility QAPI Committee at their regular meetings and will be included in Committee discussion to assist with problem solving as necessary. Suggestions from the Committee will be incorporated into action planning and follow up.	

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F 565	Continued From page 9 kitchen leadership and staff. The administrator stated at the May (2018) resident council they talked about starting a resident food group that would meet more frequently, than the monthly resident council meeting. The administrator reviewed the minutes and confirmed that discussion of a food group was not evident in the minutes. The administrator stated the residents are correct with their food concerns. Review of the Combined Federal and State Bill of Rights revised November 2016 included: 5. The resident has a right to organize and participate in resident groups in the facility. D. The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. a. The facility must be able to demonstrate their response and rational for such response.	F 565		
F 572 SS=F	Notice of Rights and Rules CFR(s): 483.10(g)(1)(16) §483.10(g) Information and Communication. §483.10(g)(1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. §483.10(g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident	F 572		7/13/18

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F 572	Continued From page 10 understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to give the correct version of resident rights to admitting residents. This had the potential to affect all 47 residents residing in the facility. Findings include: Review of the facility's Resident Handbook given to new admissions revealed it contained a version of resident rights dated 7/1/07 and not the most current Bill of Rights dated 11/28/16. On 6/14/18, at 8:44 a.m., the social services designee (SSD) confirmed the 7/1/07 version of the Bill of Rights were given to residents upon admission. The SSD indicated the new version of The Combined Federal and Minnesota Resident Bill of Rights dated 11/28/16, was provided to every resident at one time soon after the 11/28/16, update. This rights booklet was also currently available at the information corner of the facility and the SSD offered them at care conferences. However, the SSD confirmed the booklets were not provided to residents on admission. Rather, residents at admission are getting the rights	F 572	1. Facility, through the Social Services Designee identified all residents that had not received updated Bill of Rights information. Updated Bill of Rights documents are being provided to and discussed with all residents admitted after the distribution of the updated rights booklets and acknowledgements will be recorded. This will be completed by 07/13/18. 2. The Resident Handbook and the admission packet have been updated to include the most current version of the Bill of Rights. 06/14/2018. This updated material will be shared with all new admissions and acknowledgement of the same will be kept with resident records. 3. A Residents Rights policy has been updated/created and will serve as the guide in sharing, distributing and communicating this information on an ongoing basis. 06/27/2018 4. The Social Service Designee shall maintain records and acknowledgement of proper distribution of Residents Rights	

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F 572	Continued From page 11 dated 2007. On 6/14/18 at 9:27 a.m., the administrator confirmed residents were getting an old version of their rights at admission. A copy of the letter that indicated the date residents received the new rights booklet was requested but not received from the facility. A policy on provision of resident rights was requested but not received from the facility.	F 572	upon admission. In addition she will assure proper postings in the building and that education will be provided to the Resident Council annually and documented in the minutes of the meetings. Designee will also monitor ongoing compliance and report to the facility QAPI Committee on an ongoing basis. Reports will be for a minimum of 3 months and will then be adjusted in frequency based on compliance.	
F 623 SS=D	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 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.	F 623		7/13/18

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F 623	Continued From page 12	F 623		

(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 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

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F 623	Continued From page 13 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 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 document review, the facility failed to notify the ombudsman of a hospital transfer for 2 of 2 residents (R20, R31) reviewed for hospitalization. Findings include:	F 623	1. Facility has notified the ombudsman of the missing hospital transfers for R20 and R31. 07/11/2018. 2. Facility has created an updated Notice of Discharge Policy, 06/25/2018 to include the use of a monthly tracking sheet to	

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F 623	Continued From page 14 R20's Admission Record, dated 6/13/18, indicated R20 had diagnoses that included Alzheimer's disease, enterocolitis (inflammation of the digestive tract) due to clostridium difficile (C-Diff, an infection of the colon), acute kidney failure, functional urinary incontinence, diabetes, and gout. R20's progress note dated 5/13/18, indicated R20 had 5 large loose stools, was lethargic and more confused than usual; the physician was notified of R20's condition and a telephone order was received to transfer R20 to the hospital. R20's family member was notified of the hospitalization. R20's Census List dated 6/14/18, indicated a hospital leave from 5/13/18 to 5/17/18. R20's Physician Discharge Summary dated 5/17/18, indicated R20 was hospitalized due to worsening generalized weakness and dehydration. R20 had been diagnosed with C-Diff and was receiving oral antibiotics. R20's progress note dated 5/17/18, indicated he returned to the facility at 2:10 p.m. Review of R20's record does not reflect the ombudsman was notified of the facility-initiated transfer. R31's progress notes dated 5/12/18, indicated R31 had not been feeling well and was short of breath; family was notified of R31's change of condition and indicated R31 should go to the hospital if needed. Progress note then indicated the physician was notified of R31's condition; the physician gave a telephone order to transfer R31 to the hospital for further evaluation. R31 was subsequently admitted to the hospital.	F 623	record all required notices to the Ombudsman. Social Service Designee will complete the log and send it to the Ombudsman as required and not later than monthly as a summary of the required notice. 3. Social Service Designee will audit records not less than monthly to assure the appropriate distribution and acknowledgement of discharge notices. 4. Social Service Designee will monitor compliance and report monthly results to the facility QAPI Committee. Social Service Designee will also coordinate with other departments in the event of failure to comply with required notices and time frames to develop an system changes that are necessary to meet compliance expectations. Monitoring will continue by the Social Service Designee until there are 3 successive months of compliance and will be reevaluated at that time.	

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F 623	Continued From page 15 R31's progress note dated 5/14/18, indicated R31 had returned to the facility at approximately 3:10 p.m. R31's record does not reflect the ombudsman was notified of the facility-initiated transfer. On 6/12/18, at 4:13 p.m. social services designee (SSD) stated notifications to the ombudsman had not been completed for residents whom were transferred to the hospital and had not been aware of the requirement. Facility policy Transfer or Discharge Documentation dated 4/1/17, included: 4) All discharge forms must be faxed to the Office of the State Ombudsman for review. The policy did not specifically address Ombudsman notification related to emergency hospitalization transfers.	F 623		
F 625 SS=D	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	F 625		7/13/18

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F 625	Continued From page 16 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 document review, the facility failed to provide a written copy of the bed hold policy for 2 of 2 residents (R20, R31) who were transferred to the hospital. Findings include: R20's Admission Record, dated 6/13/18, indicated R20 had diagnoses that included Alzheimer's disease, enterocolitis (inflammation of the digestive tract) due to clostridium difficile (C-Diff, an infection of the colon), acute kidney failure, functional urinary incontinence, diabetes, and gout. R20's quarterly Minimum Data Set (MDS) an assessment, dated 4/15/18, identified R20 had severe cognitive impairment and required extensive assistance for transfers, bed mobility and toileting. R20's progress note dated 5/13/18, indicated R20 had 5 large loose stools, was lethargic and more confused than usual; the physician was notified of	F 625	1. Bed hold agreements for R20 & R31 were completed and added to the resident record. 2. The facility revised the Bed Hold Agreement Policy 07/06/2018 to include the proper notification, acknowledgement and the distribution and filing of bed hold notices. Business Office shall be provided a copy of the notice for filing and accuracy checking. 3. Ongoing tracking and monitoring of the notice requirements will be logged by the Social Service Designee via an updated and ongoing log of activity. 06-27-2018 This log will be reviewed after each potential bed hold situation and will be compiled and analyzed monthly for timely compliance. 4. Results of the logging activity will be reported to the facility QAPI Committee by the Social Service Designee at their	

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F 625	Continued From page 17 R20's condition and a telephone order was received to transfer R20 to the hospital. R20's family member was notified of the hospitalization. R20's Census List dated 6/14/18, indicated a hospital leave from 5/13/18 to 5/17/18. R20's Physician Discharge Summary dated 5/17/18, indicated R20 was hospitalized due to worsening generalized weakness and dehydration. R20 had been diagnosed with C-Diff and was receiving oral antibiotics. Review of R20's record identified no documentation that a bed hold notification had been provided prior to being hospitalized to R20 or R20's responsible party. On 6/14/18, at 8:43 a.m., the social services designee (SSD) indicated she had looked to see if a bed hold had been given to R20 and found no evidence that one was completed for his 5/13/18 to 5/17/18 hospitalization. R31's quarterly Minimum Data Set (MDS) an assessment dated 5/11/18, identified R31 was cognitively intact. R31's progress notes dated 5/12/18, at 9:56 p.m. indicated R31 had not been feeling well and was short of breath; family was notified of R31's change of condition and indicated R31 should go to the hospital if needed. Progress note then indicated the physician was notified of R31's condition; the physician gave a telephone order to transfer R31 to the hospital for further evaluation. R31's progress note dated 5/13/18, at 4:31 a.m. indicated the facility received a status update that R31 had been admitted to the hospital.	F 625	regular meetings and will have appropriate follow up action based on monitoring results. Results will be presented by the Social Service Designee until there is compliance for a 6 month period and at that time will be reevaluated to determine if ongoing monitoring is necessary. Regardless of monthly monitoring, agreements will be discussed and filed in a timely manner in resident records by the Social Service Designee.	

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F 625	Continued From page 18 Review of R31's record identified no documentation a bed hold notification had been provided to R31 or R31's responsible party before transfer to hospital. On 6/12/18, at 9:17 a.m. registered nurse (RN)-B verified lack of evidence a bed hold notification had been provided to R31 or responsible party. RN-B indicated the notification should have been provided prior to transfer. On 6/13/18, at 10:58 a.m. director of nursing (DON) stated bed hold notifications were to be provided prior to the transfer unless the situation of the transfer is urgent and resident or the resident's responsible party is not in a position to agree to anything; then notification should be given as soon as practicable. A facility undated Bed Hold Policy, included: It is the policy of Warroad Senior Living Center to hold the bed of a current resident if he/she needs to be hospitalized or goes on therapeutic leave. The resident/responsible party must be notified concerning the bed hold policy of WSLC and sign the policy as evidence that they have been properly notified prior to being charged by any service. 3) In cases of emergency transfer, staff will attempt to provide the resident with a copy and will notify the responsible party of the transfer and policy within 24 hours. Staff will follow up with a phone call to clarify any questions concerning the policy on the next business day.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments.	F 641		7/18/18

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F 641	Continued From page 19 The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure oral/dental status lacked evidence a quarterly Minimum Data Set (MDS) an assessment was accurately completed for 1 of 1 resident (R12) in the sample who were reviewed for dental status and service Findings include: R12's Admission Record dated 6/14/18, included diagnoses of Alzheimer's disease and dementia with behavioral disturbance. R12's annual MDS dated 10/1/17, indicated R12 had severe cognitive impairment and had unclear speech. The MDS indicated R12 did not have any oral/dental issues during the assessment period. However, the pain Care Area Assessment indicated, R12 had pained facial expression at times, such as facial grimaces and furrowing of brow and could not be determined if non-verbal gestures were pain related. However, R12 had a history of back pain and was having presumed oral pain from prior dental surgery in which 14 teeth had been extracted on 7/25/17, according to an oral surgeon's letter dated 7/31/17. R12's record lacked evidence of documentation of a physical oral/dental examination and assessment had been completed for coding of the annual MDS. R12's quarterly MDS dated, 1/1/18, indicated R12 had severe cognitive impairment and had unclear speech. The MDS indicated R12 did not have any	F 641	1) The affected resident has been assessed here at WSLC by Cindy Dross-Sandy, DDS, with recommendation for referral to oral surgeon to remove remaining teeth. Family has agreed to surgery and an appointment has been made for July 30, 2018. Resident was started on Augmentin for facial flushing and fever on June 29, 2018. Pain monitoring had already been on nurse charting board, but has also added to e-Mar as of July 6, 2018, and an order obtained for prn Tramadol in addition to scheduled Tramadol and Tylenol in the event of pain observed. MDS nurse will modify 10/1/17, 1/1/18, and 4/3/18 MDS assessments by 7/15/2018 to accurately reflect dental issues resident was experiencing. Quarterly MDS dated 7/4/2018 has been completed, along with an additional dental assessment completed on 7/3/2018, both have been reviewed by DON as accurate related to dental issues. 2) DON will conduct a review of the most recent MDS assessments for all residents that have their own teeth with any variant conditions by 7/15/2018 for accuracy related to dental conditions as compared with progress over the quarter. Inaccuracies will be corrected by MDS RN and followed up on in terms of resident dental care by	

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F 641	Continued From page 20 facial pain or difficulty/discomfort when chewing. R12's record lacked evidence of documentation of a physical oral/dental examination and assessment had been completed for coding of the quarterly MDS. R12's quarterly MDS dated 4/3/18, indicated R12 had severe cognitive impairment, and had unclear speech. The MDS indicated R12 did not have any facial pain or difficulty/discomfort when chewing. The MDS identified R12 had pain 1-2 days as noted by facial expressions or protective body movements. R12's record lacked evidence of documentation of a physical oral/dental examination and assessment had been completed for coding of the quarterly MDS. R12's record reflected ongoing evidence of dental concerns that were not captured or assessed on the annual or quarterly assessments. -A facility referral form dated, 11/28/17, included; nursing observation that R12 had been yelling more and grinding her teeth. Possible tooth pain. Physician's recommendation was to talk with family member (FM)-A to see if R12 needed a dental appointment. The other option is pain control but I do not know if there is infection of teeth which if present could get worse. -Nursing health status note dated 12/15/17, included when physician was at the facility in November 2017, R12 was showing signs of possible mouth pain again and talked about possibility of having remaining teeth extracted.	F 641	3) Dental assessments will be completed by RN in conjunction with quarterly MDS assessments, and a field added to WSLC Care Conference form to trigger a discussion with resident/family related to dental needs. A reminder was provided to all nursing staff to report any evidence of oral pain to charge nurse in nursing newsletter on June 24, and this will also be included in the July 12 nursing meeting agenda. MDS coordinator/Unit coordinator(s) will conduct quarterly dental assessments for all residents at WSLC. ”Dental assessment complete” has been added to the Quarterly Care Conference Summary that guides discussions with residents/families. 4) MDS coordinator/Unit Coordinator(s) will bring a list of MDS assessments performed each week to High Risk Committee. DON will audit for three months for completion of quarterly dental assessments, an additional three months if we have not achieved 100%. Results of High Risk Meeting discussion and trending will be presented to the facility QAPI Committee for their review as well in similar time frame as listed above.	

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F 641	Continued From page 21	F 641		

-Nurse health status note dated 4/12/18, only nine days after the quarterly MDS dated 4/3/18, was completed included R12 had lost one of her molar teeth that looked like it had rotted out.

On 6/11/18, at 5:40 p.m. R12 had been observed in the dining room being fed by an unidentified nursing assistant (NA). R12 was observed to be making facial grimaces, clenching fists, and pushing self away from table while being fed and given liquids. R12 was also observed to have several missing teeth.

On 6/14/18, at 12:59 p.m. registered nurse (RN)-A stated the oral cavity is assessed annually with dental assessments. RN-A confirmed that the individual's oral cavity is assessed by her when doing R12's annual assessment. When R12's assessment was done in October it was coded as no problems noted; therefor a Care Area Assessment was not triggered for further assessment and care planning. RN-A could not recall if an actual inspections of R12's oral cavity were completed for the completion of the MDS's. RN-A confirmed the MDSs had not identified any oral health concerns. RN-A confirmed that the assessment indicated no teeth, swelling, lesions, broken teeth, pain or difficulty with chewing were identified. RN-A indicated that she felt there were no dental issues and was unclear if pain was related to dental or something else.

The MDS 3.0 RAI (Resident Assessment Instrument) Manual last updated 10/1/17, directed users to complete the following steps for assessment for coding purposes:
"Steps for Assessment
1. Ask the resident about the presence of chewing problems or mouth or facial

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F 641	Continued From page 22 pain/discomfort. 2. Ask the resident, family, or significant other whether the resident has or recently had dentures or partials. (If resident or family/significant other reports that the resident recently had dentures or partials, but they do not have them at the facility, ask for a reason.) 3. If the resident has dentures or partials, examine for loose fit. Ask him or her to remove, and examine for chips, cracks, and cleanliness. Removal of dentures and/or partials is necessary for adequate assessment. 4. Conduct exam of the resident ' s lips and oral cavity with dentures or partials removed, if applicable. Use a light source that is adequate to visualize the back of the mouth. 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. The assessor should use his or her gloved fingers to adequately feel for masses or loose teeth. 5. If the resident is unable to self-report, then observe him or her while eating with dentures or partials, if indicated, to determine if chewing problems or mouth pain are present. 6. 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 and any resident who exhibits dental or oral issues." Dental Services procedure dated 3/9/17, indicated oral health review will be completed with the data collection annually.	F 641		
F 680	Qualifications of Activity Professional	F 680		7/16/18

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F 680 SS=C	Continued From page 23 CFR(s): 483.24(c)(2)(i)(ii)(A)-(D) §483.24(c)(2) The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who- (i) Is licensed or registered, if applicable, by the State in which practicing; and (ii) Is: (A) Eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or (B) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a therapeutic activities program; or (C) Is a qualified occupational therapist or occupational therapy assistant; or (D) Has completed a training course approved by the State. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a qualified activity director (AD) was in charge of the activity program. This had the potential to impact all 47 residents of the facility. Findings include: On 6/13/18, at 1:27 p.m., the AD stated she started in her position during the summer of 2017 and starting taking an activity director course shortly after. On 6/13/18, at 2:15 p.m., the administrator stated they advertised for a qualified activity director but did not find someone who met the qualifications.	F 680	1. Executive Director has contacted LifeCare Medical Center for assistance in providing program support with a fully qualified director. LifeCare has the services of a qualified COTA who will agree to serve in a capacity to provide qualified leadership to the department. Contract negotiations are underway to outline the agreement and implement the change necessary to become compliant. Contract will be in place not later than 07/16/2018 2. Executive Director will monitor and continue to follow the contract arrangement until our Director completes	

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F 680	Continued From page 24 The administrator stated the current AD had worked previously in activities, and he thought she met the requirements based on previous experience. In addition, they enrolled the AD in an activity director class immediately upon hiring her. On 6/14/18, at 9:21 a.m., the administrator confirmed the AD's previous experience from 7/2012, through 9/2017, only adds up to 14.5 months of activity experience in the last 5 years; and the requirement was 2 years. A policy identifying the qualifications of an activity professional was requested but not provided.	F 680	her educational training and is fully qualified. At that time the agreement with LifeCare will be terminated or altered to reflect the current needs of the department. 3. Executive Director has created a policy on the qualifications of an activity professional in the facility and will assure that the program meets these requirements and qualifications. 06/16/2018.	
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 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 a facility acquired pressure ulcer, and provide consistent monitoring to promote healing for 1 of 1 resident (R20) reviewed for pressure	F 686	1) Resident has bolstered air mattress in place with repositioning every hour and prn. Tegaderm foam has been applied to coccyx, to be changed with nurse assessment every three days. Weekly	7/24/18

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F 686	Continued From page 25 ulcers. Findings include: R20's Admission Record, dated 6/13/18, indicated R20 had diagnoses that included Alzheimer's disease, enterocolitis (inflammation of the digestive tract) due to clostridium difficile (C. Diff, an infection of the colon, often causes diarrhea), acute kidney failure, functional urinary incontinence, diabetes, and gout. R20's quarterly Minimum Data Set (MDS) an assessment, dated 4/15/18, identified R20 had severe cognitive impairment and required extensive assistance for transfers, bed mobility and toileting. The MDS identified R20 as frequently incontinent of urine and always continent of bowel. The MDS further indicated R20 was at risk to develop pressure ulcers, and had not had a pressure ulcer on the previous quarterly assessment. Finally, the MDS indicated R20 was on a turning and repositioning program and had lotion or ointment applied to his skin. There was not a Care Area Assessment (CAA) related to skin or pressure ulcer prevention. R20's Care Plan, dated 10/21/15, indicated R20 was at risk for skin breakdown related to the need for extensive assistance with bed mobility and repositioning, and had occasional incontinence. The care plan identified the goal was for R20 to have intact skin, free of redness, blisters or discoloration. Interventions included to turn or reposition at least every two hours; R20 had an air bed and ROHO cushion (pressure preventing) in his wheelchair to help maintain skin integrity. The care plan did not identify the stage II pressure ulcer which was first identified on	F 686	skin rounds by PT wound specialist will be conducted until the wound is resolved. Resident's wound has improved. 2) Body audits will be performed on all residents that need extensive assistance with repositioning to identify other residents with possible undetected and untreated pressure ulcers by July 15, 2018. 3) Skin incident form changed on 6/23/2018 to include "Notify DON or unit coordinator immediately of any pressure ulcer or skin problem on a pressure point". This change was included in nursing newsletter on June 24, and early detection with skin incident form will be included at nursing staff meeting agenda on July 12. Licensed nurses will be assigned an EduCare Module on pressure ulcers to be completed by July 24, 2018. Pressure ulcers have been added as agenda item on weekly High Risk Meeting Agenda to improve communication flow, care planning, and follow through until resolution. 4) Pressure ulcers will be tracked through skin incident forms/body audits and reported to QAPI. DON will monitor High Risk Committee oversight of pressure ulcers or potential pressure ulcers through resolution and report to QAPI Committee quarterly. Reporting will be for a minimum of 6 months and will continue based on the recommendation of the Committee at that time.	

