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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: W6S5

Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245184**
2.STATE VENDOR OR MEDICAID NO.
(L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER EAST**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

4. TYPE OF ACTION: 7
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) **05/12/2006**

6. DATE OF SURVEY **06/17/2015** (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 **116** (L18)

13.Total Certified Beds **116** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	116			
(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 :
Kyla Einertson, HFE NE II 06/30/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/30/2015 (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
09/01/1972
(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 07/15/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/18/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 30, 2015

Ms. Dori Mutch, Administrator
Golden Livingcenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

RE: Project Number S5184027

Dear Ms. Mutch:

On May 22, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 4, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 17, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 29, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 4, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 28, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 4, 2015, effective June 28, 2015 and therefore remedies outlined in our letter to you dated May 22, 2015, 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.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245184	A. Building B. Wing	6/17/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **06/13/2015**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **06/13/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **06/13/2015**
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **06/13/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **06/13/2015**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **06/13/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **06/13/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **06/13/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **06/13/2015**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **06/13/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **06/13/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **06/13/2015**
ID Prefix **F0334** Reg. # **483.25(n)** LSC	Correction Completed **06/13/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **06/13/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **06/13/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	06/30/2015	31221	06/17/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245184	A. Building B. Wing	6/17/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **06/13/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **06/13/2015**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **06/13/2015**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GPN/kfd	06/30/2015	31221	06/17/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 5/4/2015

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245184	A. Building B. Wing **01 - MAIN BUILDING 01**	6/29/2015

Name of Facility	Street Address, City, State, Zip Code
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **06/13/2015**	ID Prefix	Correction Completed **06/13/2015**	ID Prefix	Correction Completed **06/13/2015**
Reg. # **NFPA 101** LSC K0054		Reg. # **NFPA 101** LSC K0062		Reg. # **NFPA 101** LSC K0069	
ID Prefix	Correction Completed **06/28/2015**	ID Prefix	Correction Completed **06/13/2015**	ID Prefix	Correction Completed **06/13/2015**
Reg. # **NFPA 101** LSC K0143		Reg. # **NFPA 101** LSC K0144		Reg. # **NFPA 101** LSC K0147	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # LSC		Reg. # LSC		Reg. # LSC	

Reviewed By _____ **State Agency**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/28/2015	_____	**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?** **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: W6S5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00953

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245184**
2.STATE VENDOR OR MEDICAID NO.
(L2) **690925600**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOLDEN LIVINGCENTER - ROCHESTER EAST**
(L4) **501 EIGHTH AVENUE SOUTHEAST**
(L5) **ROCHESTER, MN** (L6) **55904**

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) **05/12/2006**

6. DATE OF SURVEY **05/04/2015** (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 **116** (L18)

13.Total Certified Beds **116** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	116			
(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 :
Marietta Lee, HFE NE II 06/08/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/16/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
09/01/1972
(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 06/18/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 4721

May 22, 2015

Ms. Dori Mutch, Administrator
Golden Livingcenter - Rochester East
501 Eighth Avenue Southeast
Rochester, Minnesota 55904

RE: Project Number S5184027

Dear Mr. Kallstrom:

On May 4, 2015, 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 actual harm that is not immediate jeopardy (Level G), 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;

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:

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
gary.nederhoff@state.mn.us
Telephone: (507) 206-2731
Fax: (507) 206-2711

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 June 13, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 13, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 August 4, 2015 (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 November 4, 2015 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Telephone: (651) 201-7205 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 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
	245184	A. BUILDING _____ B. WING _____	05/04/2015

JUN 4 - 2015
MN Dept of Health
Rochester

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	Submission of this Response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This plan of Correction is submitted as the facility's credible allegation of compliance.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	6/8/15 GPN	

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

Dori Mutch - Administrator signed 06/03/2015 per GN - Supervisor | 06/03/2015

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

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	245184	A. BUILDING _____ B. WING _____	05/04/2015

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to notify the physician of the weight gain for 1 of 1 resident (R205) reviewed who had dialysis treatments three times weekly. Findings include: R205 was admitted on 4/20/15, with diagnosis listed on the admission record which included end stage renal disease (ESRD) and diabetes mellitus. Review of physician orders dated 4/20/15, revealed that resident weight was to be done daily and the nurse practitioner/medical doctor (NP/MD) should be notified if the resident had a weight increase of two (2) to three (3) pounds (#) in a 24 hour period, or if resident had weight increase of five (5) #'s over baseline. When the admission clinical health status assessment dated 4/20/15 was reviewed, documentation was lacking to indicate an admission weight was completed nor did the document indicate that R205 received dialysis services.	F 157	F157 -MD has been updated regarding weight changes for R205. -All residents with a weight loss condition change have the potential to be affected by the identified practice. -Licensed staff have been educated on Physician Notification for change of condition. Education done 5/21/15 -Random bi-weekly audits will be conducted to ensure MD notification is made timely. Audits will be reviewed at QAPI and action planned as needed. -The DNS/Designee is the responsible party. -Corrective action will be completed by 6/13/2015.	6/13/15

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F 157	Continued From page 2 Review of daily weights for R205 documented on either the weights and vitals summary printout and/or the treatment administration record (TAR) revealed the following: 4/20/15-no weight recorded 4/21/15-108.2 # 4/22/15-108 # 4/23/15-109 # 4/24/15-109 # 4/25/15- no weight recorded- Saturday 4/26/15--116.8 # (not reported to physician) 4/27/15- 116.8 # (not reported to physician) 4/28/15- no weight recorded-Tuesday 4/29/15-117 # (again not reported to physician) 4/30/15-no weight- recorded There was no evidence the NP/MD had been notified of the 7.8 # weight increase from 4/24/15 (109#) to 4/26/15 (116.8#). The NP/MD had not been notified of the weight increase of 2-3 #'s/24 hour period nor the 5# weight increase over baseline on 4/21/15 (108.2#) to 4/26/15 (116.8#) per the admission orders. During interview on 4/29/15, at 3:00 p.m. the director of nursing (DON) verified R205 received a renal diet and there were no written instructions available for staff related to dialysis care included on the temporary care plan nor the nursing assistant care guide. During interview on 4/30/15, at 10:30 a.m. the DON verified the weights as noted above and verified lack of daily weights and lack of physician notification when weights were up two or more pounds per physicians orders.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT	F 225		

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F 225	Continued From page 3 ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.	F 225	F225 Investigation has been completed into resident incidents for R4, R51, and R135. -All residents have the potential to be affected by the identified practice. -All staff will be educated of the requirement to report incidents of potential abuse/neglect immediately to the ED or designee and all reports of abuse/neglect will be reported to the appropriate state agency in a timely manner. The ED or designee will conduct all investigations to include interviews with employees, visitors, or residents who may have knowledge of the alleged incident. Education provided 5/21.6/2,6/4,6/9 -Random bi-weekly audits will be conducted of incident reports to ensure any allegations of abuse or neglect have been reported to the ED or designee in a timely manner, reported to the appropriate state agency and have been thoroughly investigated. Any required re-education will be conducted at that time. Audits will be reviewed at QAPI and action planned as needed. -ED/Designee is the responsible party. -Corrective action will be completed by 6-13-2015.	6/13/15

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F 225	Continued From page 4 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report allegations of physical abuse to the administrator and designated State agency for 2 of 2 residents (R4 and R51) reviewed for resident to resident altercations; and failed to report and initiate an investigation into potential self abuse for 1 of 1 (R135) reviewed who had been identified as potentially attempting to cause self-harm. Findings include: R4's significant change Minimum Data Set (MDS) dated 4/6/15, identified R4 had no cognitive impairment and no behaviors. R4's care plan dated 4/16/15, indicated the resident utilized an electric wheelchair for mobility, and staff was instructed to remove the resident from potentially dangerous situations and from other residents who disturb her. R51's quarterly MDS dated 2/17/15, identified R51 had no cognitive impairment but had experienced behaviors of screaming or cursing at others 1-3 times in during the 7 day look back period. R51's care plan dated 4/29/15, indicated the resident utilized an electric wheelchair for mobility and had a history of difficulty operating the wheelchair and, "driving it aggressively." R4's facility progress notes dated 4/26/15, read that R4 reported R51 had push by her with his wheelchair so he didn't miss the elevator, and in the process R51 "Hit or jammed," R4's right	F 225		

