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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: W5XP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00382

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245399**

2.STATE VENDOR OR MEDICAID NO.
(L2) **087497000**

3. NAME AND ADDRESS OF FACILITY
(L3) **LITTLE FALLS CARE CENTER**
(L4) **1200 FIRST AVENUE NORTHEAST**
(L5) **LITTLE FALLS, MN** (L6) **56345**

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) **01/01/2014**

6. DATE OF SURVEY **12/28/2016** (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 **32** (L18)
13.Total Certified Beds **32** (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
	32			
(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 :
Kathy Lucas, Unit Supervisor — 12/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 01/24/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 01/30/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/15/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245399
January 24, 2017

Ms. Amy Walker, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

Dear Ms. Walker:

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 December 13, 2016 the above facility is certified for or recommended for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 24, 2017

Ms. Amy Walker, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: Project Number S5399027

Dear Ms. Walker:

On November 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 3, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 3, 2016, effective December 13, 2016 and therefore remedies outlined in our letter to you dated November 22, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245399 Y1	A. Building B. Wing Y2	12/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0272	Correction	ID Prefix F0279	Correction	ID Prefix F0280	Correction
Reg. # 483.20(b)(1)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed
LSC	12/13/2016	LSC	12/13/2016	LSC	12/13/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0311	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(2)	Completed
LSC	12/13/2016	LSC	12/13/2016	LSC	12/13/2016
ID Prefix F0314	Correction	ID Prefix F0318	Correction	ID Prefix F0322	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(e)(2)	Completed	Reg. # 483.25(g)(2)	Completed
LSC	12/13/2016	LSC	12/13/2016	LSC	12/13/2016
ID Prefix F0441	Correction	ID Prefix F0465	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. # 483.70(h)	Completed	Reg. #	Completed
LSC	12/13/2016	LSC	12/13/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) KL/KJ	DATE 01/24/2017	SIGNATURE OF SURVEYOR 38202	DATE 12/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
11/3/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: W5XP

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2.STATE VENDOR OR MEDICAID NO.
(L2) **087497000**

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(L3) **LITTLE FALLS CARE CENTER**
(L4) **1200 FIRST AVENUE NORTHEAST**
(L5) **LITTLE FALLS, MN** (L6) **56345**

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) **01/01/2014**

6. DATE OF SURVEY **11/03/2016** (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 **32** (L18)

13.Total Certified Beds **32** (L17)

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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: (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(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 :
Jennifer Bahr, HFE NE II — 12/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 12/13/2016 (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
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 12/15/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 22, 2016

Ms. Amy Walker, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

RE: Project Number S5399027

Dear Ms. Walker:

On November 4, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Kathy Lucas, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 13, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

Failure to submit an acceptable 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved 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.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 3, 2017 (three months after

the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 3, 2017 (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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
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
	245399	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. An investigation of complaint H5399021 was completed and found not to be substantiated. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being;	F 272		12/13/16

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

Electronically Signed | 12/02/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 272	Continued From page 1 Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to comprehensively assess for the use of psychotropic (mood altering) medication during the assessment reference dates (ARD) for 2 of 5 residents (R9, R44) reviewed for unnecessary medications. Findings include: R9's admission Minimum Data Set (MDS) dated 10/16/16, indicated R9 had diagnoses of dementia, anxiety disorder and depression. The MDS also indicated R9 was taking an antianxiety the last seven days and antidepressant medication the last seven days. R9's psychotropic drug use Care Area Assessment (CAA) was	F 272	LFHS conducts comprehensive assessments of each resident on admission, annually and with a significant change. R#9- a comprehensive psychotropic drug assessment was completed. R#44- a comprehensive psychotropic drug assessment was completed. All residents taking psychotropic medications have a potential to be affected by a deficient practice in this area.	

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	245399	A. BUILDING _____ B. WING _____	11/03/2016

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F 272	Continued From page 2 initiated, however, the assessment worksheet was never completed. R9's Admission Observations (where the facility documents the admission CAAs started 10/9/16, and completed 10/14/16, did not contain a comprehensive psychotropic drug assessment. R44's significant change MDS dated 10/19/16, indicated R44 had diagnoses of dementia, anxiety disorder and depression. The MDS also indicated R9 was taking an antipsychotic the last seven days, an antianxiety the last seven days and antidepressant medication the last seven days. R9's psychotropic drug use CAA was initiated, however, the assessment worksheet was never completed. R44's General Nurses Observations (where the facility documents the CAAs after admission) started 10/19/16, and completed 10/19/16, did not contain a comprehensive psychotropic drug assessment. During interview on 11/3/16, at 2:25 p.m. registered nurse (RN)-C stated that she was responsible for completing the MDS on the residents. RN-C stated that she did not do a psychotropic drug use CAAs during the ARD period for R9 and R44. RN-C further stated that she never completed the psychotropic drug use CAA's on any resident during the assessment period unless it was during the first week of the month regardless of the ARD period. However, RN-C could not provide the last two comprehensive psychotropic medication assessments for R44. RN-C also stated that a psychotropic drug CAA had never been completed on admission for any resident, as the	F 272	All Nursing staff involved in writing psych med assessment were re-educated on process of completing psychotropic medication assessments. All other residents receiving a psychotropic medication will have a psychotropic medication assessment completed. DON or designee will audit Comprehensive psychotropic medication assessments to ensure they are completed timely. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation. Completion date for F 272 is: 12/13/16	

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F 272	Continued From page 3 facility is not sure what medications were warranted. RN-C also stated the facility does not utilize the worksheets provided with the facility's electronic MDS record but rather documents the assessments under admission or general nursing observations. During interview on 11/3/16, at 4:01 p.m. the director of nursing stated a comprehensive assessment for psychotropic drug use was expected to be completed on admission, annually and with a significant change MDS. The facility policy Psychotropic Medications dated 10/1/15, did not address a comprehensive assessment would be completed during admission, annual or significant change MDS.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		12/13/16

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F 279	Continued From page 4 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for the use of a continuous positive airway pressure (CPAP) breathing machine for 1 of 1 resident (R40) who used a CPAP. In addition, the facility failed to develop a comprehensive care plan which included range of motion (ROM) services for 1 of 1 residents (R23) reviewed for a restorative program. Findings include: R40's Face Sheet printed on 11/03/16, indicated R40's diagnoses included chronic respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the body's tissues), primary spontaneous pneumothorax, chronic obstructive pulmonary disease (lung condition - COPD) unspecified, obstructive sleep apnea (a disorder where a person has one or more pauses in breathing or shallow breathing while sleeping). R40's quarterly Minimum Data Set (MDS) dated 10/24/16, indicated R40 had severe cognitive impairment,and utilized oxygen (O2) therapy. R40's care plan dated 3/06/16, identified R40 was at risk for shortness of breath (SOB), and directed nursing staff to elevate head of bed (HOB), monitor for SOB, and maintain O2 at 3-4 liters per nasal cannula. The care plan lacked direction for CPAP use.	F 279	LFHS develops comprehensive Care plans to describe services to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. R#40- care plan and NAR group sheets were updated to include CPAP to be placed when resident requests. R#23 care plan was updated to include a Restorative ROM Program. All residents on CPAP and that receive ROM have the potential to be affected by a deficient practice in this area. Nursing staff involved care plan documentation were re-educated on the process of completing a care plan for CPAP and restorative ROM programs. Care plans for residents with a restorative ROM programs and who use CPAP were reviewed and revised prn. DON or designee will perform chart audits to ensure care plans are accurate for CPAP and Restorative Rom programs. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter.	

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F 279	Continued From page 5 R40's physician orders dated 10/04/16, indicated R40 was to have CPAP machine applied 3 times a day (day, evening, night) and anytime lying in bed. During interview on 10/31/16, at 1:37 p.m. family member (F)-A stated R40's CPAP machine should be on when he was sleeping or napping. R40 was observed sleeping with O2 per nasal cannula at 3 liters on, and CPAP sitting on R40's night stand. During observations on 10/31/16, at 2:25 p.m., 11/1/16, at 6:50 p.m., 11/2/16, at 7:10 a.m., R40 was in bed sleeping with HOB elevated, O2 nasal cannula on and CPAP on nightstand. During interview on 11/02/16, at 9:49 a.m. registered nurse (RN)-A stated R40's CPAP should be on the care plan. During interview on 11/03/16, at 11:00 a.m. director of nursing (DON) stated R40's CPAP should be on the care plan. R23's quarterly MDS dated 10/5/16, identified R23 had moderate cognitive impairment and no functional limitation in ROM in both upper and lower extremities. During interview on 11/2/16, at 12:07 p.m. physical therapist (PT)-A stated R23 had received therapy when she was admitted to the facility and had been discharged with therapy recommendation for upper and lower extremity ROM. An undated, un-titled facility nursing assistant	F 279	Audit results will be brought to the QAPI committee for review and further recommendation. Completion date for 279 is 12/13/16	

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F 279	Continued From page 6 group sheet identified R23 was on a restorative nursing program (RNP) but did not list ROM under the program. R23's care plan dated 1/31/16, indicated R23 needing assistance with mobility. It did not identify R23 as being on a restorative program or receiving ROM. During interview on 11/3/16, at 1:38 p.m. RN-A stated R23 was to receive ROM once a day six days a week. RN-A stated R23's ROM abilities were assessed quarterly along with updating the nursing assistant group sheets and care plan. During interview on 11/3/16, at 3:55 p.m. RN-C stated she was in the process of updating the care plans to reflect restorative programs. RN-C stated R23's care plan did not contain a restorative program and should. During interview on 11/3/16, at 4:16 p.m. the DON stated she would expect a restorative ROM program to be on the care plan. A facility policy entitled Range of Motion, reviewed 11/8/15, directed restorative ROM programs will be added to the care plan and care guide by the nurse manager.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		12/13/16

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F 280	Continued From page 7 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan for the presence of dentures/natural teeth for 1 of 3 residents (R7) reviewed for dental services. Findings include: R7's annual Minimum Data Set (MDS) dated 7/22/16, indicated no dental concerns or problems. Facility General Nurses's Observation notes dated 5/10/16, indicated R7 had upper and lower dentures, which she did not wear. General Nurses's Observation notes dated 7/22/16 and 8/19/16, indicated R7 had upper and lower dentures, however, the dentures were missing. General Nurses's Observation note dated	F 280	LFHS ensure the resident's oral status is reflected on the individual plan of care. R# 7 care plan and NAR group sheet was updated to reflect the absence of natural teeth or dentures. All residents' care plans were reviewed to ensure the care plan reflects their oral status and oral hygiene needs. Nursing staff were re-educated on assessing oral status and process to inform Nurse Manager who is in charge of updating care plans. DON or designee will perform care plan audits to ensure care plans regarding the resident's oral status are complete. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then	

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F 280	Continued From page 8 10/20/16, indicated R7's dentures had been missing for months and indicated R7 had no natural teeth. An undated, un-titled facility nursing assistant group sheet, identified R7 had partial dentures on the top of her mouth and directed staff to brush her teeth. R7's current care plan, last revised 8/14/16, directed staff to brush R7's own existing teeth and to clean R7's dentures overnight. During observation on 10/31/16, at 2:22 p.m. R7 did not have any teeth or dentures in her mouth. During dining observation on 11/1/16, at 6:14 p.m. R7 was again edentulous while eating supper. Nursing assistant (NA)-D assisted R7 to eat and stated R7 did not wear dentures and had no natural teeth. During interview on 11/2/16, at 8:19 a.m. NA-I stated R7 sometimes refused oral cares but thought she had natural teeth. NA-I looked at an un-titled facility care sheet to confirm R7 had teeth. During interview on 11/2/16, at 8:50 a.m. licensed practical nurse (LPN)-A stated R7 had natural teeth on the bottom of her mouth. During interview on 11/2/16, at 10:15 a.m. registered nurse (RN)-A stated R7 had no natural teeth and used to have dentures. However, R7 often threw them in the trash, so family removed them home from the facility. RN-A further stated R7's care plan had not been revised because R7 did have dentures "just not in the facility" and may	F 280	once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation. Completion date for F 280 is 12/13/ 16	

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F 280	Continued From page 9 wear them again at some point. During interview on 11/2/16, at 1:23 p.m. RN-C stated the care plans were updated as changes are made. During interview on 11/2/16, at 1:34 p.m. the director of nursing stated the care plan should have been updated to reflect the change in R7's teeth and denture status. A facility policy entitled Care Plans, last reviewed 9/1/15, indicated it was the responsibility of the Nurse Manager to review and change care plans in the electronic medical record (EMR) and, in addition, communicate changes to the nursing team.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed follow the plan of care to ensure assistance with ambulation was provided for 1 of 1 residents (R23) reviewed for ambulation with a restorative program; and the facility failed to provide services to relieve pressure to heel pressure ulcer for 1 of 3 residents reviewed for pressure ulcers; and failed to (R2) check placement of a gastrostomy tube (G-tube) as directed by the care plan for 1 of 1 resident (R40)	F 282	LFHS ensures services are provided by qualified persons in accordance with the resident's plan of care. Restorative and NAR staff caring for R #23 were re-educated on the resident's ambulation and ROM programs and documentation of the programs. NAR staff caring for R#2 were	12/13/16

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F 282	Continued From page 10 who had a G-tube. Findings Include: R23's quarterly Minimum Data Set (MDS) dated 10/5/16, identified a moderate cognitive impairment and needed extensive assistance of one person to walk both in her room and outside. R23's current care plan dated 1/31/16, directed staff to walk R23 resident in order to prevent a decline in ambulation. An undated un-titled facility nursing assistant group sheet, identified R23 was on a restorative nursing program (RNP) and directed staff to walk R23 to meals. During observation on 11/1/16, at 5:32 p.m., R23 was seated in her wheelchair. Nursing assistant (NA)-D was observed to put foot pedals onto R23's wheelchair and proceeded to push R23 to the dining room for supper. No attempt or offer was made to walk with R23. During interview on 11/2/16, at 8:00 p.m. NA-D stated the nursing assistants typically pushed R23 in her wheelchair to meals and further stated R23 did not walk as much as she used to. During observation on 11/2/16, at 8:05 a.m. R23 was again being pushed in her wheelchair from the nurse's station into the dining room for breakfast. During interview on 11/2/16, at 7:44 a.m. licensed practical nurse (LPN)-E stated R23 was on a restorative program but did not walk that morning	F 282	re-educated on the resident's program for providing pressure relief to heels and the need to report refusals to the Nurse. NAR Group sheets were reviewed and revised to include current pressure relief program for heels and Restorative Ambulation and ROM programs. Nursing staff caring for R#40 were re-educated on checking placement of a G-tube per facility policy and MD orders. All residents with G-tubes, pressure relief programs for heels and restorative programs have plans of care that must be followed by staff caring for the resident. Care plans remain readily available for staff. All nursing staff were re-educated on the availability of plans of care and the need to follow the resident's specific plan of care. DON or designee will perform random observational audits of Restorative ROM and Amb programs. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. DON or designee will perform random observational audits of pressure relief programs for heel pressure relief. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter.	

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F 282	Continued From page 11 due to knee pain. During observation on 11/2/16, at 11:52 p.m. R23 was seated in her wheelchair. R23 had been transferred from the bed into the wheelchair by NA-G and NA-I. R23 was then observed to again be pushed in her wheelchair to lunch. During interview on 11/2/16, at 12:02 p.m., NA-G stated R23 had refused to walk to lunch. NA-G stated R23 does not ever walk to meals and was not aware R23 was on a restorative ambulation program. During interview on 11/2/16, at 12:07 p.m. physical therapist (PT)-A stated R23 had received therapy when she was admitted to the facility and had been discharged with therapy recommendations for a restorative ambulation program. PT-A stated R23's goals was to ambulate 25 ft (feet) to 50 ft at a time. During interview on 11/3/16, at 7:46 a.m. NA-H stated R23 used to walk to meals before her room changed, as her previous room was closer to the dining room. NA-H did not think R23 could walk all the way from her current room to the dining room, but thought staff could attempt to walk her once R23 was closer to the dining room. During interview on 11/3/16, at 1:38 p.m. registered nurse (RN)-A stated the nursing assistants were responsible for walking with R23 and thought R23's restorative ambulation program was being done as she often saw R23 ambulate to the bathroom and in her room. RN-A thought the ambulation documentation was not representative of R23's walking and staff needed education on charting.	F 282	DON or designee will perform random observational audits of checking G-tube placement, A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation. Completion date for F 282 is 12/13/16.	

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F 282	Continued From page 12	F 282		

During interview on 11/3/16, at 4:16 p.m. director of nursing (DON) stated the inconsistency in R23's ambulation program was due to documentation errors by the nursing assistants.

R2's 14-day scheduled assessment MDS dated 10/12/16, identified R2 was at risk of pressure ulcers, had one stage 2 pressure ulcer and one unstageable pressure ulcer, and none worsening. It also identified pressure reducing device for the chair and bed, and R2 was on a turning and repositioning program.

R2's care plan dated 10/31/16, identified staff were to provide extensive assistance as follows:

- Assistance with turning and repositioning when in bed.
- Assist of two to take resident to the toilet.
- Assistance of two staff for ambulation
- R2 had a pressure ulcer to coccyx / low back, with an intervention of an air mattress of an air mattress and to turn and reposition every two to three hours.
- Monitor for positioning in wheelchair
- Cushion to wheelchair

Nursing assistant care sheet indicated R2 was to be repositioned every two to three hours. It also identified skin issues, float heels, and air mattress.

During observation on 11/2/16, at 7:06 a.m. R2 was lying in bed on her right side. Both heels were noted to be directly on the mattress, not floated.

During observation on 11/2/16, at 7:39 a.m. the

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F 282	Continued From page 13	F 282		

DON and RN-C entered R2's room to perform dressing changes to the pressure ulcers on her right medial buttock and left heel. RN-C stated R2's heels were not floated in bed. RN-C assisted to place a pillow beneath R2's legs to float the heels off the bed.