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5/20/18.

R20's Physician Discharge Summary dated 5/17/18 after a four day hospitalization, indicated R20 was hospitalized due to worsening generalized weakness and dehydration. R20 had been diagnosed with C. Diff and was receiving oral antibiotics. The hospital discharge notes, dated 5/17/18, indicated R20 had blanchable redness, intact skin on his coccyx, sacrum, left and right buttocks. Treatment was to apply cavilon cream (barrier) and provide repositioning.

R20's progress note dated 5/17/18, indicated he returned to the facility at 2:10 p.m. and there were no skin issues to note.

A 5/18/18, progress note indicated R20's perineal area was slightly red and lantiseptic barrier cream was applied.

The first identification of an open area on R20's perineal area was evident in a 5/20/18, 12:43 p.m. progress note that identified a 0.7 centimeter (cm) open area noted to the top of R20's intragluteal fold (between the buttocks) upon waking that morning. The note indicated the area appeared to be from moisture, as R20 had 2 loose stools that shift. The area was cleansed and Lantiseptic barrier cream was applied. The note indicated the information would be passed on for staff to continue to apply cream and R20 was to be turned on each side rather than on his back when in bed to help aid in healing.

R20's health status notes dated 5/21/18, at 3:31 a.m. indicated R20 was repositioned every 2 hours while in bed, was incontinent of bladder, had no bowel movements and the open area to

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his coccyx was covered with duoderm (a wound dressing with water resistant outer layer).

R20's skin/wound note dated 5/21/18, at 12:29 p.m. indicated an open area to the right buttock. The area was cleansed with saline and covered with a duoderm.

A progress note dated 5/22/18, indicated R20 had an open area to the buttock near the intragluteal fold that was previously covered with a duoderm, but this was not sticking. The note indicated the nurse removed the duoderm and Lantiseptic (barrier cream) was applied to the area for protection.

Progress notes dated 5/23/18, indicated Lantiseptic cream was applied to an open area on top of the intragluteal fold. The area was described as red and had a small open area.

A progress note dated 5/25/18, indicated a physician was notified regarding R20's loose stools. The note lacked indication that the physician was notified of a coccyx, or intragluteal fold, pressure ulcer.

A skin/wound note on 5/28/18, indicated there was an open area to the left buttock and that the area was covered with Lantiseptic.

A skin/wound note dated 6/1/18, provided the first complete description and assessment of the open area on R20's perineal area. The note identified a Stage II pressure ulcer to R20's coccyx that measured 2.4 cm by 2.6 cm. The wound bed was described as red with a black center and irregular borders. The wound was cleansed, skin prep (prepares skin for adhesive dressings),

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Medihoney (helps with wound healing) and tegaderm foam (transparent, breathable dressing) were applied. The note indicated that the dressing would be changed daily and as needed if the dressing got soiled or was falling off. The note further indicated R20 had an air bed, Roho cushion to his wheelchair and was being repositioned every 2 hours and as needed.

On 5/31/18, a treatment administration was completed for tegaderm foam to ulcer on sacral/coccyx region; cleanse, apply skin prep and tegaderm foam daily and as needed until healed; one time a day for ulcer.

Review of R20's medical record lacks documentation of orders or treatment administration record to coccyx area pressure ulcer prior to 5/31/18.

Review of R20's medical record revealed the last tissue tolerance test and skin observation tools were completed on 4/13/18, prior to his C. Diff diagnosis and hospitalization.

A 6/11/18, progress note indicated R20 had a 1.0 cm circular healing open area on his coccyx.

A 6/11/18, High Risk Committee progress note indicated R20 had a new bolstered air bed and was allowing staff to turn and reposition him every 2 hours. The note did not identify R20 as having a Stage II pressure ulcer.

Review of R20's medical record lacks indication of provider notification, family notification, or care plan updates regarding the Stage II pressure ulcer on R20's coccyx which was first identified on 5/20/18.

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On 6/12/18, at 9:49 a.m., R20 was observed in bed on an alternating air pressure mattress.

On 6/13/18, from 7:05 a.m. until 8:32 a.m., R20 was observed in bed on an alternating air pressure mattress. At 8:32 a.m., nursing assistant (NA)-A and NA-B repositioned R20 according to his care plan, removing a pillow from his right side and repositioning R20 with a pillow under his left side.

On 6/13/18, at 10:48 a.m., registered nurse (RN)-D and RN-BB, were observed changing the dressing to R20's coccyx pressure ulcer. The wound was described as "almost gone"; measured at 0.9 cm x 0.5 cm x 0.1 cm; and the wound bed described as 90% white/yellow slough with 10% granulation tissues surrounding slough. The periwound was described as pink and intact.

On 6/13/18, at 11:17 a.m., RN-BB stated wound rounds were done every two weeks, she was part of wound rounds, and these were considered a formal assessment. RN-BB also indicated staff are to be charting on wounds on bath days. RN-BB confirmed R20's wound was not fully assessed until 5/30/18 (which was ten days after first noted). RN-BB stated she usually gets an incident report or a note from staff that triggers her to assess a wound. RN-BB confirmed R20 returned from the hospital with a reddened but intact area on his coccyx. RN-BB further confirmed it was a facility acquired pressure ulcer; and while the initial notes on it were from 5/20/18 and 5/21/18, she does not remember knowing about it before 5/30/18.

On 6/13/18, at 1:13 p.m. licensed practical nurse

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(LPN)-A confirmed she wrote R20's 5/21/18, skin/wound note as that was his bath day. LPN-A indicated this was not the first identification of the wound, as she remembers removing a duoderm and replacing it. LPN-A indicated she didn't know who put the original duoderm on, or when the wound first opened. LPN-A stated she was just following suit with the treatment she had found on the wound.

On 6/13/18, at 1:54 p.m. the director of nursing stated they are implementing a new skin incident report that will hopefully improve the reporting and monitoring process. The DON stated staff weren't clear on the right thing to do with the current report form. The DON indicated RN-BB was a certified wound specialist.

The facility's Prevention of Pressure Ulcers policy, dated 6/11/15, indicated the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, and reported to the practitioner, physician and family, and addressed. The policy further directed staff to routinely assess and document the condition of the resident's skin through use of a Weekly Skin Integrity Form for any signs and symptoms of irritation or breakdown. The policy also directed staff to report any signs of a developing pressure ulcer to a nurse supervisor and physician.

The facility's Pressure Ulcer Guidelines policy, dated 7/29/15, indicated wound rounds would be completed on all residents with pressure ulcers weekly and as needed by the RN for all new and established pressure ulcers. The policy further specified the following be completed on a weekly basis:

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--Observe, measure, and document pressure ulcers weekly on the Weekly Pressure Ulcer Documentation Flow Sheet.
--If deteriorating or non-healing wounds are noted, update the physician.
--Implement any new wound treatment orders obtained.
--Complete documentation to include location and staging.
--Update the care plan to include addition of any new wound treatment or nursing interventions or discontinuation of any established interventions when a wound was healed.

Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP):

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage

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F 686	Continued From page 32 should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions).	F 686		
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 complete a comprehensive nutritional assessment and evaluation based a significant weight loss over five months for 1 of 5 residents (R27) reviewed for nutrition.	F 692	1. On June 13th 2018 a nutrition assessment was completed for resident R27 by consultant dietitian, Linda Bump. Additional interventions have been implemented to increase calorie intake including providing resident with additional	7/16/18

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F 692	Continued From page 33 Findings include: R27's Admission Record, dated 6/13/18, indicated R27 was admitted on 1/22/18, had diagnoses that included atrial fibrillation, diabetes, hypokalemia, hypertension, congestive heart failure, chronic obstructive pulmonary disease and chronic kidney disease. R27's admission Minimum Data Set (MDS) an assessment dated 1/19/18, indicated his weight was 157 pounds. R27's quarterly MDS dated 5/1/18, indicated R27 weighed 140 pounds which was a 17 pound weight loss over five months. R27 and was not on a physician prescribed weight loss program. The MDS indicated this was a loss of 5% or more in the last month or a loss of 10% or more in the last 6 months. R27's Care Plan dated 5/2/18, indicated R27 had diabetes and an intervention was to request a dietary consult for nutritional regimen and ongoing monitoring and to provide a glucerna supplement twice daily related to weight loss. R27's care plan also indicated R27 was prescribed a diabetic diet and his current weight was 140 pounds with the goal of maintaining weight within 5% of 140 pounds, and consuming at least 50% of at least 2 meals daily. An intervention was for a registered dietician to evaluate and make diet change recommendations as needed. R27's medication administration record for May 2018 dated 5/1/18, indicated an order for Lasix 40 milligrams (mg) that he received once daily. The	F 692	snacks at 10:00am, 2:00pm and HS snacks, along with Glucerna BID that had been previously ordered. 2. An audit of quarterly nutrition assessments for all other residents will be completed on July 7 and 8th 2018 by consultant dietitian Linda Bump. Assessments will be completed for any residents identified. Follow ups will be completed by onsite RD. Weight loss reports will be reviewed for all residents during the first High Risk meeting of each month. Any new or recurring weight concerns will be follow up by the RD and during High Risk meetings until deemed resolved. 3. A monthly audit of new admission will be completed by the Registered Dietitian. Results will be reported at QAPI meetings until goal of 100% assessment completion is met for 2 consecutive months. As stated above, weight loss reports including weights from the past 12 months will be reviewed at the first High Risk meeting of every month to identify any additional weight risks not previously identified. 4. Monthly audits of new admissions, quarterly assessments and any additional residents of weight concern will be performed by onsite RD. Findings will be documented. Results will be reported at QAPI meetings until goal of 100% for 2 consecutive months is met.	

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administration record also indicated R27 received Glucerna supplement twice daily for weight loss.

R27's physician orders dated 6/13/18, indicated a change in dose of Lasix (a diuretic) for 20 mg once daily.

On 6/12/18, at 9:20 a.m., R27 was observed alone in his room with a breakfast plate in front of him: R27 had eaten about 25% of his gravy and biscuit, drank part of his milk, juice and coffee.

On 6/13/18, at 8:50 a.m., a breakfast tray was brought to R27 in his room; R27 was alone.

A 5/1/18, nursing progress note identified a new diagnosis of diabetes and physician notification of a 7 pound weight loss in the last month. The physician ordered a glucerna supplement.

Review of R27's progress notes does not reveal a dietary assessment or progress note nor was one provided when requested.

On 6/13/18, at 11:54 a.m., registered nurse (RN)-BB stated R27 had been slowly failing. RN-BB confirmed a dietary assessment had not been done for R27. RN-BB also stated R27 started on a supplement on 5/4/18, and that he had been newly diagnosed as a diabetic. RN-BB stated she does not work on Tuesdays and that was when R27's physician came to the facility, which made it "hard." RN-BB stated R27 doesn't eat as much as he didn't have much of an appetite. RN-BB stated R27's wife came and ate supper with R27 in his room, but RN-BB did not know if R27's wife was able to make it as much as previously. RN-BB didn't think the high risk committee or the interdisciplinary team had talked

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WARROAD CARE CENTER	1401 LAKE STREET NORTHWEST WARROAD, MN 56763

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about R27's decline in eating recently.

On 6/13/18, at 12:07 p.m., the director of nursing (DON) stated the high risk committee meets every week, but there had not been a method for carry-through to ensure that areas of concern were resolved. The DON stated the high risk committee discussed R27 on 5/14/18 regarding a fall and weight loss, but she did not see any follow up in subsequent meetings. The DON also indicated there had been issues with the dietary department, that it hadn't been strong for a long time in regards to nutritional assessments. The DON indicated a dietician had been hired, then left for medical concern and they were eagerly awaiting her return. The DON stated there was a dietician consultant hired by the facility, but she did not know how much the consultant had done with individual resident assessments. The DON also stated she didn't know what else could be done for R27, other than the current supplement.

On 6/13/18, at 2:50 p.m., the consultant dietician (CD) stated she had been hired by the facility to help with the lack of leadership and experience in the dietary department. The CD stated the dietary manager position had changed several times in the last two years and assessments were not done by the last manager. The CD stated that the new dietician hired this spring has had to focus on resident satisfaction issues and just getting meals on the table and had not had time to address systems work. The CD stated that in January 2018, she began by developing a good nutritional assessment for facility use, and then getting nutritional assessments completed for each resident in the facility. The CD stated she completed this work in January and February 2018, and stopped when the new dietician was

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F 692	Continued From page 36 hired. The CD verified there was no nutritional assessment done for R27, that an assessment should have been done on R27, and that R27 must have slipped through the cracks. The CD also stated there had been no dietary representative at care conferences for almost a year, no formal system to monitor weight changes and indicated the nurses were "carrying the ball" because the previous dietary manager had not been doing a formal nutritional assessment. The facility policy titled Nutrition screening for Referrals to the Registered Dietitian Nutritionist dated 2017, indicated facility staff would screen individuals for nutrition risk on admission, at regular intervals, or whenever a change in condition warrants, using a validated nutrition screening tool and approved process. The policy further directed staff to complete a validated screening form upon admission, and quarterly.	F 692		
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 ensure pain had been assessed in order to identify appropriate interventions and/or medical attention for 1 of 1 resident (R12) reviewed for dental pain. This resulted in a harm level for R12.	F 697	1) The affected resident has been assessed here at WSLC by Cindy Dross-Sandy, DDS, with recommendation for referral to oral surgeon to remove remaining teeth. Family has agreed to surgery and an appointment has been made for July 30, 2018. Resident was	7/16/18

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F 697	Continued From page 37 Findings include: R12 was observed on 6/11/18, at 5:40 p.m. in the dining room being fed by an unidentified nursing assistant (NA). R12 was observed to be making facial grimaces, clenching fists, and pushing self away from table while being fed and given liquids. R12 was observed to have several missing teeth. R12's Admission Record dated 6/14/18, included diagnoses of Alzheimer's disease, dementia with behavioral disturbance, and pain in unspecified shoulder. R12's annual Minimum Data Set (MDS) dated 10/1/17, indicated that R12 had severe cognitive impairment and was rarely/never able to make self understood or understand others. R12 required extensive assistance with eating and oral cares. The MDS indicated R12 had indicators of pain (facial expressions - grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) one to two days and received scheduled pain medication. Section L for dental was coded as "none of the above were present" related to broken teeth, missing teeth, likely cavities, inflamed/bleeding gums, mouth or facial pain. However, the MDS was coded inaccurately as R12 underwent oral surgery to extract 14 teeth on 7/25/17. R12's pain Care Area Assessment (CAA) dated 10/1/17, indicated R12 does have pained facial expression at times, such as grimacing, furrow brow, etc.. It is not clear that this is pain-related due to R12's difficult time with communication and is mostly not possible to have a conversation with. R12 did have a history of back pain and	F 697	started on Augmentin for facial flushing and fever on June 29, 2018. Pain monitoring had already been on nurse charting board, but has also added to e-Mar as of July 6, 2018, and an order obtained for prn Tramadol in addition to scheduled Tramadol and Tylenol in the event of pain observed. 2) An oral inspection with pain assessment will be completed by an RN on all WSLC residents with their own teeth in poor condition by July 10, 2018, and dental examination appointments will be made if appropriate. A dental contract has been established with Cindy Dross-Sandy, DDS, who performs dental examinations at WSLC if needed. 3) Dental assessments will be completed by RN in conjunction with quarterly MDS assessments, and a field added to WSLC Care Conference form to trigger a discussion with resident/family related to dental needs. A reminder was provided to all nursing staff to report any evidence of oral pain to charge nurse in nursing newsletter on June 24, and this will also be included in the July 12 nursing meeting agenda. "Unmanaged Pain" has been added to high risk flow sheet and standard agenda as an additional trigger point to ensure pain is addressed. 4) WSLC Director of Nursing or designee will monitor dental assessments completed quarterly with appropriate follow up and report findings to the facility QAPI Committee. Reports will be	

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F 697	Continued From page 38 was having presumed oral pain prior to dental surgery. Care plan will include interventions to monitor for and keep pain controlled. R12's quarterly MDS dated 4/3/18, indicated no notations in the oral care section and pain 1-2 days as noted by facial expressions or protective body movements. However, the MDS was coded inaccurately as R12 underwent oral surgery to extract 14 teeth on 7/25/17. R12's care plan provided on 6/14/18, directed one to two staff members to provide personnel hygiene which included oral care. The hygiene care plan indicated R12 had her own teeth and did not identify R12 had missing teeth. The care plan did not specify how or when to provide oral care and did not include and/or identification of goals to maintain dental health. The care plan directed staff to administer medications, monitor/record pain characteristics, report to nurse any signs or symptoms of non-verbal pain, and notify physician if interventions are unsuccessful or if current complaints were a significant change from past experience of pain. R12's care plan did not include dental pain. Pain in Advanced Dementia (PAINAD) assessment completed 4/3/18, indicated R12 to score a one on a 0 to 10 scale (0="no pain" to 10="severe pain"). The pain assessment did not identity the location of the pain. Physician's orders for pain relief include acetaminophen 160 mg (milligrams)/5 ml (milliliter) give 15 ml every 6 hours as needed for back pain; acetaminophen 160 mg/5 ml, give 15 ml one time per day for back pain; Tramadol 50 mg give 0.5 tablet twice daily for pain in shoulder.	F 697	provided for a minimum of six months and until such time the Committee determines there is no longer a need based on satisfactory performance and documentation.	