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F 225	Continued From page 5 hand/wrist. R4 immediately complained of pain and injury to her right hand and wrist, and R4 was sent to the Emergency Department (ED) for X-ray of her right wrist, and no fracture was found. The progress note further indicated, "Four letter explicative were exchanged amongst the two residents and loud voices were heard..." During interview on 4/27/15, at 5:30 p.m., R4 stated recently she had tried to get off the elevator with her electric wheelchair when another resident (identified to be R51) was getting onto the elevator in an electric wheelchair. R4 stated she asked R51 to back up, and R51 refused and again used verbal abuse toward R4 as R51 continued to try to enter the elevator in his electric wheelchair. R4 stated R51's wheelchair hit her arm, and R4 stated she now has no feeling in the last two fingers of her right hand. R4 stated she reported the incident to the nurse immediately, and went to the emergency room due to swelling in her the right hand. R4 stated she had no broken bones in her hand, however, she is now wearing a splint and continues to have pain in her right hand and wrist. Document review of the Incident Submission report submitted to the state agency on 4/26/15, indicated there was verbal Abuse between R4 and R51. The incident description read, "Resident [R51] rushed by another resident [R4] in electric wheelchair to get into the elevator quickly; alleged verbal altercation between residents." The Incident report indicated the incident occurred on 4/25/15, however, it was not reported to the state agency until the following day. Although the incident was a resident to resident altercation which resulted in injury to R4, the facility submitted the incident only referring to a verbal	F 225		

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F 225	Continued From page 6 altercation. During interview on 4/29/15, at 12:08 p.m., the administrator stated he received telephone notification of the incident on 4/26/15, at 7:30 p.m., and was not immediately notified of the incident between R4 and R51 on 4/25/15. The administrator verified the resident to resident altercation was not reported to the state agency immediately. An incident report for R135 dated 3/14/15, at 10:31 p.m. indicated a nursing assistant (NA) had reported the resident had been found with an ace-wrap wound around her neck that she was pulling on to tighten it. The incident report indicated no injury had been noted to the resident's neck. The report (unsigned by who had completed it) had also documented that the resident had been questioned as to whether she had intended to harm herself, but the resident had not responded. There was no documentation on the report, or in the resident's chart of any further investigation as to the issue of whether or not the resident was attempting to cause herself harm. During an observation of R135's room on 4/30/15, at 10:15 a.m. it was observed the call light cord availble was long. The current care plan was reviewed 4/29/15. Although the care plan identified the resident had a diagnosis of dementia without behavioral disturbance, there was no reference to the resident's potential for self-harm nor interventions to minimize the resident's risk for self-harm. A quarterly Minimum Data Set (MDS) dated	F 225		

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F 225	Continued From page 7 2/5/15, identified the resident as cognitively intact, who presented with mood symptoms 2-6 days a week. The MDS indicated the resident felt little pleasure, felt depressed or hopeless, felt badly about herself or that she had let herself or others down, and nearly every day felt tired and/or had little energy. A subsequent Medicare MDS 4/7/15 reflected R135 continued feeling down, depressed, and hopeless, but indicated R135 had no thoughts of death. Licensed social worker (LSW)-B was interviewed regarding the incident on 4/30/15, at 9:20 a.m. LSW-B stated she was unaware of the incident, but said she should have been made aware so she could perform mentation testing. LSW-B verified care planning approaches had not been developed for R135's depressive symptoms. The administrator was interviewed on 4/30/15, at 9:53 a.m. and stated he was also unaware of the incident, and verified he should have been immediately notified of the situation so an investigation could have followed. The facility policy titled Reporting and Investigation of Alleged Violations of Federal and State laws involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, and Misappropriation of Residents property dated 12/18/14, instructed allegations of mistreatment are reported immediately to the executive director (administrator), and reported to the state agency in accordance with existing state laws. The policy identified abuse included resident-to-resident abuse, regardless of whether serious harm resulted. The facility policy titled Policies and Procedures	F 225		

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F 225	Continued From page 8 Regarding Investigation and Reporting of Alleged Violation of Federal or State laws Involving Maltreatment, or Injuries of Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements dated 9/2011, indicated reportable incidents must be reported to the state agency immediately. The policy indicated immediately was defined as, "as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred was received."	F 225	F226 Investigation has been completed into resident incidents for R4, R51, and R135. -All residents have the potential to be affected by the identified practice. -All staff will be educated of the requirement to report incidents of potential abuse/neglect immediately to the ED or designee and all reports of abuse/neglect will be reported to the appropriate state agency in a timely manner. The ED or designee will conduct all investigations to include interviews with employees, visitors, or residents who may have knowledge of the alleged incident. -Random bi-weekly audits will be conducted of incident reports to ensure any allegations of abuse or neglect have been reported to the ED or designee in a timely manner, reported to the appropriate state agency and have been thoroughly investigated. Any required re-education will be conducted at that time. Audits will be reviewed at QAPI and action planned as needed. -Education provided on 5/21,6/2,6/4,and 6/9 -ED/Designee is the responsible party. -Corrective action will be completed by 6-13-2015.	6/13/15
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse policy for immediately reporting of allegations of physical abuse to the administrator and designated State agency for 2 of 2 residents (R4 and R51) reviewed for resident to resident altercations; and for reporting and initiation of an investigation into potential self abuse for 1 of 1 (R135) reviewed who had been identified as potentially attempting to cause self-harm. Findings include: The facility policy titled Reporting and Investigation of Alleged Violations of Federal and	F 226		

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F 226	Continued From page 9 State laws involving Mistreatment, Neglect, Abuse, Injuries of Unknown Source, and Misappropriation of Residents property dated 12/18/14, instructed allegations of mistreatment are reported immediately to the executive director (administrator), and reported to the state agency in accordance with existing state laws. The policy identified abuse included resident-to-resident abuse, regardless of whether serious harm resulted. The facility policy titled Policies and Procedures Regarding Investigation and Reporting of Alleged Violation of Federal or State laws Involving Maltreatment, or Injuries of Unknown Source in Accordance with Federal and Minnesota State Vulnerable Adult Act Requirements dated 9/2011, indicated reportable incidents must be reported to the state agency immediately. The policy indicated immediately was defined as, "as soon as possible, but no longer than 24 hours from the time initial knowledge that the incident occurred was received." R4's significant change Minimum Data Set (MDS) dated 4/6/15, identified R4 had no cognitive impairment and no behaviors. R4's care plan dated 4/16/15, indicated the resident utilized an electric wheelchair for mobility, and staff was instructed to remove the resident from potentially dangerous situations and from other residents who disturb her. R51's quarterly MDS dated 2/17/15, identified R51 had no cognitive impairment and had behaviors of screaming or cursing at others 1-3 times in the 7 day look back period.	F 226		

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F 226	Continued From page 10 R51's care plan dated 4/29/15, indicated the resident utilized an electric wheelchair for mobility and had a history of difficulty operating the wheelchair and, "driving it aggressively." R4's facility progress notes dated 4/26/15, read that R4 reported R51 had push by her with his wheelchair so he didn't miss the elevator, and in the process R51 "Hit or jammed," R4's right hand/wrist. R4 immediately complained of pain and injury to her right hand and wrist, and R4 was sent to the Emergency Department (ED) for X-ray of her right wrist, and no fracture was found. The progress note further indicated, "Four letter explicative were exchanged amongst the two residents and loud voices were heard..." During interview on 4/27/15, at 5:30 p.m., R4 stated recently she had tried to get off the elevator with her electric wheelchair when another resident (identified to be R51) was getting onto the elevator in an electric wheelchair. R4 stated she asked R51 to back up, and R51 refused and again used verbal abuse toward R4 as R51 continued to try to enter the elevator in his electric wheelchair. R4 stated R51's wheelchair hit her arm, and R4 stated she now has no feeling in the last two fingers of her right hand. R4 stated she reported the incident to the nurse immediately, and went to the emergency room due to swelling in her the right hand. R4 stated she had no broken bones in her hand, however, she is now wearing a splint and continues to have pain in her right hand and wrist. Document review of the Incident Submission report submitted to the state agency on 4/26/15, indicated there was verbal Abuse between R4 and R51. The incident description read, "Resident	F 226		