On 11/3/16, at 8:54 a.m. continuous observation began. R2 was observed sitting in her wheelchair in the dining room, eating breakfast. R2's left foot was observed in opened back slipper, with the back half of the slipper and foot, including the heel, resting on the foot rest, and the front half off of the foot rest. At 9:56 a.m. R2 was assisted to the activity room, with left foot observed unchanged. At 10:28 a.m. R2 remained in the activity room for coffee. Activity director (AD) assisted R2 to the table, making no offer to adjust the left foot. At 11:10 a.m. AD assisted R2 out of the activity room, and to her room. At 11:18 a.m. R2 asked to use the bathroom, and NA-F entered to assist. Continuous observation ended at this time. For 2 hours and 24 minutes, R2 remained in her wheelchair, with her foot observed with the heel resting on the foot rest. During this time, staff did not offer to reposition and R2 was not observed to reposition independently.

During interview on 11/2/16, at 7:24 a.m. NA-A denied being aware of any skin issues with R2. When she helped to reposition R2 in the morning, the pillow had been kicked out from beneath her knees, and R2 did not want it replaced. NA-A verified R2's heels were resting directly on the mattress at this time, not being floated.

During interview on 11/2/16, at 8:54 a.m. RN-C stated R2 has a nursing order to float the heels when in bed. RN-C verified R2's heels were not

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F 282	Continued From page 14 floated that morning when she entered to do wound care, and was not aware of how often this happens. RN-C stated staff are expected to report any changes or non-compliance to one of the RNs. During interview on 11/3/16, at 1:38 p.m. RN-C stated R2's heel should not be resting directly on the footrest, and staff education was provided. Facility policy titled Care Plans, undated, indicated where the care plans can be found as well as identified the care plan includes the care and services that must be provided to meet those goals, and the frequency of these services. It also indicated under nursing responsibilities nursing assistants are to chart daily on resident status to provide up-to-date information on resident activities of daily living needs. R40's care plan dated 6/16/16, directed nurses to check placement of G-tube, administer medications via the G-tube following physician's orders R40's physician order dated 10/4/16, directed G-tube feeding Jevity 1.2 at 65 milliliters (ml) per hour times 24 hours. R40's medication orders indicate he was to receive his medications via G-tube with 30 cubic centimeters (cc) flushes before and after medication. During observation on 10/31/16, at 2:25 p.m.	F 282		

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F 282	Continued From page 15 LPN-A prepared to change the bottle of Jevity running in R40's G-tube. LPN-A took a 60 cc syringe, placed it into a graduate container of water, withdrew 60 ccs of tab water, opened R40's G-tube port, and cleaned port with alcohol wipe. LPN-A placed the tip of the syringe into the G-tube port and attempted to flush tube with 60 ccs of water, and met resistance. LPN-A did not check for G-tube placement by aspiration or auscultation prior to starting the Jevity infusion. During interview on 10/31/16, at 2:25 p.m. LPN-A stated R40 had a G-tube and did not check for G-tube placement prior to flush or starting infusion of Jevity. During observation on 11/01/16, at 7:37 p.m. LPN-B prepared medication and placed in medication in cup to administer through R40's G-tube. LPN-B turned off feeding pump, disconnected the tubing, and placed the 60 ccs syringe into the G-tube port, and poured 60 ccs of distilled water into syringe to flush via gravity and met resistance. LPN-B did not check for G-tube placement by aspiration or auscultation. RN-A entered R40's room and attempted to assist LPN-B with flushing the G-tube. RN-A did not check for G-tube placement by aspiration or auscultation. LPN-B used a different 60 cc syringe with a narrow tip and was able to flush G-tube and administer medication. LPN-B did not check for G-tube placement by aspiration or auscultation prior to administering medications. During interview on 11/01/16, at 8:15 p.m. LPN-B stated she had not checked G-tube for placement prior to water flush or administering medication per policy and care plan. During interview on 11/01/16, at 8:20 p.m. RN-A stated the G-tube needed to be checked for placement by aspiration or auscultation prior flushing, medication administration, and starting	F 282		

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F 282	Continued From page 16 new feeding. RN-A stated R40's care plan dated 6/16/16, was not followed. During interview on 11/03/16, at 11:00 a.m. the DON stated R40's care plan was correct and she expected placement of the G-tube be checked every time prior to medication administration, flushes, and starting the tube feeding.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to apply a continuous positive airway pressure (CPAP) breathing machine as directed or document the refusal of the use of the CPAP for 1 of 1 resident (R40) who utilized a CPAP. In addition, the facility failed to re-assess and develop interventions related to positioning for 1 of 1 residents (R23) who was observed to lean in the wheelchair. Findings include: R40's undated Face Sheet printed on 11/03/16, indicated R40's diagnoses included chronic respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the body's tissues), primary spontaneous pneumothorax, chronic	F 309	LFHS ensures each resident receives care and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. R#40- New physician orders were obtained for CPAP use. R#23- was re-assessed by occupational therapy and a new wheelchair was provided. All residents who utilize a CPAP and who utilize wheelchairs have the potential to be affected by a deficient practice in this area.	12/13/16

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F 309	Continued From page 17 obstructive pulmonary disease (lung condition-COPD) unspecified, obstructive sleep apnea (a disorder where a person has one or more pauses in breathing or shallow breathing while sleeping). R40's General Nurse's Observation Note, which serves as the care area assessment (CAA) dated 10/19/16, indicated R40 was assessed as sleeping 8-9 hours a night and 2-3 naps daily. R40's quarterly Minimum Data Set (MDS) dated 10/24/16, indicated R40 had severe cognitive impairment, utilized oxygen (O2) therapy, received extensive assistance with bed mobility, toileting, and needed total assistance with transfers using a hoyer lift. R40's care plan dated 3/06/16, identified R40 was at risk for shortness of breath (SOB), and directed staff to elevate head of bed (HOB), monitor for SOB, and maintain O2 at 3-4 liters per nasal cannula. Care plan lacked direction for CPAP use. R40's physician orders dated 10/04/16, indicated R40 was to have CPAP machine applied 3 times a day (day, evening, night) and anytime lying in bed. R40's physician note dated 10/24/16, indicated R40's wife was concerned about the hypoxic event R40 had on 10/23/16. Physician order was to continue with same plan of care. R40's electronic Treatment Administration Record (ETAR) dated October 2016, directed nurses to apply CPAP anytime lying in bed, and initial each shift. The ETAR lacked indication if CPAP was	F 309	All residents who utilize a wheelchair will be assessed for proper positioning and refer to therapy as needed. Nursing staff were re-educated on the use of CPAP and documentation of refusals of CPAP. All Nursing staff were also re-educated on wheelchair positioning, and the need to report to the Nurse Manager if repositioning is unsuccessful. DON or designee will conduct random observational audits for wheelchair positioning. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. DON or designee will conduct random observational audits for CPAP use. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendation. Completion date for F 309 is 12/13/16	

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F 309	Continued From page 18 applied, refused, or removed. R40's nursing notes from 10/01/16, through 10/31/16, did not indicate if or whether R40 had refused the CPAP treatment. During interview on 10/31/16, at 1:37 p.m. family member (F)-A stated R40's CPAP machine should be on when he was sleeping or napping. At that time, R40 was observed sleeping with O2 per nasal cannula at 3 liters on, and CPAP sitting on R40's night stand. During observation on 10/31/16, at 2:25 p.m. R40 was sleeping in bed, and breathing through his mouth with O2 on at 3 liters per nasal cannula, HOB elevated and CPAP was sitting on night stand. Licensed practical nurse (LPN)-A was in R40's room and had a difficult time arousing R40 and asked him if he was sleeping at night. LPN-A did not acknowledge that R49 was not utilizing the CPAP During observation on 11/01/16, at 6:50 p.m. R40 was in bed sleeping with HOB elevated, O2 nasal cannula on and CPAP on nightstand. During observation on 11/01/16, at 7:28 p.m. R40 was in bed sleeping with HOB elevated, O2 nasal cannula on and CPAP on nightstand. During observation on 11/02/16, at 7:10 a.m. R40 was in bed sleeping with HOB elevated, O2 nasal cannula on and CPAP on nightstand . During observation on 11/02/16, at 8:55 a.m. R40 was in bed sleeping with HOB elevated, O2 nasal cannula on and CPAP on nightstand.	F 309		

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During interview on 11/02/16, at 9:49 a.m. registered nurse (RN)-A stated R40 had his CPAP since admission on 2/06/16, and used the CPAP machine anytime he was sleeping, during the night, and at his request. RN-A stated documentation on the ETAR does not reflect if the CPAP was applied, refused, or removed. RN-A stated R40 refused CPAP at times, and refusals would be charted in the nursing progress notes. RN-A stated she would expect to see the CPAP on R40's care plan.

During interview on 11/02/16, at 10:13 a.m. licensed practical nurse (LPN)-A stated R40 would wear the CPAP when he was feeling SOB, after each nebulizer treatment, and if O2 saturations are below 90%. LPN-A stated R40 liked to wear the CPAP when he was napping. LPN-A stated at that time the documentation on the ETAR was completed for the whole shift and did not reflect if the CPAP was applied, refused, or removed. Review of the ETAR indicated O2 saturation rates were normal at 90 or above.

During interview on 11/03/16, at 11:00 a.m. the director of nursing (DON) stated R40's CPAP should be applied as directed. The DON stated CPAP should be on the care plan.

R23's quarterly MDS dated 10/5/16, indicated R23 had moderate cognitive impairment, used a wheelchair, and needed extensive assistance with locomotion.

During observation on 11/1/16, at 12:46 p.m. R23 was hunched over and leaning to the right in her standard wheelchair.

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F 309	Continued From page 20 During observation on 11/1/16, at 4:59 p.m. R23 was seated in her wheelchair in the hallway right outside her room. While seated, R23 leaned to the right side of her wheelchair with her right shoulder pressed up against arm rest. After a few minutes, her head fell forward and to the right as she appeared to be asleep. At 5:32 p.m. R23 was assisted into the dining room. Staff did not attempt to reposition R23 prior to dinner. During dining observation on 11/1/16, from 5:38 p.m. to 6:12 p.m. R23 was observed hunched over and leaning to the right in her wheelchair. R23's head was hanging down so far it almost touched the armrest of the wheelchair. Staff attempts were made to encourage R23 to eat her supper, however, no attempts were made to reposition R23. During observation on 11/2/16, at 7:18 a.m. R23 was seated in a different standard wheelchair by the nurse's station. In this wheelchair, R23 continued to be hunched over and leaning forward with her head hanging down. She was no longer leaning to the right. At 8:05 a.m. R23 was assisted into the dining room. No attempts to reposition R23 were made by staff. R23's care plan dated 1/31/16, indicated needing assistance with wheelchair mobility. R23's care plan did not contain interventions related to positioning nor did it direct staff on how to intervene. During interview on 11/2/16, at 7:44 a.m. LPN-E stated R23 had received a new wheelchair that morning but was not aware of who brought it in. LPN-E stated R23 tended to lean more when she	F 309		

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F 309	Continued From page 21	F 309		

was tired, and staff should offer repositioning to her bed or recliner. LPN-E was unsure if R23's standard wheelchair had been sized or assessed for positioning.

During interview on 11/2/16, at 9:07 a.m. occupational therapist (OT)-A observed R23's position in the wheelchair and stated R23 sat hunched over most often. OT-A stated the current wheelchair seemed "a bit big" for R23 and the armrests were a little high. OT-A stated when a resident is more "sloppy" in the wheelchair or is not able to hold themselves up, staff should make a referral to therapy to assess the wheelchair. OT-A was unaware if R23's wheelchair had been assessed by therapy.

During interview on 11/2/16, at 2:24 p.m. nursing assistant (NA)-G stated R23 leaned most often after meals and when she was exhausted. NA-G stated she tried to reposition R23, either in the recliner or by placing pillows behind her back. NA-G further stated she wished "there is more we [staff] could do."

During interview on 11/3/16, at 7:46 a.m. NA-H stated she would ask R23 to "sit up more" when R23 was leaning in her wheelchair. NA-H stated she would roll up a small pillow or blanket in R23's wheelchair and thought the care plan should have interventions the staff could do for positioning.

During interview 11/3/16, at 8:03 a.m. physical therapist (PT)-A stated therapy would attempt to assess wheelchair on admissions to make sure they were appropriate and sized correctly. PT-A stated R23's current wheelchair seemed a little wide and therapy had not been consulted to

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F 309	Continued From page 22 assess it. PT-A further stated it was not routine for therapy to assess all wheelchairs. During interview on 11/3/16, at 1:38 p.m. RN-A was not aware of R23 receiving a new wheelchair, further stating she had assessed R23's wheelchair upon admission, felt it was appropriate, and did not need to be re-assessed. RN-A stated R23 tended to have a bent over posture and expected staff to reposition R23 if she was uncomfortable in the wheelchair. RN-A further stated the expectation would be for the nursing assistants to notify the nurses if R23 was leaning more in the wheelchair; however, RN-A stated the positioning expectations were not on R23's care plan because "it was a given, just common sense." During interview on 11/3/16, at 4:16 p.m. the DON stated wheelchairs were assessed as needed and if residents were leaning or having positioning issues it would be an indication for therapy to assess them. The DON stated staff were expected to reposition residents and assess them as needed. The DON further stated she would expect positioning interventions to be on the care plans. A facility policy entitled, Adaptive and Positioning Equipment, undated, directed the facility to provide equipment to "achieve their [residents] highest most practicable level of function." The policy also directed nursing to make referrals to therapy for positioning and adaptive equipment recommendations.	F 309		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		12/13/16

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F 311	Continued From page 23 A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to reassess and consistently implement an ambulation program for 1 of 1 residents (R23) reviewed for ambulation with a restorative program. Findings Include: R23's quarterly Minimum Data Set (MDS) dated 10/5/16, identified R23 had moderate cognitive impairment and needed extensive assistance of one person to walk both in her room and outside. R23's current signed physician orders, dated 9/8/16, indicated R23 was to walk to meals three times a day. An undated, un-titled facility nursing assistant group sheet identified R23 was on a restorative nursing program (RNP) and directed staff to walk R23 to meals. R23's current care plan dated 1/31/16, directed staff to walk R23 in order to prevent a decline in ambulation. The Facility Treatment Sheet Records, for 8/16, 9/16, and 10/16, contained the order to walk R23 to meals 3 times per day. The Treatment Sheets were not marked by nursing staff to show ambulation had occurred.	F 311	LFHS ensures each resident is given the appropriate treatment and services to maintain or improve his or her abilities. R#23 was referred to Physical therapy on 11-2-16 for ambulation assessment. A restorative ambulation program was developed and entered on the care plan and NAR group sheet. All residents on restorative ambulation have the potential to be affected by a deficient practice in this area. All residents with ambulation programs will be reviewed to ensure that the service is appropriate. All NAR and Nursing staff were educated on R23□s ambulation program and documentation of restorative ambulation programs. Random observational audits will be completed to ensure that ambulation programs are being implemented. DON or designee will conduct random audits. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and monthly thereafter.	

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F 311	Continued From page 24 A facility document entitled, Walking Therapy Detail Report, from 2/1/16 to 7/1/17, showed the total walking/restorative care services R23 had received. It identified R23 had received restorative ambulation one day in June, fourteen days in July, twenty two days in August, fourteen days in September, and seven days in October. It identified R23 had not received restorative ambulation yet in November. During observation on 11/1/16, at 5:32 p.m. R23 was seated in her wheelchair. Nursing assistant (NA)-D was observed to put foot pedals onto R23's wheelchair and proceeded to push R23 to the dining room for supper. No attempt or offer was made to walk with R23. During interview on 11/2/16, at 8:00 p.m. NA-D stated the nursing assistants typically pushed R23 in her wheelchair to meals and further stated R23 did not walk as much as she used to. NA-D stated the staff did not walk with R23 that night because R23 was "out of it" and the unit was "kind of crazy." During observation on 11/2/16, at 8:05 a.m. R23 was being pushed in her wheelchair from the nurse's station into the dining room for breakfast. During interview on 11/2/16, at 7:44 a.m. licensed practical nurse (LPN)-E stated R23 was on a restorative program but did not walk that morning due to knee pain. LPN-E further stated the nursing assistants were responsible for walking with R23, however, due to the "hustle and bustle throughout the day," was not sure the walking was documented or that they informed the nurse so R23 could be pre-medicated before walks.	F 311	Audit results will be brought to the QAPI committee for review and further recommendation. Completion date for F 311 is 12/13/16	

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During observation on 11/2/16, at 11:52 p.m. R23 was in her room seated in her wheelchair. R23 had been transferred from the bed into the wheelchair by NA-G and NA-I. R23 was again observed to be pushed in her wheelchair to lunch.

During interview on 11/2/16, at 12:02 p.m. NA-G stated R23 had refused to walk to lunch and further stated it was hard for R23 to even stand that afternoon. NA-G stated R23 does not ever walk to meals and was not aware R23 was on a restorative ambulation program.

During interview on 11/2/16, at 12:07 p.m. physical therapist (PT)-A stated R23 had received therapy when she was admitted to the facility and had been discharged with therapy recommendations for a restorative ambulation program. PT-A stated R23's goal was to ambulate 25 ft (feet) to 50 ft at a time. PT-A further stated therapy screens all residents quarterly which would identify a decline in mobility, however, was unable to find the quarterly screenings or therapy recommendations for R23.

During interview on 11/3/16, at 7:46 a.m. NA-H stated R23 used to walk to meals before her room changed, as her previous room was closer to the dining room. NA-H did not think R23 could walk all the way from her current room to the dining room, but thought staff could attempt to walk her once R23 was closer to the dining room.

During observation on 11/3/16, at 8:03 a.m. PT-A ambulated R23 in the facility hallway and stated R23 did not have a functional decline in ambulation. However, PT-A stated a lesser goal of ambulating once a day may be more appropriate for R23, since switching rooms, the

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distance between her room and the dining room was longer.