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The last Dental Observation completed on 9/30/16, indicated R12 was resistive to oral cares, staff attempt to brush teeth twice daily, but R12 will often clench mouth shut. Staff have tried giving R12 a prepared toothbrush with toothpaste and verbally prompt to brush but R12 is uncooperative. Will continue attempting oral cares and schedule dental exams as necessary. No further dental observations/assessments were completed.

Review of R12's record revealed ongoing and worsening of oral pain and oral health without dental treatment and services.
-on 7/25/17, oral surgery for extraction of 14 teeth (per letter from oral surgeon dated 7/31/18).
-on 11/28/17, (referral form) nursing observation that R12 had been yelling more and grinding her teeth. Possible tooth pain. Physician's recommendation was to talk with son to see if he wants a dental appointment. The other option is pain control but did not know if there is infection of teeth which if present could get worse.

R12's record lacked evidence of an oral assessment or attempts of, the record further lacked evidence of monitoring for signs and symptoms of infection, and also lacked evidence R12's family member (FM)-A was contacted in reference to a dental appointment for further evaluation.

-on 12/15/17, (health status note) when physician was here in November, R12 was showing signs of possible mouth pain again and talked about possibility of having remaining teeth extracted. FM-B notified and asked if it looks like there is an increase in pain or infection, should

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arrangements be made to extract remaining teeth? FM-B responded "yes, if it would help keep her comfortable."

R12's record continued to lack evidence of oral examinations and documentation of monitoring for oral pain and or signs and symptoms of infection. From 12/15/17 to 4/12/18, the record had no mention and did not address or evaluate dental/oral health.

Review of nursing progress notes (PN) and interdisciplinary team (IDT) notes from 4/12/18, through present day reflected an increase in staff observations of R12 demonstrating oral discomfort.
- 4/12/18, PN, R12 lost one of her molar teeth that looked like it had rotten out.
- 5/16/18, IDT, indicated grinding more - monitor tooth pain.
-5/25/18, PN, R12 did not like the cold juice when taking medications.
-5/26/18, PN, R12 had been grinding teeth this shift, when drinking cold liquid would pull back and get upset. R12 was asked multiple times if teeth hurt and at one point R12 did say "yes." R12 will not open mouth to allow you to look at teeth.
-5/27/18, PN, R12 was noted to be grinding her teeth on and off this shift, cold liquids irritate her and she pulls away.
-5/30/18, PN, R12 did pull her head back while taking a drink through a straw and then stopped drinking.
-5/30/18, IDT, indicated teeth? "my teeth twitter" "yes" " Call Dentist."
-5/31/2018, PN, when attempting to look in mouth to see current condition of teeth R12 clamped lips together and would not open mouth.

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-6/1/18, PN, R12 was grinding her teeth at the lunch table.
-6/5/18, PN, R12 was noted to have reddened area to lower left jaw and upper right jaw, possibly due to tooth decay. Will notify family and make appointments as needed.
-6/8/18, PN, R12 was grinding her teeth this shift while at the supper table, while changing into pajamas, and getting ready for bed.
-6/9/18, PN, R12 pulled her head back and would shake her upper torso when trying to give food.
-6/11/18, PN, R12 was noted to be grinding teeth while taking morning medications in milk.
-6/11/18, PN, R12 was grinding teeth this evening while getting her PM medications.
-6/13/18, PN, included "teeth? in pain"

Despite documented concerns with teeth/oral pain, an examination/assessment of R12's oral cavity or attempts of assessment even after identification of possible signs and symptoms of infection was not completed. There was no ongoing monitoring of signs and symptoms of a possible oral infection. The physician was not notified of the notations of increased oral pain since 5/26/18, and was not notified of the signs and symptoms of an oral infection that began on 6/5/18. In addition, the record lacked evidence the family was notified R12 had lost a tooth, R12 had demonstrated an increase in oral pain, and the signs and symptoms of infection. The record further lacked evidence a dentist was contacted and/or a referral made as directed on 12/15/17, by a family member.

R12's physician progress notes reviewed did not address oral/dental status.

On 6/13/18, at 11:35 a.m. R12 was being fed in

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the dining room by nursing assistant (NA)-C and registered nurse (RN)-E was observing. R12 was observed making facial grimaces when drinking supplement from a straw. NA-C stated that the facial grimaces indicated that R12 was in pain although could not determine if it was related to sucking through straw or the liquids being cold.
-At 12:04 p.m. RN-E stated she had spoken to son after referral on 11/28/17, and son wanted to hold off with dental referrals for awhile longer. RN-E stated at this time they were just monitoring her pain and signs or symptoms of infection daily. RN-E stated monitoring was what R12's family wishes were. RN-E verbalized there was no documentation of conversations with family.
-At 12:36 p.m. RN-E was interviewed regarding progress note 6/5/18, which indicated family would be notified and appointments made as needed. RN-E stated she tried to contact FM-A and FM-B, left messages with them, had not heard back, and did not document the attempt in the record. RN-E confirmed R12's discomfort noted while drinking from a straw at lunch today could have been from dental discomfort.
-At 12:45 p.m. NA-C stated R12 was showing an increase in mouth pain for the last month to month and a half. NA-C indicated R12 used to use a straw all the time and now could not without grimacing.
-At 12:51 p.m. contacted family member (FM)-A who is the primary contact by telephone. FM-A stated R12 had 13 teeth pulled last year. FM-A stated there had not been any recent contact from the nursing home regarding recent signs of oral discomfort and FM-A would expect to be contacted with that concern.
-At 2:33 p.m. director of nursing (DON) indicated her expectation was an appointment should have been made for R12 since she was experiencing

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signs of discomfort. The RN should not be awaiting contact from family as we already have the approval from them dated 12/15/17, to have teeth extracted if resident was experiencing pain.

On 6/14/18, at 7:22 a.m. NA-A stated R12 made weird noises all the time, and it is common with Alzheimer's. NA-A added R12 grinds teeth. NA-A stated R12 was in pain, grinded her teeth all the time when awake and asleep. NA-A stated the pain had been reported to the RN. NA-A indicated that R12 has had decreased appetitive for awhile, however, could not recall for how long.
-At 7:49 a.m. NA-C stated R12 was choosing not to eat and guessed it was related to pain. NA-C also stated R12 winced with the cold liquids and when using a straw R12 pulled back and grimaced. NA-C further stated, R12 would also do that with food too at times and at times it appeared that R12's teeth bothered her. NA-C indicated that last week, the left lower side of mouth was swollen/red and was reported to nurse. NA-C also indicated, R12 grinded her teeth most days, and would not let staff use a toothbrush but they use a diluted mouthwash and a pink swab which R12 resisted everyday by pulling her body back. NA-C then stated R12 had a little bit of a mouth odor, and there were days R12 would not eat much and on other days she would eat everything, and could not tell if it was because of her teeth or dementia. NA-A indicated that she lets beverages come to room temperature before offering and R12 takes them better.
-At 8:09 a.m. NA-A entered room with breakfast tray consisting of oatmeal and carnation instant breakfast. R12 kept lips clamped shut, turned head away and verbalized "no." NA-A would touch R12's lips with spoon and straw to attempt

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to get R12 to open mouth. NA-A indicated that R12's face appeared pink in color, but added R12 gets really warm. R12 began to take bites and drink milk, no grimacing noted or difficulty swallowing.
-At 8:36 a.m. NA-A stated R12 consumed entire breakfast. NA-A made an attempt to do oral care with a pink swab and diluted mouthwash. R12 opened mouth once and sucked on swab then opened mouth again at which time NA-A placed pink swab on left side of mouth in a back and forward motion. R12 yelled out and pushed swab out of mouth. NA-A attempted to cleanse mouth three times with R12 holding mouth clamped tightly closed.
-At 9:49 a.m. contacted dentist by telephone. R12 was never seen in the dentist office but dentist visited R12 on 6/21/17, at nursing home, concluding there were many teeth in need of extraction. FM-A decided only the bad teeth needed to be removed and left the molars in place. Dentist stated there have been no further consults regarding R12 and dentist does not have a contract with the nursing home.
-At 10:30 a.m. activities aides (AA)-C indicated R12 had been grinding teeth. AA-C stated she usually assists R12 with eating three times a week and had not noticed any problems with cold drinks, just noticed tightness of her mouth and some sweating. No swelling of checks noted. During the last 2 weeks AA-C stated puckering/tightening of mouth increased and indicated pain could be the reason.
-At 11:00 a.m. licensed practical nurse (LPN)-B stated she had not noticed grimacing/pulling away when drinking although R12 was only observed when administering medications. LPN-B stated swelling in the jaw area could be an indication of a tooth issue, which could be an infection, might

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require hospitalization, intravenous medications, sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) could occur and possible death. LPN-B stated chances are pretty good that could happen with R12. When LPN-B examined R12's oral cavity she noted filled teeth and some of them were black. LPN-B indicated R12 has grinded teeth for a long time.
-At 12:14 p.m. RN-E stated R12 began having dental concerns sometime last summer noting poor teeth and not allowing oral cares to be completed. The plan was to have all teeth extracted although family member intervened and requested only infected teeth be removed. RN-E believes R12 has three remaining teeth. RN-E stated R12 had recently been experiencing pain but unsure if it is dental or back issues from past accident. RN-E indicated it was difficult to examine R12's oral cavity. RN-E stated telephone conversations with family have occurred, although not documented, indicating to just keep monitoring. RN-E stated redness noted on 6/5/18, was just slight and was not reported to physician. RN-E was not able to speak regarding risks of sepsis. RN-E stated the MDS coordinator completes the oral assessments. RN-E indicated charting is not completed regarding oral cares. When asked expectation if staff reported pain to RN-E she indicated she would do an assessment, which she stated she attempted although did not document attempt and did not notify physician.

-At 12:59 p.m. RN-A stated an oral exam and dental assessment is completed with annual MDS. RN-A indicated when completing R12's annual MDS October 2017, no problems were noted on the assessment although she could not recall if she looked into R12's oral cavity. RN-A

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stated R12 had pain at the time but was unclear if dental or something else.

-At 2:20 p.m. director of nursing (DON) stated a dentist should have been contacted for R12. DON confirmed a signed contract with a dentist for emergency services did not exist. DON stated the family should have been contacted and there should have been documentation regarding any conversations with family. It would be expected that risk and benefits should have been discussed with family.

Attempts to contact FM-B were unsuccessful.

Dental Services procedure dated 3/9/17, indicated oral health review will be completed with the data collection annually. Residents will be promptly referred to a dentist.

Pain policy dated 3/1/17:
directed physician and staff to identify individuals who have pain or who are at risk for having pain related to oral or dental pathology.
nursing staff will assess when there is onset of new pain or worsening of existing pain.
nursing staff to assess pain using a consistent approach and a standardized pain assessment instrument
nursing staff will observe resident (during rest and movement) for evidence of pain
the staff and physician will also evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, including complication such as sleep/rest, social activities, appetitive.
the physician will help identify causes of pain; for example by examining the resident directly, reviewing history, and discussion with staff.

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F 697	Continued From page 47 nursing staff will reassess the individual's pain and related consequences at regular intervals; at least each shift for newly identified pain. Pain Assessment and Management procedure dated 3/1/17: pain management includes: assessing the potential for pain, effectively recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of pain, developing and implementing approaches to pain management, identifying and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of interventions, modifying approaches as necessary, conduct a comprehensive pain assessment quarterly, when there is onset of new pain or worsening of existing pain, assess the resident's pain and consequences of pain at least each shift for acute pain. report the following information to physician: significant changes in the level of the resident's pain, adverse effects from pains medications, prolonged, unrelieved pain despite care plan interventions.	F 697		
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	F 755		7/12/18

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F 755	Continued From page 48 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 observation and interview, the facility failed to ensure a controlled medication (lorazepam) that has potential for abuse was reconciled to ensure rapid detection of potential diversion for 1 of 2 storage rooms toured at the facility. This had the potential to affect residents who were prescribed lorazepam on an emergency basis. Findings include On 6/13/18, at 1:27 p.m. the medication storage room was toured with registered nurse (RN)-D. During the tour a box was noted in the refrigerator which contained lorazepam 2.0 milligram (mg) liquid. This box was contained in a plastic bag	F 755	1) Lock boxes were purchased for A and B wing medication room refrigerators and Lorazepam was placed under double lock on June 14 with reconciliation process established for emergency kit controlled medication requiring refrigeration. Reconciliation has been accomplished every shift since June 14 at shift change with two nurses signing. 2) Intervention above will resolve this deficient practice for all residents at WSLC. 3) Medication Storage Policy has been established, approved by consulting pharmacist, and will be discussed with nurses during July 12 nursing staff	

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F 755	Continued From page 49 labeled E-kit (emergency kit). RN-D stated the medication was part of the E-Kit which required refrigeration. RN-D indicated lorazepam was a controlled medication that had a potential for abuse and required reconciliation (counted by two nurses every shift) to avoid diversion. RN-D indicated the facility was not counting this medication and it would not be easily identifiable if doses were missing. On 6/13/18, at 2:29 p.m. the director of nursing (DON) verified lorazepam was considered a controlled medication that had potential for abuse and required reconciliation by nurses every shift. DON confirmed this practice was not occurring at the facility and the facility did not have a system in place for the reconciliation of refrigerated E-Kit controlled medications. The facility Policy and Procedure for Storage of Controlled Medications was requested although not provided by the facility.	F 755	meeting. 4) DON receives e-kit controlled medication requiring refrigeration reconciliation sheets monthly and will monitor compliance and report discrepancies or areas of concern to QAPI Committee. A field was added to consulting pharmacist monthly audit sheet to include checking proper storage and reconciliation of refrigerated controlled medications.	
F 790 SS=F	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency dental services to meet the needs of each resident;	F 790		7/12/18

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F 790	Continued From page 50 §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain dental services for 1 of 1 resident (R12) reviewed for dental care. In addition, the facility failed to obtain an agreement to obtain emergency dental services which could affect all 47 residents at the facility. Findings include: R12 had been observed on 06/11/18, at 5:40 p.m. located in the dining room being fed by an unidentified nursing assistant (NA). R12 was	F 790	1) The affected resident has been assessed here at WSLC by Cindy Dross-Sandy, DDS, with recommendation for referral to oral surgeon to remove remaining teeth. Family has agreed to surgery and an appointment has been made for July 30, 2018. Resident was started on Augmentin for facial flushing and fever on June 29, 2018. Pain monitoring had already been on nurse charting board, but has also added to e-Mar as of July 6, 2018, and an order	

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F 790	Continued From page 51 observed to be making facial grimaces, clenching fists, and pushing self away from table while being fed and given liquids. R12 was observed to have several missing teeth. R12's annual Minimum Data Set (MDS) an assessment dated 10/1/17, indicated R12 had severe cognitive impairment and was rarely/never able to make self understood or understand others. R12 required extensive assistance with eating and oral cares. The MDS indicated R12 had indicators of pain (facial expressions - grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) one to two days and received scheduled pain medication. Review of R12's notes: -on 7/25/17 oral surgery for extraction of 14 teeth (per letter from oral surgeon dated 7/31/18) -on 11/28/17, (referral form) nursing observation that R12 had been yelling more and grinding her teeth. Possible tooth pain. Physician's recommendation was to talk with family member (FM)-A to see if R12 needs a dental appointment. The other option is pain control but I do not know if there is infection of teeth which if present could get worse. -on 12/15/17, (health status note) when physician was here in November, R12 was showing signs of possible mouth pain again and talked about possibility of having remaining teeth extracted. FM-B notified and asked if it looks like there is an increase in pain or infection, should arrangements be made to extract remaining teeth? FM-B responded "yes, if it would help keep her comfortable." Review of nursing progress notes showed an increase in observations of R12 demonstrating	F 790	obtained for prn Tramadol in addition to scheduled Tramadol and Tylenol in the event of pain observed. 2) An oral inspection with pain assessment will be completed by an RN on all WSLC residents with their own teeth in poor condition by July 10, 2018, and dental examination appointments will be made if appropriate. A dental contract has been established with Cindy Dross-Sandy, DDS, who performs dental examinations at WSLC if needed. 3) Dental assessments will be completed by RN in conjunction with quarterly MDS assessments, and a field added to WSLC Care Conference form to trigger a discussion with resident/family related to dental needs. A reminder was provided to all nursing staff to report any evidence of oral pain to charge nurse in nursing newsletter on June 24, and this will also be included in the July 12 nursing meeting agenda. 4) WSLC Director of Nursing or designee will monitor dental assessments completed quarterly with appropriate follow up and report findings to the facility QAPI Committee. Reports will be provided for a minimum of six months and until such time the Committee determines there is no longer a need based on satisfactory performance and documentation.	

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F 790	Continued From page 52	F 790		

oral discomfort:
-on 4/12/18, R12 lost one of her molar teeth that looked like it had rotten out.
- on 5/25/2018, R12 did not like the cold juice when taking medications.
-on 5/26/2018, R12 had been grinding teeth this shift, when drinking cold liquid would pull back and get upset. R12 was asked multiple times if teeth hurt and at one point R12 did say "yes". R12 will not open mouth to allow you to look at teeth.
- on 5/27/18, R12 was noted to be grinding her teeth on and off this shift, cold liquids irritate her and she pulls away.
- on 5/30/18, R12 did pull her head back while taking a drink through a straw and then stopped drinking.
- on 5/31/18, when attempting to look in mouth to see current condition of teeth R12 clamped lips together and would not open mouth.
- on 6/1/18, R12 was grinding her teeth at the lunch table.
- on 6/5/18, R12 was noted to have reddened area to lower left jaw and upper right jaw, possibly due to tooth decay. Will notify family and make appointments as needed.
- on 6/8/18, R12 was grinding her teeth this shift while at the supper table, while changing into pajamas, and getting ready for bed.
- on 6/9/18, R12 pulled her head back and would shake her upper torso when trying to give food.
- on 6/11/18, R12 was noted to be grinding teeth while taking morning medications in milk.
- on 6/11/18 R12 was grinding teeth this evening while getting her PM medications.