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F 226	Continued From page 11 [R51] rushed by another resident [R4] in electric wheelchair to get into the elevator quickly; alleged verbal altercation between residents." The Incident report indicated the incident occurred on 4/25/15, however, it was not reported to the state agency until the following day. Although the incident was a resident to resident altercation which resulted in injury to R4, the facility submitted the incident only referring to a verbal altercation. During interview on 4/29/15, at 12:08 p.m., the administrator stated he received telephone notification of the incident on 4/26/15, at 7:30 p.m., and was not immediately notified of the incident between R4 and R51 on 4/25/15. The administrator verified the resident to resident altercation was not reported to the state agency immediately. R135's incident report dated 3/14/15, at 10:31 p.m. noted a nursing assistant (NA) reported the resident was discovered with an ace-wrap wound around her neck and was found pulling on the wrap to tighten it. No injury was noted to the resident's neck. The (unidentified) writer had questioned the resident whether she had intended to harm herself, but the resident did not answer. No investigation or further information regarding the potential for self-harm was found in the resident's record. On 4/30/15, at 10:15 a.m. R135 was observed attending an activity dice game. Although the resident participated in the game, she initiated no conversation with others present. R135's room included a call light with a long cord. The care plan provided 4/29/15, identified the	F 226		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 12 resident had a diagnosis of dementia without behavioral disturbance. Information was not included related to the resident's potential for self-harm and nor was a plan developed to minimize the resident's risk for self-harm. A quarterly Minimum Data Set (MDS) dated 2/5/15 identified the resident as cognitively intact. She presented with mood symptoms 2-6 days a week where she felt little pleasure, felt depressed or hopeless and badly about herself or that she had let herself or others down, and nearly every day she felt tired and/or had little energy. A subsequent Medicare MDS 4/7/15 reflected R135 continued feeling down, depressed, and hopeless, but had no thoughts of death. The care plan provided 4/29/15, did not identify a problem related to depression or the incident and no interventions had been developed. A licensed social worker (LSW)-B was interviewed regarding the incident on 4/30/15, at 9:20 a.m. LSW-B stated she was unaware of the incident, but felt she should have been made aware so she could perform mentation testing. LSW-B verified care planning approaches had not been developed. The administrator was interviewed on 4/30/15, at 9:53 a.m. and stated he was also unaware of the incident, but said he should have been immediately notified of the situation and an investigation should have then followed.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or	F 241		

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	245184	A. BUILDING _____ B. WING _____	05/04/2015

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F 241	Continued From page 13 enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights were answered in dignified manner for 1 of 1 (R81) resident whose call light was repeatedly turned off. Findings include: R81 was lying in bed during an observation on 4/29/15, at 7:21 a.m. R81 stated very loudly, "I want to get up soon" at which time he also activated his call light. Continuous observations were then conducted and the following was observed: At 7:37 a.m. an unknown nursing assistant (NA) entered room and donned gloves. She looked around the room, turned the light off, and then left the room without addressing R81. R81 continued to talk loudly as he lay in bed stating, "I want something to eat. I need to get up. I have my call light on. Come on, can't you help me? Oh come on. Are you going to starve me too? I have my call light on. Can't you help me?" Although R81 had not commented about his roommate's television, at 7:52 a.m. NA-D entered the room and informed R81's roommate that R81 had requested the television volume be lowered. NA-D then tuned off R81's call light and left the room. Later, when R81 realized his call light had been turned off, he turned it back on and continued to state loudly, "I want to get up, I'm so	F 241	F241 -R81 call light is being answered in a timely manner and R81 needs are being met before call light is turned off. -All residents have the potential to be affected. -Staff will be educated on call light response, need to answer call light timely, and meeting resident needs. -Random bi-weekly audits will be performed on call light response to include meeting resident needs. Audit results will be reviewed at QAPI and action planned as needed. -DNS/Designee is the responsible party. -Education provided on 5/21,6/2,6/4,6/9 -Corrective action will be completed by 6-13-2015.	6/13/15

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F 241	Continued From page 14 nervous lying here." At 7:55 a.m. NA-C entered R81's room, turned the call light off and told the resident, "I am working on the other side. I told them to come help you." R81 continued to loudly request to get up." At 8:01 a.m. R81 repeated loudly, "I want to get up! I want to get up!" R81 continuously requested to get up and talked about eating breakfast. When he realized his call light had again been turned off, he activated it and stated, "That is what they always do. They aren't supposed to turn it off until they help me, but they just come in and turn it off." At 8:07 a.m. R81 continued talking to himself about wanting to get up, when NA-D entered the room and said, "They will get you up," as she turned off the call light and left the room. When asked why the resident's call light was turned off NA-D responded, "I am working on the west side. He lives on the east side." NA-D then told the resident, "I will tell them you want to get up," and again turned off the call light that the resident had again activated. The resident then turned the call light back on. At 8:12 a.m. R81 continued lying in bed talking loudly about wanting to get up when NA-E entered the room. NA-E informed the resident if NA-F did not come soon, when she was finished assisting another resident who needed oxygen, "I will come and help you." R81 continued stating he wanted to get up and put his call light back on five minutes later. NA-C stated in an interview on 4/29/15 at 8:18	F 241		

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F 241	Continued From page 15 a.m. "I turn the light off when I ask him what he wants. We are done with our work on the other side, so I came here to help on this side." NA-E arrived to assist R81, as well. During an interview with registered nurse (RN)-A explained on 4/30/15, at 8:50 a.m. "I would expect that when they answer the call light, they need to give the resident a time someone will be coming in to help him. I don't want the staff to just say 'someone is coming.'" The director of nursing (DON) stated on 4/30/15, at 9:08 a.m. "If they are a NA and they answer the call light, they are expected to meet his needs. They should not turn his light off with out helping him. It is a dignity issue." R81's quarterly Minimum Data Set (MDS) dated 1/29/15, revealed the resident was moderately cognitively impaired, displayed no behavioral problems, and required extensive assistance for activities of daily living, dressing, transfers and locomotion. R81's care plan dated 9/30/14, indicated self-care and mobility impairments. Progress notes revealed on 4/29/15, "Resident is alert & oriented with confusion. He is able to communicate his needs to staff and able to use call light effectively..." A policy regarding call lights dated 1/26/15, directed staff as follows: All facility personnel must be aware of call lights at all time...Answer ALL call lights promptly whether or not you are assigned to the resident... Never make the resident feel you are too busy to give assistance; offer further assistance before you leave the	F 241		

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F 241	Continued From page 16 room..." A dignity policy dated 2/26/15, indicated "All residents will be treated in a manner and in an environment that maintains and enhances each resident's dignity and respect in full recognition of his or her individuality. Treat residents with dignity and respect maintains and enhances each resident's self-worth and improves his or her psychosocial well-being and quality of life."	F 241		
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. 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	F 280	F280 -R113 and R135 have had their care plans revised to address current conditions. -All residents have the potential to be affected if care plans are not updated with changes. -Licensed staff have been educated to update care plans as the need arises on 5/21, and 6/2. Licensed staff have also been educated to review resident care plans with scheduled care conferences, annually, quarterly, and with significant changes and update as needed. -Random bi-weekly audits will be conducted in conjunction with weekly care conferences to ensure care plans are updated to address current conditions. Any required re-education and/or updates will be conducted at that time Audits will be reviewed at QAPI and action planned as needed. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-201.5	6/13/15

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F 280	Continued From page 17 review the facility failed to revise the care plan for 1 of 1 resident (R113) in the sample with ambulation assistive devices; failed to revise the care plan for 1 of 3 residents (R135) reviewed with a Foley catheter. Findings include: R113 was admitted to the facility on 1/30/12 according to the facility admission record with diagnoses that included but was not limited to dementia, Alzheimer's disease, anxiety, depression, pain in joint pelvic region and thigh, osteoporosis, personal history of fall, hearing loss, and difficulty in walking. R113's quarterly Minimum Data Set (MDS) dated 4/10/15 indicated severe cognitive impairment with a Brief Interview for Mental Status score of 6, was independent with ambulation and transfers after set up, balance was steady during transitions and walking, used a cane or crutch, and had sustained two falls without injury since the previous assessment date. R113's care plan last reviewed on 3/10/15 read at risk for falls related to hx [history] of falls, use of Remeron. "Interventions included but was not limited to: encourage use of walker, give antianxiety medication per nurse practitioner, use walker when ambulating as he is unsteady at times." The care plan also indicated R113 used a cane for ambulation. A nursing progress note dated 4/16/15 read, "Resident was walking down the hall with his cane and then he got into elevator and gently sat on the floor of the elevator... When up to 2nd floor nursing assistants assisted him to his room by	F 280		

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F 280	Continued From page 18 pushing him in a wheelchair." R113 was observed walking with a cane on 4/29/15 at 8:29 a.m., at 10:52 a.m., and at 11:32 a.m. The resident was not observed to walk with a walker during the survey. During an interview on 04/30/15, 2:19 p.m. registered nurse (RN)-A stated, resident chose to use the cane, it's the resident's choice to use the walker or not. RN-A stated the care plan should be updated to reflect the choice of using either assistive device. R135 was admitted on 11/1/14, with diagnoses noted on the care plan last reviewed on 3/18/15, which included: unspecified debility, abnormality of gait, spinal stenosis, osteoarthritis, retention of urine and acute kidney failure. R135's quarterly Minimum Data Set (MDS) dated 2/19/15, indicated moderate cognitive impairment with a BIMS of 12, and was frequently incontinent of bowel and bladder. During a review of R135's care plan, last reviewed 3/29/15, staff were directed to evaluate frequency and timing of incontinence episodes due to R135's occasional bowel and bladder incontinence. The current care plan did not include information regarding R135's indwelling catheter and did not reflect R135's current needs. During an observation on 4/18/15, at 7:19 a.m. R135 was seated in the wheelchair in the room with a catheter bag attached to the wheelchair. During a review of the nursing progress notes, dated 4/17/15, R135 returned from the facility after hospitalization with a "Foley in place, not	F 280		