During interview on 11/3/16, at 1:38 p.m. registered nurse (RN)-A stated the nursing assistants were responsible for walking with R23 and thought R23's restorative ambulation program was being done as she often saw R23 ambulate to the bathroom and in her room. RN-A further stated LPN's were responsible for monitoring the completion of the ambulation program. RN-A thought the ambulation documentation was not representative of R23's walking and staff needed education on charting. RN-A stated R23 rarely refused walking, especially with encouragement. RN-A stated the new distance between R23 room and the dining room was "under review" but had not been fully reassessed.

During interview on 11/3/16, at 3:55 p.m. RN-C stated restorative programs were not getting done consistently as ordered and were currently re-doing the ambulation program facility wide.

During interview on 11/3/16, at 4:16 p.m. the director of nursing stated the inconsistency in R23's ambulation program was due to documentation errors by the nursing assistants.

A facility policy entitled Restorative Nursing Program Policy, reviewed 8/23/15, indicated it was the responsibility of the Restorative Coordinator (a registered nurse) to establish restorative goals for residents, monitors all aspects of the restorative program, and oversees the documentation of nursing/restorative assistants.

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F 311	Continued From page 27 A copy of R23's facility document entitled, Restorative Nursing Program (containing therapy recommendations) was requested but not provided.	F 311		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary services to provide services to promote the healing of pressure ulcers and prevent infection for 1 of 3 residents (R2) reviewed for pressure ulcers who was not observed to have pressure relief to the heel, and buttocks, and improper infection control technique was provided during wound cares. Findings include: R2's Face Sheet identified admission to the facility on 9/30/16, with diagnosis including anemia, weakness, and major depressive disorder. The admission Minimum Data Set (MDS) dated	F 314	Based on the resident□s comprehensive skin assessment, LHFS ensures a resident with a pressure ulcer receives the necessary treatment and services to promote healing and prevent new ulcers from developing. R#2□s care plan and NAR group sheets were reviewed and revised prn to reflect current plan of care for buttock ulcer and heel ulcer and Therapy to assess for pressure relieving footwear. All residents with current pressure ulcers are at risk for a deficient practice in this area. All residents with current pressure ulcers	12/13/16

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F 314	Continued From page 28 10/7/16, identified R2 was at risk of pressure ulcers, had one Stage 2 pressure ulcer and one unstageable pressure ulcer, had a pressure reducing device for the chair and bed, and R2 was on a turning and repositioning program. The 14-day scheduled assessment MDS dated 10/12/16, identified R2 was at risk of pressure ulcers, had one stage 2 pressure ulcer and one unstageable pressure ulcer, and none worsening. It also identified pressure reducing device for the chair and bed, and R2 was on a turning and repositioning program. During observation on 11/2/16, at 7:06 a.m. R2 was lying in bed on her right side. Both heels were noted to be directly on the mattress, not floated (lifted off mattress to relieve pressure). During observation on 11/2/16, at 7:39 a.m. the director of nursing (DON) and registered nurse (RN)-C entered R2's room to perform dressing changes to the pressure ulcers on her right medial buttock and left heel. RN-C donned gloves, removed the old dressing from the buttock, and donned clean gloves, without performing hand hygiene. At this time, RN-C indicated being unable to see the wound base, and identified the wound on the buttock as unstageable. RN-C then sprayed the area with Sea Cleans (wound cleanser). With the same gloves, RN-C placed the new dressing on the wound. At this time, the gloves were removed, incontinent pad fastened, and pants pulled back up. RN-C then proceeded to don clean gloves, covered R2's torso, and removed the dressing from the left heel. This wound was also identified as unstageable. RN-C also verified R2's heels were not floated in bed. The Sea Cleans was	F 314	will be reassessed and interventions will be developed based upon the assessment. NAR staff were re-educated on R#2□s care plan, including the turning and repositioning program pertaining to heel protection (and the need to report to the nurse if the resident is refusing heel protection). Nursing staff were re-educated on infection control techniques during dressing changes. DON or designee will conduct random observational audits of residents with a heel ulcer or at high risk of heel breakdown identified to require heel protection. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x 2 weeks, then once weekly for 2 weeks, then monthly thereafter. DON or designee will conduct random observational audits of dressing changes to ensure proper infection control technique, 2Xweek x 2, weekly X2, and monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation. Completion date for F 314 is 12/13/16.	

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sprayed on the wound, and gloves were changed, without performing hand hygiene. A clean dressing was placed on the wound. The gloves were then removed, and RN-C assisted to place a pillow beneath R2's legs to float the heels off the bed, then lowered the bed with the attached remote. At this time, RN-C went to the bathroom and washed her hands.

On 11/3/16, at 8:54 a.m. continuous observation began. R2 was observed sitting in her wheelchair in the dining room, eating breakfast. R2's left foot was observed in opened back slipper, with the back half of the slipper and foot, including the heel, resting directly on the foot rest, and the front half off of the foot rest. Therapy staff was sitting next to resident, with no offer to assist to reposition R2's left foot. At 9:56 a.m. R2 was assisted to the activity room, with left foot observed unchanged. At 10:28 a.m. R2 remained in the activity room for coffee. Activity director (AD) assisted R2 to the table, making no offer to adjust the left foot. At 11:10 a.m. AD assisted R2 out of the activity room, and to her room. At 11:18 a.m. R2 asked to use the bathroom, and NA-F entered to assist. Continuous observation ended at this time. For 2 hours and 24 minutes, R2 remained in her wheelchair, with her foot observed with the heel resting on the foot rest. During this time, staff did not offer to reposition and R2 was not observed to reposition independently.

BUTTOCK

Skin Condition Report For Selected Conditions reports dated 9/30/16 through 11/1/16, identified the following related to a pressure ulcer on the right upper buttocks:

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F 314	Continued From page 30 9/30/16 Stage 2 1.7 x 1.5 cm wound base visible 50% granulation tissue 50% epithelial tissue no odor minimal clear drainage present on admission pressure redistributing mattress pressure redistributing cushion for wheelchair reposition side to side in bed and in recliner 10/4/16 1.5 x 1.4 No change to appearance of wound. 10/11/16 1.0 x 1.0 100% epithelial tissue 10/18/16 0.8 x 0.7 cm open wound edges even and unremarkable pressure reducing or relieving device(s) in place devices used on the bed surface and chair surface wound base visible 100% epithelial tissue scant clear drainage 10/21/16 0.6 x 0.4 cm moderate tan thin drainage no open areas wound bed appeared white	F 314		

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F 314	Continued From page 31 10/25/16 Stage 2 0.5 x 0.4 cm scant clear thin drainage 100% epithelial tissue wound bed appeared pink 11/1/16 1.0 x 1.8 dressing removed and observed to be contaminated with possible feces "This wound was healing but is now observed to have had a change. After reviewing past week it is determined that cushion previously in place on chair was changed by family due to chair being washed and returning without a cushion cover. Family felt resident was sweating. Family replaced cushion with one from home." Further documentation indicated, "Cushion was replaced today to a pressure relieving cushion. Resident continues to be repositioned q 2-3 [every 2-3] hours and is observed today to reposition on mattress. Dressing changes ordered to daily. Deterioration noted in site. Unable to accurately stage. Slough and/or eschar covered." Facility electronic Treatment Administration Record (ETAR) Report for October, 2016, identified an order dated 10/6/16, "Light exudate: Foam dressing Q3days [every three days] or prn [as needed] to upper rt [right] buttock 1 time per day every 3 days during Evening, Special Instructions: clean and place appropriate size meplex. Notify RN of changes in wound." Staff initialed this as being completed every 3 days as ordered. The order changed to, "dressing change to coccyx/low back 1 time per day during Day, Document Dressing Change: Document Characteristics - Drainage & Odor Skin and	F 314		

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F 314	Continued From page 32 Wound, Special Instructions: Meplex change daily. document characteristics, drainage. Notify RN of any s/s [signs and symptoms] of infection." HEEL Skin Condition Report For Selected Conditions dated 9/30/16 through 10/25/16, identified the following related to a pressure ulcer on the left heel: 9/30/16 unstageable 2.7 x 4.0 wound base not visible 100% eschar tissue surrounding tissue is macerated margins are irregular drainage thick, scant, yellow color present on admission noted to have placed pressure on heel while in bed, noted as dated 10/1/16 turn and repositioning in place on group sheets sheep skin booties when up in wheelchair float heels when laying down pressure reducing device in bed and in wheelchair 10/4/16 2.7 x 4.0 (only measurements available from RN-C - no note) 10/11/16 2.6 x 4.0 (only measurements available from RN-C - no note)	F 314		

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F 314	Continued From page 33 10/19/16 2.6 x 4.0 (only measurements available from RN-C - no note) 10/19/16 wound base not visible 100% eschar tissue 2.6 x 4.0 10/21/16 drainage thin, scant, brownish red 10/25/16 wound base not visible slough and/or eschar covered 2.6 x 4.0 no drainage apparent covered with black eschar 11/1/16 2.4 x 3.7 (only measurements available from RN-C - no note) Facility ETAR Report for October, 2016, identified an order dated 10/6/16, "Moderate/Heavy Exudate: Foam dressing QD [every day] to left heel 1 time per day during Evening, Special Instructions: Clean wound and dress. Please notify RN if change in wound site." Staff initialed this as being completed daily. The same order continued for November 2016, and was signed as being completed daily. R2's care plan dated 10/31/16, identified staff were to provide extensive assistance as follows: - Assistance with turning and repositioning when	F 314		

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in bed.
- Assist of two to take resident to the toilet.
- Assistance of two staff for ambulation
- R2 had a pressure ulcer to coccyx / low back, with an intervention of an air mattress and to turn and reposition every two to three hours.
- Monitor for positioning in wheelchair
- Cushion to wheelchair

Nursing assistant care sheet indicated R2 was to be repositioned every two to three hours. It also identified skin issues, float heels, and air mattress.

Facility Admissions Observation form for R2 dated 9/30/16, and completed on 10/7/16, identified on 9/30/16, RN-C documented, "Right medial Buttock: 1.7cm [centimeters] x 1.5cm ulcer, irregular shaped, light red wound bed, minimal drainage. removed xlarge aquacel foam dressing, placed 3x3 mepiplex." Has area on coccyx that is nonblanching. Duoderm was applied. It also identified left heel has a black necrotic area. Duoderm was applied. "Left Heel: 2.7 cm x 4 cm ulcer, scant thick drainage at the edges of wound bed, wound bed covered with eschar. Peeled Aquacel Foam dressing back to observe site and replaced dressing to site.

Physical Therapy Evaluation & Plan of Treatment form dated 9/30/16, indicated R2 was referred to therapy following a hospital stay. It also identified a pressure sore on the left heel. No mention was made to a pressure ulcer on the mid right buttock.

Review of occupational and physical therapy documentation dated 9/30/06 through 11/3/16, failed to identify a pressure ulcer on the mid right buttock, or a request for evaluation of an

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appropriate cushion.

During interview on 10/31/16, at 12:31 p.m. registered nurse (RN)-C stated R2 had an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough) to the left heel as well as a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) to the upper right buttock.

During interview on 11/2/16, at 7:24 a.m. nursing assistant (NA)-A denied being aware of any skin issues with R2. When she helped to reposition R2 in the morning, the pillow had been kicked out from beneath her knees, and R2 did not want it replaced. NA-A verified R2's heels were resting directly on the mattress at this time, not being floated.

During interview on 11/2/16, at 8:54 a.m. RN-C stated staff would be expected to notify nursing if the dressing on the buttock is saturated, contaminated, or loose. Staff are also expected to notify RN-A with any changes on the floor, and if there were a change in skin condition. RN-C denied being aware of the frequent incontinence, and denied being informed of the change in the pressure ulcer prior to doing wound rounds on 11/1/16. On admission, the dressing change was ordered every three days, and on 11/1/16, it was changed to daily. Both orders were to be changed more frequently as needed also. RN-C stated R2 has a nursing order to float the heels when in bed. RN-C verified R2's heels were not floated that morning when she entered to do wound care, and was not aware of how often this happens. RN-C stated staff are expected to

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report any changes or non-compliance to one of the RNs.

During interview on 11/2/16, at 10:25 a.m. family member (F)-C stated initially the chair and the cushion were lost, and then the chair was located, but the cushion remained missing for a number of days. The pad was located a number of days later. F-C stated the chair was missing for two to three days, and the pad was missing about three to five days.

During interview on 11/3/16, at 1:00 p.m. F-D stated per her notes, the wheelchair was missing on 10/16 and found on 10/17. The cushion remained missing, and R2 was provided a vinyl black and yellow cushion to use. On 10/19/16, during the care conference, family complained that the cushion was missing and R2 had complained that her bottom was hurting. On 10/24/16, RN-A provided R2 with a different cushion. On 11/1/16, RN-C provided the cushion currently being used.

During interview on 11/3/16, at 1:31 p.m. NA-F stated R2 has a dressing on her upper right buttock. It was being changed every three days, and was changed to daily. NA-F stated staff would look if R2 had a cushion, but would not verify it with a name or anything. Staff are aware the cushion should not be replaced without clarifying with an RN. NA-F was not aware that the chair or cushion had been missing. She stated R2 is to be turned and repositioned every two to three hours. NA-F stated R2 has her own black slippers that she wears. There is no back to the slipper, and is not aware of any special footwear R2 is to be wearing.

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During interview on 11/3/16, at 2:29 p.m. RN-A stated R2 is currently in therapy, but is not sure if R2 was referred for a proper cushion, but believed therapy always looked at residents for the wheelchair size. The cushion that is in the wheelchair at any point should be used. After admission resident's skin is checked within the first 24 hours, and a cushion and air mattress is applied as needed, which staff are always to use. RN-A stated she would expect that staff notice if there were a change in the cushion and this be reported to the RN. RN-A was unwilling to state that there was a decline in the wound if it was previously a Stage 2, and currently unstageable. RN-A added, "[R2] really likes the slippers." RN-A stated she would expect staff report any noncompliance or change in floating the heels, and verified she has not been informed of any concerns with this.

During interview on 11/3/16, at 1:38 p.m. RN-C verified the wound to the upper buttock went from a Stage 2 to unstageable. The dressing change was increased from every three days to daily. The nurse practitioner was notified, and indicated to continue current orders, and verified being aware of a change to the wound. When she discovered the change on 11/1/16, during wound rounds, RN-C placed the correct cushion on the wheelchair. RN-C stated she believed the root cause for the change in the wound was the incorrect cushion being used. She denied knowledge of the different cushion being used, and would expect if staff notice this, they inform her. RN-C stated when the cushion was missing, she found a black and yellow cushion that was adequate for pressure ulcers. Family replaced this with a flatter cushion from home, since they did not like the black and yellow cushion,

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 38	F 314		

indicating it made R2 sweat. However, they did not inform the facility they had changed the cushion. R2 used the thinner cushion for one week. When she became aware, RN-C replaced the cushion to what R2 is currently using. RN-C stated the change in the pressure ulcer was avoidable, had the cushion not been changed. RN-C also stated she assumed therapy would assess for a proper cushion, but was not able to say for sure if this had been done for R2, and was unable to find any documentation. RN-C also stated assessment determined there was no need to change the turning and repositioning schedule from every two to three hours after the change in the wound. However, RN-C also stated no assessment had been completed to determine if this schedule was still sufficient while R2 was in bed or chair. Related to the heel, RN-C stated R2's heel should not be resting directly on the footrest, and staff education was provided.

During interview on 11/3/16, at 2:10 p.m. DON stated RN-C is wound certified, and with her recommendations, there is not a change that required assessment. DON also indicated RN-C was more appropriate to recommend interventions than therapy as she is wound certified. DON would not acknowledge ulcer had worsened going from a Stage 2 to unstageable, since she had not seen it when R2 was admitted. DON stated NAs would report if they noted a change in the cushion, but added they are not trained in this. They would know there is a cushion, but that is it. Further interview at 2:57 p.m. DON stated there was a change due to the cushion the family placed in the chair, and verified there is no process in place to ensure the care planned seat cushion was in place for

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F 314	Continued From page 39 resident with a pressure ulcer. Facility policy titled, Skin Ulcer Protocol, updated 11/1/15, indicated services will be provided to prevent, treat, and monitor progress of all healing ulcer(s). It also instructed staff to report all open skin ulcers to the wound nurse, improve circulation by changing position frequently, and review all current interventions to ensure they remain appropriate.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently provide range of motion (ROM) services as recommended for 1 of 1 residents (R23) reviewed on a restorative ROM program. Findings Include: R23's quarterly Minimum Data Set (MDS) dated 10/5/16, identified R23 had moderate cognitive impairment and no functional limitation in ROM in both upper and lower extremities. A facility document entitled Physical Therapy (PT)	F 318	R# 23 was referred to Occupational Therapy for ROM program on 11-2-16. A restorative range of motion program was developed and entered on the care plan and NAR sheet. Restorative and NAR staff were educated on R#24□s ROM program. All residents with restorative ROM programs have the potential to be impacted by a deficient practice as it relates to range of motion services.	12/13/16

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F 318	Continued From page 40 Module, dated 1/12/16, indicated R23 had a right lower extremity flexion limitation noted during the initial ROM assessment. A General Nurse's Observation, dated 10/5/16, contained a Restorative Assessment indicating R23 participated in upper and lower extremity ROM six times weekly, related to diagnosis of Osteoporosis and previous Left Hip Fracture. An undated, un-titled facility nursing assistant group sheet, identified R23 was on a restorative nursing program (RNP) but did not list ROM under the program. R23's care plan dated 1/31/16, indicated R23 needing assistance with mobility. It did not identify R23 as being on a restorative program or receiving ROM. During observation on 11/1/16, at 6:47 p.m. nursing assistant (NA)-E assisted R23 to perform evening cares before assisting to transfer R23 from her wheelchair into bed. No ROM exercises were performed before R23 went to bed. During observation on 11/2/16, at 7:18 a.m. R23 was seated in her wheelchair by the nurse's station. R23's morning cares had been performed. No ROM was observed. During interview on 11/2/16, at 7:44 a.m. licensed practical nurse (LPN)-E stated R23 received ROM services from the nursing assistants in the morning with morning cares. LPN-E was unsure if R23 had received ROM that morning. During interview on 11/2/16, at 11:52 a.m. nursing assistant (NA)-G stated R23 received ROM in the	F 318	All residents with ROM programs will be reviewed to ensure that the services are appropriate. DON/designee will conduct random observational audits to ensure that ROM programs are being completed and documented. A minimum of 2 audits per week for 2 weeks, then 2 x week x2 weeks, then once weekly for 2 weeks and monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation. Completion date for F 318 is 12/13/16.	