Review of Interdisciplinary Team daily handwritten reports:
- on 5/16/18 indicated grinding more - monitor

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F 790	Continued From page 53 tooth pain - on 5/30/18, indicated teeth? "my teeth twitter" "yes" Call Dentist - on 6/13/18, indicated teeth? in pain There had been no indication that a dental appointment was set up for R12 even with evident oral pain with eating/drinking over past month. On 6/14/18 at 2:20 p.m. director of nursing (DON) stated absolutely a dentist should have been contacted for R12. Lack of dental agreement: On 6/14/18, at 8:54 a.m. Administrator provided a written statement indicating still looking for signed copy of dental contract with a dentist. By end of survey there was no signed dental agreement provided by the facility. Dental Services procedure dated 3/9/17, indicated facility offers routine dental services to residents. The facility has a written agreement with dental services that visits on a regular basis. Oral health review will be completed with the data collection annually. Pain policy dated 3/1/17: directed physician and staff to identify individuals who have pain or who are at risk for having pain related to oral or dental pathology.	F 790		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides-	F 804		7/24/18

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F 804	Continued From page 54 §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food temperatures were of resident preference for palatability level for 1 of 1 resident (R13) reviewed for food palatability. Findings include: R13's Admission Record dated 6/14/18, indicated R13 had diagnosis that included diabetes, Vitamin D deficiency, and vascular dementia without behavioral disturbance. R13's admission Minimum Data Set (MDS) an assessment, dated 4/4/18, indicated he could clearly understand others, had no behaviors and did not reject cares. R13's Care Plan dated 3/29/18, indicated R13 was able to feed himself after set up. R13's care plan also indicated he was able to make simple daily decisions and make himself understood. On 6/11/18, at 7:38 p.m., R13 stated food could be improved as green beans are served often, no one at his table liked them, and breakfast foods were not always hot. On 6/13/18, at 7:42 a.m., R13 stated his eggs were warm and liked them hot. R13's table mate heard the conversation and agreed the food was	F 804	The facility will maintain acceptable parameters for food and drink that is palatable, attractive and at a safe and appetizing temperature. 1. Resident comments from survey findings were reviewed in addition to comments from Resident Council minutes. 2. RD, or Kitchen Manager will attend Resident Counsel meetings upon invitation to address any concerns relating to food service activities. 3. Follow up of any concerns from Resident Counsel or daily meal service will take place in a timely manner and will be reported at Resident Counsel meetings on a regular basis. As of 7/6/18 all staff have been education on safe food holding and service, as well as educating staff on taking temperatures prior to service. Policy and Procedures for holding and serving foods to a palatable temperature will be revised by 7/12/18. Staff will also be educated on customer service skills pertaining to resident satisfaction during meals by 7/24/18. 4. Food temperatures will be logged daily at time of service. Weekly audits will be conducted by kitchen manager and will	

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F 804	Continued From page 55 warm and not hot as they liked. On 6/14/18, at 8:14 a.m., R13 was observed finishing breakfast. When asked about breakfast, R13 stated, "it was good today." When asked if it was hot enough, R13 replied, "Well, it's never that!" and said we could write down we don't get hot food. On 6/14/18, at 8:20 a.m., a breakfast test plate was requested from dietary aide (DA)-A. DA-A used a thermometer to test the oatmeal, which was at 158 degrees Fahrenheit (F); the egg bake, which was at 138 F, and the sausage which was temped at 85 F. DA-A stated she had put the food in the steam tables at the station at approximately 7:15 a.m. When tasted, the oatmeal tasted hot, the egg bake and the sausage luke warm. See F565: regarding resident council having a grievance of not serving foods hot for several months without a resolution. The facility Food Temperatures policy, dated 2017, indicated all hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135F. Review of other policies lacked direction on palatability of food temperatures.	F 804	be reported at QAPI meetings. Audits will be performed for 3 days out each week on resident meal satisfaction either by the Director of Dining Service or under her direction. They will be conducted in a random dining room and at random meal times as chosen by the Director. Sampling will be reviewed to make sure we are covering all dining rooms and each of the three main meal times. Audits will be reported by the Director at Resident Food & Council meetings and QAPI meetings until goal 85% appropriate responses is met for 2 consecutive months. At that time the Committee will change audit frequency and number until they are comfortable that the problem has been resolved on an ongoing basis.	
F 812 SS=L	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.	F 812		7/24/18

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F 812	Continued From page 56 (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 appropriately cool vegetable beef soup in a manner that prevented and/or minimize the risk for food borne illness. This deficient practice resulted in an immediate jeopardy (IJ) due to the potential risk of serious illness for all 47 residents who resided in the facility and received meals from the kitchen. The immediate IJ was identified on 6/11/18, when it was determined the vegetable beef soup had not cooled to the appropriate temperature within the required timeframe in order to prevent the growth of infectious organisms which cause food borne illnesses. The administrator and the director of nursing (DON) were informed of the IJ on 6/11/18, at 8:26 p.m. The IJ was removed on 6/13/18, but non-compliance remained at the lower scope and severity of an F, widespread, no actual harm with potential for more than minimal harm that is not immediate jeopardy. Findings include:	F 812	1. on 06/12/2018 the facility provided a Plan of Correction for the Immediate Jeopardy situation that included the following: Monday 06-11-18 1. Upon notification of the problem by the survey team the Chef Manager was notified by phone and we initiated alternate menu planning for the next day. Approximately 8:50 p.m. 2. Items in the cooler were specifically identified with the Chef manager over the phone, removed and disposed. Approximately 9:00 p.m. 3. Chef Manager returned to the kitchen to inspect for any similar concerns in the cooler or other food storage areas. Approximately 9:15 p.m. 4. Communicated the situation with the Dining Services Director/ Registered Dietitian who is currently on maternity leave. She indicated the ability to come to	

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F 812	Continued From page 57 During the initial kitchen tour on 6/11/18, at 3:14 p.m. with cook (C)-A, the following was observed sitting on the counter, uncovered: -A two gallon, square plastic container with approximately a ¼ inch congealed surface. The container was completely full. -A two gallon stock pot type kettle with approximately a ½ inch thick, crust like, congealed surface. The pot was ½ full. At the time of the observation, C-A stated she had finished making vegetable beef soup at 2:00 p.m.. and placed it in the above containers and on the counter to cool. C-A stated at that time the soup was put into the containers, it measured 207 degrees. C-A stated the soup was for the next day's lunch meal. C-A stated it would take about an hour and a half to cool down to the appropriate temperature. The soup had not been stirred since placed on the counter. At the request of the surveyor, C-A checked the temperature of both containers which revealed both measured 120 degrees. C-A stated the soup was getting closer to being able to be put in the refrigerator and would be putting the soup in the cooler once it had cooled down some more. -At 5:15 p.m. the dietary manager (DM) confirmed the findings and stated for now, they had put the soup in the coolers. The DM stated the cooling time for food should be less than two hours. The DM also stated within two hours, the temperature of the cooling food should have been below the danger zone (period when bacteria grow most rapidly) of 41 degrees. The DM also stated in order to properly cool food, it should have been put into smaller divided containers and directly into the cooler. The DM stated he had	F 812	the facility in the morning to assist with Plan of Correction and follow up. Approximately 9:45 p.m. Tuesday 06-12-18 5. Met with morning Cook [Serve Safe Certified] and discussed upcoming menu and looked for any issues that may be of concern for similar food handling safety related issues. Approximately 6:15 a.m. 6. Contacted Consultant Dietitian to seek assistance with training materials and suggestions for immediate response for training. Approximately 8:00 a.m. 7. Dining Services Director arrived on site to begin plan for immediate training of team members. Approximately 10:15 a.m. Following pages further indicate our plans to correct the deficient practice and obtain compliance. 1. Dining Services Director reviewed the policy manual that has been under her review and development to replace existing policies. [Becky Dorner] Related policies were reviewed and will be rolled out to staff onsite starting 06/12/2018. [General Food Preparation and handling & General HACCP Guidelines for Safe Food Handling.]Staff members not scheduled today will be trained prior to their next scheduled shift. All training records will be maintained. In addition the facility through the Director will purchase online training to	

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F 812	Continued From page 58 worked at the facility for about two months and was previously ServSafe certified, however, he had not kept up the certification. In addition, the DM stated there was only one kitchen staff member that was currently ServSafe certified. -At 6:03 p.m. both containers of soup were observed on the bottom shelf of the cooler. The DM stated he was unsure what time the soup was actually placed in the cooler and referred to a "log." The DM stated according to the documentation on the "log," the soup measured 100 degrees at 4:30 p.m. just prior to it being put in the cooler, however, he did not know if that was for both containers, or just one. The DM verified there was no further documentation of the soup's temperatures having been taken/monitored as it was cooling. At this time, the DM obtained the temperature of both containers. The plastic container's soup was 130 degrees and the metal pot was 90 degrees. The DM stated he was uncertain of the cooling protocols for all foods and was in the process of purchasing cooling/ice sticks to aid in the rapid cooling of foods but confirmed he had not ordered any, yet. -At 6:38 p.m. the DM confirmed the soup should have been cooled sooner and faster. The DM again confirmed the soup had less than two hours for cooling time to prevent bacterial growth, therefore should have been placed in a cooler in smaller divided containers in order to cool properly in order to prevent food borne illness. The DM stated the soup was going to be discarded. On 6/14/18, at 11:47 a.m. the registered dietician (RD) who was on leave had arrived at the facility	F 812	supplement policy implementation. Training will begin on 06/13/2018 and will be completed by /06/20/2018 [Becky Dorner Food Safety Made Easy In-service.] Additional online training [ServSafe Food Handler Online] will be completed with all departmental staff by June 30, 2018. To monitor compliance with policy and online training the following monitoring will be initiated immediately and will continue until compliance is satisfactory. All results will be reviewed daily by the Chef Manager and/or department director. Trended results will be shared with QAPI Committee and reviewed at their regularly scheduled meetings. [Critical Control Point Documentation Form] Additional information to include with previous POC: Staff members completed review of related policies prior to their next schedule shift. All completed review by 6/16/18. Staff members were educated on proper food handling including cooling procedures using Becky Dorner Food Safety Made Easy on 6/20/2018. Pre and post tests were given and completed at time of completion. All staff members will complete ServSafe Food Handler Certificate online training by 7/10/18. Any new hires will complete training on safe food handling during orientation prior to start date using Becky Dorner□s Food Safety Made Easy including pre and post	

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F 812	Continued From page 59 to assist with the removal of the IJ, confirmed the soup was not cooled properly and was discarded. The RD stated education would be provided to the staff. On 6/14/18, at 12:21 p.m. the on call dietary consultant stated the administrator had informed her of the IJ and agreed the soup was improperly cooled which could have caused food borne illness if consumed. The facility's undated, General HACCP Guidelines for Food Safety policy and procedure bullet #5, titled, Essentials of Cooling, directed the staff to cool food from 135 degrees to 70 degrees in two hours and from 70 degrees to 41 degrees in four hours, not to exceed six hours. If food was not cooled to 41 degrees within six hours, reheat to 65 degrees for at least 15 seconds (within two hours) and discard if not served immediately. This included mechanically altered foods. Take temperatures frequently to determine if altered methods of cooling are needed. The policy also directed staff to: -divide food into several smaller batches, and in containers that permitted the food to cool rapidly. Place in smaller pre-chilled stainless steel pans. -Place pans in an ice bath and stir foods as they cool, then refrigerate (ice bath should contain more ice than water). Avoid cooling foods in storage refrigerators or freezers. (This can bring the total temperature of the unit to an unsafe level). -Place cooling items on the top shelf of the refrigerator or freezer uncovered or loosely covered in two inch shallow pans and stir every 15 to 60 minutes. -Allow air to circulate around the food.	F 812	tests. All training records will be maintained. Cooling logs for CCP foods are being used and records will be maintained for 1 year. Audits of temperature log will be performed weekly by Kitchen Manager and monthly by RD. New menu□s including recipes with CCP□s have been ordered and will be implemented by 7/23/18. Appropriate kitchen staff will be trained to the mandatory use of new recipes. RD will sign every menu and diet spread highlighting foods of concern relating to CCP□s. New small wares appropriate for cooling will be purchased including cooling rods by 7/23/18.	

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F 812	Continued From page 60 On 6/13/18, at 11:08 a.m. the administrator was notified that the IJ had been removed after the following facility interventions were implemented: -discarded the soup at 9:00 p.m. on 6/11/18, and initiated an alternate menu in place of the soup. -inspected the kitchen for any similar concerns in the coolers and other food storage areas. -notified the RD who was on leave and agreed to come to the facility to assist with the removal plan and education. -reviewed the upcoming menu for any potential concerns related to cooling/food handling. -contacted the consultant dietician to seek assistance with training materials and suggestions. -reviewed and/or revised policies and procedures related to the proper cooling of foods. -online education (ServSafe Food Handler) related to food safety was purchased and the training for all dining service team members would begin on 6/13/18, and would be completed by 6/20/18. -revised/updated current policies and procedures. -educated all kitchen staff on the revised/updated policies and procedures specifically related to the safe and proper cooling of foods.	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;	F 865		7/24/18

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F 865	Continued From page 61 §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 document review, the facility failed to conduct ongoing quality assessment (QA) and assurance activities and develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware of that had the potential to adversely affect all 47 residents residing in the facility. Findings include: On 6/14/18, at 1:30 p.m. director of nursing (DON) stated the facility's QAPI plan that would include policies and protocols that would identify and correct its own quality deficiencies was in development stage and had not yet been implemented. DON stated quality assurance projects had been identified by the Casper report and infection control logs. DON indicated that for existing quality assurance projects goals with timelines with corresponding written action plans with timelines had not been established . DON indicated there was not a good system in place to identify other areas for needed quality improvement. DON further stated, although the	F 865	1) Deficient practices that impacted specific residents have been addressed under comments and plans specifically related to lack of compliance under other tags in this statement of deficiency. 2) Identification of other residents with the potential to be affected by specific deficient practices has been addressed under respective tags as well. 3) A final draft of a comprehensive facility QAPI plan has been finalized and will be presented for discussion and approval at a QAPI Committee Meeting scheduled for July 25, 2018. The standardized QAPI Committee Meeting Agenda has been enhanced to incorporate resident council concerns, staff education requirements, and other topics being monitored in follow up to survey findings. 4) Executive Director and DON will oversee QAPI Committee, and ensure that agenda items are discussed at each meeting with appropriate assignments of follow up items, timelines, and follow through until resolution. Documentation of these discussions and activities will be	

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F 865	Continued From page 62 quality assurance (QA) committee was aware of the lack of leadership and training in the dietary department; goals and action plans to resolve the situation had not been developed. In addition, the QA committee had not been apprised nor had the committee identified the continued resident council grievances pertaining to food quality and the lack of required dementia care training and 12 hour annual nurse aide training. The following areas of deficient practices were identified during the course of survey that were not identified for performance improvement initiatives and/or was there evidence of QA monitoring systems to assist in ascertaining areas in need of improvement by the QA committee: See F812: Based on observation, interview, and document review the facility failed to use the safe cooling methods of soup for future use in a manner that would minimize and/or prevent the risk for food-borne illness. This had the potential to effect all 47 residents resident in the facility. This deficient practice resulted in an immediate jeopardy that was identified on 6/11/18. See F697: Based on observation, interview and document review, the facility failed to ensure pain had been assessed in order to identify appropriate interventions and/or medical attention for 1 of 1 residents (R12) reviewed for dental pain. This deficient practice resulted in harm. See F565: Based on interview and document review, the facility failed to address the resident council's concerns related to food temperature, quantity and quality, during a survey initiated resident council meeting with 8 of 15 residents	F 865	maintained in the meeting minutes	

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F 865	Continued From page 63 (R36, R40, R26, R6, R34, R38, R41 and R8) active members of the facility resident council. See F947: Based on interview, and document review, the facility failed to ensure 12 hours of annual in-service training was completed by 4 of 4 nursing assistants (NA-G, NA-H, NA-I, NA-J) whose personnel records were reviewed. In addition, the facility failed to ensure required dementia training was completed by 4 of 4 nursing assistants (NA-D, NA-E, NA-F) whose personnel records were reviewed. The following areas of deficient practices were identified during the course of the survey that were identified in the QA committee minutes provided by the director of nursing; however, lacked overall quality assurance activities in order to maintain compliance with identified areas of deficient practices. The minutes further lacked evidence of identification of comprehensive action plans that included specific goals, and time frames for completion. The minutes also lacked, evidence interventions were implemented, analyzed, reevaluated and revised as necessary to ensure successful completion. See F692: Based on interview and document review, the facility failed to complete a comprehensive nutritional assessment and prevent, assess, and monitor subsequent significant weight loss for 1 of 5 residents (R27) reviewed for nutrition. See F804: Based on observation, interview, and document review the facility failed to ensure hot foods were served at a palatable temp. Minutes dated 7/12/17, identified multiple	F 865		

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F 865	Continued From page 64	F 865		

grievances made in March, pertaining to food quality, however, did not reflect concerns from the resident council. Minutes also reflected one resident with excessive/unexplained weight loss and indicated a team was established and working on identifying residents at risk for weight loss. However, the minutes lacked developed goals with timelines and corresponding action plans with timelines for sustainability or improvement.

Minutes dated 10/10/17, identified an increase in number of residents (2) with excessive/unexplained weight loss, however, one had gained weight and was not expected to reflect unexplained weight loss next quarter. Minutes further reflected, ongoing concerns with low resident satisfactions and grievances for dining services; the minutes reflected negotiations for consulting dietician and newly hired dining services director. The minutes did not reflect identification of resident council concerns pertaining to food quality. The minutes lacked developed goals with timelines and corresponding action plans for improvement.

Minutes dated 1/3/18, lacked identification of the resident council grievances pertaining to food quality and indicated no grievances were made in the 4th quarter. The minutes also did not address progress on the excessive/unplanned weight loss. The minutes indicated a goal to improve resident satisfaction scores for dining with a plan to implement a two year performance improvement project. Minutes lacked identification of goals with timelines and corresponding action plans with timelines for improvement.