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F 280	Continued From page 19 ordered to take out at this time d/t [due to] chronic UTI's" (urinary tract infections). During a review of nursing progress noted, dated 4/21/15, for R135, "...has an indwelling Foley catheter for urinary needs....." During an interview on 4/30/15, at 1:39 a.m. the director of nursing (DON) indicated resident care plans should be updated when a resident plan of care changes. This is in regards to the Foley catheter for R135. A facility policy regarding updating of resident care plans was requested but not provided.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure a temporary care plan was developed for 2 of 3 residents (R203 & R205) in the sample who were admitted within the past two weeks. Findings include: R203 was admitted on 4/17/15, at 3:25 p.m. with admission diagnoses (Order Summary Report dated 4/19/15 active orders as of 4/17/15) including rheumatoid arthritis [chronic, systemic inflammatory disorder that primarily affects joints], ulcer of the lower limb, abscess of anal and rectal	F 281	F281 -R203 no longer resides in the facility. R205 has had a care plan developed. -Newly admitted residents have the potential to be affected if care needs are not care planned on admission. -Licensed staff have been educated on development of the temporary care plan upon admission. -Random bi-weekly audits will be completed on admitted residents to insure temporary care plans are developed timely. Audit results will be reviewed at QAPI. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015.	6/13/15

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F 281	Continued From page 20 regions, pain in ankle and foot joint and generalized pain. Care plan dated initiated 4/17/2015 includes a focus of "pressure ulcer actual or at risk due to: pressure ulcer present under cast. Has three open areas on coccyx area." Lacked goals or interventions for pressure ulcer or open areas and had not developed interventions to minimize the risk for developing additional pressure ulcers. In addition the care plan lacked pain management problem, goal, and interventions. Wound Evaluation Flow Sheet dated 4/17/15 completed by RN-B listed the following areas assessed: 1. Abscess of coccyx 1 cm length x .2 cm width. Stage 1 pressure ulcer. Current treatment, cleanse cover with Mepiborder (self-adhesive absorbent dressing). No interventions listed. 2. Abscess coccyx 2 cm length x 1 cm width x .3 cm depth. No treatment listed. Current preventative interventions include wheelchair cushion and turn reposition. No time frame listed for repositioning. 3. Abscess coccyx 2 cm length x 1 cm width. Current treatment mepiborder. Current preventative interventions wheelchair cushion, turn and reposition. No times frames listed for repositioning. Resident Status and Care Plan, undated, indicated skin that included non-healing ulcers three on the rectum, one left leg, and one left foot. Resident Status and Care Plan, undated, indicated pain, everywhere but elbows with a rating of six out of ten. No interventions listed.	F 281		

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F 281	Continued From page 21 On 4/27/15 at 3:03 p.m. R203 reported, "I have ulcerations on my bottom that are supposed to be treated daily. I know my bottom is a lot sorer. I've lost headway since I came in. They never cleared up the meds with the doctor for what I am supposed to have. The ambulance came and took me to the ER, they [facility] wouldn't give me pain meds. They told me I couldn't go but I was in pain." R205 admitted on 4/20/15, with diagnosis listed on the admission record which included end stage renal disease (ESRD) and diabetes mellitus. Document review of physician orders dated 4/20/15, revealed orders for daily weights one time a day, notify NP/MD (nurse practitioner/medical doctor) if resident had weight increase of two to three pounds in one 24 hour period, or if resident had weight increase of five pounds over baseline. Document review of the admission clinical health status, dated 4/20/15, lacked any indication R205 received dialysis services; no mention of access site location, bruit, or thrill. The assessment lacked an admission weight. The clinical health status was signed completed on 4/20/15. Document review of the resident status, an initial care plan, not dated, identified R205 received a renal diet and the nursing assistant care guide, not titled and not dated, revealed instructions that R205 received a renal diabetic diet. There were no other instructions in the initial care plan related to dialysis care. During interview on 4/29/15, at 7:19 a.m. a	F 281		

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F 281	Continued From page 22 trained medication assistant (TMA)-A indicated the dialysis access sight to be the right lower rib area. During observations on 4/29/15, at 8:28 a.m., TMA-A entered R205's room, asked R205 where the access site was located, observed the site located on right chest, and stated, "guess I learned something new today." During interview on 4/29/15, at 8:35 a.m., nursing assistant (NA)-I stated R205's access sight was on the right chest. NA-I stated R205 was on fluid restriction. NA-I indicated not aware of the fluid restriction limit. During interview on 4/30/15, at 8:30 a.m. director of nursing stated she expected dialysis care instructions to be included on the initial care plan, nursing assistant care guide, medication administration record, and treatment administration record.	F 281		
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 to provide services in accordance with the plan of care for 2 of 34 residents (R113, R147) assessed to need assistance to meet activities of daily living.	F 282	F282 -R147 no longer resides in the facility. R113 receives assistance from staff based on individualized assessed needs per the care plan. -All residents have the potential to be affected by the identified practice. -CNA's will be educated to provide cares as directed on the CNA assignment sheets. Licensed staff have been educated to update the CNA assignment sheets as needed with changes made to the comprehensive care plan.	

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F 282	Continued From page 23 Findings include: R113 care plan included the reporting and monitoring of skin concerns, however, a dark purple bruise had not been reported to the nurse nor monitored per care plan: During an observation on 4/28/15, at 1:21 p.m. R113 had a dark purple bruise on his left forearm with approximate measurements of 3 centimeters (cm) in diameter that was not identified by staff. Identification of the bruise was not evident in the medical record. The facility failed to ensure R113's care plan was being followed demonstrated by, lack of skin surveillance and/or lack of reporting of injury of unknown origin as directed by the care plan. R113 was admitted to the facility on 1/30/12 according to the facility admission record with diagnoses that included but was not limited to dementia, Alzheimer's disease, anxiety, depression, anemia, and macular degeneration, and osteoporosis, personal history of fall, hearing loss, and difficulty in walking. R113's quarterly Minimum Data Set (MDS) dated 4/10/15 indicated severe cognitive impairment with a Brief Interview for Mental Status score of 6, was independent with ambulation and transfers after set up. R113's care plan last revised on 1/23/14 indicated risk for bruising due to medication usage of aspirin with an individualized goal of " resident shall have bruising assessed and intervention placed to prevent further skin impairment." The care plan included instruction to staff " assess equipment that may be causing bruised area ..., notify MD/NP [medical doctor/nurse practitioner] to review med regimen, observe and document any new bruises noted, if unknown contact ED/designee per VA [vulnerable adult]. " The	F 282	-Random bi-weekly audits will be conducted to ensure CNA assignment sheets are current with resident comprehensive care plans. Any required re-education and/or updates will be conducted at that time Audits will be reviewed at QAPI and action planned as needed. -Education provided on 5/21, and 62. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015.	6/13/15

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F 282	Continued From page 24 care plan also included the instruction to "inspect skin with care. Report reddened areas, rashes, bruising, or open areas to charge nurse." Progress notes for the month of April 2015 did not contain documentation of the identification of the bruise to the left forearm. Furthermore, an incident report was not found in the medical record pertaining to the bruise. The identification and monitoring of the bruise was not evident in the medical record. During an interview on 4/29/15, at 11:52 a.m. LPN-C verified the bruise on R11's forearm. Verified the no documentation related to the identification of the bruise in the nursing progress notes and verified an incident report had not been initiated. LPN-C then indicated she needed to document and investigate. R147 care plan was not followed in regards to stage II pressure ulcers were to have daily skin monitoring, weekly skin inspections and assessments were completed in accordance with the care plan. During an interview on 4/30/15, at 12:16 p.m. R147 stated he did not get out of bed because of weakness and pain. R147 stated he had sores on his bottom that had been there for a long time. R147 stated staff had not assisted or reminded him to reposition at all today. During an observation on 4/30/15, at 1:06 p.m. nursing assistant (NA)-E rolled R147 onto right side. Bottom revealed chafing of bilateral upper buttocks, and entire upper portion of the sacrum and upper gluteals were red in color with areas that were slow to blanch. The right buttock showed two open wounds one covered by slough. R147 was admitted to the facility on hospice on 4/2/15 according to the facility admission record	F 282		