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F 318	Continued From page 41	F 318		

therapy room and attended restorative therapy groups after breakfast or in the afternoon. NA-G further stated R23 had not received ROM yet that morning.

During interview on 11/2/16, at 12:07 p.m. physical therapist (PT)-A stated R23 had received therapy when she was admitted to the facility and had been discharged with therapy recommendation for upper and lower extremity ROM. PT-A was unsure of the frequency with which ROM was recommended and was unable to find the original recommendations. PT-A further stated no ROM was done in the therapy room.

During observation on 11/3/16, at 8:03 a.m. PT-A performed ROM with R23 while sitting in her wheelchair. PT-A stated R23 did not have a functional decline in ROM.

During interview on 11/3/16, at 7:46 a.m. NA-H stated the facility had two restorative assistants who were trained to perform ROM. When asked who completed ROM services if the restorative assistants were not in the facility, NA-H replied, "nobody, I don't think."

During interview on 11/3/16, at 8:59 a.m. NA-F stated the nursing assistants were responsible for completing ROM if the restorative assistants were not available, however, NA-F thought ROM was not being completed due to staffing issues. NA-F further stated the facility used to set aside the afternoons for restorative assistants to complete ROM. Now the restorative assistants would try to get ROM in by setting up group activities.

During interview on 11/3/16, at 2:05 p.m. NA-E

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F 318	Continued From page 42	F 318		

stated the restorative assistants tried to complete ROM seven days a week. NA-E stated the way staffing was, she worked more as a nursing assistant than in the restorative role. NA-E further stated when working in the restorative role she would be pulled onto the floor to do nursing cares.

During interview on 11/3/16, at 1:38 p.m. registered nurse (RN)-A stated R23 was to receive ROM once a day, six days a week. RN-A stated the restorative assistants were responsible for completing ROM with the residents, however, the facility had struggled with staffing and did not always have restorative staff. On those days, the nursing assistant responsible for "Group C" were also responsible for ROM. RN-A stated that day she or the director of nursing (DON) were responsible for ROM as "Group C" did not have a nursing assistant. RN-A further stated the facility had attempted to offer more group activities for the residents to stay active, although, she acknowledged no one evaluated if the groups were equivalent to receiving ROM.

During interview on 11/3/16, at 3:55 p.m. RN-C stated the daily restorative ROM programs were not getting done consistently as ordered due to staffing. RN-C further stated the restorative staff were pulled from that role onto the floor to perform nursing cares.

During interview on 11/3/16, at 4:16 p.m. the DON stated the facility had three trained restorative assistants. If restorative staff are not available, the facility would attempt to find someone to cover and would move forward from there. The DON stated she would expect a restorative ROM program to be on the care plan.

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F 318	Continued From page 43 A facility document entitled, Therapy Audit, from 2/1/16 to 11/3/16, showed the ROM services R23 had received. It identified R23 had received ROM 2 days in February, six days in June, twenty one days in July, fifteen days in August, twelve days in September, and seven days in October. It indicated R23 had not received any ROM in March, April, or May and had not received ROM yet for November. A facility policy entitled Range of Motion, reviewed 11/8/15, directed restorative ROM programs were to be conducted daily, on a one to one basis, and ROM exercises were to be performed in the residents' rooms. A copy of R23's facility document entitled, Restorative Nursing Program (containing therapy recommendations) was requested but not provided.	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal	F 322		12/13/16

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F 322	Continued From page 44 ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to check placement of the gastrostomy tube (G-tube, a tube to the stomach for feeding) prior to the administration of an eternal feeding and medication for 1 of 1 residents (R40) who had a G-tube. Findings include: R40's physician order dated 10/4/16, directed G-tube feeding Jevity 1.2 at 65 milliliters (ml) per hour times 24 hours. R40's medication orders indicated he was to receive his medications via G-tube with 30 cubic centimeter (cc) flushes before and after medication. R40's care plan dated 11/02/16, directed nurses to check placement of G-tube, administer medications via the G-tube following physician's orders. During observation on 10/31/16, at 2:25 p.m. licensed practical nurse (LPN)-A prepared to change bottle of Jevity running in R40's G-tube. LPN-A took a 60 cc syringe, placed it into a graduate container of water, withdrew 60 cc's of tab water, opened R40's G-tube port, and cleaned port with alcohol wipe. LPN-A placed the tip of the syringe into the G-tube port and attempted to flush tube with 60 cc's of water, and met resistance. LPN-A did not check for G-tube placement by aspiration or auscultation. LPN-A removed 60 cc syringe, closed G-tube port and	F 322	LFHS ensures a resident with a G-tube receives the appropriate treatment and services to prevent complications and if possible, to restore normal eating skills. R#40- Nursing staff caring for R#40 was re-educated on the process for checking placement of the G-tube. All residents with G-tubes have the potential to be affected by a practice deficient in this area. All licensed staff were re-educated on checking placement of a G-tube as directed by the facility G-tube policy and MD order's. DON or designee will complete random observational audits of G-tube care to ensure appropriate checking of placement of the tube. A minimum of 2 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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F 322	Continued From page 45 stated she needed to use a syringe with a narrow tip. LPN-A got a different 60 cc syringe with a narrow tip from R40's closet, filled the syringe with 60 cc of water, and opened the G-tube port and flushed G-tube. LPN-A did not check for G-tube placement by aspiration or auscultation. LPN-A connected new tube feeding to R40's G-tube port and started the feeding pump. LPN-A confirmed R40 had a G-tube and she did not check for G-tube placement prior to flush or starting infusion of Jevity. During observation on 11/01/16, 7:37 p.m. LPN-B prepared medication and placed medication in a cup to administer through R40's G-tube and entered R40's room. LPN-B who had a stethoscope around her neck, washed her hands and donned gloves, then poured 30 cc's of tap water into the medication cup to dissolve the medication prior to administration. LPN-B turned off feeding pump, disconnected the tubing, and placed the 60 cc's syringe into the G-tube port. LPN-B then poured 60 cc's of distilled water into syringe to flush via gravity and met resistance. LPN-B was unable to administer the flush with water after several attempts to manipulate tubing. LPN-B did not check for G-tube placement by aspiration or auscultation. LPN-B got on the walkie talkie and asked the nurse to bring some coke to R40's room to flush G-tube. Registered nurse (RN)-A entered room and attempted to assist LPN-B with flushing G-tube by repositioning R40 and massaging the G-tube tubing. RN-A did not check for G-tube placement by aspiration or auscultation. LPN-B used a different 60 cc syringe with a narrow tip and was able to flush G-tube and administer medication. LPN-B did not check for G-tube placement by aspiration or auscultation. During interview on 11/01/16, 8:15 p.m. LPN-B	F 322	Completion date for F 322 is 12/13/16	

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F 322	Continued From page 46 stated at that time she had not checked G-tube for placement prior to flush or administering medication. During interview on 11/01/16, 8:20 p.m. RN-A stated the G-tube needed to be checked for placement by aspiration or auscultation prior to flushing, medication administration, and starting new feeding. RN-A confirmed enteral feeding policy dated 6/01/16, was current. RN-A confirmed at that time R40 G-tube should have been checked for placement especially when meeting resistance. During interview on 11/03/16, at 11:00 a.m. director of nursing (DON) stated R40's care plan was correct and she expected placement of the G-tube be checked every time prior to medication administration, flushes, and starting the tube feeding. The facility policy Medication Administered through an Enteral Tube revised 7/8/16, directed nurse to check tube placement prior to administering medications and feeding via a G-tube. The policy provided step-by-step instructions on checking the tube for placement.	F 322		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441		12/13/16

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F 441	Continued From page 47 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand hygiene was implemented for 1 of 1 resident (R2) observed for wound care. In addition, the facility failed to ensure appropriate infection control practices were followed for 1 of 1 resident (R49) who was in contact isolation. Findings include: R2 was observed on 11/2/16, at 7:39 a.m. as the	F 441	LFHS has established an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. R#2-Nursing staff providing wound care for R#2 were re-educated on proper hand hygiene (washing hands when changing gloves) with wound care.	

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F 441	Continued From page 48 director of nursing (DON) and registered nurse (RN)-C entered R2's room to perform dressing changes to the pressure ulcers on her right medial buttock and left heel. RN-C donned gloves, removed the old dressing from the buttock, and donned clean gloves, without performing hand hygiene. RN-C then sprayed the area with Sea Cleans (wound cleanser). With the same gloves, RN-C placed the new dressing on the wound. At this time, the gloves were removed, incontinent pad fastened, and pants pulled back up. RN-C then proceeded to don clean gloves (without washing hands), covered R2's torso, and removed the dressing from the left heel. The Sea Cleans was sprayed on the wound, and gloves were changed, without performing hand hygiene. A clean dressing was placed on the wound. The gloves were then removed, and RN-C assisted to place a pillow beneath R2's legs to float the heels off the bed, lowered the bed with the attached remote. At this time, RN-C went to the bathroom and washed her hands. During interview on 11/2/16, at 9:24 a.m. RN-C stated she typically performs hand hygiene between each wound, but not after removing the soiled gloves each time. RN-C also verified no hand hygiene was performed until finished with the entire process during the observation. During interview on 11/3/16, at 2:10 p.m. DON stated staff are expected to perform hand hygiene after each glove change. Facility policy titled Dressing Change - Clean, undated, instructed staff to: - Put on gloves - Remove soiled dressings and discard into	F 441	R#49- The soiled laundry hamper was placed inside the room and staff caring for R#49 were re-educated on performing hand hygiene before leaving the room. All residents have the potential to be affected by a practice deficient in this area. All NAR and Nursing staff were re-educated on hand hygiene and infection control precautions. DON/designee will conduct observational audits of hand hygiene at random times throughout the 24 hour period. A minimum of 2 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and monthly thereafter. DON/designee will conduct observational audits of wound care to ensure appropriate infection control techniques are used, 2Xweek x2, then 2 audits/week x2 weeks, then once weekly for 2 weeks and monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation. Completion date for F 441 is 12/13/16.	

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F 441	Continued From page 49 plastic bag at foot of bed - Remove gloves and discard - Wash hands. Put on clean gloves. Cleanse wound with prescribed solution if ordered. - Apply prescribed medications as ordered - Apply dressings and secure with tape - Remove gloves and wash hands. R49 had a clostridium difficile (C. difficile) infection, and the facility did not implement appropriate infection control precautions. The Center for Disease Control (CDC) guidelines for health care facilities directed the following when caring for residents with a C. Difficile infection: Isolate patients with C. difficile immediately. Wear gloves and gowns when treating patients with C. difficile, even during short visits. Hand sanitizer does not kill C. difficile, and although hand washing works better, it still may not be sufficient alone, thus the importance of gloves. Clean room surfaces thoroughly on a daily basis while treating a patient with C. difficile and upon patient discharge or transfer. Supplement cleaning as needed with use of bleach or another EPA-approved, spore-killing disinfectant. R49's diagnosis list identified enterocolitis due to clostridium difficile (a spore-forming bacteria that can cause swelling and irritation of the large intestine, or colon. This inflammation, known as colitis, can cause diarrhea, fever, and abdominal cramps). Progress note dated 10/21/16, lab tested positive for clostridium difficile on 10/13/16. R49's significant change Minimum Data Set (MDS) dated 10/20/16, indicated R49 had moderately impaired cognition, required extensive assistance with bed mobility, transfers, toileting, was frequently incontinent of urine, and was	F 441		

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F 441	Continued From page 50 always incontinent of bowel. During observation on 10/31/16, at 11:30 p.m. a dirty linen hamper was outside R49's room. During observation on 11/02/16, at 1:12 p.m. nursing assistant (NA)-A exited R49's room and removed her potentially contaminated gown outside of R49's room, and placed the gown in the dirty linen hamper outside R49's room. NA-A walked down hall about 40 feet away entered bathroom by nursing station, and washed hands with soap and water. During observation on 11/02/16, at 1:23 p.m. occupational therapist (OT)-A exited R49's room and removed her potentially contaminated gown outside R49's room and placed gown in dirty linen hamper outside R49's room. OT-A stated R49 was on contact precautions for C. difficile, and needed to remove your mask, gloves, and wash hands with soap and water prior to leaving R49's room. OT-A further stated the gown was removed outside of R49's room and placed in the hamper. During observation on 11/02/16, at 1:36 p.m. licensed practical nurse (LPN)-A put on a gown, mask, and gloves prior to entering R49's room. LPN-A entered R49's room and approached R49 and explained she was going to check for edema. LPN-A lifted up R49's right pant leg, and placed her gloved hand on his leg, applying pressure to leg. LPN-A did the same to left leg. LPN-A removed mask and gloves and discarded them in the trash can in R49's room. LPN-A exited R49's room, and removed the potentially contaminated gown outside of R49's room, and placed the gown in dirty linen hamper outside R49's room. LPN-A proceeded down hallway to nursing station where she entered the bathroom, and washed her hands with soap and water. LPN-A was interviewed and stated at that time handwashing should be done in R49's room prior to exiting	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 51 room. During interview on 11/20/16, at 2:30 p.m. NA-A stated she removed her mask and gloves in R49's room, and stated she washed hands in bathroom by nurse's station. During interview on 11/02/16, at 1:17 p.m. NA-B stated R49 was in isolation for C. difficile, and before entering R49's room you put on a mask, gloves and a gown. When exiting R49's room the mask and gloves are removed, and thrown in trash can, hands are washed in room before exiting, and gown is placed in dirty hamper outside of R49's room. NA-B stated she washes her hands using the hand sanitizer, instead of soap and water prior to leaving room. During interview on 11/03/2016, 11:02 a.m. the director of nursing stated her expectations for C. difficile and stated hands should be washed with soap and water before leaving R49's room and the dirty laundry hamper should be kept inside of R49's room. The facility policy 6.0 Infection Prevention and Control Program dated 1/16, directed Contact precautions are instituted for residents with symptomatic C. difficile infection. Policy 6.14 Isolation Precautions-Transmission Based dated 8/15 directs staff be sure that an adequate supply of antiseptic soap and paper towels are maintained in the room during the isolation period. Remove the gown and perform hand hygiene before leaving the resident's environment.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465		12/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 52 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain resident care equipment for 2 or 2 residents (R23, R33) whose wheelchair and foot pad were is disrepair. Findings Include: R23's quarterly Minimum Data Set (MDS) dated 10/5/16, indicated R23 used a wheelchair for mobility. During observation on 11/1/16, at 6:47 p.m. R23 presented with multiple long cracks in the black fabric of her left wheelchair armrest. The cracks extended length wise along the armrest and white foam padding was visible through the cracks. During interview on 11/1/16, at 7:10 p.m. nursing assistant (NA)-E stated she was not aware of the cracks but should staff should be paying attention to R23's armrests. NA-E stated the armrest would not be able to be cleaned well, and further stated, staff should have filled out a maintenance slip to see if the armrest could be fixed or to get R23 a different chair. R33's annual MDS dated 9/28/16, indicated R33 used a wheelchair for mobility with functional limitations in R33's lower extremities. During observation on 10/31/16, at 1:58 p.m. R33 presented with a blue rectangular pad, measuring 10 inches (in) by 17 in, under his feet and ankles while sitting in his wheelchair. The pad, located	F 465	LFHS provides a safe, functional,sanitary, and comfortable environment for residents, staff and the public. R #23-new wheelchair armrests were obtained and placed on wheelchair. R #33- the calf protector was removed and replaced. All residents that utilize wheelchairs have the potential to be affected by a deficient practice. All staff were re-educated on maintaining resident equipment specifically wheelchairs and reporting any wheelchair that is in disrepair. Maintenance director or designee will conduct an audit of all resident wheelchairs, then will continue random audits weekly with their environmental checks. Audit results will be brought to the QAPI committee for review and further recommendation. Completion date for F 465 is 12/13/16.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 53 between R33's leg rests, appeared to be torn on both sides with duck tape covering the torn areas. Upon further inspection on 11/3/16, at 10:51 a.m. the duck tape was wrapped completely around the bottom and back of the cushion while R33 rested his ankles on the tape. NA-F stated the pad had ripped and the duck tape was holding the pad together. NA-F further stated the pad was to ensure R33's legs would not catch between the foot pedals. She also stated R33 should not have his feet on the duck tape, someone should have noticed the tape, and filled out a maintenance slip to for it to be repaired. During interview on 11/3/16, at 1:50 p.m. director of maintenance stated he had not received any repair requests for the wheelchair pads or armrests. The DOM stated staff should fill out maintenance slips for equipment in disrepair so it could be fixed. During interview on 11/3/16, at 4:56 p.m. registered nurse (RN)-A stated she would expect staff to fill out a maintenance form for care equipment in disrepair so the equipment could be fixed. An facility policy entitled, Maintenance Slip Policy, undated, instructing staff to fill out maintenance forms for repairs in order to maintain "equipment in a safe and operable manner."	F 465		

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

F539925

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **03 - EAST BUILDING** B. WING _____	**11/04/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Federal Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the Little Falls Care Center 2016 East Building Addition was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. The facility was inspected as two buildings: Little Falls Care Center consists of two buildings separated by a 2 hour fire separation. Building 03, the East Building Addition is a 1 story building without a basement built in 2016 and was determined to be Type II(111) construction. Building 03, the Mechanical Room building is a 1 story building without a basement and was determined to be Type II(111) construction. Since Building 03 was built under the 2000 edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code and Building 04 was built to the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code the two buildings were inspected separately. The facility is divided into 3 smoke compartments with 1-hour and 2-hour fire barriers. The facility is fully protected with an automatic sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **03 - EAST BUILDING** B. WING _____	**11/04/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 which includes corridor smoke detection throughout and in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code 2015 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

F5399025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **04 - MECHANICAL ROOMS** B. WING _____	**11/04/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	**1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345**

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K 000	INITIAL COMMENTS FIRE SAFETY A Federal Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, the Little Falls Care Center 2016 East Building Addition was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. The facility was inspected as two buildings: Building 04 - The Mechanical Room building is a 1 story building without a basement and was determined to be Type II(111) construction. Since Building 03 was built under the 2000 edition of the National Fire Protection Association (NFPA) Standard 101 Life Safety Code and Building 04 was built to the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code the two buildings were inspected separately. The facility is fully protected with an automatic sprinkler system installed in accordance with NFPA 13 The Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system which includes corridor smoke detection throughout and in all common areas, installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. All sleeping rooms have smoke detection and hazardous areas have automatic fire detection in accordance with the Minnesota State Fire Code	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245399	A. BUILDING **04 - MECHANICAL ROOMS** B. WING _____	**11/04/2016**

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K 000	Continued From page 1 2015 edition. The fire alarm system is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 28 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
November 22, 2016

Ms. Amy Walker, Administrator
Little Falls Care Center
1200 First Avenue Northeast
Little Falls, MN 56345

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5399027

Dear Ms. Walker:

The above facility was surveyed on November 4, 2016 through November 4, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 Department of Health orders being submitted 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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 Kathy Lucas, Unit Supervisor at (320) 223-7343.