Minutes dated 4/4/18, lacked identification of the

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F 865	Continued From page 65 resident council grievances and did not address residents with excessive/unexplained weight loss. The minutes reflected the dietary project start date was delayed related to department leadership. Minutes lacked identification of goals with timelines and corresponding action plans with timelines for improvement. The facility did not provide a policy and procedure for quality assurance activities.	F 865		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include,	F 880		7/12/18

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F 880	Continued From page 66 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. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.	F 880		

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F 880	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain dental services for 1 of 1 resident (R12) reviewed for dental care. In addition, the facility failed to obtain an agreement to obtain emergency dental services which could affect all 47 residents at the facility. Findings include: R12 had been observed on 06/11/18, at 5:40 p.m. located in the dining room being fed by an unidentified nursing assistant (NA). R12 was observed to be making facial grimaces, clenching fists, and pushing self away from table while being fed and given liquids. R12 was observed to have several missing teeth. R12's annual Minimum Data Set (MDS) an assessment dated 10/1/17, indicated R12 had severe cognitive impairment and was rarely/never able to make self understood or understand others. R12 required extensive assistance with eating and oral cares. The MDS indicated R12 had indicators of pain (facial expressions - grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) one to two days and received scheduled pain medication. Review of R12's notes: -on 7/25/17 oral surgery for extraction of 14 teeth (per letter from oral surgeon dated 7/31/18) -on 11/28/17, (referral form) nursing observation that R12 had been yelling more and grinding her teeth. Possible tooth pain. Physician's recommendation was to talk with family member (FM)-A to see if R12 needs a dental appointment. The other option is pain control but I do not know	F 880	1) The affected resident has been assessed here at WSLC by Cindy Dross-Sandy, DDS, with recommendation for referral to oral surgeon to remove remaining teeth. Family has agreed to surgery and an appointment has been made for July 30, 2018. Resident was started on Augmentin for facial flushing and fever on June 29, 2018. Pain monitoring had already been on nurse charting board, but has also added to e-Mar as of July 6, 2018, and an order obtained for prn Tramadol in addition to scheduled Tramadol and Tylenol in the event of pain observed. 2) An oral inspection with pain assessment will be completed by an RN on all WSLC residents with their own teeth in poor condition by July 10, 2018, and dental examination appointments will be made if appropriate. A dental contract has been established with Cindy Dross-Sandy, DDS, who performs dental examinations at WSLC if needed. 3) Dental assessments will be completed by RN in conjunction with quarterly MDS assessments, and a field added to WSLC Care Conference form to trigger a discussion with resident/family related to dental needs. A reminder was provided to all nursing staff to report any evidence of oral pain to charge nurse in nursing newsletter on June 24, and this will also be included in the July 12 nursing meeting agenda.	

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F 880	Continued From page 68 if there is infection of teeth which if present could get worse. -on 12/15/17, (health status note) when physician was here in November, R12 was showing signs of possible mouth pain again and talked about possibility of having remaining teeth extracted. FM-B notified and asked if it looks like there is an increase in pain or infection, should arrangements be made to extract remaining teeth? FM-B responded "yes, if it would help keep her comfortable." Review of nursing progress notes showed an increase in observations of R12 demonstrating oral discomfort: -on 4/12/18, R12 lost one of her molar teeth that looked like it had rotten out. - on 5/25/2018, R12 did not like the cold juice when taking medications. -on 5/26/2018, R12 had been grinding teeth this shift, when drinking cold liquid would pull back and get upset. R12 was asked multiple times if teeth hurt and at one point R12 did say "yes". R12 will not open mouth to allow you to look at teeth. - on 5/27/18, R12 was noted to be grinding her teeth on and off this shift, cold liquids irritate her and she pulls away. - on 5/30/18, R12 did pull her head back while taking a drink through a straw and then stopped drinking. - on 5/31/18, when attempting to look in mouth to see current condition of teeth R12 clamped lips together and would not open mouth. - on 6/1/18, R12 was grinding her teeth at the lunch table. - on 6/5/18, R12 was noted to have reddened area to lower left jaw and upper right jaw, possibly due to tooth decay. Will notify family and make	F 880	4) WSLC Director of Nursing or designee will monitor dental assessments completed quarterly with appropriate follow up and report findings to the facility QAPI Committee. Reports will be provided for a minimum of six months and until such time the Committee determines there is no longer a need based on satisfactory performance and documentation.	

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appointments as needed.
- on 6/8/18, R12 was grinding her teeth this shift while at the supper table, while changing into pajamas, and getting ready for bed.
- on 6/9/18, R12 pulled her head back and would shake her upper torso when trying to give food.
- on 6/11/18, R12 was noted to be grinding teeth while taking morning medications in milk.
- on 6/11/18 R12 was grinding teeth this evening while getting her PM medications.

Review of Interdisciplinary Team daily handwritten reports:
- on 5/16/18 indicated grinding more - monitor tooth pain
- on 5/30/18, indicated teeth? "my teeth twitter" "yes" Call Dentist
- on 6/13/18, indicated teeth? in pain

There had been no indication that a dental appointment was set up for R12 even with evident oral pain with eating/drinking over past month.

On 6/14/18 at 2:20 p.m. director of nursing (DON) stated absolutely a dentist should have been contacted for R12.

Lack of dental agreement:
On 6/14/18, at 8:54 a.m. Administrator provided a written statement indicating still looking for signed copy of dental contract with a dentist. By end of survey there was no signed dental agreement provided by the facility.

Dental Services procedure dated 3/9/17, indicated facility offers routine dental services to residents. The facility has a written agreement with dental services that visits on a regular basis.

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F 880	Continued From page 70 Oral health review will be completed with the data collection annually. Pain policy dated 3/1/17: directed physician and staff to identify individuals who have pain or who are at risk for having pain related to oral or dental pathology.	F 880		
F 947 SS=E	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. §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 document review, the facility failed to ensure 12 hours of annual in-service training was completed by 4 of 4 nursing assistants (NA-G, NA-H, NA-I, NA-J) whose personnel records were reviewed. In addition, the facility failed to ensure required	F 947	1) Staff found to be deficient in education are included in facility-wide plan required staff education plan (see below, #2). 2) WSLC staff education spreadsheet was updated on 6/14/2018 to assess WSLC	7/23/18

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	245329	A. BUILDING _____ B. WING _____	06/14/2018

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WARROAD CARE CENTER	1401 LAKE STREET NORTHWEST WARROAD, MN 56763

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F 947	Continued From page 71 dementia training was completed by 3 of 4 nursing assistants (NA-D, NA-E, NA-F) whose personnel records were reviewed. Findings include Required 12 hours of training: NA-G was hired on 6/21/16, NA-G's employee record indicated she had completed 6 hours of the 12 required training hours from 6/21/16 to 6/11/18. NA-H was hired on 6/28/16. NA-H's employee record indicated she had completed 10.7 hours of the 12 required training hours from 6/28/16 to 6/11/18. NA-I was hired on 6/27/16. NA-H's employee record indicated she had completed 8.7 hours of the 12 required training hours from 6/27/16 to 6/11/18. NA-J was hired on 6/5/14. NA-J's employee record indicated she had completed 10.4 hours of the 12 required training hours from 6/5/14 to 6/11/18. Dementia care training: NA-D was hired on 1/12/18. NA-D's employee record indicated she had completed 4 of the 5 required dementia care training modules since hire date. NA-E was hired on 12/19/17. NA-E's employee record indicated she had completed zero of the 5 required training modules since hire date.	F 947	staff dementia training and annual education hours, and calculate how many hours each employee needed for compliance. On 6/15/2018, a schedule was developed based on the number of classes each employee had to complete, with deadlines to get all employees through the required EduCare modules by July 20,2018. Employees were enrolled in the appropriate EduCare modules, and received a list of their required modules. Employees were informed that they will be unable to work after their education deadline until education has been completed. On 6/28/2018 eight non-direct care staff members participated in group Educare dementia modules, and by 7/20/2018, non-direct care staff will be caught up. 3) WSLC will no longer allow employees to start working until required onboarding dementia education is complete, and employees will be required to attend General Orientation education in person or on Educare within the first month of hire. If an employee is unable to attend General Orientation within the first month of hire, they will not be allowed to start working until EduCare General orientation requirements are complete. HR Manager will oversee staff education requirements, and provide updates to department managers. Department managers will review staff education status during employee evaluations to ensure that education requirements are being met.	

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F 947	Continued From page 72 NA-F was hired on 4/4/18. NA-F's employee record indicated at the start of the survey on 6/11/18, had not completed any dementia training, however, all the required training was completed on 6/12/18. On 6/13/18, at 11:37 a.m. director of nursing (DON) confirmed nursing assistants were behind on fulfillment of required annual 12 hour training. DON stated the plan was to wait until the NAs anniversary date and assign on-line learning modules accordingly. DON indicated dementia training was required upon hire, and then annually. DON stated facility had moved away from the on-line dementia training modules and implemented a curriculum entitled Buddies Forever Dementia Communication Coaching with a focus on communication that used more of an in-person hands on approach to learning. DON indicated "Buddie System" was part of new hire orientation and was taught/completed over 25 minutes, however, a video was available that last approximately 2 hours. DON indicated the facility had just started going back to the assigning the online modules in order to meet dementia training criteria and competency. On 6/13/18, at 12:20 p.m. human resources manager (HRM) verified the lack of education requirements for dementia care and required 12 hour annual nurse aide training requirements. HRM stated the facility was working on getting staff caught up and assigning education at there annual performance review evaluations.	F 947	4) Staff education compliance related to dementia and 12 hours of annual CNA education compliance will be reported to QAPI Committee by Human Resources Manager on a regular basis and for a minimum of 9 months. At that time, based on reported results the Committee will evaluate the need for ongoing reporting.	

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on June 12, 2018. At the time of this survey, Warroad Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care 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:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/08/2018

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email 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. Warroad Care Center is a 1-story building without a basement that was built in 2009 and was determined to be built of Type V(111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility also has smoke detection in the resident rooms that is tied into the nurse call system. The facility has a capacity of 49 beds and had a census of 46 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 131 SS=E	Multiple Occupancies CFR(s): NFPA 101 Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain the proper 2 hour fire resistive ratings for occupancies as described in the Life Safety Code (NFPA 101) 2012 edition section 19.1.3.3. This deficient practice could allow for the transfer of smoke or fire from another occupancy and affect an undetermined amount of staff and visitors.	K 131	Since the date of the survey Tony Thompson, Director of Maintenance, has been in contact with the original vendor who supplied the doors during construction. We have researched testing to see if the doors are mislabeled or are in fact the wrong doors. Research has shown that verification and retagging would be time consuming and the most	7/31/18

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K 131	Continued From page 3 Findings include: On the facility tour between 7:30 am to 12:00 pm on 06/12/2018 observations revealed on the 2 hour fire barrier separating the B & C bldg. , the cross corridor doors were rated for 20 minutes only, they should be 90 minute and there were several one inch conduits above the ceiling line at the cross corridor doors that were not properly fire stopped. Observations revealed at the 2 hour fire barrier separating the C bldg and the assisted living has cross corridor doors rated for 20 minutes only, they should be 90 minute and there is a one inch conduit by environmental services above the ceiling that was not properly fire stopped. This deficient condition was confirmed by the facility Maintenance Director.	K 131	expedient way to fix will be to replace the doors with new units meeting code requirements. Vendor is preparing a final quote and doors will be ordered as soon as that quote is available. Installation will depend on vendor order fulfillment and will be expedited as much as possible, at this time it is anticipated to be the end of July 2018. All fire wall penetrations without proper fire stopping were corrected on 06-13-2018 by Tony Thompson.	
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9	K 321		6/25/18

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K 321	Continued From page 4 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one hazardous storage room in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.2.1.3. This deficient condition could allow smoke or fire to enter the corridor making it untenable and affect the quick and efficient exiting for an undetermined amount of staff and visitors. Findings include: On the facility tour between 7:30 am to 12:00 pm on 06/12/2018 observations revealed a data room, also used for combustible storage was over 100 sq feet and did not have a self closing door. This deficient condition was confirmed by the facility Maintenance Director.	K 321	All combustible material was removed from the storage room under the direction of Tony Thompson, Director of Maintenance. Alternate locations will be found for ongoing storage.	
K 331 SS=D	Interior Wall and Ceiling Finish CFR(s): NFPA 101 Interior Wall and Ceiling Finish	K 331		6/19/18

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K 331	Continued From page 5 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2 Indicate flame spread rating(s). _____ This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review the facility failed to provide the proper documentation to identify the interior finish class of the walls in building C, with combustible materials as stated in the Life Safety Code, NFPA 101 2012 edition section 19.3.3.2. This deficient practice could create an additional fuel load in a fire condition and cause a fire to spread more quickly which could affect the exiting of all residents staff and visitors in that section. Findings include: On the facility tour between 7:30 am to 12:00 pm on 06/12/2018 documentation review revealed there was no record of the flame spread ratings of the wood panels and trim in bldg C. This deficient condition was confirmed by the facility Maintenance Director.	K 331	Paperwork indicating proper flame spread ratings was provided to the Inspector by Tony Thompson, Director of Maintenance. Documentation will be filed and maintained in facility records.	
K 346 SS=F	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of	K 346		6/18/18

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K 346	Continued From page 6 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. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of of all 49 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On the facility tour between 7:30 am to 12:00 pm on 06/12/2018 documentation review revealed there was no record of a fire alarm system out of service policy. This deficient condition was confirmed by the facility Maintenance Director.	K 346	Policy was updated/created to clearly indicate fire alarm system out procedures. Tony Thompson, Director of Maintenance was responsible for development and implementation of the new/revised plan. This plan will be filed with other emergency planning documentation and implemented in appropriate situations as required.	
K 354 SS=F	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	K 354		6/18/18

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K 354	Continued From page 7 inspected and risks are determined, 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. This deficient practice could affect the facility's ability for early response and notification of a fire and would affect the safety of all 49 residents as well as an undetermined number of staff, and visitors to the facility . Findings include: On the facility tour between 7:30 am to 12:00 pm on 06/12/2018 documentation review revealed there was no record of a fire sprinkler system out of service policy. This deficient condition was confirmed by the facility Maintenance Director.	K 354	Policy was updated/created to clearly indicate sprinkler system out procedures. Tony Thompson, Director of Maintenance was responsible for development and implementation of the new/revised plan. This plan will be filed with other emergency planning documentation and implemented in appropriate situations as required.	
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		6/13/18

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K 372	Continued From page 8 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of two smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 25 of the 49 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 7:30 am to 12:00 pm on 06/12/2018 observations revealed penetrations in the following smoke barriers. 1. B-wing across from room 1B139 a 1/2" x 3" inch above the ceiling line. 2. B-wing above the ceiling by the drinking fountains a 8" x 10" cut out. 3. B-wing above the cross corridor doors for lake of the woods, a 1 1/2 x 1 1/2 inch sq hole. This deficient condition was confirmed by the	K 372	All noted observations were repaired to meet code requirements by Tony Thompson, Director of Maintenance.	

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K 372	Continued From page 9 facility Maintenance Director.	K 372		
K 521 SS=F	HVAC CFR(s): NFPA 101 HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility did not maintain the heating, ventilation, and air conditioning in accordance with the 2012 LSC NFPA 101 9.2, 19.5.2.1 and NFPA 90A. This deficient practice could effect all 49 residents. Findings include: On the facility tour between 7:30 am to 12:00 pm on 06/12/2018 documentation review revealed there was no record of the last inspection of the fire/smoke dampers in the last four years. This deficient condition was confirmed by the facility Maintenance Director.	K 521	Upon completion of the inspection Tony Thompson, Director of Maintenance, contacted our vendor for fire/smoke damper testing. That testing was scheduled and completed on 07-05-2018. Records of the inspection results will be maintained by the Director.	7/5/18
K 711 SS=F	Evacuation and Relocation Plan CFR(s): NFPA 101 Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of	K 711		7/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245329	A. BUILDING **02 - WARROAD CARE CENTER** B. WING _____	**06/12/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD CARE CENTER	**1401 LAKE STREET NORTHWEST WARROAD, MN 56763**

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K 711	Continued From page 10 an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to maintain a Fire Safety Plan as required in NFPA 101 Life Safety Code, 2012 edition section 19.7.2.2. This deficient practice could cause confusion in an emergency and affect all 49 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 7:30 am to 12:00 pm on 06/12/2018 documentation review revealed the fire safety plan did not include a description for evacuation of the smoke compartment and preparation of floors and building for evacuation. This deficient condition was confirmed by the facility Maintenance Director.	K 711	Plan was updated to include description for evacuation of the smoke compartment and preparation of floors and building for evacuation by Tony Thompson, Director of Maintenance. Plan changes will be incorporated into orientation and training for new and existing staff members as well as all scheduled fire emergency training exercises.	