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F 282	Continued From page 25 with diagnoses that included but not limited to: malignant neoplasm of the kidney, bone, and lungs, hypercalcemia (high calcium), malaise and fatigue, history of venous thrombosis (blood clot), obesity, peripheral and cerebrovascular disease, and rheumatoid arthritis. R147's admission Minimum Data Set (MDS) dated 4/9/15 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 14, required extensive assistance of two staff members for activities of daily living of bed mobility, transfers, dressing, and toileting. The MDS indicated R147 did not ambulate and bilateral lower extremities had range of motion impairments. The MDS further revealed a formal and clinical skin assessment were used, did not have pressure ulcers, and no topical applications of ointments were used. R147's Hospice admission Physical/Clinical Monitoring nursing documentation dated 4/2/15 indicated a non-surgical wound and read, "see detailed skin assessment: Not applicable" The documentation lacked description, location, and measurements. The documentation also indicated a stage I pressure ulcer on buttocks, it was protected, and the area was not measured. The assessment further indicated the wounds were not observed, dressing was not changed, " per hospital discharge summary: Mepilex dressing to bilateral gluteals". R147's Hospice Physical Clinical Monitoring nursing documentation dated 4/7/15 again indicated the presence of a non-surgical wound and a detailed skin assessment was not applicable. The documentation reflected the stage I pressure ulcer on buttocks had healed. R147's Hospice Physical/Clinical Monitoring nursing documentation dated 4/21/15 indicated intact skin. However, the corresponding skilled	F 282		

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F 282	Continued From page 26 nursing note dated 4/21/15 read, "pt has irritated skin on coccyx region. RN [registered nurse] applied barrier cream to this area and wrote order for staff to apply TID [three times per day] and prn [as needed]." According to the documentation on the TAR the treatment was not provided on four occasions between 4/21/15 and 4/28/15 according to the hospice order. R147's Comprehensive Skin Assessment that included Tissue Tolerance Observation (a skin assessment used to determine skin tolerance to pressure over bony prominences; used to determine repositioning schedule) dated 4/2/15 was not completed. The assessment was blank. R147's facility care plan dated 4/10/15 indicated R147 was non-weight bearing and required the use of a mechanical Hoyer lift for transfers. The care plan instructed staff to "inspect skin with care. Report reddened areas, rashes, bruising, or open areas to charge nurse" The care plan also included "pressure ulcer actual or risk due to; assistance required in bed mobility, Braden score of 18 or < [less], obesity, dx [diagnoses] of cancer, pain, use of psychotropic medications." R147's individualized goal was "skin will remain intact" The care plan further instructed staff to "complete Braden scale per living center policy, conduct weekly skin inspection ....provide thorough skin care after each incontinent episode and apply barrier cream, and skin assessment to be completed per living center policy.	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	F 309	F309 -R96 wound care has been assessed, care planned, and is being provided and monitored. Dialysis care has been assessed, care planned, and is being provided for R205. -All residents have the potential to be affected by the identified practice. -Licensed staff have been educated on proper assessing and providing necessary care for resident needs. -Audits will be conducted bi-weekly to ensure cares are being provided to maintain highest practicable well-being. Audit results will be reviewed at QAPI.	

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F 309	Continued From page 27 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 ensure care was coordinated for 1 of 1 resident (R205) in the sample who received dialysis services and failed to ensure resident's wound was monitored and treatment done timely for 1 of 2 residents (R96) reviewed for wounds. Findings include: R205 Lacked initial care planning interventions for staff to care for resident receiving dialysis and lack of daily weights and reporting weight gain as physician ordered: R205 was admitted with orders for renal failure and on dialysis. However, there was not temporary care plan developed for facility staff to meet fluid restriction, what to do in case of bleeding at access site, lack of physician ordered daily weights and also reporting weights of two or more pounds in one day was not done. R205 was admitted to the facility on 4/20/15, with diagnosis that included end stage renal disease and diabetes mellitus, according to the facility admission record. Document review of the facility admission clinical health status, an assessment dated 4/20/15, revealed no indication R205 received dialysis services, access site location, bruit, or thrill. The	F 309	-Education provided 5/21, and6/2 -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015.	6/13/15

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F 309	Continued From page 28 assessment lacked an admission weight. The clinical health status was signed completed on 4/20/15. During observations on 4/28/15, at 4:11 p.m., R205's dialysis access sight was observed on the right upper chest, covered with a clear dressing. The area was clean and dry. During interview at that time, R205 stated was on a special diet that included low potassium and fluid restriction, although was unaware of fluid limit. R205 stated dialysis did not like her to have too many fluids. R205 stated had talked with facility dietician regarding diet, fluids, and likes and dislikes. R205 stated received dialysis on Mondays, Wednesdays, and Fridays and would leave the facility at 11:00 a.m., on those days. R205 stated the facility was to send a sack lunch along to dialysis but that "doesn't happen." Stated goes without eating or buys something to eat at dialysis to eat until return to facility in time for supper. Observations at that time, revealed 1/2 cup coffee, 4 ounce glass of water, and a small gray covered cup with straw (water), on the over the bed table, pizza which R205 ordered and had delivered. During interview on 4/28/15, at 4:24 p.m., licensed practical nurse-E (LPN-E) stated R205 was on fluid restriction of 1.5 liters and the access sight was upper right chest. During interview on 4/29/15, at 7:19 a.m., trained medication assistant (TMA)-A indicated the dialysis access sight to be the right lower rib area. At 8:28 a.m., TMA-A entered R205's room, asked R205 where the access sight was located, observed the sight located on right chest, and stated, "Guess I learned something new today."	F 309		

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F 309	Continued From page 29 During interview on 4/29/15, at 8:35 a.m., nursing assistant-I (NA-I) stated R205's access sight was on the right chest. NA-I stated R205 was on fluid restriction. NA-I indicated not aware of the fluid restriction limit. During observations on 4/29/15, at 8:47 a.m., breakfast tray was delivered to R205 in resident room. Breakfast consisted of 4 ounces apple juice, 8 ounces milk, cup of coffee, 12 ounces waster, scrambled eggs, 1 slice dry toast, and cooked cereal. R205 immediately began to eat. During observations on 4/29/15, at 10:58 a.m., R205 sat in a wheelchair in the facility lobby waiting for van ride to dialysis and had a sack lunch which included a meat sandwich and sprite pop. Document review of the facility resident status and care plan, an initial care plan not dated, identified R205 received a renal diet. There were no other instructions in the initial care plan related to dialysis care. Review of facility nursing assistant care guide used by nursing assistant to give care to R205 included renal diabetic diet and no information on care and what to do in case access site starts to bleed. Document review of physician orders dated 4/20/15, included daily weights one time a day, notify nurse practitioner/medical doctor (NP/MD) if resident had weight increase of two to three pounds in one 24 hour period, or if resident had weight increase of five pounds over baseline. Weights documented for R205 for a period from 4/20/15 admission to 4/30/15 even though	F 309		

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F 309	Continued From page 30 physician ordered daily weights: 4/21/15-108.2 pounds 4/22/15-108 pounds 4/23/15-109 pounds 4/24/15-109 pounds 4/26/15--116.8 pounds (had over 7 pound weight gain in past two days and no indication physician was notified of weight gain) 4/27/15- 116.8 pounds 4/29/15-117 pounds (again no indication of 8 pound weight gain in past 5 days to the physician) During interview on 4/30/15, at 10:30 a.m., director of nursing verified the weights as noted above and no others provided. She verified the physician orders dated 4/20/15, directed daily weights and to notify NP/MD of weight increase of two to three pounds in 24 hours or five pounds above baseline. Director of nursing verified the facility lacked evidence of baseline weight and stated baseline weight would be the first weight taken in facility. During interview on 4/29/15, at 3:00 p.m., director of nursing said R205 ' s temporary care plan did not contain dialysis information for care and emergency procedure in case of access site bleed. Also verified there were no written dialysis care instructions for nursing assistants on the nursing assistant care guide. During interview on 4/29/15, at 3:10 p.m., director of dietary services verified R205 received dialysis diet which included low potassium and low salt diet, and did not have physician orders for fluid restriction. Director of dietary services stated she became aware on 4/28/15, of R205's complaint of lack of sack lunches sent to dialysis and now dietary delivers the sack lunch directly to resident	F 309		

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F 309	Continued From page 31 1/2 hour prior to leaving for dialysis appointments. R96 received a skin tear and ongoing monitoring and changing of dressing to promote healing was not done timely: R96's significant change Minimum Data Set (MDS) dated 3/31/15, indicated R96 was cognitively intact, no behaviors, needs extensive assistance for transfers, bed mobility, activities of daily living and toileting. R96's care plan dated 2/18/15, indicated a diagnosis of paralysis agitans (Parkinson ' s disease), acquired torsion dystonia (an involuntary movement disorder). The care plan also listed a need for an assistive device (mechanical lift). An observation on 4/28/15, at 4:08 p.m. R96 was in her room where the resident was independently engaging in an activity. A bandage on her right shin, front side of her leg about 4 inches above her ankle. The bandage had old blood on it. R96 said she bumped it and it did not hurt. An observation on 4/29/15, at 8:36 a.m. a nursing assistant (NA)-G told R96 she was going to have a nurse look at her open area on her leg. NA-G said she was not sure how it happened because she wiggles her legs and it bumped on a wheelchair. NA-G went to get the nurse and licensed practical nurse (LPN) - B came in to check her skin. LPN-B removed the bandage on her right shin and said the scratch on her leg is about 3 inches (estimating). LPN-B said she didn't know how it happened. When asked, she said the bandage should be changed every 3 days. LPN-B verified there was no date on the old bandage. LPN-B said she would check on	F 309		