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,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)
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
	00382	A. BUILDING: _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

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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		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 October 31st - November 3rd 2016, 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. An investigation of complaint H5399021 was completed and found not to be substantiated. 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	2 000		

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2 000	Continued From page 2 MINNESOTA STATE STATUTES/RULES.	2 000		
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by:	2 540		12/13/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 540	Continued From page 3 Based on interview and document review, the facility failed to comprehensively assess for the use of psychotropic (mood altering) medication during the assessment reference dates (ARD) for 2 of 5 residents (R9, R44) reviewed for unnecessary medications. Findings include: R9's admission Minimum Data Set (MDS) dated 10/16/16, indicated R9 had diagnoses of dementia, anxiety disorder and depression. The MDS also indicated R9 was taking an antianxiety the last seven days and antidepressant medication the last seven days. R9's psychotropic drug use Care Area Assessment (CAA) was initiated, however, the assessment worksheet was never completed. R9's Admission Observations (where the facility documents the admission CAAs started 10/9/16, and completed 10/14/16, did not contain a comprehensive psychotropic drug assessment. R44's significant change MDS dated 10/19/16, indicated R44 had diagnoses of dementia, anxiety disorder and depression. The MDS also indicated R9 was taking an antipsychotic the last seven days, an antianxiety the last seven days and antidepressant medication the last seven days. R9's psychotropic drug use CAA was initiated, however, the assessment worksheet was never completed. R44's General Nurses Observations (where the facility documents the CAAs after admission) started 10/19/16, and completed 10/19/16, did not contain a comprehensive psychotropic drug assessment.	2 540	LFHS conducts comprehensive assessments of each resident on admission, annually and with a significant change. R#9- a comprehensive psychotropic drug assessment was completed. R#44- a comprehensive psychotropic drug assessment was completed. All residents taking psychotropic medications have a potential to be affected by a deficient practice in this area. All Nursing staff involved in writing psych med assessment were re-educated on process of completing psychotropic medication assessments. All other residents receiving a psychotropic medication will have a psychotropic medication assessment completed. DON or designee will audit Comprehensive psychotropic medication assessments to ensure they are completed timely. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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	00382	A. BUILDING: _____ B. WING _____	11/03/2016

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2 540	Continued From page 4 During interview on 11/3/16, at 2:25 p.m. registered nurse (RN)-C stated that she was responsible for completing the MDS on the residents. RN-C stated that she did not do a psychotropic drug use CAAs during the ARD period for R9 and R44. RN-C further stated that she never completed the psychotropic drug use CAA's on any resident during the assessment period unless it was during the first week of the month regardless of the ARD period. However, RN-C could not provide the last two comprehensive psychotropic medication assessments for R44. RN-C also stated that a psychotropic drug CAA had never been completed on admission for any resident, as the facility is not sure what medications were warranted. RN-C also stated the facility does not utilize the worksheets provided with the facility's electronic MDS record but rather documents the assessments under admission or general nursing observations. During interview on 11/3/16, at 4:01 p.m. the director of nursing stated a comprehensive assessment for psychotropic drug use was expected to be completed on admission, annually and with a significant change MDS. The facility policy Psychotropic Medications dated 10/1/15, did not address a comprehensive assessment would be completed during admission, annual or significant change MDS. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) and/or designee could review policy and provide education for staff regarding completion of an individualized comprehensive resident assessment including care area assessments for admission, annual	2 540		

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2 540	Continued From page 5 and significant changes. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 540		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for the use of a continuous positive airway pressure (CPAP) breathing machine for 1 of 1 resident (R40) who used a CPAP. In addition, the facility failed to develop a comprehensive care plan which included range of motion (ROM) services for 1 of 1 residents (R23) reviewed for a restorative program. Findings include: R40's Face Sheet printed on 11/03/16, indicated R40's diagnoses included chronic respiratory	2 560	LFHS develops comprehensive Care plans to describe services to attain or maintain the resident□s highest practicable physical, mental and psychosocial well-being. R#40- care plan and NAR group sheets were updated to include CPAP to be placed when resident requests. R#23 care plan was updated to include a Restorative ROM Program. All residents on CPAP and that receive ROM have the potential to be affected by	12/13/16

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2 560	Continued From page 6 failure with hypoxia (deficiency in the amount of oxygen reaching the body's tissues), primary spontaneous pneumothorax, chronic obstructive pulmonary disease (lung condition - COPD) unspecified, obstructive sleep apnea (a disorder where a person has one or more pauses in breathing or shallow breathing while sleeping). R40's quarterly Minimum Data Set (MDS) dated 10/24/16, indicated R40 had severe cognitive impairment,and utilized oxygen (O2) therapy. R40's care plan dated 3/06/16, identified R40 was at risk for shortness of breath (SOB), and directed nursing staff to elevate head of bed (HOB), monitor for SOB, and maintain O2 at 3-4 liters per nasal cannula. The care plan lacked direction for CPAP use. R40's physician orders dated 10/04/16, indicated R40 was to have CPAP machine applied 3 times a day (day, evening, night) and anytime lying in bed. During interview on 10/31/16, at 1:37 p.m. family member (F)-A stated R40's CPAP machine should be on when he was sleeping or napping. R40 was observed sleeping with O2 per nasal cannula at 3 liters on, and CPAP sitting on R40's night stand. During observations on 10/31/16, at 2:25 p.m., 11/1/16, at 6:50 p.m., 11/2/16, at 7:10 a.m., R40 was in bed sleeping with HOB elevated, O2 nasal cannula on and CPAP on nightstand. During interview on 11/02/16, at 9:49 a.m. registered nurse (RN)-A stated R40's CPAP should be on the care plan.	2 560	a deficient practice in this area. Nursing staff involved care plan documentation were re-educated on the process of completing a care plan for CPAP and restorative ROM programs. Care plans for residents with a restorative ROM programs and who use CPAP were reviewed and revised prn. DON or designee will perform chart audits to ensure care plans are accurate for CPAP and Restorative Rom programs. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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2 560	Continued From page 7 During interview on 11/03/16, at 11:00 a.m. director of nursing (DON) stated R40's CPAP should be on the care plan. R23's quarterly MDS dated 10/5/16, identified R23 had moderate cognitive impairment and no functional limitation in ROM in both upper and lower extremities. During interview on 11/2/16, at 12:07 p.m. physical therapist (PT)-A stated R23 had received therapy when she was admitted to the facility and had been discharged with therapy recommendation for upper and lower extremity ROM. An undated, un-titled facility nursing assistant group sheet identified R23 was on a restorative nursing program (RNP) but did not list ROM under the program. R23's care plan dated 1/31/16, indicated R23 needing assistance with mobility. It did not identify R23 as being on a restorative program or receiving ROM. During interview on 11/3/16, at 1:38 p.m. RN-A stated R23 was to receive ROM once a day six days a week. RN-A stated R23's ROM abilities were assessed quarterly along with updating the nursing assistant group sheets and care plan. During interview on 11/3/16, at 3:55 p.m. RN-C stated she was in the process of updating the care plans to reflect restorative programs. RN-C stated R23's care plan did not contain a restorative program and should. During interview on 11/3/16, at 4:16 p.m. the DON stated she would expect a restorative ROM	2 560		

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2 560	Continued From page 8 program to be on the care plan. A facility policy entitled Range of Motion, reviewed 11/8/15, directed restorative ROM programs will be added to the care plan and care guide by the nurse manager. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed follow the plan of care to ensure assistance with ambulation was provided for 1 of 1 residents (R23) reviewed for ambulation with a restorative program; and the facility failed to provide services to relieve pressure to heel pressure ulcer for 1 of 3 residents reviewed for pressure ulcers; and failed to (R2) check	2 565	LFHS ensure the resident□s oral status is reflected on the individual plan of care. R# 7 care plan and NAR group sheet was updated to reflect the absence of natural teeth or dentures. All residents□ care plans were reviewed to	12/13/16

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2 565	Continued From page 9 placement of a gastrostomy tube (G-tube) as directed by the care plan for 1 of 1 resident (R40) who had a G-tube. Findings Include: R23's quarterly Minimum Data Set (MDS) dated 10/5/16, identified a moderate cognitive impairment and needed extensive assistance of one person to walk both in her room and outside. R23's current care plan dated 1/31/16, directed staff to walk R23 resident in order to prevent a decline in ambulation. An undated un-titled facility nursing assistant group sheet, identified R23 was on a restorative nursing program (RNP) and directed staff to walk R23 to meals. During observation on 11/1/16, at 5:32 p.m., R23 was seated in her wheelchair. Nursing assistant (NA)-D was observed to put foot pedals onto R23's wheelchair and proceeded to push R23 to the dining room for supper. No attempt or offer was made to walk with R23. During interview on 11/2/16, at 8:00 p.m. NA-D stated the nursing assistants typically pushed R23 in her wheelchair to meals and further stated R23 did not walk as much as she used to. During observation on 11/2/16, at 8:05 a.m. R23 was again being pushed in her wheelchair from the nurse's station into the dining room for breakfast. During interview on 11/2/16, at 7:44 a.m. licensed practical nurse (LPN)-E stated R23 was on a	2 565	ensure the care plan reflects their oral status and oral hygiene needs. Nursing staff were re-educated on assessing oral status and process to inform Nurse Manager who is in charge of updating care plans. DON or designee will perform care plan audits to ensure care plans regarding the resident's oral status are complete. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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2 565	Continued From page 10 restorative program but did not walk that morning due to knee pain. During observation on 11/2/16, at 11:52 p.m. R23 was seated in her wheelchair. R23 had been transferred from the bed into the wheelchair by NA-G and NA-I. R23 was then observed to again be pushed in her wheelchair to lunch. During interview on 11/2/16, at 12:02 p.m., NA-G stated R23 had refused to walk to lunch. NA-G stated R23 does not ever walk to meals and was not aware R23 was on a restorative ambulation program. During interview on 11/2/16, at 12:07 p.m. physical therapist (PT)-A stated R23 had received therapy when she was admitted to the facility and had been discharged with therapy recommendations for a restorative ambulation program. PT-A stated R23's goals was to ambulate 25 ft (feet) to 50 ft at a time. During interview on 11/3/16, at 7:46 a.m. NA-H stated R23 used to walk to meals before her room changed, as her previous room was closer to the dining room. NA-H did not think R23 could walk all the way from her current room to the dining room, but thought staff could attempt to walk her once R23 was closer to the dining room. During interview on 11/3/16, at 1:38 p.m. registered nurse (RN)-A stated the nursing assistants were responsible for walking with R23 and thought R23's restorative ambulation program was being done as she often saw R23 ambulate to the bathroom and in her room. RN-A thought the ambulation documentation was not representative of R23's walking and staff needed education on charting.	2 565		

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2 565	Continued From page 11 During interview on 11/3/16, at 4:16 p.m. director of nursing (DON) stated the inconsistency in R23's ambulation program was due to documentation errors by the nursing assistants. R2's 14-day scheduled assessment MDS dated 10/12/16, identified R2 was at risk of pressure ulcers, had one stage 2 pressure ulcer and one unstageable pressure ulcer, and none worsening. It also identified pressure reducing device for the chair and bed, and R2 was on a turning and repositioning program. R2's care plan dated 10/31/16, identified staff were to provide extensive assistance as follows: - Assistance with turning and repositioning when in bed. - Assist of two to take resident to the toilet. - Assistance of two staff for ambulation - R2 had a pressure ulcer to coccyx / low back, with an intervention of an air mattress of an air mattress and to turn and reposition every two to three hours. - Monitor for positioning in wheelchair - Cushion to wheelchair Nursing assistant care sheet indicated R2 was to be repositioned every two to three hours. It also identified skin issues, float heels, and air mattress. During observation on 11/2/16, at 7:06 a.m. R2 was lying in bed on her right side. Both heels were noted to be directly on the mattress, not floated. During observation on 11/2/16, at 7:39 a.m. the	2 565		

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2 565	Continued From page 12 DON and RN-C entered R2's room to perform dressing changes to the pressure ulcers on her right medial buttock and left heel. RN-C stated R2's heels were not floated in bed. RN-C assisted to place a pillow beneath R2's legs to float the heels off the bed. On 11/3/16, at 8:54 a.m. continuous observation began. R2 was observed sitting in her wheelchair in the dining room, eating breakfast. R2's left foot was observed in opened back slipper, with the back half of the slipper and foot, including the heel, resting on the foot rest, and the front half off of the foot rest. At 9:56 a.m. R2 was assisted to the activity room, with left foot observed unchanged. At 10:28 a.m. R2 remained in the activity room for coffee. Activity director (AD) assisted R2 to the table, making no offer to adjust the left foot. At 11:10 a.m. AD assisted R2 out of the activity room, and to her room. At 11:18 a.m. R2 asked to use the bathroom, and NA-F entered to assist. Continuous observation ended at this time. For 2 hours and 24 minutes, R2 remained in her wheelchair, with her foot observed with the heel resting on the foot rest. During this time, staff did not offer to reposition and R2 was not observed to reposition independently. During interview on 11/2/16, at 7:24 a.m. NA-A denied being aware of any skin issues with R2. When she helped to reposition R2 in the morning, the pillow had been kicked out from beneath her knees, and R2 did not want it replaced. NA-A verified R2's heels were resting directly on the mattress at this time, not being floated. During interview on 11/2/16, at 8:54 a.m. RN-C stated R2 has a nursing order to float the heels when in bed. RN-C verified R2's heels were not floated that morning when she entered to do	2 565		

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2 565	Continued From page 13 wound care, and was not aware of how often this happens. RN-C stated staff are expected to report any changes or non-compliance to one of the RNs. During interview on 11/3/16, at 1:38 p.m. RN-C stated R2's heel should not be resting directly on the footrest, and staff education was provided. R40's care plan dated 6/16/16, directed nurses to check placement of G-tube, administer medications via the G-tube following physician's orders R40's physician order dated 10/4/16, directed G-tube feeding Jevity 1.2 at 65 milliliters (ml) per hour times 24 hours. R40's medication orders indicate he was to receive his medications via G-tube with 30 cubic centimeters (cc) flushes before and after medication. During observation on 10/31/16, at 2:25 p.m. LPN-A prepared to change the bottle of Jevity running in R40's G-tube. LPN-A took a 60 cc syringe, placed it into a graduate container of water, withdrew 60 ccs of tab water, opened R40's G-tube port, and cleaned port with alcohol wipe. LPN-A placed the tip of the syringe into the G-tube port and attempted to flush tube with 60 ccs of water, and met resistance. LPN-A did not check for G-tube placement by aspiration or auscultation prior to starting the Jevity infusion. During interview on 10/31/16, at 2:25 p.m. LPN-A stated R40 had a G-tube and did not check for G-tube placement prior to flush or starting infusion of Jevity. During observation on 11/01/16, at 7:37 p.m. LPN-B prepared medication and placed in medication in cup to administer through R40's G-tube. LPN-B turned off feeding pump, disconnected the tubing, and placed the 60 ccs	2 565		

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2 565	Continued From page 14 syringe into the G-tube port, and poured 60 ccs of distilled water into syringe to flush via gravity and met resistance. LPN-B did not check for G-tube placement by aspiration or auscultation. RN-A entered R40's room and attempted to assist LPN-B with flushing the G-tube. RN-A did not check for G-tube placement by aspiration or auscultation. LPN-B used a different 60 cc syringe with a narrow tip and was able to flush G-tube and administer medication. LPN-B did not check for G-tube placement by aspiration or auscultation prior to administering medications. During interview on 11/01/16, at 8:15 p.m. LPN-B stated she had not checked G-tube for placement prior to water flush or administering medication per policy and care plan. During interview on 11/01/16, at 8:20 p.m. RN-A stated the G-tube needed to be checked for placement by aspiration or auscultation prior flushing, medication administration, and starting new feeding. RN-A stated R40's care plan dated 6/16/16, was not followed. During interview on 11/03/16, at 11:00 a.m. the DON stated R40's care plan was correct and she expected placement of the G-tube be checked every time prior to medication administration, flushes, and starting the tube feeding. Facility policy titled Care Plans, undated, indicated where the care plans can be found as well as identified the care plan includes the care and services that must be provided to meet those goals, and the frequency of these services. It also indicated under nursing responsibilities nursing assistants are to chart daily on resident status to provide up-to-date information on resident activities of daily living needs. SUGGESTED METHOD OF CORRECTION:	2 565		