Electronically delivered
June 28, 2018

Mr. Mark Bertilrud, Administrator
Warroad Care Center
1401 Lake Street Northwest
Warroad, MN 56763

Re: State Nursing Home Licensing Orders - Project Number S5329027

Dear Mr. Bertilrud:

The above facility was surveyed on June 11, 2018 through June 14, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman, Unit Supervisor at (218) 308-2104 or lyla.burkman@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

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
	00797	A. BUILDING: _____ B. WING _____	06/14/2018

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WARROAD CARE CENTER	1401 LAKE STREET NORTHWEST WARROAD, MN 56763

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 11, 12, 13 & 14, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to conduct ongoing quality assessment (QA) and assurance activities and develop and implement appropriate plans of action to correct quality deficiencies identified during the survey that the facility was aware of or should have been aware of that had the potential to adversely affect all 47 residents residing in the facility. Findings include	2 255	Corrected	7/27/18

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2 255	Continued From page 3 On 6/14/18, at 1:30 p.m. director of nursing (DON) stated the facility's QAPI plan that would include policies and protocols that would identify and correct its own quality deficiencies was in development stage and had not yet been implemented. DON stated quality assurance projects had been identified by the Casper report and infection control logs. DON indicated that for existing quality assurance projects goals with timelines with corresponding written action plans with timelines had not been established . DON indicated there was not a good system in place to identify other areas for needed quality improvement. DON further stated, although the quality assurance (QA) committee was aware of the lack of leadership and training in the dietary department; goals and action plans to resolve the situation had not been developed. In addition, the QA committee had not been apprised nor had the committee identified the continued resident council grievances pertaining to food quality and the lack of required dementia care training and 12 hour annual nurse aide training. The following areas of deficient practices were identified during the course of survey that were not identified for performance improvement initiatives and/or was there evidence of QA monitoring systems to assist in ascertaining areas in need of improvement by the QA committee: See F812: Based on observation, interview, and document review the facility failed to use the safe cooling methods of soup for future use in a manner that would minimize and/or prevent the risk for food-borne illness. This had the potential to effect all 47 residents resident in the facility. This deficient practice resulted in an immediate jeopardy that was identified on 6/11/18.	2 255		

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2 255	Continued From page 4 See F697: Based on observation, interview and document review, the facility failed to ensure pain had been assessed in order to identify appropriate interventions and/or medical attention for 1 of 1 residents (R12) reviewed for dental pain. This deficient practice resulted in harm. See F565: Based on interview and document review, the facility failed to address the resident council's concerns related to food temperature, quantity and quality, during a survey initiated resident council meeting with 8 of 15 residents (R36, R40, R26, R6, R34, R38, R41 and R8) active members of the facility resident council. See F947: Based on interview, and document review, the facility failed to ensure 12 hours of annual in-service training was completed by 4 of 4 nursing assistants (NA-G, NA-H, NA-I, NA-J) whose personnel records were reviewed. In addition, the facility failed to ensure required dementia training was completed by 4 of 4 nursing assistants (NA-D, NA-E, NA-F) whose personnel records were reviewed. The following areas of deficient practices were identified during the course of the survey that were identified in the QA committee minutes provided by the director of nursing; however, lacked overall quality assurance activities in order to maintain compliance with identified areas of deficient practices. The minutes further lacked evidence of identification of comprehensive action plans that included specific goals, and time frames for completion. The minutes also lacked, evidence interventions were implemented, analyzed, reevaluated and revised as necessary to ensure successful completion.	2 255		

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2 255	Continued From page 5 See F692: Based on interview and document review, the facility failed to complete a comprehensive nutritional assessment and prevent, assess, and monitor subsequent significant weight loss for 1 of 5 residents (R27) reviewed for nutrition. See F804: Based on observation, interview, and document review the facility failed to ensure hot foods were served at a palatable temp. Minutes dated 7/12/17, identified multiple grievances made in March, pertaining to food quality, however, did not reflect concerns from the resident council. Minutes also reflected one resident with excessive/unexplained weight loss and indicated a team was established and working on identifying residents at risk for weight loss. However, the minutes lacked developed goals with timelines and corresponding action plans with timelines for sustainability or improvement. Minutes dated 10/10/17, identified an increase in number of residents (2) with excessive/unexplained weight loss, however, one had gained weight and was not expected to reflect unexplained weight loss next quarter. Minutes further reflected, ongoing concerns with low resident satisfactions and grievances for dining services; the minutes reflected negotiations for consulting dietician and newly hired dining services director. The minutes did not reflect identification of resident council concerns pertaining to food quality. The minutes lacked developed goals with timelines and corresponding action plans for improvement. Minutes dated 1/3/18, lacked identification of the resident council grievances pertaining to food	2 255		

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2 255	Continued From page 6 quality and indicated no grievances were made in the 4th quarter. The minutes also did not address progress on the excessive/unplanned weight loss. The minutes indicated a goal to improve resident satisfaction scores for dining with a plan to implement a two year performance improvement project. Minutes lacked identification of goals with timelines and corresponding action plans with timelines for improvement. Minutes dated 4/4/18, lacked identification of the resident council grievances and did not address residents with excessive/unexplained weight loss. The minutes reflected the dietary project start date was delayed related to department leadership. Minutes lacked identification of goals with timelines and corresponding action plans with timelines for improvement. The facility did not provide a policy and procedure for quality assurance activities. SUGGESTED METHOD OF CORRECTION: The adminstrator could in-service the entire interdisciplinary team on the requirements for having a quality assessment program that identifies residenet related concerns and determine if interventions are improving the outcome of the identified concerns. Also to appoint a person to monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING:	2 302		7/27/18

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2 302	Continued From page 7 MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Alzheimer's training for 3 of 3 nursing assistants (NA-D, NA-E, NA-F) reviewed who provided direct care services. In addition, the facility failed to provide consumers with written information regarding the Alzheimer's training program. This had the potential to affect residents with Alzheimer disease and related disorders in the facility and their families	2 302	Corrected.	

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2 302	Continued From page 8 Findings include NA-D was hired on 1/12/18. NA-D's employee record indicated she had completed 4 of the 5 required dementia care training modules since hire date. NA-E was hired on 12/19/17. NA-E's employee record indicated she had completed zero of the 5 required training modules since hire date. NA-F was hired on 4/4/18. NA-F's employee record indicated at the start of the survey on 6/11/18, had not completed any dementia training, however, all the required training was completed on 6/12/18 after bring this concern to management. On 6/13/18, at 11:37 a.m. director of nursing (DON) confirmed nursing assistants were behind on fulfillment of the required dementia care training. DON indicated dementia care training was completed during new hire orientation and then annually. DON stated the facility had moved away from the on-line dementia training modules and implemented a curriculum entitled Buddies Forever Dementia Communication Coaching with a focus on communication that used more of an in-person hands on approach to learning. DON indicated "Buddie System" was part of new hire orientation and was taught/completed over 25 minutes, however, a video was available that lasted approximately 2 hours. DON indicated the facility had just started going back to the assigning the online modules in order to meet dementia training criteria and competency. The Buddies Forever Dementia Communication Coaching curriculum was reviewed for the required components of dementia training. The	2 302		

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2 302	Continued From page 9 curriculum lacked education and training components for assistance with activities of daily living and problem solving with challenging behaviors. The curriculum indicated the approximate length of the training was 2 hours. The facilities General Orientation syllabus dedicated 25 minutes for Buddies Forever, Communication Strategies for People with Dementia. The facility also lacked evidence consumers were provided with a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered either in written or electronic form. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the Alzheimer's training is provided in written or electronic form, to residents and families or other persons who request it, describing the training program and the related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The administrator, director of nursing, or designee could develop a system to educate staff and develop a monitoring system to ensure compliance as directed by the written plan of care. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		

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2 830	Continued From page 10	2 830		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure pain had been assessed in order to identify appropriate interventions and/or medical attention for 1 of 1 resident (R 12) reviewed for dental pain. Findings include: R12 was observed on 6/11/18, at 5:40 p.m. in the dining room being fed by an unidentified nursing assistant (NA). R12 was observed to be making facial grimaces, clenching fists, and pushing self away from table while being fed and given liquids. R12 was observed to have several missing teeth. R12's Admission Record dated 6/14/18, included diagnoses of Alzheimer's disease, dementia with behavioral disturbance, and pain in unspecified shoulder.	2 830	Corrected.	7/16/18

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WARROAD CARE CENTER	1401 LAKE STREET NORTHWEST WARROAD, MN 56763

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2 830	Continued From page 11	2 830		

R12's annual Minimum Data Set (MDS) dated 10/1/17, indicated that R12 had severe cognitive impairment and was rarely/never able to make self understood or understand others. R12 required extensive assistance with eating and oral cares. The MDS indicated R12 had indicators of pain (facial expressions - grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) one to two days and received scheduled pain medication. Section L for dental was coded as "none of the above were present" related to broken teeth, missing teeth, likely cavities, inflamed/bleeding gums, mouth or facial pain. However, the MDS was coded inaccurately as R12 underwent oral surgery to extract 14 teeth on 7/25/17.

R12's pain Care Area Assessment (CAA) dated 10/1/17, indicated R12 does have pained facial expression at times, such as grimacing, furrow brow, etc.. It is not clear that this is pain-related due to R12's difficult time with communication and is mostly not possible to have a conversation with. R12 did have a history of back pain and was having presumed oral pain prior to dental surgery. Care plan will include interventions to monitor for and keep pain controlled.

R12's quarterly MDS dated 4/3/18, indicated no notations in the oral care section and pain 1-2 days as noted by facial expressions or protective body movements. However, the MDS was coded inaccurately as R12 underwent oral surgery to extract 14 teeth on 7/25/17.

R12's care plan provided on 6/14/18, directed one to two staff members to provide personnel hygiene which included oral care. The hygiene care plan indicated R12 had her own teeth and

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2 830	Continued From page 12 did not identify R12 had missing teeth. The care plan did not specify how or when to provide oral care and did not include and/or identification of goals to maintain dental health. The care plan directed staff to administer medications, monitor/record pain characteristics, report to nurse any signs or symptoms of non-verbal pain, and notify physician if interventions are unsuccessful or if current complaints were a significant change from past experience of pain. R12's care plan did not include dental pain. Pain in Advanced Dementia (PAINAD) assessment completed 4/3/18, indicated R12 to score a one on a 0 to 10 scale (0="no pain" to 10="severe pain"). The pain assessment did not identity the location of the pain. Physician's orders for pain relief include acetaminophen 160 mg (milligrams)/5 ml (milliliter) give 15 ml every 6 hours as needed for back pain; acetaminophen 160 mg/5 ml, give 15 ml one time per day for back pain; Tramadol 50 mg give 0.5 tablet twice daily for pain in shoulder. The last Dental Observation completed on 9/30/16, indicated R12 was resistive to oral cares, staff attempt to brush teeth twice daily, but R12 will often clench mouth shut. Staff have tried giving R12 a prepared toothbrush with toothpaste and verbally prompt to brush but R12 is uncooperative. Will continue attempting oral cares and schedule dental exams as necessary. No further dental observations/assessments were completed. Review of R12's record revealed ongoing and worsening of oral pain and oral health without dental treatment and services. -on 7/25/17, oral surgery for extraction of 14 teeth	2 830		

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2 830	Continued From page 13 (per letter from oral surgeon dated 7/31/18). -on 11/28/17, (referral form) nursing observation that R12 had been yelling more and grinding her teeth. Possible tooth pain. Physician's recommendation was to talk with son to see if he wants a dental appointment. The other option is pain control but did not know if there is infection of teeth which if present could get worse. R12's record lacked evidence of an oral assessment or attempts of, the record further lacked evidence of monitoring for signs and symptoms of infection, and also lacked evidence R12's family member (FM)-A was contacted in reference to a dental appointment for further evaluation. -on 12/15/17, (health status note) when physician was here in November, R12 was showing signs of possible mouth pain again and talked about possibility of having remaining teeth extracted. FM-B notified and asked if it looks like there is an increase in pain or infection, should arrangements be made to extract remaining teeth? FM-B responded "yes, if it would help keep her comfortable." R12's record continued to lack evidence of oral examinations and documentation of monitoring for oral pain and or signs and symptoms of infection. From 12/15/17 to 4/12/18, the record had no mention and did not address or evaluate dental/oral health. Review of nursing progress notes (PN) and interdisciplinary team (IDT) notes from 4/12/18, through present day reflected an increase in staff observations of R12 demonstrating oral discomfort. - 4/12/18, PN, R12 lost one of her molar teeth	2 830		

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2 830	Continued From page 14 that looked like it had rotten out. - 5/16/18, IDT, indicated grinding more - monitor tooth pain. -5/25/18, PN, R12 did not like the cold juice when taking medications. -5/26/18, PN, R12 had been grinding teeth this shift, when drinking cold liquid would pull back and get upset. R12 was asked multiple times if teeth hurt and at one point R12 did say "yes." R12 will not open mouth to allow you to look at teeth. -5/27/18, PN, R12 was noted to be grinding her teeth on and off this shift, cold liquids irritate her and she pulls away. -5/30/18, PN, R12 did pull her head back while taking a drink through a straw and then stopped drinking. -5/30/18, IDT, indicated teeth? "my teeth twitter" "yes" " Call Dentist." -5/31/2018, PN, when attempting to look in mouth to see current condition of teeth R12 clamped lips together and would not open mouth. -6/1/18, PN, R12 was grinding her teeth at the lunch table. -6/5/18, PN, R12 was noted to have reddened area to lower left jaw and upper right jaw, possibly due to tooth decay. Will notify family and make appointments as needed. -6/8/18, PN, R12 was grinding her teeth this shift while at the supper table, while changing into pajamas, and getting ready for bed. -6/9/18, PN, R12 pulled her head back and would shake her upper torso when trying to give food. -6/11/18, PN, R12 was noted to be grinding teeth while taking morning medications in milk. -6/11/18, PN, R12 was grinding teeth this evening while getting her PM medications. -6/13/18, PN, included "teeth? in pain" Despite documented concerns with teeth/oral	2 830		

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pain, an examination/assessment of R12's oral cavity or attempts of assessment even after identification of possible signs and symptoms of infection was not completed. There was no ongoing monitoring of signs and symptoms of a possible oral infection. The physician was not notified of the notations of increased oral pain since 5/26/18, and was not notified of the signs and symptoms of an oral infection that began on 6/5/18. In addition, the record lacked evidence the family was notified R12 had lost a tooth, R12 had demonstrated an increase in oral pain, and the signs and symptoms of infection. The record further lacked evidence a dentist was contacted and/or a referral made as directed on 12/15/17, by a family member.

R12's physician progress notes reviewed did not address oral/dental status.

On 6/13/18, at 11:35 a.m. R12 was being fed in the dining room by nursing assistant (NA)-C and registered nurse (RN)-E was observing. R12 was observed making facial grimaces when drinking supplement from a straw. NA-C stated that the facial grimaces indicated that R12 was in pain although could not determine if it was related to sucking through straw or the liquids being cold.
-At 12:04 p.m. RN-E stated she had spoken to son after referral on 11/28/17, and son wanted to hold off with dental referrals for awhile longer. RN-E stated at this time they were just monitoring her pain and signs or symptoms of infection daily. RN-E stated monitoring was what R12's family wishes were. RN-E verbalized there was no documentation of conversations with family.
-At 12:36 p.m. RN-E was interviewed regarding progress note 6/5/18, which indicated family would be notified and appointments made as needed. RN-E stated she tried to contact FM-A

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2 830	Continued From page 16	2 830		

and FM-B, left messages with them, had not heard back, and did not document the attempt in the record. RN-E confirmed R12's discomfort noted while drinking from a straw at lunch today could have been from dental discomfort.
-At 12:45 p.m. NA-C stated R12 was showing an increase in mouth pain for the last month to month and a half. NA-C indicated R12 used to use a straw all the time and now could not without grimacing.
-At 12:51 p.m. contacted family member (FM)-A who is the primary contact by telephone. FM-A stated R12 had 13 teeth pulled last year. FM-A stated there had not been any recent contact from the nursing home regarding recent signs of oral discomfort and FM-A would expect to be contacted with that concern.
-At 2:33 p.m. director of nursing (DON) indicated her expectation was an appointment should have been made for R12 since she was experiencing signs of discomfort. The RN should not be awaiting contact from family as we already have the approval from them dated 12/15/17, to have teeth extracted if resident was experiencing pain.

On 6/14/18, at 7:22 a.m. NA-A stated R12 made weird noises all the time, and it is common with Alzheimer's. NA-A added R12 grinds teeth. NA-A stated R12 was in pain, grinded her teeth all the time when awake and asleep. NA-A stated the pain had been reported to the RN. NA-A indicated that R12 has had decreased appetitive for awhile, however, could not recall for how long.
-At 7:49 a.m. NA-C stated R12 was choosing not to eat and guessed it was related to pain. NA-C also stated R12 winced with the cold liquids and when using a straw R12 pulled back and grimaced. NA-C further stated, R12 would also do that with food too at times and at times it appeared that R12's teeth bothered her. NA-C

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indicated that last week, the left lower side of mouth was swollen/red and was reported to nurse. NA-C also indicated, R12 grinded her teeth most days, and would not let staff use a toothbrush but they use a diluted mouthwash and a pink swab which R12 resisted everyday by pulling her body back. NA-C then stated R12 had a little bit of a mouth odor, and there were days R12 would not eat much and on other days she would eat everything, and could not tell if it was because of her teeth or dementia. NA-A indicated that she lets beverages come to room temperature before offering and R12 takes them better.
-At 8:09 a.m. NA-A entered room with breakfast tray consisting of oatmeal and carnation instant breakfast. R12 kept lips clamped shut, turned head away and verbalized "no." NA-A would touch R12's lips with spoon and straw to attempt to get R12 to open mouth. NA-A indicated that R12's face appeared pink in color, but added R12 gets really warm. R12 began to take bites and drink milk, no grimacing noted or difficulty swallowing.
-At 8:36 a.m. NA-A stated R12 consumed entire breakfast. NA-A made an attempt to do oral care with a pink swab and diluted mouthwash. R12 opened mouth once and sucked on swab then opened mouth again at which time NA-A placed pink swab on left side of mouth in a back and forward motion. R12 yelled out and pushed swab out of mouth. NA-A attempted to cleanse mouth three times with R12 holding mouth clamped tightly closed.
-At 9:49 a.m. contacted dentist by telephone. R12 was never seen in the dentist office but dentist visited R12 on 6/21/17, at nursing home, concluding there were many teeth in need of extraction. FM-A decided only the bad teeth needed to be removed and left the molars in

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2 830	Continued From page 18	2 830		

place. Dentist stated there have been no further consults regarding R12 and dentist does not have a contract with the nursing home.
-At 10:30 a.m. activities aides (AA)-C indicated R12 had been grinding teeth. AA-C stated she usually assists R12 with eating three times a week and had not noticed any problems with cold drinks, just noticed tightness of her mouth and some sweating. No swelling of checks noted. During the last 2 weeks AA-C stated puckering/tightening of mouth increased and indicated pain could be the reason.
-At 11:00 a.m. licensed practical nurse (LPN)-B stated she had not noticed grimacing/pulling away when drinking although R12 was only observed when administering medications. LPN-B stated swelling in the jaw area could be an indication of a tooth issue, which could be an infection, might require hospitalization, intravenous medications, sepsis (a life-threatening condition that arises when the body's response to infection causes injury to its own tissues and organs) could occur and possible death. LPN-B stated chances are pretty good that could happen with R12. When LPN-B examined R12's oral cavity she noted filled teeth and some of them were black. LPN-B indicated R12 has grinded teeth for a long time.
-At 12:14 p.m. RN-E stated R12 began having dental concerns sometime last summer noting poor teeth and not allowing oral cares to be completed. The plan was to have all teeth extracted although family member intervened and requested only infected teeth be removed. RN-E believes R12 has three remaining teeth. RN-E stated R12 had recently been experiencing pain but unsure if it is dental or back issues from past accident. RN-E indicated it was difficult to examine R12's oral cavity. RN-E stated telephone conversations with family have occurred, although not documented, indicating to just keep

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2 830	Continued From page 19	2 830		

monitoring. RN-E stated redness noted on 6/5/18, was just slight and was not reported to physician. RN-E was not able to speak regarding risks of sepsis. RN-E stated the MDS coordinator completes the oral assessments. RN-E indicated charting is not completed regarding oral cares. When asked expectation if staff reported pain to RN-E she indicated she would do an assessment, which she stated she attempted although did not document attempt and did not notify physician.

-At 12:59 p.m. RN-A stated an oral exam and dental assessment is completed with annual MDS. RN-A indicated when completing R12's annual MDS October 2017, no problems were noted on the assessment although she could not recall if she looked into R12's oral cavity. RN-A stated R12 had pain at the time but was unclear if dental or something else.

-At 2:20 p.m. director of nursing (DON) stated a dentist should have been contacted for R12. DON confirmed a signed contract with a dentist for emergency services did not exist. DON stated the family should have been contacted and there should have been documentation regarding any conversations with family. It would be expected that risk and benefits should have been discussed with family.

Attempts to contact FM-B were unsuccessful.