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F 309	Continued From page 32 when it was last changed. She applied a new bandage and dated it. An interview on 4/30/15, at 8:56 a.m. RN-B said wound rounds were started and I measured it today. It measured 4 cm x 0.6 cm tear on the front of her leg. A progress note dated 4/22/15, at 01:53 indicated "Resident alert and able to communicate needs to staff, dressing changed on Rt [right] shin tonight. pain with removal..." Another note dated 4/19/15, at 1:18 p.m. indicated "Resident have a skin tear in her lower right leg, measures 3.2 by 0.1 NA reported that, NA was pushing the resident Wheel chair [chair] to the dining room and stopped her in the middle of the hall way to answer the call light of another resident when NA coming out the resident room, finds out that another resident back his chair against her leg. the event was witnessed by the resident itself and resident backed his chair. DR. [doctor] was notified at 1820 [6:20 p.m.], family was notified at 1828 [6:28 p.m.] and DNS [director of nursing services] was notified..." No further progress note addressing the open area on lower right leg. An incident reported for R96 dated 4/18/15, indicates right leg skin tear 3.2 x. 1 cm. This happened when another resident back into R96 in the hall way. Treatment record for April 2015, indicated monitoring, cleansing and changing dressing started on April 29th. Which was the day surveyor questioned staff on the care and treatment for skin tear. A skin integrity guidelines, undated read,	F 309		

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F 309	Continued From page 33 "licensed nurse will be responsible for performing a skin evaluation/observation weekly, utilizing the Weekly Skin Review UDA."	F 309	F314 -R147 and R203 no longer reside in the facility. R51 has been assessed for pressure ulcer risk with interventions implemented and care planned to prevent further skin breakdown. -All residents at risk for pressure ulcer development have the potential to be affected by the identified practice. -Nursing staff have been educated on assessing risk for pressure ulcer development, weekly skin observations, and care planning interventions to prevent further breakdown. Educated 5/21, and 6/2 -Random bi-weekly audits will be conducted to ensure those residents determined at risk for skin breakdown have the necessary interventions in place to prevent further breakdown. Any required re-education will be conducted at that time Audits will be reviewed at QAPI and action planned as needed. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015.	6/13/15
F 314 SS=G	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 complete a skin reassessment after development of pressure ulcer/s and develop treatments and services interventions to promote healing and prevent new pressure ulcers from developing for 3 of 3 residents (R51, R147, R203) reviewed with pressure ulcers. This resulted in harm for R51. Findings include: R51 returned from the hospital on April 7, 2015 and was observed to have a redden groin area extending to buttocks area which was treated with powder. On 4/21/15 progress notes identified two open red areas on buttocks which were treated and covered with dressings. However, was no skin reassessment completed after finding these open area and no new preventative skin	F 314		

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F 314	Continued From page 34 interventions put in place to help the open wounds heal and prevent new ones from developing. On April 29, 2015 surveyors observed two stage II pressure ulcers on buttocks and again there had not been a skin reassessment or interventions based on the skin reassessment completed from 4/21/15 when the facility was first aware of the open wounds on buttock area. 21/15. After surveyors brought this to the facility's attention a comprehensive skin reassessment was completed, the doctor was notified of the presence of the two stage II pressure ulcers and care plan interventions were being developed. Also R51 had not been repositioned from 7:00 a.m. to 12:00 p.m. a total of 5 hours on April 29, 2015. The lack of skin reassessment and development of skin interventions and development of two stage II pressure ulcers resulted in harm to R51. R51 was admitted to the facility on 11/7/14 according to the physician's order summary report dated 4/8/15. Also the report included diagnosis as Obesity, diabetes with neuro manifests type II (adult onset) and not under control even with the use of insulin, obstructive chronic bronchitis with exacerbation and acute respiratory failure. R51 admission Minimum Data Set (MDS) dated 11/18/14 noted R51 was cognitively intact and needed extensive assistance with activities of daily living except supervision with eating. Used a wheelchair for all movement as only able to stand with one assist. Also indicated he was at risk for developing pressure ulcers, and had pressure reducing device for bed and on a turning/repositioning program. However the current care plan did not support a turning or	F 314		

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F 314	Continued From page 35 repositioning program. R51's quarterly MDS dated 2/17/15 indicated no cognitive impairment with a Brief Interview for Mental Status score of 15, required extensive assistance from one staff for bed mobility, extensive assistance from two staff for transfers, and used an indwelling urinary catheter. In addition, the MDS indicated a risk for pressure ulcers and a clinical assessment was used in the determination of pressure ulcer risk (a pressure ulcer risk assessment was not evident in the medical record during or near the assessment time frame). During an interview with R51 on 4/29/15 at 2:04 p.m. he said, "I've been sitting here all day, they [nursing assistants-NAs] have only come in to stand me up one time all day long!" During observation at 2:15 p.m. nursing assistant (NA)-K used a mechanical lift to stand R51 and observed two brown dressings on each buttock cheek. Licensed practical nurse (LPN)-A then removed the two brown adhesive dressing from R51's right and left buttock. There was red blood noted to drip from the dressings and from the buttock wounds to the floor. LPN-A took measurements at this time with left wound measured 0.75 centimeters (cm) by (x) 0.2 cm and right wound measured 0.1 x .0.001 cm. Surrounding skin of bilateral wounds was deep red colored with some excoriation present. R51 displayed facial grimaces during the procedure and stated, "hurry up that hurts and I can't breathe." The resident was then lowered to the recliner that had a pad that was soiled with body secretions and wrinkled sheet with the undressed wounds coming in contact with the soiled pad. LPN-A came back a short time later and applied dressings to the open	F 314		

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F 314	Continued From page 36 wounds. The lack of barrier between the open ulcers and the soiled pad was an infection concern. Progress note dated 4/21/15 read, "Continued redness but has decreased, two areas noted that get bleedy. Resident had extra large stool and caused more bleeding from wounds d/t [do to] pressure. Cleansed area, applied zgard all over groin and buttock area, applied two telfas [non-adherent bandage] to areas that bled." R51's care plan that had a last review date of 11/12/14 indicated R51 had a physical functioning deficit related to self-care impairment, and mobility impairment; required a mechanical lift for transfers. The care plan directed staff to inspect skin with care and report reddened areas, rashes, and bruises to charge nurse. The care plan included, Pressure ulcer actual or at risk due to; assistance required in recliner mobility, diagnoses of diabetes, presence of edema. The interventions to decrease the risk or prevent pressure ulcers included but was not limited to complete Braden scale per living center policy, conduct weekly skin inspection, do not massage over bony prominence, skin assessment to be completed per living center policy, and treatments as ordered. The current care plan did not contain any repositioning schedule. R51's Treatment Administration Record (TAR) for April 2015 included the order to perform weekly skin checks with vital signs every Wednesday evening. Documentation reflected the last skin check was performed on 4/1/15, however documentation of the skin evaluation was not found in the medical record. The order for skin checks and vital signs was discontinued on	F 314		

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F 314	Continued From page 37 4/7/15, a physician or nursing order to discontinue the skin checks was not found in the medical record. Documentation on the TAR indicated Z-Guard had not been applied as ordered by the physician seven times between 4/14/15 through 4/29/15. Documentation also reflected Gold Bond Powder had not been applied as ordered by the physician 4 times between 4/23/15 through 4/29/15. The Gold Bond powder was used to treat the redden scrotum rash. During an interview on 4/29/15, at 2:04 p.m. R51 explained he could not sleep in a bed related to breathing difficulties and had the bed removed so he had room for the chair. R51 stated he was unable to come to a standing position independently and depended on staff for mobility. During an interview on 4/29/15, at 2:36 p.m. registered nurse (RN)-C explained R51 was given education about pressure ulcers prevention and treatment when he refused to use the bed and R51 did not want the bed. Progress notes dated 4/17/15 at 2:22 p.m. staes bed was tried the week previously and lated only three days then removed. The bed was removed from the room to save space. RN-C stated R51 did not tolerate laying down. RN-C stated R51's usual routine was frequently up and down during the day. RN-C did not know when the last time R51 was repositioned today. During an interview on 4/29/15, at 3:04 p.m. director of nursing (DON) confirmed wound tracking for R51 had not been completed well, and explained a better system was needed. DON further said the resident's red perineal area	F 314		