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2 565	Continued From page 15 The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan for the presence of dentures/natural teeth for 1 of 3 residents (R7) reviewed for dental services. Findings include: R7's annual Minimum Data Set (MDS) dated 7/22/16, indicated no dental concerns or problems. Facility General Nurses's Observation notes	2 570	LFHS ensure the resident□s oral status is reflected on the individual plan of care. R# 7 care plan and NAR group sheet was updated to reflect the absence of natural teeth or dentures. All residents□ care plans were reviewed to ensure the care plan reflects their oral status and oral hygiene needs. Nursing staff were re-educated on	12/13/16

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	00382	A. BUILDING: _____ B. WING _____	11/03/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LITTLE FALLS CARE CENTER	1200 FIRST AVENUE NORTHEAST LITTLE FALLS, MN 56345

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2 570	Continued From page 16 dated 5/10/16, indicated R7 had upper and lower dentures, which she did not wear. General Nurses's Observation notes dated 7/22/16 and 8/19/16, indicated R7 had upper and lower dentures, however, the dentures were missing. General Nurses's Observation note dated 10/20/16, indicated R7's dentures had been missing for months and indicated R7 had no natural teeth. An undated, un-titled facility nursing assistant group sheet, identified R7 had partial dentures on the top of her mouth and directed staff to brush her teeth. R7's current care plan, last revised 8/14/16, directed staff to brush R7's own existing teeth and to clean R7's dentures overnight. During observation on 10/31/16, at 2:22 p.m. R7 did not have any teeth or dentures in her mouth. During dining observation on 11/1/16, at 6:14 p.m. R7 was again edentulous while eating supper. Nursing assistant (NA)-D assisted R7 to eat and stated R7 did not wear dentures and had no natural teeth. During interview on 11/2/16, at 8:19 a.m. NA-I stated R7 sometimes refused oral cares but thought she had natural teeth. NA-I looked at an un-titled facility care sheet to confirm R7 had teeth. During interview on 11/2/16, at 8:50 a.m. licensed practical nurse (LPN)-A stated R7 had natural teeth on the bottom of her mouth.	2 570	assessing oral status and process to inform Nurse Manager who is in charge of updating care plans. DON or designee will perform care plan audits to ensure care plans regarding the resident's oral status are complete. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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2 570	Continued From page 17 During interview on 11/2/16, at 10:15 a.m. registered nurse (RN)-A stated R7 had no natural teeth and used to have dentures. However, R7 often threw them in the trash, so family removed them home from the facility. RN-A further stated R7's care plan had not been revised because R7 did have dentures "just not in the facility" and may wear them again at some point. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure compliance with revision of care plans. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 570		
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.	2 830		12/13/16

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2 830	Continued From page 18 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to apply a continuous positive airway pressure (CPAP) breathing machine as directed or document the refusal of the use of the CPAP for 1 of 1 resident (R40) who utilized a CPAP. In addition, the facility failed to re-assess and develop interventions related to positioning for 1 of 1 residents (R23) who was observed to lean in the wheelchair. Findings include: R40's undated Face Sheet printed on 11/03/16, indicated R40's diagnoses included chronic respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the body's tissues), primary spontaneous pneumothorax, chronic obstructive pulmonary disease (lung condition-COPD) unspecified, obstructive sleep apnea (a disorder where a person has one or more pauses in breathing or shallow breathing while sleeping). R40's General Nurse's Observation Note, which serves as the care area assessment (CAA) dated 10/19/16, indicated R40 was assessed as sleeping 8-9 hours a night and 2-3 naps daily. R40's quarterly Minimum Data Set (MDS) dated 10/24/16, indicated R40 had severe cognitive impairment, utilized oxygen (O2) therapy, received extensive assistance with bed mobility, toileting, and needed total assistance with transfers using a hoyer lift.	2 830	LFHS ensures each resident receives care and services to attain or maintain their highest practicable physical, mental and psychosocial well-being. R#40- New physician orders were obtained for CPAP use. R#23- was re-assessed by occupational therapy and a new wheelchair was provided. All residents who utilize a CPAP and who utilize wheelchairs have the potential to be affected by a deficient practice in this area. Nursing staff were re-educated on the use of CPAP and documentation of refusals of CPAP. All Nursing staff were also re-educated on wheelchair positioning, and the need to report to the Nurse Manager if repositioning is unsuccessful. DON or designee will conduct random observational audits for wheelchair positioning. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. DON or designee will conduct random observational audits for CPAP use. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then	

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2 830	Continued From page 19 R40's care plan dated 3/06/16, identified R40 was at risk for shortness of breath (SOB), and directed staff to elevate head of bed (HOB), monitor for SOB, and maintain O2 at 3-4 liters per nasal cannula. Care plan lacked direction for CPAP use. R40's physician orders dated 10/04/16, indicated R40 was to have CPAP machine applied 3 times a day (day, evening, night) and anytime lying in bed. R40's physician note dated 10/24/16, indicated R40's wife was concerned about the hypoxic event R40 had on 10/23/16. Physician order was to continue with same plan of care. R40's electronic Treatment Administration Record (ETAR) dated October 2016, directed nurses to apply CPAP anytime lying in bed, and initial each shift. The ETAR lacked indication if CPAP was applied, refused, or removed. R40's nursing notes from 10/01/16, through 10/31/16, did not indicate if or whether R40 had refused the CPAP treatment. During interview on 10/31/16, at 1:37 p.m. family member (F)-A stated R40's CPAP machine should be on when he was sleeping or napping. At that time, R40 was observed sleeping with O2 per nasal cannula at 3 liters on, and CPAP sitting on R40's night stand. During observation on 10/31/16, at 2:25 p.m. R40 was sleeping in bed, and breathing through his mouth with O2 on at 3 liters per nasal cannula, HOB elevated and CPAP was sitting on night stand. Licensed practical nurse (LPN)-A was in R40's room and had a difficult time arousing R40	2 830	once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI Committee for review and further recommendation.	

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2 830	Continued From page 20 and asked him if he was sleeping at night. LPN-A did not acknowledge that R49 was not utilizing the CPAP During observation on 11/01/16, at 6:50 p.m. R40 was in bed sleeping with HOB elevated, O2 nasal cannula on and CPAP on nightstand. During observation on 11/01/16, at 7:28 p.m. R40 was in bed sleeping with HOB elevated, O2 nasal cannula on and CPAP on nightstand. During observation on 11/02/16, at 7:10 a.m. R40 was in bed sleeping with HOB elevated, O2 nasal cannula on and CPAP on nightstand . During observation on 11/02/16, at 8:55 a.m. R40 was in bed sleeping with HOB elevated, O2 nasal cannula on and CPAP on nightstand. During interview on 11/02/16, at 9:49 a.m. registered nurse (RN)-A stated R40 had his CPAP since admission on 2/06/16, and used the CPAP machine anytime he was sleeping, during the night, and at his request. RN-A stated documentation on the ETAR does not reflect if the CPAP was applied, refused, or removed. RN-A stated R40 refused CPAP at times, and refusals would be charted in the nursing progress notes. RN-A stated she would expect to see the CPAP on R40's care plan. During interview on 11/02/16, at 10:13 a.m. licensed practical nurse (LPN)-A stated R40 would wear the CPAP when he was feeling SOB, after each nebulizer treatment, and if O2 saturations are below 90%. LPN-A stated R40 liked to wear the CPAP when he was napping. LPN-A stated at that time the documentation on the ETAR was completed for the whole shift and	2 830		

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2 830	Continued From page 21 did not reflect if the CPAP was applied, refused, or removed. Review of the ETAR indicated O2 saturation rates were normal at 90 or above. During interview on 11/03/16, at 11:00 a.m. the director of nursing (DON) stated R40's CPAP should be applied as directed. The DON stated CPAP should be on the care plan. R23's quarterly MDS dated 10/5/16, indicated R23 had moderate cognitive impairment, used a wheelchair, and needed extensive assistance with locomotion. During observation on 11/1/16, at 12:46 p.m. R23 was hunched over and leaning to the right in her standard wheelchair. During observation on 11/1/16, at 4:59 p.m. R23 was seated in her wheelchair in the hallway right outside her room. While seated, R23 leaned to the right side of her wheelchair with her right shoulder pressed up against arm rest. After a few minutes, her head fell forward and to the right as she appeared to be asleep. At 5:32 p.m. R23 was assisted into the dining room. Staff did not attempt to reposition R23 prior to dinner. During dining observation on 11/1/16, from 5:38 p.m. to 6:12 p.m. R23 was observed hunched over and leaning to the right in her wheelchair. R23's head was hanging down so far it almost touched the armrest of the wheelchair. Staff attempts were made to encourage R23 to eat her supper, however, no attempts were made to reposition R23. During observation on 11/2/16, at 7:18 a.m. R23 was seated in a different standard wheelchair by the nurse's station. In this wheelchair, R23	2 830		

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2 830	Continued From page 22 continued to be hunched over and leaning forward with her head hanging down. She was no longer leaning to the right. At 8:05 a.m. R23 was assisted into the dining room. No attempts to reposition R23 were made by staff. R23's care plan dated 1/31/16, indicated needing assistance with wheelchair mobility. R23's care plan did not contain interventions related to positioning nor did it direct staff on how to intervene. During interview on 11/2/16, at 7:44 a.m. LPN-E stated R23 had received a new wheelchair that morning but was not aware of who brought it in. LPN-E stated R23 tended to lean more when she was tired, and staff should offer repositioning to her bed or recliner. LPN-E was unsure if R23's standard wheelchair had been sized or assessed for positioning. During interview on 11/2/16, at 9:07 a.m. occupational therapist (OT)-A observed R23's position in the wheelchair and stated R23 sat hunched over most often. OT-A stated the current wheelchair seemed "a bit big" for R23 and the armrests were a little high. OT-A stated when a resident is more "sloppy" in the wheelchair or is not able to hold themselves up, staff should make a referral to therapy to assess the wheelchair. OT-A was unaware if R23's wheelchair had been assessed by therapy. During interview on 11/2/16, at 2:24 p.m. nursing assistant (NA)-G stated R23 leaned most often after meals and when she was exhausted. NA-G stated she tried to reposition R23, either in the recliner or by placing pillows behind her back. NA-G further stated she wished "there is more we [staff] could do."	2 830		

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2 830	Continued From page 23 During interview on 11/3/16, at 7:46 a.m. NA-H stated she would ask R23 to "sit up more" when R23 was leaning in her wheelchair. NA-H stated she would roll up a small pillow or blanket in R23's wheelchair and thought the care plan should have interventions the staff could do for positioning. During interview 11/3/16, at 8:03 a.m. physical therapist (PT)-A stated therapy would attempt to assess wheelchair on admissions to make sure they were appropriate and sized correctly. PT-A stated R23's current wheelchair seemed a little wide and therapy had not been consulted to assess it. PT-A further stated it was not routine for therapy to assess all wheelchairs. During interview on 11/3/16, at 1:38 p.m. RN-A was not aware of R23 receiving a new wheelchair, further stating she had assessed R23's wheelchair upon admission, felt it was appropriate, and did not need to be re-assessed. RN-A stated R23 tended to have a bent over posture and expected staff to reposition R23 if she was uncomfortable in the wheelchair. RN-A further stated the expectation would be for the nursing assistants to notify the nurses if R23 was leaning more in the wheelchair; however, RN-A stated the positioning expectations were not on R23's care plan because "it was a given, just common sense." During interview on 11/3/16, at 4:16 p.m. the DON stated wheelchairs were assessed as needed and if residents were leaning or having positioning issues it would be an indication for therapy to assess them. The DON stated staff were expected to reposition residents and assess them as needed. The DON further stated she	2 830		

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2 830	Continued From page 24 would expect positioning interventions to be on the care plans. A facility policy entitled, Adaptive and Positioning Equipment, undated, directed the facility to provide equipment to "achieve their [residents] highest most practicable level of function." The policy also directed nursing to make referrals to therapy for positioning and adaptive equipment recommendations. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could review and revise as necessary the policies and procedures regarding CPAP usage and orders as well as wheelchair positioning. The DON could provide training for all appropriate staff on these policies and procedures. The quality assessment and assurance committee could do random audits of physician orders to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to	2 895		12/13/16

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2 895	Continued From page 25 increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to consistently provide range of motion (ROM) services as recommended for 1 of 1 residents (R23) reviewed on a restorative ROM program. Findings Include: R23's quarterly Minimum Data Set (MDS) dated 10/5/16, identified R23 had moderate cognitive impairment and no functional limitation in ROM in both upper and lower extremities. A facility document entitled Physical Therapy (PT) Module, dated 1/12/16, indicated R23 had a right lower extremity flexion limitation noted during the initial ROM assessment. A General Nurse's Observation, dated 10/5/16, contained a Restorative Assessment indicating R23 participated in upper and lower extremity ROM six times weekly, related to diagnosis of Osteoporosis and previous Left Hip Fracture. An undated, un-titled facility nursing assistant group sheet, identified R23 was on a restorative nursing program (RNP) but did not list ROM under the program. R23's care plan dated 1/31/16, indicated R23 needing assistance with mobility. It did not identify R23 as being on a restorative program or receiving ROM.	2 895	LFHS ensures each resident is given the appropriate treatment and services to maintain or improve his or her abilities. R#23 was referred to Physical therapy on 11-2-16 for ambulation assessment. A restorative ambulation program was developed and entered on the care plan and NAR group sheet. All residents on restorative ambulation have the potential to be affected by a deficient practice in this area. All NAR and Nursing staff were educated on R23□s ambulation program and documentation of restorative ambulation programs. Random observational audits will be completed to ensure that ambulation programs are being implemented. DON or designee will conduct random audits. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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2 895	Continued From page 26 During observation on 11/1/16, at 6:47 p.m. nursing assistant (NA)-E assisted R23 to perform evening cares before assisting to transfer R23 from her wheelchair into bed. No ROM exercises were performed before R23 went to bed. During observation on 11/2/16, at 7:18 a.m. R23 was seated in her wheelchair by the nurse's station. R23's morning cares had been performed. No ROM was observed. During interview on 11/2/16, at 7:44 a.m. licensed practical nurse (LPN)-E stated R23 received ROM services from the nursing assistants in the morning with morning cares. LPN-E was unsure if R23 had received ROM that morning. During interview on 11/2/16, at 11:52 a.m. nursing assistant (NA)-G stated R23 received ROM in the therapy room and attended restorative therapy groups after breakfast or in the afternoon. NA-G further stated R23 had not received ROM yet that morning. During interview on 11/2/16, at 12:07 p.m. physical therapist (PT)-A stated R23 had received therapy when she was admitted to the facility and had been discharged with therapy recommendation for upper and lower extremity ROM. PT-A was unsure of the frequency with which ROM was recommended and was unable to find the original recommendations. PT-A further stated no ROM was done in the therapy room. During observation on 11/3/16, at 8:03 a.m. PT-A performed ROM with R23 while sitting in her wheelchair. PT-A stated R23 did not have a functional decline in ROM.	2 895		

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2 895	Continued From page 27 During interview on 11/3/16, at 7:46 a.m. NA-H stated the facility had two restorative assistants who were trained to perform ROM. When asked who completed ROM services if the restorative assistants were not in the facility, NA-H replied, "nobody, I don't think." During interview on 11/3/16, at 8:59 a.m. NA-F stated the nursing assistants were responsible for completing ROM if the restorative assistants were not available, however, NA-F thought ROM was not being completed due to staffing issues. NA-F further stated the facility used to set aside the afternoons for restorative assistants to complete ROM. Now the restorative assistants would try to get ROM in by setting up group activities. During interview on 11/3/16, at 2:05 p.m. NA-E stated the restorative assistants tried to complete ROM seven days a week. NA-E stated the way staffing was, she worked more as a nursing assistant than in the restorative role. NA-E further stated when working in the restorative role she would be pulled onto the floor to do nursing cares. During interview on 11/3/16, at 1:38 p.m. registered nurse (RN)-A stated R23 was to receive ROM once a day, six days a week. RN-A stated the restorative assistants were responsible for completing ROM with the residents, however, the facility had struggled with staffing and did not always have restorative staff. On those days, the nursing assistant responsible for "Group C" were also responsible for ROM. RN-A stated that day she or the director of nursing (DON) were responsible for ROM as "Group C" did not have a nursing assistant. RN-A further stated the facility had attempted to offer more group activities for the residents to stay active, although, she	2 895		

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2 895	Continued From page 28 acknowledged no one evaluated if the groups were equivalent to receiving ROM. During interview on 11/3/16, at 3:55 p.m. RN-C stated the daily restorative ROM programs were not getting done consistently as ordered due to staffing. RN-C further stated the restorative staff were pulled from that role onto the floor to perform nursing cares. During interview on 11/3/16, at 4:16 p.m. the DON stated the facility had three trained restorative assistants. If restorative staff are not available, the facility would attempt to find someone to cover and would move forward from there. The DON stated she would expect a restorative ROM program to be on the care plan. A facility document entitled, Therapy Audit, from 2/1/16 to 11/3/16, showed the ROM services R23 had received. It identified R23 had received ROM 2 days in February, six days in June, twenty one days in July, fifteen days in August, twelve days in September, and seven days in October. It indicated R23 had not received any ROM in March, April, or May and had not received ROM yet for November. A facility policy entitled Range of Motion, reviewed 11/8/15, directed restorative ROM programs were to be conducted daily, on a one to one basis, and ROM exercises were to be performed in the residents' rooms. A copy of R23's facility document entitled, Restorative Nursing Program (containing therapy recommendations) was requested but not provided.	2 895		