Dental Services procedure dated 3/9/17, indicated oral health review will be completed with the data collection annually. Residents will be promptly referred to a dentist.

Pain policy dated 3/1/17:
directed physician and staff to identify individuals who have pain or who are at risk for having pain

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2 830	Continued From page 20 related to oral or dental pathology. nursing staff will assess when there is onset of new pain or worsening of existing pain. nursing staff to assess pain using a consistent approach and a standardized pain assessment instrument nursing staff will observe resident (during rest and movement) for evidence of pain the staff and physician will also evaluate how pain is affecting mood, activities of daily living, sleep, and the resident's quality of life, including complication such as sleep/rest, social activities, appetitive. the physician will help identify causes of pain; for example by examining the resident directly, reviewing history, and discussion with staff. nursing staff will reassess the individual's pain and related consequences at regular intervals; at least each shift for newly identified pain. Pain Assessment and Management procedure dated 3/1/17: pain management includes: assessing the potential for pain, effectively recognizing the presence of pain, identifying the characteristics of pain, addressing the underlying causes of pain, developing and implementing approaches to pain management, identifying and using specific strategies for different levels and sources of pain, monitoring for the effectiveness of interventions, modifying approaches as necessary, conduct a comprehensive pain assessment quarterly, when there is onset of new pain or worsening of existing pain, assess the resident's pain and consequences of pain at least each shift for acute pain. report the following information to physician: significant changes in the level of the resident's pain, adverse effects from pains medications, prolonged, unrelieved pain despite care plan	2 830		

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2 830	Continued From page 21 interventions. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review policies and procedures for oral/dental care, pain assessments, and monitoring. The DON or designee could then provide education to staff on reporting oral/dental change of conditions, and then providing any necessary follow-up and/or documentation. The DON or designee could reassess residents to identify any potential residents at risk for oral/dental problems then develop individual comprehensive care plans. Then the DON could develop an auditing system for quality assurance and provide results to the quality assurance committee in order to maintain compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent	2 900		8/1/18

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2 900	Continued From page 22 new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess a facility acquired pressure ulcer, and provide consistent monitoring to promote healing for 1 of 1 resident (R20) reviewed for pressure ulcers. Findings include: R20's Admission Record, dated 6/13/18, indicated R20 had diagnoses that included Alzheimer's disease, enterocolitis (inflammation of the digestive tract) due to clostridium difficile (C. Diff, an infection of the colon, often causes diarrhea), acute kidney failure, functional urinary incontinence, diabetes, and gout. R20's quarterly Minimum Data Set (MDS) an assessment, dated 4/15/18, identified R20 had severe cognitive impairment and required extensive assistance for transfers, bed mobility and toileting. The MDS identified R20 as frequently incontinent of urine and always continent of bowel. The MDS further indicated R20 was at risk to develop pressure ulcers, and had not had a pressure ulcer on the previous quarterly assessment. Finally, the MDS indicated R20 was on a turning and repositioning program and had lotion or ointment applied to his skin. There was not a Care Area Assessment (CAA) related to skin or pressure ulcer prevention. R20's Care Plan, dated 10/21/15, indicated R20 was at risk for skin breakdown related to the need for extensive assistance with bed mobility and	2 900	Corrected.	

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repositioning, and had occasional incontinence. The care plan identified the goal was for R20 to have intact skin, free of redness, blisters or discoloration. Interventions included to turn or reposition at least every two hours; R20 had an air bed and ROHO cushion (pressure preventing) in his wheelchair to help maintain skin integrity. The care plan did not identify the stage II pressure ulcer which was first identified on 5/20/18.

R20's Physician Discharge Summary dated 5/17/18 after a four day hospitalization, indicated R20 was hospitalized due to worsening generalized weakness and dehydration. R20 had been diagnosed with C. Diff and was receiving oral antibiotics. The hospital discharge notes, dated 5/17/18, indicated R20 had blanchable redness, intact skin on his coccyx, sacrum, left and right buttocks. Treatment was to apply cavilon cream (barrier) and provide repositioning.

R20's progress note dated 5/17/18, indicated he returned to the facility at 2:10 p.m. and there were no skin issues to note.

A 5/18/18, progress note indicated R20's perineal area was slightly red and lantiseptic barrier cream was applied.

The first identification of an open area on R20's perineal area was evident in a 5/20/18, 12:43 p.m. progress note that identified a 0.7 centimeter (cm) open area noted to the top of R20's intragluteal fold (between the buttocks) upon waking that morning. The note indicated the area appeared to be from moisture, as R20 had 2 loose stools that shift. The area was cleansed and Lantiseptic barrier cream was applied. The note indicated the information would be passed

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on for staff to continue to apply cream and R20 was to be turned on each side rather than on his back when in bed to help aid in healing.

R20's health status notes dated 5/21/18, at 3:31 a.m. indicated R20 was repositioned every 2 hours while in bed, was incontinent of bladder, had no bowel movements and the open area to his coccyx was covered with duoderm (a wound dressing with water resistant outer layer).

R20's skin/wound note dated 5/21/18, at 12:29 p.m. indicated an open area to the right buttock. The area was cleansed with saline and covered with a duoderm.

A progress note dated 5/22/18, indicated R20 had an open area to the buttock near the intragluteal fold that was previously covered with a duoderm, but this was not sticking. The note indicated the nurse removed the duoderm and Lantiseptic (barrier cream) was applied to the area for protection.

Progress notes dated 5/23/18, indicated Lantiseptic cream was applied to an open area on top of the intragluteal fold. The area was described as red and had a small open area.

A progress note dated 5/25/18, indicated a physician was notified regarding R20's loose stools. The note lacked indication that the physician was notified of a coccyx, or intragluteal fold, pressure ulcer.

A skin/wound note on 5/28/18, indicated there was an open area to the left buttock and that the area was covered with Lantiseptic.

A skin/wound note dated 6/1/18, provided the first

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2 900	Continued From page 25 complete description and assessment of the open area on R20's perineal area. The note identified a Stage II pressure ulcer to R20's coccyx that measured 2.4 cm by 2.6 cm. The wound bed was described as red with a black center and irregular borders. The wound was cleansed, skin prep (prepares skin for adhesive dressings), Medihoney (helps with wound healing) and tegaderm foam (transparent, breathable dressing) were applied. The note indicated that the dressing would be changed daily and as needed if the dressing got soiled or was falling off. The note further indicated R20 had an air bed, Roho cushion to his wheelchair and was being repositioned every 2 hours and as needed. On 5/31/18, a treatment administration was completed for tegaderm foam to ulcer on sacral/coccyx region; cleanse, apply skin prep and tegaderm foam daily and as needed until healed; one time a day for ulcer. Review of R20's medical record lacks documentation of orders or treatment administration record to coccyx area pressure ulcer prior to 5/31/18. Review of R20's medical record revealed the last tissue tolerance test and skin observation tools were completed on 4/13/18, prior to his C. Diff diagnosis and hospitalization. A 6/11/18, progress note indicated R20 had a 1.0 cm circular healing open area on his coccyx. A 6/11/18, High Risk Committee progress note indicated R20 had a new bolstered air bed and was allowing staff to turn and reposition him every 2 hours. The note did not identify R20 as having a Stage II pressure ulcer.	2 900		

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2 900	Continued From page 26 Review of R20's medical record lacks indication of provider notification, family notification, or care plan updates regarding the Stage II pressure ulcer on R20's coccyx which was first identified on 5/20/18. On 6/12/18, at 9:49 a.m., R20 was observed in bed on an alternating air pressure mattress. On 6/13/18, from 7:05 a.m. until 8:32 a.m., R20 was observed in bed on an alternating air pressure mattress. At 8:32 a.m., nursing assistant (NA)-A and NA-B repositioned R20 according to his care plan, removing a pillow from his right side and repositioning R20 with a pillow under his left side. On 6/13/18, at 10:48 a.m., registered nurse (RN)-D and RN-BB, were observed changing the dressing to R20's coccyx pressure ulcer. The wound was described as "almost gone"; measured at 0.9 cm x 0.5 cm x 0.1 cm; and the wound bed described as 90% white/yellow slough with 10% granulation tissues surrounding slough. The periwound was described as pink and intact. On 6/13/18, at 11:17 a.m., RN-BB stated wound rounds were done every two weeks, she was part of wound rounds, and these were considered a formal assessment. RN-BB also indicated staff are to be charting on wounds on bath days. RN-BB confirmed R20's wound was not fully assessed until 5/30/18 (which was ten days after first noted). RN-BB stated she usually gets an incident report or a note from staff that triggers her to assess a wound. RN-BB confirmed R20 returned from the hospital with a reddened but intact area on his coccyx. RN-BB further confirmed it was a facility acquired pressure	2 900		

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ulcer; and while the initial notes on it were from 5/20/18 and 5/21/18, she does not remember knowing about it before 5/30/18.

On 6/13/18, at 1:13 p.m. licensed practical nurse (LPN)-A confirmed she wrote R20's 5/21/18, skin/wound note as that was his bath day. LPN-A indicated this was not the first identification of the wound, as she remembers removing a duoderm and replacing it. LPN-A indicated she didn't know who put the original duoderm on, or when the wound first opened. LPN-A stated she was just following suit with the treatment she had found on the wound.

On 6/13/18, at 1:54 p.m. the director of nursing stated they are implementing a new skin incident report that will hopefully improve the reporting and monitoring process. The DON stated staff weren't clear on the right thing to do with the current report form. The DON indicated RN-BB was a certified wound specialist.

The facility's Prevention of Pressure Ulcers policy, dated 6/11/15, indicated the facility should have a system/procedure to assure assessments are timely and appropriate and changes in condition are recognized, evaluated, and reported to the practitioner, physician and family, and addressed. The policy further directed staff to routinely assess and document the condition of the resident's skin through use of a Weekly Skin Integrity Form for any signs and symptoms of irritation or breakdown. The policy also directed staff to report any signs of a developing pressure ulcer to a nurse supervisor and physician.

The facility's Pressure Ulcer Guidelines policy, dated 7/29/15, indicated wound rounds would be completed on all residents with pressure ulcers

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weekly and as needed by the RN for all new and established pressure ulcers. The policy further specified the following be completed on a weekly basis:
--Observe, measure, and document pressure ulcers weekly on the Weekly Pressure Ulcer Documentation Flow Sheet.
--If deteriorating or non-healing wounds are noted, update the physician.
--Implement any new wound treatment orders obtained.
--Complete documentation to include location and staging.
--Update the care plan to include addition of any new wound treatment or nursing interventions or discontinuation of any established interventions when a wound was healed.

Pressure Ulcer stages defined by the National Pressure Ulcer Advisory Panel (NPUAP):

Stage 1 Pressure Injury: Non-blanchable erythema of intact skin
Intact skin with a localized area of non-blanchable erythema, which may appear differently in darkly pigmented skin. Presence of blanchable erythema or changes in sensation, temperature, or firmness may precede visual changes. Color changes do not include purple or maroon discoloration; these may indicate deep tissue pressure injury.

Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis
Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible. Granulation tissue, slough and eschar are not

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2 900	Continued From page 29 present. These injuries commonly result from adverse microclimate and shear in the skin over the pelvis and shear in the heel. This stage should not be used to describe moisture associated skin damage (MASD) including incontinence associated dermatitis (IAD), intertriginous dermatitis (ITD), medical adhesive related skin injury (MARSI), or traumatic wounds (skin tears, burns, abrasions). SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food temperatures were of resident preference for palatability level for 1 of 1 resident (R13)	2 960	Corrected.	7/16/18

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2 960	Continued From page 30 reviewed for food palatability. Findings include: R13's Admission Record dated 6/14/18, indicated R13 had diagnosis that included diabetes, Vitamin D deficiency, and vascular dementia without behavioral disturbance. R13's admission Minimum Data Set (MDS) an assessment, dated 4/4/18, indicated he could clearly understand others, had no behaviors and did not reject cares. R13's Care Plan dated 3/29/18, indicated R13 was able to feed himself after set up. R13's care plan also indicated he was able to make simple daily decisions and make himself understood. On 6/11/18, at 7:38 p.m., R13 stated food could be improved as green beans are served often, no one at his table liked them, and breakfast foods were not always hot. On 6/13/18, at 7:42 a.m., R13 stated his eggs were warm and liked them hot. R13's table mate heard the conversation and agreed the food was warm and not hot as they liked. On 6/14/18, at 8:14 a.m., R13 was observed finishing breakfast. When asked about breakfast, R13 stated, "it was good today." When asked if it was hot enough, R13 replied, "Well, it's never that!" and said we could write down we don't get hot food. On 6/14/18, at 8:20 a.m., a breakfast test plate was requested from dietary aide (DA)-A. DA-A used a thermometer to test the oatmeal, which was at 158 degrees Fahrenheit (F); the egg bake,	2 960		

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2 960	Continued From page 31 which was at 138 F, and the sausage which was temped at 85 F. DA-A stated she had put the food in the steam tables at the station at approximately 7:15 a.m. When tasted, the oatmeal tasted hot, the egg bake and the sausage luke warm. See F565: regarding resident council having a grievance of not serving foods hot for several months without a resolution. The facility Food Temperatures policy, dated 2017, indicated all hot food items must be cooked to appropriate internal temperatures, held and served at a temperature of at least 135 F. Review of other policies lacked direction on palatability of food temperatures. SUGGESTED METHOD OF CORRECTION: The certified dietary manager (CDM) and/or designee could identify and develop a more palatable dining experience and could provide appropriate staff education regarding food preparation, included temperatures. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21025	MN Rule 4658.0615 Food Temperatures Potentially hazardous food must be maintained at 40 degrees Fahrenheit (four degrees centigrade) or below, or 150 degrees Fahrenheit (66 degrees centigrade) or above. "Potentially hazardous food" means any food subject to continuous time and temperature controls in order to prevent the rapid and progressive growth of infectious or toxigenic microorganisms.	21025		7/16/18

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21025	Continued From page 32 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to appropriately cool vegetable beef soup in a manner that prevented and/or minimize the risk for food borne illness. This could affect alll residents in the facility who ate food from the kitchen. Findings include: During the initial kitchen tour on 6/11/18, at 3:14 p.m. with cook (C)-A, the following was observed sitting on the counter, uncovered: -A two gallon, square plastic container with approximately a ¼ inch congealed surface. The container was completely full. -A two gallon stock pot type kettle with approximately a ½ inch thick, crust like, congealed surface. The pot was ½ full. At the time of the observation, C-A stated she had finished making vegetable beef soup at 2:00 p.m.. and placed it in the above containers and on the counter to cool. C-A stated at that time the soup was put into the containers, it measured 207 degrees. C-A stated the soup was for the next day's lunch meal. C-A stated it would take about an hour and a half to cool down to the appropriate temperature. The soup had not been stirred since placed on the counter. At the request of the surveyor, C-A checked the temperature of both containers which revealed both measured 120 degrees. C-A stated the soup was getting closer to being able to be put in the refrigerator and would be putting the soup in the cooler once it had cooled down some more.	21025	Corrected.	

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21025	Continued From page 33 -At 5:15 p.m. the dietary manager (DM) confirmed the findings and stated for now, they had put the soup in the coolers. The DM stated the cooling time for food should be less than two hours. The DM also stated within two hours, the temperature of the cooling food should have been below the danger zone (period when bacteria grow most rapidly) of 41 degrees. The DM also stated in order to properly cool food, it should have been put into smaller divided containers and directly into the cooler. The DM stated he had worked at the facility for about two months and was previously ServSafe certified, however, he had not kept up the certification. In addition, the DM stated there was only one kitchen staff member that was currently ServSafe certified. -At 6:03 p.m. both containers of soup were observed on the bottom shelf of the cooler. The DM stated he was unsure what time the soup was actually placed in the cooler and referred to a "log." The DM stated according to the documentation on the "log," the soup measured 100 degrees at 4:30 p.m. just prior to it being put in the cooler, however, he did not know if that was for both containers, or just one. The DM verified there was no further documentation of the soup's temperatures having been taken/monitored as it was cooling. At this time, the DM obtained the temperature of both containers. The plastic container's soup was 130 degrees and the metal pot was 90 degrees. The DM stated he was uncertain of the cooling protocols for all foods and was in the process of purchasing cooling/ice sticks to aid in the rapid cooling of foods but confirmed he had not ordered any, yet. -At 6:38 p.m. the DM confirmed the soup should have been cooled sooner and faster. The DM	21025		

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again confirmed the soup had less than two hours for cooling time to prevent bacterial growth, therefore should have been placed in a cooler in smaller divided containers in order to cool properly in order to prevent food borne illness. The DM stated the soup was going to be discarded.

On 6/14/18, at 11:47 a.m. the registered dietician (RD) who was on leave had arrived at the facility to assist with the removal of the IJ, confirmed the soup was not cooled properly and was discarded. The RD stated education would be provided to the staff.

On 6/14/18, at 12:21 p.m. the on call dietary consultant stated the administrator had informed her of the IJ and agreed the soup was improperly cooled which could have caused food borne illness if consumed.

The facility's undated, General HACCP Guidelines for Food Safety policy and procedure bullet #5, titled, Essentials of Cooling, directed the staff to cool food from 135 degrees to 70 degrees in two hours and from 70 degrees to 41 degrees in four hours, not to exceed six hours. If food was not cooled to 41 degrees within six hours, reheat to 65 degrees for at least 15 seconds (within two hours) and discard if not served immediately. This included mechanically altered foods. Take temperatures frequently to determine if altered methods of cooling are needed. The policy also directed staff to:

-divide food into several smaller batches, and in containers that permitted the food to cool rapidly. Place in smaller pre-chilled stainless steel pans.
-Place pans in an ice bath and stir foods as they cool, then refrigerate (ice bath should contain

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21025	Continued From page 35 more ice than water). Avoid cooling foods in storage refrigerators or freezers. (This can bring the total temperature of the unit to an unsafe level). -Place cooling items on the top shelf of the refrigerator or freezer uncovered or loosely covered in two inch shallow pans and stir every 15 to 60 minutes. -Allow air to circulate around the food. SUGGESTED METHOD OF CORRECTION: The dietary director or designee, could provide training for all dietary staff staff related to cooling food safely in order to prevent and/or minimize food borne illness. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Seven (7) days.	21025		
21335	MN Rule 4658.0725 Subp. 3 A&B Providing Routine & Emergency Oral Health Ser Subp. 3. Emergency dental services. A. A nursing home must provide, or obtain from an outside resource, emergency dental services to meet the needs of each resident. Emergency dental services include services needed to treat: an episode of acute pain in teeth, gums, or palate; broken or otherwise damaged teeth; or any other problem of the oral cavity, appropriately treated by a dentist, that requires immediate attention. B. When emergency dental problems arise, a nursing home must contact a dentist within 24 hours, describe the dental problem, and document and implement the dentist's plans and	21335		7/16/18

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21335	Continued From page 36 orders. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain dental services for 1 of 1 resident (R12) reviewed for dental care. Findings include: R12 had been observed on 06/11/18, at 5:40 p.m. located in the dining room being fed by an unidentified nursing assistant (NA). R12 was observed to be making facial grimaces, clenching fists, and pushing self away from table while being fed and given liquids. R12 was observed to have several missing teeth. R12's annual Minimum Data Set (MDS) an assessment dated 10/1/17, indicated R12 had severe cognitive impairment and was rarely/never able to make self understood or understand others. R12 required extensive assistance with eating and oral cares. The MDS indicated R12 had indicators of pain (facial expressions - grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) one to two days and received scheduled pain medication. Review of R12's notes: -on 7/25/17 oral surgery for extraction of 14 teeth (per letter from oral surgeon dated 7/31/18) -on 11/28/17, (referral form) nursing observation that R12 had been yelling more and grinding her teeth. Possible tooth pain. Physician's recommendation was to talk with family member (FM)-A to see if R12 needs a dental appointment. The other option is pain control but I do not know if there is infection of teeth which if present could	21335	Corrected.	