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F 314	Continued From page 38 should have been tracked on the blue sheets so we could make sure it was healing and not getting worse. Also if the wounds do get worse we would notify the physician and get new orders for a different treatment. On 4/29/15, at 4:01 p.m. a nursing progress note authored by RN-A, wounds were referred to as "excoriation" and "some bleeding" was noted. The progress note indicated the current treatment ordered was Z-guard ointment [not consistent with physician's order to apply Z-guard to the perirectal area, not the buttocks], the nurse practitioner (NP) had been notified and a new order was given for Bourdreaux's Butt Paste topically to area three times a day. During an interview on 4/29/15, at 4:32 p.m. RN-A confirmed she had contacted nurse practitioner (NP). During an interview on 4/29/15, at 5:08 p.m. DON indicated she had completed an assessment of the buttocks wounds. DON then stated, "I am staging those wounds at stage II pressure ulcers they are both located over the ischium where there would be pressure." DON stated a foam dressing had been applied and explained the Bourdreaux's Butt Paste was not appropriate for those wounds. DON further explained a bed would be put in R51's room so that he could be laid down to obtain an accurate wound assessment and an appropriate dressing would be applied. The DON further explained the NP would look at the wound on 4/30/15. The corresponding nursing progress note authored by the DON at 5:22 p.m. read, "Resident has a dark red bottom with an open area on lower right ischium and left lower ischium ...right wound	F 314		

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F 314	Continued From page 39 measures 1.1 x .75 [cm] left wound measures 1.2 x .3 [cm]. Areas are stage II from pressure and exacerbated by moisture association ..." During an interview on 4/29/15, at 5:40 p.m. LPN-A stated at 2:00 p.m. she had cleaned the area with normal saline and applied another Mepilex. LPN-A confirmed she did not document the wound findings nor treatment given. During an interview on 4/29/15, at 5:57 p.m. NA-B stated she had worked the day shift. NA-B stated she had provided morning cares around 7:00 a.m. for R51 (R51 was assigned to NA-B for the day shift for cares) that had included perineal care and a partial bed bath; during cares the dressings had come off the wounds. NA-B stated she stood R51 at noon and there had been blood on sheet that covered the chair and bottom looked raw. NA-B stated R51 reported his bottom hurt. NA explained a nurse applied dressings to the wounds after she had reported it to the nurse. NA-B stated she had not stood him or repositioned him between 7:00 a.m. and 12:00 p.m. the next time R51 stood up again was around noon and blood had been observed on the chair pad. During an interview on 5/1/15, at 8:24 a.m. DON confirmed the current care plan for R51 was initiated and revised on 11/12/2015 and no changes have been made since then. DON further explained the care plan would be now updated to reflect the two stage II pressure ulcers and skin condition. The DON stated R51 should be on repositioning program and included in the care plan. The DON also explained wound treatment concerns were identified in the past and they are currently working on them.	F 314		

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F 314	Continued From page 40 R147 lacked timely repositioning (went over 6 hours) when assessed as having two pressure and lacked a comprehensive skin reassessment and development of interventions to promote healing: During an interview on 4/30/15, at 12:16 p.m. R147 stated he did not get out of bed because of weakness and pain. R147 stated he had sores on his bottom that had been there for a long time. R147 stated staff had not assisted or reminded him to reposition at all today. During an observation on 4/30/15, at 1:06 p.m. nursing assistant (NA)-E rolled R147 onto right side. Bottom revealed chafing of bilateral upper buttocks, and entire upper portion of the sacrum and upper gluteal's were red in color with areas that were slow to blanch. The right buttock showed 2 open wounds one covered by slough. During an observation and interview on 4/30/15, at 1:16 p.m. RN-B rolled R147 to right side. RN-B measured the wounds and stated the right upper buttock is 0.3 centimeters (cm) x (by) 0.7 cm. RN-B explained wound was a stage II pressure ulcer. RN-B then measured the wound below and reported the measurements of 0.4 x 0.4 cm. RN-B stated that this wound was an unstageable pressure ulcer because the base cannot be seen. RN-B then stated she would dress the wounds and notify the physician. R147 was admitted to the facility on hospice on 4/2/15 according to the facility admission record with diagnoses that included but not limited to: malignant neoplasm of the kidney, bone, and lungs, obesity, peripheral and cerebrovascular	F 314		

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F 314	Continued From page 41 disease and rheumatoid arthritis. R147's admission Minimum Data Set (MDS) dated 4/9/15 indicated no cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 14, required extensive assistance of two staff members for activities of daily living of bed mobility, transfers, dressing, and toileting. The MDS indicated R147 did not ambulate and bilateral lower extremities had range of motion impairments. The MDS further revealed a formal and clinical skin assessment were used, did not have pressure ulcers, and no topical applications of ointments were used. R147's hospital discharge summary dated 4/2/2015 indicated a gluteal skin alteration described as red erythema and the wound bed was mixed. The summary indicated the wound was covered with a Mepilex (type of bandage). R147's Admission Clinical Health Status assessment dated 4/2/15 indicated no skin alterations or problems. The Braden Scale for Predicting Pressure Ulcers score indicated moderate risk for pressure ulcers with a score of 14. The assessment further indicated R147 had generalized weakness. R147's Hospice admission Physical/Clinical Monitoring nursing documentation dated 4/2/15 indicated a non-surgical wound and read, "See detailed skin assessment: Not applicable" The documentation lacked description, location, and measurements of the wounds. The documentation also indicated a stage I pressure ulcer on buttocks, it was protected, and the area was not measured.	F 314		

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F 314	Continued From page 42 R147's Hospice Physical Clinical Monitoring nursing documentation dated 4/7/15 again indicated the presence of a non-surgical wound and a detailed skin assessment was not applicable. The documentation reflected the stage I pressure ulcer on buttocks had healed. R147's Hospice Physical/Clinical Monitoring nursing documentation dated 4/21/15 indicated intact skin. However, the corresponding skilled nursing note dated 4/21/15 read, "pt has irritated skin on coccyx region. RN [registered nurse] applied barrier cream to this area and wrote order for staff to apply TID [three times per day] and prn [as needed]." According to the documentation on the TAR the treatment was not provided on four occasions between 4/21/15 and 4/28/15. R147's Comprehensive Skin Assessment that included Tissue Tolerance Observation (a skin assessment used to determine skin tolerance to pressure over bony prominences; used to determine repositioning schedule) dated 4/2/15 was not completed. Progress notes dated 4/5/15 read, "No new skin concerns" and indicated to treatments or dressings. Progress note dated 4/9/15 read, "... no apparent skin issues were noted at this time." These were the only two progress notes that mentioned R147 ' s skin conditions. R147's care plan dated 4/10/15 indicated R147 was non-weight bearing and required the use of a mechanical Hoyer lift for transfers. The care plan instructed staff to inspect skin with care. Report reddened areas, rashes, bruising, or open areas to charge nurse. The care plan also included under pressure ulcer actual or risk due to;	F 314		

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F 314	Continued From page 43 assistance required in bed mobility, Braden score of 18 or < [less], obesity, dx [diagnoses] of cancer, pain, use of psychotropic medications. R147's individualized goal was skin will remain intact. The care plan further instructed staff to complete Braden scale per living center policy and conduct weekly skin inspection and provide throughout skin care after each incontinent episode and apply barrier cream. However, the care plan lacked a turning and/or repositioning schedule based on a comprehensive skin assessment. During an interview on 4/30/15, at 1:31 p.m. NA-E stated she had checked on R147 a number of times however, did not reposition him since arriving to work at 7:00 a.m. During an interview on 5/1/15, at 8:24 a.m. DON confirmed the care plan had not been updated to include the two current open pressure ulcers nor revised to include interventions based on the comprehensive skin reassessment. The DON stated R51 should be on a consistent repositioning schedule. A facility policy Clinical Guideline: Skin Integrity last reviewed 2/25/10 read All resident will be assessed/observed for risk of skin breakdown within 24 hours of admission, quarterly and as necessitated by change in condition. Living Center develops a routine to review residents with wounds or at risk on a weekly basis. Director of nursing services (DNS) will be responsible to implement and monitor the skin integrity program. Wound status is monitored on a weekly basis. Assessment/observation is to be completed within the first twenty-four hours of admission/quarterly/significant change of	F 314		

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F 314	Continued From page 44 condition using the Clinical Health Status Tool, If identified risk present the interventions will be documented in the immediate plan of care or comprehensive care plan. To demonstrate satisfactory compliance with guideline wound evaluation flow sheet is being used, DNS or designee evaluates wounds on a weekly basis. Residents will be observed by certified nursing assistant (CAN) daily for reddened/open areas. Changes will be reported to the licensed nurse and documented, initiate positioning schedule to meet individual resident needs and minimize concentrated pressure to skin. The nursing order for weekly observation will be entered on all resident's and print out on the Treatment Administration Record and licensed nurse to document weekly on all wounds using the wound evaluation glow sheet. R203 was admitted to the facility on 4/17/15 with three current pressure ulcers and the facility had not completed a temporary care plan to include treatments and services and provide these services on a consistent basis to promote healing and prevent further ulcers from developing. R203 was asked by surveyor on 4/27/15 at 3:03 p.m. if they had any medical concerns and R203 stated she had open wounds. I just got a cast today located on left lower extremity and that nobody would wrap my leg before the cast. Ulcerations on my bottom are supposed to be treated daily. " Treated one time since a week ago Friday when I came in on 4/17. One dressing change since then. The hospital assured me the treatments would continue but they have not. I know my bottom is a lot sorer. I had terrible diarrhea, it takes 45 minutes to get cleaned up." R203 was observed sitting in her wheelchair, frequently shifting positions while being	F 314		