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2 895	Continued From page 29 Suggested Method of Correction: The Director of Nursing or designee could schedule an in-service to address the importance of residents receiving appropriate treatment and services for range of motion limitations. An assessment and appropriate treatment intervention plan could be provided by the staff for these residents. A monitoring program could be established in order to assure an on-going effective rehabilitative program for residents with range of motion. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
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 new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide necessary	2 900	Based on the resident□s comprehensive skin assessment, LHFS ensures a	12/13/16

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2 900	Continued From page 30 services to provide services to promote the healing of pressure ulcers and prevent infection for 1 of 3 residents (R2) reviewed for pressure ulcers who was not observed to have pressure relief to the heel, and buttocks, and improper infection control technique was provided during wound cares. Findings include: R2's Face Sheet identified admission to the facility on 9/30/16, with diagnosis including anemia, weakness, and major depressive disorder. The admission Minimum Data Set (MDS) dated 10/7/16, identified R2 was at risk of pressure ulcers, had one Stage 2 pressure ulcer and one unstageable pressure ulcer, had a pressure reducing device for the chair and bed, and R2 was on a turning and repositioning program. The 14-day scheduled assessment MDS dated 10/12/16, identified R2 was at risk of pressure ulcers, had one stage 2 pressure ulcer and one unstageable pressure ulcer, and none worsening. It also identified pressure reducing device for the chair and bed, and R2 was on a turning and repositioning program. During observation on 11/2/16, at 7:06 a.m. R2 was lying in bed on her right side. Both heels were noted to be directly on the mattress, not floated (lifted off mattress to relieve pressure). During observation on 11/2/16, at 7:39 a.m. the director of nursing (DON) and registered nurse (RN)-C entered R2's room to perform dressing changes to the pressure ulcers on her right medial buttock and left heel. RN-C donned	2 900	resident with a pressure ulcer receives the necessary treatment and services to promote healing and prevent new ulcers from developing. R#2□s care plan and NAR group sheets were reviewed and revised prn to reflect current plan of care for buttock ulcer and heel ulcer and Therapy to assess for pressure relieving footwear. All residents with current pressure ulcers are at risk for a deficient practice in this area. NAR staff were re-educated on R#2□s care plan, including the turning and repositioning program pertaining to heel protection (and the need to report to the nurse if the resident is refusing heel protection). Nursing staff were re-educated on infection control techniques during dressing changes. DON or designee will conduct random observational audits of residents with a heel ulcer or at high risk of heel breakdown identified to require heel protection. A minimum of 3 audits per week for 2 weeks, then 2 audits/week x 2 weeks, then once weekly for 2 weeks, then monthly thereafter. DON or designee will conduct random observational audits of dressing changes to ensure proper infection control technique, 2Xweek x 2, weekly X2, and monthly thereafter.	

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2 900	Continued From page 31 gloves, removed the old dressing from the buttock, and donned clean gloves, without performing hand hygiene. At this time, RN-C indicated being unable to see the wound base, and identified the wound on the buttock as unstageable. RN-C then sprayed the area with Sea Cleans (wound cleanser). With the same gloves, RN-C placed the new dressing on the wound. At this time, the gloves were removed, incontinent pad fastened, and pants pulled back up. RN-C then proceeded to don clean gloves, covered R2's torso, and removed the dressing from the left heel. This wound was also identified as unstageable. RN-C also verified R2's heels were not floated in bed. The Sea Cleans was sprayed on the wound, and gloves were changed, without performing hand hygiene. A clean dressing was placed on the wound. The gloves were then removed, and RN-C assisted to place a pillow beneath R2's legs to float the heels off the bed, then lowered the bed with the attached remote. At this time, RN-C went to the bathroom and washed her hands. On 11/3/16, at 8:54 a.m. continuous observation began. R2 was observed sitting in her wheelchair in the dining room, eating breakfast. R2's left foot was observed in opened back slipper, with the back half of the slipper and foot, including the heel, resting directly on the foot rest, and the front half off of the foot rest. Therapy staff was sitting next to resident, with no offer to assist to reposition R2's left foot. At 9:56 a.m. R2 was assisted to the activity room, with left foot observed unchanged. At 10:28 a.m. R2 remained in the activity room for coffee. Activity director (AD) assisted R2 to the table, making no offer to adjust the left foot. At 11:10 a.m. AD assisted R2 out of the activity room, and to her room. At 11:18 a.m. R2 asked to use the	2 900	Audit results will be brought to the QAPI committee for review and further recommendation.	

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2 900	Continued From page 32 bathroom, and NA-F entered to assist. Continuous observation ended at this time. For 2 hours and 24 minutes, R2 remained in her wheelchair, with her foot observed with the heel resting on the foot rest. During this time, staff did not offer to reposition and R2 was not observed to reposition independently. BUTTOCK Skin Condition Report For Selected Conditions reports dated 9/30/16 through 11/1/16, identified the following related to a pressure ulcer on the right upper buttocks: 9/30/16 Stage 2 1.7 x 1.5 cm wound base visible 50% granulation tissue 50% epithelial tissue no odor minimal clear drainage present on admission pressure redistributing mattress pressure redistributing cushion for wheelchair reposition side to side in bed and in recliner 10/4/16 1.5 x 1.4 No change to appearance of wound. 10/11/16 1.0 x 1.0 100% epithelial tissue 10/18/16 0.8 x 0.7 cm open wound edges even and unremarkable	2 900		

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2 900	Continued From page 33 pressure reducing or relieving device(s) in place devices used on the bed surface and chair surface wound base visible 100% epithelial tissue scant clear drainage 10/21/16 0.6 x 0.4 cm moderate tan thin drainage no open areas wound bed appeared white 10/25/16 Stage 2 0.5 x 0.4 cm scant clear thin drainage 100% epithelial tissue wound bed appeared pink 11/1/16 1.0 x 1.8 dressing removed and observed to be contaminated with possible feces "This wound was healing but is now observed to have had a change. After reviewing past week it is determined that cushion previously in place on chair was changed by family due to chair being washed and returning without a cushion cover. Family felt resident was sweating. Family replaced cushion with one from home." Further documentation indicated, "Cushion was replaced today to a pressure relieving cushion. Resident continues to be repositioned q 2-3 [every 2-3] hours and is observed today to reposition on mattress. Dressing changes ordered to daily. Deterioration noted in site. Unable to accurately stage. Slough and/or eschar covered." Facility electronic Treatment Administration	2 900		

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2 900	Continued From page 34 Record (ETAR) Report for October, 2016, identified an order dated 10/6/16, "Light exudate: Foam dressing Q3days [every three days] or prn [as needed] to upper rt [right] buttock 1 time per day every 3 days during Evening, Special Instructions: clean and place appropriate size meplex. Notify RN of changes in wound." Staff initialed this as being completed every 3 days as ordered. The order changed to, "dressing change to coccyx/low back 1 time per day during Day, Document Dressing Change: Document Characteristics - Drainage & Odor Skin and Wound, Special Instructions: Meplex change daily. document characteristics, drainage. Notify RN of any s/s [signs and symptoms] of infection." HEEL Skin Condition Report For Selected Conditions dated 9/30/16 through 10/25/16, identified the following related to a pressure ulcer on the left heel: 9/30/16 unstageable 2.7 x 4.0 wound base not visible 100% eschar tissue surrounding tissue is macerated margins are irregular drainage thick, scant, yellow color present on admission noted to have placed pressure on heel while in bed, noted as dated 10/1/16 turn and repositioning in place on group sheets sheep skin booties when up in wheelchair float heels when laying down pressure reducing device in bed and in wheelchair	2 900		

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2 900	Continued From page 35 10/4/16 2.7 x 4.0 (only measurements available from RN-C - no note) 10/11/16 2.6 x 4.0 (only measurements available from RN-C - no note) 10/19/16 2.6 x 4.0 (only measurements available from RN-C - no note) 10/19/16 wound base not visible 100% eschar tissue 2.6 x 4.0 10/21/16 drainage thin, scant, brownish red 10/25/16 wound base not visible slough and/or eschar covered 2.6 x 4.0 no drainage apparent covered with black eschar 11/1/16 2.4 x 3.7 (only measurements available from RN-C - no note) Facility ETAR Report for October, 2016, identified an order dated 10/6/16, "Moderate/Heavy Exudate: Foam dressing QD [every day] to left heel 1 time per day during Evening, Special	2 900		

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2 900	Continued From page 36 Instructions: Clean wound and dress. Please notify RN if change in wound site." Staff initialed this as being completed daily. The same order continued for November 2016, and was signed as being completed daily. R2's care plan dated 10/31/16, identified staff were to provide extensive assistance as follows: - Assistance with turning and repositioning when in bed. - Assist of two to take resident to the toilet. - Assistance of two staff for ambulation - R2 had a pressure ulcer to coccyx / low back, with an intervention of an air mattress and to turn and reposition every two to three hours. - Monitor for positioning in wheelchair - Cushion to wheelchair Nursing assistant care sheet indicated R2 was to be repositioned every two to three hours. It also identified skin issues, float heels, and air mattress. Facility Admissions Observation form for R2 dated 9/30/16, and completed on 10/7/16, identified on 9/30/16, RN-C documented, "Right medial Buttock: 1.7cm [centimeters] x 1.5cm ulcer, irregular shaped, light red wound bed, minimal drainage. removed xlarge aquacel foam dressing, placed 3x3 mepiplex." Has area on coccyx that is nonblanching. Duoderm was applied. It also identified left heel has a black necrotic area. Duoderm was applied. "Left Heel: 2.7 cm x 4 cm ulcer, scant thick drainage at the edges of wound bed, wound bed covered with eschar. Peeled Aquacel Foam dressing back to observe site and replaced dressing to site. Physical Therapy Evaluation & Plan of Treatment	2 900		

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form dated 9/30/16, indicated R2 was referred to therapy following a hospital stay. It also identified a pressure sore on the left heel. No mention was made to a pressure ulcer on the mid right buttock.

Review of occupational and physical therapy documentation dated 9/30/06 through 11/3/16, failed to identify a pressure ulcer on the mid right buttock, or a request for evaluation of an appropriate cushion.

During interview on 10/31/16, at 12:31 p.m. registered nurse (RN)-C stated R2 had an unstageable pressure ulcer (full thickness tissue loss in which the base of the ulcer is covered by slough) to the left heel as well as a Stage 2 pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough) to the upper right buttock.

During interview on 11/2/16, at 7:24 a.m. nursing assistant (NA)-A denied being aware of any skin issues with R2. When she helped to reposition R2 in the morning, the pillow had been kicked out from beneath her knees, and R2 did not want it replaced. NA-A verified R2's heels were resting directly on the mattress at this time, not being floated.

During interview on 11/2/16, at 8:54 a.m. RN-C stated staff would be expected to notify nursing if the dressing on the buttock is saturated, contaminated, or loose. Staff are also expected to notify RN-A with any changes on the floor, and if there were a change in skin condition. RN-C denied being aware of the frequent incontinence, and denied being informed of the change in the pressure ulcer prior to doing wound rounds on 11/1/16. On admission, the dressing change was

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ordered every three days, and on 11/1/16, it was changed to daily. Both orders were to be changed more frequently as needed also. RN-C stated R2 has a nursing order to float the heels when in bed. RN-C verified R2's heels were not floated that morning when she entered to do wound care, and was not aware of how often this happens. RN-C stated staff are expected to report any changes or non-compliance to one of the RNs.

During interview on 11/2/16, at 10:25 a.m. family member (F)-C stated initially the chair and the cushion were lost, and then the chair was located, but the cushion remained missing for a number of days. The pad was located a number of days later. F-C stated the chair was missing for two to three days, and the pad was missing about three to five days.

During interview on 11/3/16, at 1:00 p.m. F-D stated per her notes, the wheelchair was missing on 10/16 and found on 10/17. The cushion remained missing, and R2 was provided a vinyl black and yellow cushion to use. On 10/19/16, during the care conference, family complained that the cushion was missing and R2 had complained that her bottom was hurting. On 10/24/16, RN-A provided R2 with a different cushion. On 11/1/16, RN-C provided the cushion currently being used.

During interview on 11/3/16, at 1:31 p.m. NA-F stated R2 has a dressing on her upper right buttock. It was being changed every three days, and was changed to daily. NA-F stated staff would look if R2 had a cushion, but would not verify it with a name or anything. Staff are aware the cushion should not be replaced without clarifying with an RN. NA-F was not aware that

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the chair or cushion had been missing. She stated R2 is to be turned and repositioned every two to three hours. NA-F stated R2 has her own black slippers that she wears. There is no back to the slipper, and is not aware of any special footwear R2 is to be wearing.

During interview on 11/3/16, at 2:29 p.m. RN-A stated R2 is currently in therapy, but is not sure if R2 was referred for a proper cushion, but believed therapy always looked at residents for the wheelchair size. The cushion that is in the wheelchair at any point should be used. After admission resident's skin is checked within the first 24 hours, and a cushion and air mattress is applied as needed, which staff are always to use. RN-A stated she would expect that staff notice if there were a change in the cushion and this be reported to the RN. RN-A was unwilling to state that there was a decline in the wound if it was previously a Stage 2, and currently unstageable. RN-A added, "[R2] really likes the slippers." RN-A stated she would expect staff report any noncompliance or change in floating the heels, and verified she has not been informed of any concerns with this.

During interview on 11/3/16, at 1:38 p.m. RN-C verified the wound to the upper buttock went from a Stage 2 to unstageable. The dressing change was increased from every three days to daily. The nurse practitioner was notified, and indicated to continue current orders, and verified being aware of a change to the wound. When she discovered the change on 11/1/16, during wound rounds, RN-C placed the correct cushion on the wheelchair. RN-C stated she believed the root cause for the change in the wound was the incorrect cushion being used. She denied knowledge of the different cushion being used,

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2 900	Continued From page 40	2 900		

and would expect if staff notice this, they inform her. RN-C stated when the cushion was missing, she found a black and yellow cushion that was adequate for pressure ulcers. Family replaced this with a flatter cushion from home, since they did not like the black and yellow cushion, indicating it made R2 sweat. However, they did not inform the facility they had changed the cushion. R2 used the thinner cushion for one week. When she became aware, RN-C replaced the cushion to what R2 is currently using. RN-C stated the change in the pressure ulcer was avoidable, had the cushion not been changed. RN-C also stated she assumed therapy would assess for a proper cushion, but was not able to say for sure if this had been done for R2, and was unable to find any documentation. RN-C also stated assessment determined there was no need to change the turning and repositioning schedule from every two to three hours after the change in the wound. However, RN-C also stated no assessment had been completed to determine if this schedule was still sufficient while R2 was in bed or chair. Related to the heel, RN-C stated R2's heel should not be resting directly on the footrest, and staff education was provided.

During interview on 11/3/16, at 2:10 p.m. DON stated RN-C is wound certified, and with her recommendations, there is not a change that required assessment. DON also indicated RN-C was more appropriate to recommend interventions than therapy as she is wound certified. DON would not acknowledge ulcer had worsened going from a Stage 2 to unstageable, since she had not seen it when R2 was admitted. DON stated NAs would report if they noted a change in the cushion, but added they are not trained in this. They would know there is a

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2 900	Continued From page 41 cushion, but that is it. Further interview at 2:57 p.m. DON stated there was a change due to the cushion the family placed in the chair, and verified there is no process in place to ensure the care planned seat cushion was in place for resident with a pressure ulcer. Facility policy titled, Skin Ulcer Protocol, updated 11/1/15, indicated services will be provided to prevent, treat, and monitor progress of all healing ulcer(s). It also instructed staff to report all open skin ulcers to the wound nurse, improve circulation by changing position frequently, and review all current interventions to ensure they remain appropriate. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) could review and revise the pressure ulcer protocol. In addition, the DON could provide education to the nursing staff on the importance of assessing pressure ulcers and implementing pressure reducing interventions. The DON could develop a system for the nursing staff to monitor that interventions are implemented. The quality assessment and assurance committee could do random audits of pressure ulcers to ensure residents are receiving the appropriate care and treatment. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate	2 915		12/13/16

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2 915	Continued From page 42 treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to reassess and consistently implement an ambulation program for 1 of 1 residents (R23) reviewed for ambulation with a restorative program. Findings Include: R23's quarterly Minimum Data Set (MDS) dated 10/5/16, identified R23 had moderate cognitive impairment and needed extensive assistance of one person to walk both in her room and outside. R23's current signed physician orders, dated 9/8/16, indicated R23 was to walk to meals three times a day. An undated, un-titled facility nursing assistant group sheet identified R23 was on a restorative nursing program (RNP) and directed staff to walk R23 to meals.	2 915	R# 23 was referred to Occupational Therapy for ROM program on 11-2-16. A restorative range of motion program was developed and entered on the care plan and NAR sheet. Restorative and NAR staff were educated on R#24□s ROM program. All residents with restorative ROM programs have the potential to be impacted by a deficient practice as it relates to range of motion services. DON/designee will conduct random observational audits to ensure that ROM programs are being completed and documented. A minimum of 2 audits per week for 2 weeks, then 2 x week x2 weeks, then once weekly for 2 weeks and monthly thereafter.	

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2 915	Continued From page 43 R23's current care plan dated 1/31/16, directed staff to walk R23 in order to prevent a decline in ambulation. The Facility Treatment Sheet Records, for 8/16, 9/16, and 10/16, contained the order to walk R23 to meals 3 times per day. The Treatment Sheets were not marked by nursing staff to show ambulation had occurred. A facility document entitled, Walking Therapy Detail Report, from 2/1/16 to 7/1/17, showed the total walking/restorative care services R23 had received. It identified R23 had received restorative ambulation one day in June, fourteen days in July, twenty two days in August, fourteen days in September, and seven days in October. It identified R23 had not received restorative ambulation yet in November. During observation on 11/1/16, at 5:32 p.m. R23 was seated in her wheelchair. Nursing assistant (NA)-D was observed to put foot pedals onto R23's wheelchair and proceeded to push R23 to the dining room for supper. No attempt or offer was made to walk with R23. During interview on 11/2/16, at 8:00 p.m. NA-D stated the nursing assistants typically pushed R23 in her wheelchair to meals and further stated R23 did not walk as much as she used to. NA-D stated the staff did not walk with R23 that night because R23 was "out of it" and the unit was "kind of crazy." During observation on 11/2/16, at 8:05 a.m. R23 was being pushed in her wheelchair from the nurse's station into the dining room for breakfast.	2 915	Audit results will be brought to the QAPI committee for review and further recommendation.	