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	00797	A. BUILDING: _____ B. WING _____	06/14/2018

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get worse.
-on 12/15/17, (health status note) when physician was here in November, R12 was showing signs of possible mouth pain again and talked about possibility of having remaining teeth extracted. FM-B notified and asked if it looks like there is an increase in pain or infection, should arrangements be made to extract remaining teeth? FM-B responded "yes, if it would help keep her comfortable."

Review of nursing progress notes showed an increase in observations of R12 demonstrating oral discomfort:
-on 4/12/18, R12 lost one of her molar teeth that looked like it had rotten out.
- on 5/25/2018, R12 did not like the cold juice when taking medications.
-on 5/26/2018, R12 had been grinding teeth this shift, when drinking cold liquid would pull back and get upset. R12 was asked multiple times if teeth hurt and at one point R12 did say "yes". R12 will not open mouth to allow you to look at teeth.
- on 5/27/18, R12 was noted to be grinding her teeth on and off this shift, cold liquids irritate her and she pulls away.
- on 5/30/18, R12 did pull her head back while taking a drink through a straw and then stopped drinking.
- on 5/31/18, when attempting to look in mouth to see current condition of teeth R12 clamped lips together and would not open mouth.
- on 6/1/18, R12 was grinding her teeth at the lunch table.
- on 6/5/18, R12 was noted to have reddened area to lower left jaw and upper right jaw, possibly due to tooth decay. Will notify family and make appointments as needed.
- on 6/8/18, R12 was grinding her teeth this shift

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21335	Continued From page 38	21335		

while at the supper table, while changing into pajamas, and getting ready for bed.
- on 6/9/18, R12 pulled her head back and would shake her upper torso when trying to give food.
- on 6/11/18, R12 was noted to be grinding teeth while taking morning medications in milk.
- on 6/11/18 R12 was grinding teeth this evening while getting her PM medications.

Review of Interdisciplinary Team daily handwritten reports:
- on 5/16/18 indicated grinding more - monitor tooth pain
- on 5/30/18, indicated teeth? "my teeth twitter" "yes" Call Dentist
- on 6/13/18, indicated teeth? in pain

There had been no indication that a dental appointment was set up for R12 even with evident oral pain with eating/drinking over past month.

On 6/14/18 at 2:20 p.m. director of nursing (DON) stated absolutely a dentist should have been contacted for R12.

Pain policy dated 3/1/17:
directed physician and staff to identify individuals who have pain or who are at risk for having pain related to oral or dental pathology.

SUGGESTED METHOD OF CORRECTION:
The administrator and/or governing board could secure an agreement for emergency dental services. The director of nursing (DON) or designee could review and/or develop policies and procedures pertaining to emergency dental care. The DON or designee could then educate staff on protocols for emergency dental issues.

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21335	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21335		
21350	MN Rule 4658.0730 Subp. 2 A-C NH Dental Requirements;Written Agreement Subp. 2. Written agreement. A nursing home must maintain a written dental provider agreement with at least one dentist, licensed by the Board of Dentistry, who agrees to provide: A. routine and emergency dental care for the nursing home's residents; B. consultation on the nursing home's oral health policies and procedures; and C. oral health training for nursing home staff. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to obtain an agreement to obtain emergency dental services which could affect all 47 residents at the facility. Findings include: On 6/14/18, at 8:54 a.m. Administrator provided a written statement indicating he was still looking for signed copy of dental contract with a dentist. By end of survey there was no signed dental agreement provided by the facility. SUGGESTED METHOD OF CORRECTION: The administrator and/or governing board could obtain an agreement with at least one dentist licensed by the Board of Dentistry that would agree to provide routine and emergency dental care for the facility's residents, consultation on	21350	Corrected.	7/16/18

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21350	Continued From page 40 oral health policies and procedures, and provide oral health training for nursing home staff. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21350		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced	21390		7/16/18

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21390	Continued From page 41 by: Based on observation, interview and document review, the facility failed to obtain dental services for 1 of 1 resident (R12) reviewed for dental care. In addition, the facility failed to obtain an agreement to obtain emergency dental services which could affect all 47 residents at the facility. Findings include: R12 had been observed on 06/11/18, at 5:40 p.m. located in the dining room being fed by an unidentified nursing assistant (NA). R12 was observed to be making facial grimaces, clenching fists, and pushing self away from table while being fed and given liquids. R12 was observed to have several missing teeth. R12's annual Minimum Data Set (MDS) an assessment dated 10/1/17, indicated R12 had severe cognitive impairment and was rarely/never able to make self understood or understand others. R12 required extensive assistance with eating and oral cares. The MDS indicated R12 had indicators of pain (facial expressions - grimaces, winces, wrinkled forehead, furrowed brow, clenched teeth or jaw) one to two days and received scheduled pain medication. Review of R12's notes: -on 7/25/17 oral surgery for extraction of 14 teeth (per letter from oral surgeon dated 7/31/18) -on 11/28/17, (referral form) nursing observation that R12 had been yelling more and grinding her teeth. Possible tooth pain. Physician's recommendation was to talk with family member (FM)-A to see if R12 needs a dental appointment. The other option is pain control but I do not know if there is infection of teeth which if present could get worse.	21390	Corrected.	

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21390	Continued From page 42 -on 12/15/17, (health status note) when physician was here in November, R12 was showing signs of possible mouth pain again and talked about possibility of having remaining teeth extracted. FM-B notified and asked if it looks like there is an increase in pain or infection, should arrangements be made to extract remaining teeth? FM-B responded "yes, if it would help keep her comfortable." Review of nursing progress notes showed an increase in observations of R12 demonstrating oral discomfort: -on 4/12/18, R12 lost one of her molar teeth that looked like it had rotten out. - on 5/25/2018, R12 did not like the cold juice when taking medications. -on 5/26/2018, R12 had been grinding teeth this shift, when drinking cold liquid would pull back and get upset. R12 was asked multiple times if teeth hurt and at one point R12 did say "yes". R12 will not open mouth to allow you to look at teeth. - on 5/27/18, R12 was noted to be grinding her teeth on and off this shift, cold liquids irritate her and she pulls away. - on 5/30/18, R12 did pull her head back while taking a drink through a straw and then stopped drinking. - on 5/31/18, when attempting to look in mouth to see current condition of teeth R12 clamped lips together and would not open mouth. - on 6/1/18, R12 was grinding her teeth at the lunch table. - on 6/5/18, R12 was noted to have reddened area to lower left jaw and upper right jaw, possibly due to tooth decay. Will notify family and make appointments as needed. - on 6/8/18, R12 was grinding her teeth this shift while at the supper table, while changing into	21390		

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21390	Continued From page 43	21390		

pajamas, and getting ready for bed.
- on 6/9/18, R12 pulled her head back and would shake her upper torso when trying to give food.
- on 6/11/18, R12 was noted to be grinding teeth while taking morning medications in milk.
- on 6/11/18 R12 was grinding teeth this evening while getting her PM medications.

Review of Interdisciplinary Team daily handwritten reports:
- on 5/16/18 indicated grinding more - monitor tooth pain
- on 5/30/18, indicated teeth? "my teeth twitter" "yes" Call Dentist
- on 6/13/18, indicated teeth? in pain

There had been no indication that a dental appointment was set up for R12 even with evident oral pain with eating/drinking over past month.

On 6/14/18 at 2:20 p.m. director of nursing (DON) stated absolutely a dentist should have been contacted for R12.

Lack of dental agreement:
On 6/14/18, at 8:54 a.m. Administrator provided a written statement indicating still looking for signed copy of dental contract with a dentist. By end of survey there was no signed dental agreement provided by the facility.

Dental Services procedure dated 3/9/17, indicated facility offers routine dental services to residents. The facility has a written agreement with dental services that visits on a regular basis. Oral health review will be completed with the data collection annually.

Pain policy dated 3/1/17:

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21390	Continued From page 44 directed physician and staff to identify individuals who have pain or who are at risk for having pain related to oral or dental pathology. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure an infection control program is developed and implemented by all staff . The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21445	MN Rule 4658.0900 Subp. 3 Activity and Recreation Program; Director Subp. 3. Activity and recreation program director. The activity and recreation program director must be a person who is trained or experienced to direct the activity and recreation staff and program at that nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a qualified activity director (AD) was in charge of the activity program. This had the potential to impact all 47 residents of the facility. Findings include: On 6/13/18, at 1:27 p.m., the AD stated she	21445	Completed.	7/20/18

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21445	Continued From page 45 started in her position during the summer of 2017 and starting taking an activity director course shortly after. On 6/13/18, at 2:15 p.m., the administrator stated they advertised for a qualified activity director but did not find someone who met the qualifications. The administrator stated the current AD had worked previously in activities, and he thought she met the requirements based on previous experience. In addition, they enrolled the AD in an activity director class immediately upon hiring her. On 6/14/18, at 9:21 a.m., the administrator confirmed the AD's previous experience from 7/2012, through 9/2017, only adds up to 14.5 months of activity experience in the last 5 years; and the requirement was 2 years. A policy identifying the qualifications of an activity professional was requested but not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee, could ensure a qualified Activity Director is provided to direct organized activities and recreation in a health care setting. The administrator or designee could monitor to ensure this requirement is met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21445		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of	21800		7/16/18

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21800	Continued From page 46 treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to give the correct version of resident rights to admitting residents. This had the potential to affect all 47 residents residing in the facility. Findings include: Review of the facility's Resident Handbook given to new admissions revealed it contained a version	21800	Corrected.	

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21800	Continued From page 47 of resident rights dated 7/1/07 and not the most current Bill of Rights dated 11/28/16. On 6/14/18, at 8:44 a.m., the social services designee (SSD) confirmed the 7/1/07 version of the Bill of Rights were given to residents upon admission. The SSD indicated the new version of The Combined Federal and Minnesota Resident Bill of Rights dated 11/28/16, was provided to every resident at one time soon after the 11/28/16, update. This rights booklet was also currently available at the information corner of the facility and the SSD offered them at care conferences. However, the SSD confirmed the booklets were not provided to residents on admission. Rather, residents at admission are getting the rights dated 2007. On 6/14/18 at 9:27 a.m., the administrator confirmed residents were getting an old version of their rights at admission. A copy of the letter that indicated the date residents received the new rights booklet was requested but not received from the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review its policy's and procedures for notification of resident rights upon admission to the facility. The DON or designee could then contact the State Agency to ensure the facility has the most updated version of the Resident Bill of Rights and each admission packet includes them. The facility could develop an auditing system that monitors for ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21800		

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21800	Continued From page 48 (21) days.	21800		
21870	MN St. Statute 144.651 Subd. 18 Patients & Residents of HC Fac.Bill of Rights Subd. 18. Responsive service. Patients and residents shall have the right to a prompt and reasonable response to their questions and requests. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to address the resident council's concerns related to food temperature, quantity and quality, during a survey initiated resident council meeting with 8 of 15 residents (R36, R40, R26, R6, R34, R38, R41 and R8) active members of the facility resident council. Findings include: On 6/12/18, at 3:55 p.m., a co-chair of the resident council (R43) gave permission for the survey team to review previous minutes of resident council meetings. Review of Resident Council minutes from 8/2017 to 6/2018 revealed the following: -8/7/17: Still having a problem with food not being warm enough and the quantity of alternative menu items was not enough. -9/11/17: Still have a problem with food not being warm enough. A staff person came and said they ordered some parts for the steam tables. -10/2/17: Food was cool, cafe choices could be crispy (shrimp and fries). There was a request to have buns heated for hamburgers so that they	21870	Corrected	7/16/18

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21870	Continued From page 49	21870		

might stay warm longer.
-11/6/17: Food was cool on the Angle unit. Requests were made for more variety in salads and for soup to be offered more often as the alternate choice for the evening meal.
-12/4/17: A resident from the BB unit said the food could be warmer.
-1/8/18: Food could be warmer and more soup was requested.
-2/5/18: Too many repeats on the menu.
-3/12/18: They were running out of certain alternative menu items.
-4/9/18: Better
-5/7/18: Dietary needs work and there was still cold food, and some of the meat was tough and hard to chew. There was a request to peel cucumbers, as the peel was too hard to eat. There was no toaster in the BB unit.
-6/11/18: There were still issues with the temperature of the food, they were running out of food more frequently (especially mashed potatoes). Potatoes in the potato salad were not fully cooked. Residents were tired of chicken so frequently on the menu and the french fries were never good--they are cold or soggy.

There was no evidence of follow-up to the concerns listed in the minutes. No action forms were available for review.

On 6/13/18 at 12:30 p.m., a resident council meeting was held and the following residents attended: R36, R40, R26, R6, R34, R38, R41 and R8.

At the resident council meeting, R36 stated he had concerns about the quality of the food, as some was not cooked through. R36 also stated when he has asked for "two eggs over easy and hash browns", the staff just laugh.

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	00797	A. BUILDING: _____ B. WING _____	06/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WARROAD CARE CENTER	1401 LAKE STREET NORTHWEST WARROAD, MN 56763

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21870	Continued From page 50 In addition, R38 stated the food was not hot enough. On 6/13/18, at 1:33 p.m., the activities director (AD) stated she takes minutes at the resident council meetings and the Activity Aide (AA)-A runs the meeting. The AD stated she informs the administrator and appropriate staff of concerns that are raised and then lets the resident council know what they say. The AD stated she has no log or written documentation of any follow-up on concerns raised at the resident council. The AD confirmed there was no evidence in the minutes of follow-up to the resident council. Finally, the AD stated she feels for the residents and the facility was doing the best they could in regards to food. On 6/13/18, at 2:19 p.m., the administrator stated there had not been good follow-up regarding food concerns, stating food had been a challenging issue for the facility for months, with turnover in kitchen leadership and staff. The administrator stated at the May (2018) resident council they talked about starting a resident food group that would meet more frequently, than the monthly resident council meeting. The administrator reviewed the minutes and confirmed that discussion of a food group was not evident in the minutes. The administrator stated the residents are correct with their food concerns. Review of the Combined Federal and State Bill of Rights revised November 2016 included: 5. The resident has a right to organize and participate in resident groups in the facility. D. The facility must consider the views of a resident or family group and act promptly upon	21870		

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21870	Continued From page 51 the grievances and recommendations of such groups concerning issues of resident care and life in the facility. a. The facility must be able to demonstrate their response and rational for such response. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure that residents concerns are listened to and acted upon timely. The director of nursing or designee could review policy and procedures, train staff, monitor systems, interview residents and evaluate the process to assure the facility acts upon resident council grievances, specifically related to food concerns. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21870		
21925	MN St. Statute 144.651 Subd. 29 Patients & Residents of HC Fac.Bill of Rights Subd. 29. Transfers and discharges. Residents shall not be arbitrarily transferred or discharged. Residents must be notified, in writing, of the proposed discharge or transfer and its justification no later than 30 days before discharge from the facility and seven days before transfer to another room within the facility. This notice shall include the resident's right to contest the proposed action, with the address and telephone number of the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12). The resident, informed of this right, may choose to relocate before the notice period ends. The notice period may be shortened in situations outside the facility's control, such as a determination by utilization review, the accommodation of newly-admitted	21925		7/13/18

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21925	Continued From page 52 residents, a change in the resident's medical or treatment program, the resident's own or another resident's welfare, or nonpayment for stay unless prohibited by the public program or programs paying for the resident's care, as documented in the medical record. Facilities shall make a reasonable effort to accommodate new residents without disrupting room assignments. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the ombudsman of a hospital transfer for 2 of 2 residents (R20, R31) reviewed for hospitalization. Findings include: R20's Admission Record, dated 6/13/18, indicated R20 had diagnoses that included Alzheimer's disease, enterocolitis (inflammation of the digestive tract) due to clostridium difficile (C-Diff, an infection of the colon), acute kidney failure, functional urinary incontinence, diabetes, and gout. R20's progress note dated 5/13/18, indicated R20 had 5 large loose stools, was lethargic and more confused than usual; the physician was notified of R20's condition and a telephone order was received to transfer R20 to the hospital. R20's family member was notified of the hospitalization. R20's Census List dated 6/14/18, indicated a hospital leave from 5/13/18 to 5/17/18. R20's Physician Discharge Summary dated 5/17/18, indicated R20 was hospitalized due to worsening generalized weakness and dehydration. R20 had been diagnosed with C-Diff	21925	Corrected.	

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21925	Continued From page 53 and was receiving oral antibiotics. R20's progress note dated 5/17/18, indicated he returned to the facility at 2:10 p.m. Review of R20's record does not reflect the ombudsman was notified of the facility-initiated transfer. R31's progress notes dated 5/12/18, indicated R31 had not been feeling well and was short of breath; family was notified of R31's change of condition and indicated R31 should go to the hospital if needed. Progress note then indicated the physician was notified of R31's condition; the physician gave a telephone order to transfer R31 to the hospital for further evaluation. R31 was subsequently admitted to the hospital. R31's progress note dated 5/14/18, indicated R31 had returned to the facility at approximately 3:10 p.m. R31's record does not reflect the ombudsman was notified of the facility-initiated transfer. On 6/12/18, at 4:13 p.m. social services designee (SSD) stated notifications to the ombudsman had not been completed for residents whom were transferred to the hospital and had not been aware of the requirement. Facility policy Transfer or Discharge Documentation dated 4/1/17, included: 4) All discharge forms must be faxed to the Office of the State Ombudsman for review. The policy did not specifically address Ombudsman notification related to emergency hospitalization transfers. SUGGESTED METHOD OF CORRECTION:	21925		

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21925	Continued From page 54 The Director of Social Work or designee could review facility policies and procedures for transfer and discharge notification, and develop a system to ensure the ombudsman is given notice when the facility initiates a resident transfer to the hospital. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21925		