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2 915	Continued From page 44 During interview on 11/2/16, at 7:44 a.m. licensed practical nurse (LPN)-E stated R23 was on a restorative program but did not walk that morning due to knee pain. LPN-E further stated the nursing assistants were responsible for walking with R23, however, due to the "hustle and bustle throughout the day," was not sure the walking was documented or that they informed the nurse so R23 could be pre-medicated before walks. During observation on 11/2/16, at 11:52 p.m. R23 was in her room seated in her wheelchair. R23 had been transferred from the bed into the wheelchair by NA-G and NA-I. R23 was again observed to be pushed in her wheelchair to lunch. During interview on 11/2/16, at 12:02 p.m. NA-G stated R23 had refused to walk to lunch and further stated it was hard for R23 to even stand that afternoon. NA-G stated R23 does not ever walk to meals and was not aware R23 was on a restorative ambulation program. During interview on 11/2/16, at 12:07 p.m. physical therapist (PT)-A stated R23 had received therapy when she was admitted to the facility and had been discharged with therapy recommendations for a restorative ambulation program. PT-A stated R23's goal was to ambulate 25 ft (feet) to 50 ft at a time. PT-A further stated therapy screens all residents quarterly which would identify a decline in mobility, however, was unable to find the quarterly screenings or therapy recommendations for R23. During interview on 11/3/16, at 7:46 a.m. NA-H stated R23 used to walk to meals before her room changed, as her previous room was closer to the dining room. NA-H did not think R23 could walk all the way from her current room to the	2 915		

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2 915	Continued From page 45 dining room, but thought staff could attempt to walk her once R23 was closer to the dining room. During observation on 11/3/16, at 8:03 a.m. PT-A ambulated R23 in the facility hallway and stated R23 did not have a functional decline in ambulation. However, PT-A stated a lesser goal of ambulating once a day may be more appropriate for R23, since switching rooms, the distance between her room and the dining room was longer. During interview on 11/3/16, at 1:38 p.m. registered nurse (RN)-A stated the nursing assistants were responsible for walking with R23 and thought R23's restorative ambulation program was being done as she often saw R23 ambulate to the bathroom and in her room. RN-A further stated LPN's were responsible for monitoring the completion of the ambulation program. RN-A thought the ambulation documentation was not representative of R23's walking and staff needed education on charting. RN-A stated R23 rarely refused walking, especially with encouragement. RN-A stated the new distance between R23 room and the dining room was "under review" but had not been fully reassessed. During interview on 11/3/16, at 3:55 p.m. RN-C stated restorative programs were not getting done consistently as ordered and were currently re-doing the ambulation program facility wide. During interview on 11/3/16, at 4:16 p.m. the director of nursing stated the inconsistency in R23's ambulation program was due to documentation errors by the nursing assistants. A facility policy entitled Restorative Nursing	2 915		

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2 915	Continued From page 46 Program Policy, reviewed 8/23/15, indicated it was the responsibility of the Restorative Coordinator (a registered nurse) to establish restorative goals for residents, monitors all aspects of the restorative program, and oversees the documentation of nursing/restorative assistants. A copy of R23's facility document entitled, Restorative Nursing Program (containing therapy recommendations) was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and/or revise policies and procedures, for residents identified as benefiting from an restorative program; provide education and inservice to staff regarding care of those identified residents; and develop, or revise a monitoring system to audit care, and ensure on-going compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting,	2 930		12/13/16

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2 930	Continued From page 47 dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to check placement of the gastrostomy tube (G-tube, a tube to the stomach for feeding) prior to the administration of an eternal feeding and medication for 1 of 1 residents (R40) who had a G-tube. Findings include: R40's physician order dated 10/4/16, directed G-tube feeding Jevity 1.2 at 65 milliliters (ml) per hour times 24 hours. R40's medication orders indicated he was to receive his medications via G-tube with 30 cubic centimeter (cc) flushes before and after medication. R40's care plan dated 11/02/16, directed nurses to check placement of G-tube, administer medications via the G-tube following physician's orders. During observation on 10/31/16, at 2:25 p.m. licensed practical nurse (LPN)-A prepared to change bottle of Jevity running in R40's G-tube. LPN-A took a 60 cc syringe, placed it into a graduate container of water, withdrew 60 cc's of tab water, opened R40's G-tube port, and cleaned port with alcohol wipe. LPN-A placed the tip of the syringe into the G-tube port and attempted to flush tube with 60 cc's of water, and met resistance. LPN-A did not check for G-tube placement by aspiration or auscultation. LPN-A removed 60 cc syringe, closed G-tube port and stated she needed to use a syringe with a narrow tip. LPN-A got a different 60 cc syringe with a	2 930	LFHS ensures a resident with a G-tube receives the appropriate treatment and services to prevent complications and if possible, to restore normal eating skills. R#40- Nursing staff caring for R#40 was re-educated on the process for checking placement of the G-tube. All residents with G-tubes have the potential to be affected by a practice deficient in this area. All licensed staff were re-educated on checking placement of a G-tube as directed by the facility G-tube policy and MD order's. DON or designee will complete random observational audits of G-tube care to ensure appropriate checking of placement of the tube. A minimum of 2 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and then monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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2 930	Continued From page 48 narrow tip from R40's closet, filled the syringe with 60 cc of water, and opened the G-tube port and flushed G-tube. LPN-A did not check for G-tube placement by aspiration or auscultation. LPN-A connected new tube feeding to R40's G-tube port and started the feeding pump. LPN-A confirmed R40 had a G-tube and she did not check for G-tube placement prior to flush or starting infusion of Jevity. During observation on 11/01/16, 7:37 p.m. LPN-B prepared medication and placed medication in a cup to administer through R40's G-tube and entered R40's room. LPN-B who had a stethoscope around her neck, washed her hands and donned gloves, then poured 30 cc's of tap water into the medication cup to dissolve the medication prior to administration. LPN-B turned off feeding pump, disconnected the tubing, and placed the 60 cc's syringe into the G-tube port. LPN-B then poured 60 cc's of distilled water into syringe to flush via gravity and met resistance. LPN-B was unable to administer the flush with water after several attempts to manipulate tubing. LPN-B did not check for G-tube placement by aspiration or auscultation. LPN-B got on the walkie talkie and asked the nurse to bring some coke to R40's room to flush G-tube. Registered nurse (RN)-A entered room and attempted to assist LPN-B with flushing G-tube by repositioning R40 and massaging the G-tube tubing. RN-A did not check for G-tube placement by aspiration or auscultation. LPN-B used a different 60 cc syringe with a narrow tip and was able to flush G-tube and administer medication. LPN-B did not check for G-tube placement by aspiration or auscultation. During interview on 11/01/16, 8:15 p.m. LPN-B stated at that time she had not checked G-tube for placement prior to flush or administering medication.	2 930		

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2 930	Continued From page 49 During interview on 11/01/16, 8:20 p.m. RN-A stated the G-tube needed to be checked for placement by aspiration or auscultation prior to flushing, medication administration, and starting new feeding. RN-A confirmed enteral feeding policy dated 6/01/16, was current. RN-A confirmed at that time R40 G-tube should have been checked for placement especially when meeting resistance. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident with feeding tubes are monitored for proper placement of that feeding tube. 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.	2 930		
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;	21390		12/13/16

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21390	Continued From page 50 D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand hygiene was implemented for 1 of 1 resident (R2) observed for wound care. In addition, the facility failed to ensure appropriate infection control practices were followed for 1 of 1 resident (R49) who was in contact isolation. Findings include: R2 was observed on 11/2/16, at 7:39 a.m. as the director of nursing (DON) and registered nurse (RN)-C entered R2's room to perform dressing changes to the pressure ulcers on her right medial buttock and left heel. RN-C donned gloves, removed the old dressing from the buttock, and donned clean gloves, without performing hand hygiene. RN-C then sprayed the	21390	LFHS has established an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. R#2-Nursing staff providing wound care for R#2 were re-educated on proper hand hygiene (washing hands when changing gloves) with wound care. R#49- The soiled laundry hamper was placed inside the room and staff caring for R#49 were re-educated on performing hand hygiene before leaving the room. All residents have the potential to be affected by a practice deficient in this	

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21390	Continued From page 51 area with Sea Cleans (wound cleanser). With the same gloves, RN-C placed the new dressing on the wound. At this time, the gloves were removed, incontinent pad fastened, and pants pulled back up. RN-C then proceeded to don clean gloves (without washing hands), covered R2's torso, and removed the dressing from the left heel. The Sea Cleans was sprayed on the wound, and gloves were changed, without performing hand hygiene. A clean dressing was placed on the wound. The gloves were then removed, and RN-C assisted to place a pillow beneath R2's legs to float the heels off the bed, lowered the bed with the attached remote. At this time, RN-C went to the bathroom and washed her hands. During interview on 11/2/16, at 9:24 a.m. RN-C stated she typically performs hand hygiene between each wound, but not after removing the soiled gloves each time. RN-C also verified no hand hygiene was performed until finished with the entire process during the observation. During interview on 11/3/16, at 2:10 p.m. DON stated staff are expected to perform hand hygiene after each glove change. Facility policy titled Dressing Change - Clean, undated, instructed staff to: - Put on gloves - Remove soiled dressings and discard into plastic bag at foot of bed - Remove gloves and discard - Wash hands. Put on clean gloves. Cleanse wound with prescribed solution if ordered. - Apply prescribed medications as ordered - Apply dressings and secure with tape - Remove gloves and wash hands.	21390	area. All NAR and Nursing staff were re-educated on hand hygiene and infection control precautions. DON/designee will conduct observational audits of hand hygiene at random times throughout the 24 hour period. A minimum of 2 audits per week for 2 weeks, then 2 audits/week x2 weeks, then once weekly for 2 weeks and monthly thereafter. DON/designee will conduct observational audits of wound care to ensure appropriate infection control techniques are used, 2Xweek x2, then 2 audits/week x2 weeks, then once weekly for 2 weeks and monthly thereafter. Audit results will be brought to the QAPI committee for review and further recommendation.	

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21390	Continued From page 52 R49 had a clostridium difficile (C. difficile) infection, and the facility did not implement appropriate infection control precautions. The Center for Disease Control (CDC) guidelines for health care facilities directed the following when caring for residents with a C. Difficile infection: Isolate patients with C. difficile immediately. Wear gloves and gowns when treating patients with C. difficile, even during short visits. Hand sanitizer does not kill C. difficile, and although hand washing works better, it still may not be sufficient alone, thus the importance of gloves. Clean room surfaces thoroughly on a daily basis while treating a patient with C. difficile and upon patient discharge or transfer. Supplement cleaning as needed with use of bleach or another EPA-approved, spore-killing disinfectant. R49's diagnosis list identified enterocolitis due to clostridium difficile (a spore-forming bacteria that can cause swelling and irritation of the large intestine, or colon. This inflammation, known as colitis, can cause diarrhea, fever, and abdominal cramps). Progress note dated 10/21/16, lab tested positive for clostridium difficile on 10/13/16. R49's significant change Minimum Data Set (MDS) dated 10/20/16, indicated R49 had moderately impaired cognition, required extensive assistance with bed mobility, transfers, toileting, was frequently incontinent of urine, and was always incontinent of bowel. During observation on 10/31/16, at 11:30 p.m. a dirty linen hamper was outside R49's room. During observation on 11/02/16, at 1:12 p.m. nursing assistant (NA)-A exited R49's room and removed her potentially contaminated gown outside of R49's room, and placed the gown in the dirty linen hamper outside R49's room. NA-A walked down hall about 40 feet away entered bathroom by nursing station, and washed hands	21390		

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	00382	A. BUILDING: _____ B. WING _____	11/03/2016

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21390	Continued From page 53 with soap and water. During observation on 11/02/16, at 1:23 p.m. occupational therapist (OT)-A exited R49's room and removed her potentially contaminated gown outside R49's room and placed gown in dirty linen hamper outside R49's room. OT-A stated R49 was on contact precautions for C. difficile, and needed to remove your mask, gloves, and wash hands with soap and water prior to leaving R49's room. OT-A further stated the gown was removed outside of R49's room and placed in the hamper. During observation on 11/02/16, at 1:36 p.m. licensed practical nurse (LPN)-A put on a gown, mask, and gloves prior to entering R49's room. LPN-A entered R49's room and approached R49 and explained she was going to check for edema. LPN-A lifted up R49's right pant leg, and placed her gloved hand on his leg, applying pressure to leg. LPN-A did the same to left leg. LPN-A removed mask and gloves and discarded them in the trash can in R49's room. LPN-A exited R49's room, and removed the potentially contaminated gown outside of R49's room, and placed the gown in dirty linen hamper outside R49's room. LPN-A proceeded down hallway to nursing station where she entered the bathroom, and washed her hands with soap and water. LPN-A was interviewed and stated at that time handwashing should be done in R49's room prior to exiting room. During interview on 11/20/16, at 2:30 p.m. NA-A stated she removed her mask and gloves in R49's room, and stated she washed hands in bathroom by nurse's station. During interview on 11/02/16, at 1:17 p.m. NA-B stated R49 was in isolation for C. difficile, and before entering R49's room you put on a mask, gloves and a gown. When exiting R49's room the mask and gloves are removed, and thrown in trash can, hands are washed in room before	21390		

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21390	Continued From page 54 exiting, and gown is placed in dirty hamper outside of R49's room. NA-B stated she washes her hands using the hand sanitizer, instead of soap and water prior to leaving room. During interview on 11/03/2016, 11:02 a.m. the director of nursing stated her expectations for C. difficile and stated hands should be washed with soap and water before leaving R49's room and the dirty laundry hamper should be kept inside of R49's room. The facility policy 6.0 Infection Prevention and Control Program dated 1/16, directed Contact precautions are instituted for residents with symptomatic C. difficile infection. Policy 6.14 Isolation Precautions-Transmission Based dated 8/15 directs staff be sure that an adequate supply of antiseptic soap and paper towels are maintained in the room during the isolation period. Remove the gown and perform hand hygiene before leaving the resident's environment. Suggested Method of Correction: The administrator or designee could review policies and procedures to ensure, proper infection control regarding wound care techniques and isolation precautions are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. Time Period for Correction: Twenty one (21) days.	21390		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible.	21665		12/13/16

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21665	Continued From page 55 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain resident care equipment for 2 or 2 residents (R23, R33) whose wheelchair and foot pad were is disrepair. Findings Include: R23's quarterly Minimum Data Set (MDS) dated 10/5/16, indicated R23 used a wheelchair for mobility. During observation on 11/1/16, at 6:47 p.m. R23 presented with multiple long cracks in the black fabric of her left wheelchair armrest. The cracks extended length wise along the armrest and white foam padding was visible through the cracks. During interview on 11/1/16, at 7:10 p.m. nursing assistant (NA)-E stated she was not aware of the cracks but should staff should be paying attention to R23's armrests. NA-E stated the armrest would not be able to be cleaned well, and further stated, staff should have filled out a maintenance slip to see if the armrest could be fixed or to get R23 a different chair. R33's annual MDS dated 9/28/16, indicated R33 used a wheelchair for mobility with functional limitations in R33's lower extremities. During observation on 10/31/16, at 1:58 p.m. R33 presented with a blue rectangular pad, measuring 10 inches (in) by 17 in, under his feet and ankles while sitting in his wheelchair. The pad, located between R33's leg rests, appeared to be torn on both sides with duck tape covering the torn areas.	21665	LFHS provides a safe, functional,sanitary, and comfortable environment for residents, staff and the public. R #23-new wheelchair armrests were obtained and placed on wheelchair. R #33- the calf protector was removed and replaced. All residents that utilize wheelchairs have the potential to be affected by a deficient practice. All staff were re-educated on maintaining resident equipment specifically wheelchairs and reporting any wheelchair that is in disrepair. Maintenance director or designee will conduct an audit of all resident wheelchairs, then will continue random audits weekly with their environmental checks. Audit results will be brought to the QAPI committee for review and further recommendation.	

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21665	Continued From page 56 Upon further inspection on 11/3/16, at 10:51 a.m. the duck tape was wrapped completely around the bottom and back of the cushion while R33 rested his ankles on the tape. NA-F stated the pad had ripped and the duck tape was holding the pad together. NA-F further stated the pad was to ensure R33's legs would not catch between the foot pedals. She also stated R33 should not have his feet on the duck tape, someone should have noticed the tape, and filled out a maintenance slip to for it to be repaired. During interview on 11/3/16, at 1:50 p.m. director of maintenance stated he had not received any repair requests for the wheelchair pads or armrests. The DOM stated staff should fill out maintenance slips for equipment in disrepair so it could be fixed. During interview on 11/3/16, at 4:56 p.m. registered nurse (RN)-A stated she would expect staff to fill out a maintenance form for care equipment in disrepair so the equipment could be fixed. An facility policy entitled, Maintenance Slip Policy, undated, instructing staff to fill out maintenance forms for repairs in order to maintain "equipment in a safe and operable manner." SUGGESTED METHOD OF CORRECTION: The administrator, director of maintenance, or designee could update facility policies and procedures related to requesting and tracking for repairs of care equipment. Audits could also be completed to ensure resident care equipment is in good operating condition. TIME PERIOD FOR CORRECTION: Twenty One	21665		

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21665	Continued From page 57 (21) days.	21665		