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F 314	Continued From page 45 interviewed. On 4/28/15 at 9:00 a.m. the director of nursing (DON) was unable to find treatment sheets for dressing changes, but would continue to look. On 4/29/15 at 3:12 p.m. RN-A stated, the treatment record does not list wound dressing changes. RN-A provided a copy of the treatment record which indicated no charting exists for wounds. On 4/17/2015 at 3:25 p.m. R203 was admitted to the facility with admission diagnoses (Order Summary Report dated 4/19/15 active orders as of 4/17/15) including rheumatoid arthritis [chronic, systemic inflammatory disorder that primarily affects joints], ulcer of the lower limb, abscess of anal and rectal regions, pain in ankle and foot joint, and generalized pain. Hospital Dismissal Summary dated 4/17/15 indicates the following skin alterations: 1. Location: left ankle Type: ulcer Treatment: cast 2. Location: left lower extremity Type: ulcer Treatment: cast 3. Location: Anal Type: ulcer Treatment: Nugauze (packing) soaked & cleaned with normal saline 4. Location: Anal Type: ulcer Treatment: Xeroform (petrolatum dressing gauze) cleansed with normal saline covered with Mepilite (self-adhesive absorbent dressing). 5. Location: right lower extremity Type: puncture Treatment: Kerlix (compress applied to a wound to promote healing) Wound Evaluation Flow Sheet dated 4/17/15	F 314		

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F 314	Continued From page 46 completed by RN-B lists the following areas assessed: 1. Abscess of coccyx 1 cm length x 0.2 cm width. Stage 1 pressure ulcer. Current treatment, cleanse cover with Mepiborder (self-adhesive absorbent dressing). No interventions listed. 2. Abscess coccyx 2 cm length x 1 cm width x .3 cm depth. No treatment listed. Current preventative interventions include wheelchair cushion and turn reposition. No time frame listed for repositioning. No ulcer stage/type listed. 3. Abscess coccyx 2 cm length x 1 cm width. Current treatment mepiborder. Current preventative interventions wheelchair cushion, turn and reposition. No times frames listed for repositioning. No ulcer stage/type listed. Wound Evaluation Flow Sheet dated 4/23/15 completed by RN-B lists the following areas assessed: 1. Abscess of coccyx 1 cm length x 0.2 cm width. Current treatment, cleanse cover with Mepiborder (self-adhesive absorbent dressing). No interventions listed. 2. Abscess coccyx 1 cm length x 0.3 cm width x 0.2 cm depth. No treatment listed. Current preventative interventions include wheelchair cushion and turn reposition. No time frame listed for repositioning. 3. Abscess coccyx 1.5 cm length x 0.7 cm width. Current treatment mepiborder. Current preventative interventions wheelchair cushion, turn and reposition. No times frames listed for repositioning. Clinical Health Status dated 4/17/15 3:25 p.m. completed by RN-B section B, skin conditions, indicated three skin concern areas; one a coccyx abscess and two perianal abscesses along with a	F 314		

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F 314	Continued From page 47 note stating "others unable to visualize." Also included was Braden Scale for Predicting Pressure Sore Risk with a total score 16 indicating at risk for developing pressure ulcers. Care plan dated initiated 4/17/2015 includes a focus of "pressure ulcer actual or at risk due to: pressure ulcer present under cast. Has three open areas on coccyx area." No information related to the management of the current pressure ulcers to promote healing or inventions to minimize the risk of development of new pressure ulcers was found on the temporary care plan. No comprehensive assessments provided that included clinical, physical, and environmental risk factors. Clinical Guideline: Skin Integrity dated 2/25/10 read, " page 1 Documentation and Care Interventions for Skin Integrity: If identified risk present the interventions will be documented in the immediate plan of care or comprehensive care plan, initiate positioning schedule to meet the individual resident needs and minimize concentrated pressure to skin, nursing notifies dietary of any newly admitted or acquired pressure ulcers, nutritional assessment determines need for nutritional interventions, documentation completed by registered dietician occurs on initial notification of a new pressure ulcer." Treatment protocol on page 3 provides guidelines to care for stage 2, 3, 4, and unstageable ulcers; does not give the guidelines how to care for stage 1 pressure ulcers. Skin and Wound Care Guidelines, undated, was provided in addition to the clinical guideline.	F 314		

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F 314	Continued From page 48 According to the skin and wound care guidelines "Reddened Area stage 1 treatment options include evaluate pressure reduction methods and for moisture cleanse after each incontinence episode with cleanser or wipes. Apply Dimethicone Barrier or Paste PRN."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess the need for an indwelling Foley catheter for bladder control for 1 of 3 residents (R141) reviewed for indwelling catheters. Findings include: R141's admission record dated 1/28/14 with diagnoses which included: urinary retention, bladder atony, and history of urinary tract infections (UTI). R141's annual Minimum Data Set (MDS) assessment dated 1/27/15, indicated R141 was	F 315	F315 -R141 no longer resides in the facility. -All residents with an indwelling catheter have the potential to be affected by the identified practice. -Nursing staff have been educated on assessing residents with an indwelling urinary catheter for continued need. -Random bi-weekly audits will be conducted to residents with an indwelling catheter have a medical need for ongoing use of same. Any required re-education will be conducted at that time Audits will be reviewed at QAPI and action planned as needed. -Education provided on 5/21, and 621. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015	6/13/15

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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 315	Continued From page 49 cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13 and used an indwelling urinary catheter. R141's care plan last revised on 10/2/14 included the diagnosis of urinary retention, included instructions for routine indwelling catheter care, and directed staff to provide a urology consult as needed. The care plan also instructed staff to use a 14 French Foley catheter, and to change the catheter monthly. R141's hospital dismissal summary dated 1/21/14, indicated hospitalization had been related to diagnoses of clostridium difficile colitis, urinary tract infection, and recurrent urinary tract infection secondary to self-catheterizations. The summary read, "...family expressed concerns that her urinary tract infections are the result of improper technique when self-catheterizing. ...it was decided that an indwelling catheter, despite its associated risks, would be the best option. She preferred this option compared to having home health aides assist her with catheterization two times per day." The summary indicated diagnoses of atonic bladder was discovered on cystoscopy on 2/17/06, and confirmed by an urodynamic study completed on 3/9/06; at which point patient self-catheterization started. R141's physician's visit progress notes dated 6/23/14, 9/8/14, 12/2/14, 2/2/15 and 4/10/15 identified diagnoses of atonic bladder and read, "this was noted on cystoscopy on 2/17/06. Chronic Foley secondary to urinary retention." The physician progress notes did not include the rationale for the use of the indwelling vs. facility staff providing the catheterization twice daily per the previous routine.	F 315		

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F 315	Continued From page 50 R141's Bladder Assessment Form with an initial date of 2/2/14 identified the use of indwelling urinary Foley catheter. The assessment lacked identification of the factors which led to the determination the indwelling urinary Foley catheter was the best option while R141 resided in the nursing home. The assessment form also lacked identification of medication and diagnoses and/or medical conditions that would increase the risk or cause urinary incontinence or retention. The Evaluation for residents with Indwelling Catheters section to determine necessity of an indwelling catheter had not been completed. The assessment was last reviewed and signed on 1/30/15. During an observation on 4/29/15, at 7:52 a.m. R141 was noted to have a urine collection bag appropriately anchored to her right leg. During an interview on 4/29/15, at 7:53 a.m. R41 acknowledged the use of an indwelling catheter. R141 stated, "I used to catheterize myself for years, and then I came here and it became a permanent thing. It's not something I wanted to have in all the time! I would prefer to do the in and out, that I could do myself." During an interview on 5/1/15, at 10:52 a.m. The DON stated the catheter should have been removed when R141 was admitted and a voiding trial attempted and/or a determination of whether the indwelling catheter was the appropriate option once R141 was admitted to the nursing facility. Facility policy, Indwelling Catheter Review last reviewed on 1/5/15 read, "If the resident is admitted/re-admitted with an indwelling catheter,	F 315		

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F 315	Continued From page 51 ensure that resident has an appropriate diagnosis: urinary retention that cannot be medical or surgically corrected, urine contamination of state III or IV pressure ulcer. ...care of terminally ill or severely impaired resident for whom bed a clothing changes are contraindicated." Facility procedure Indwelling Catheter Justification/Decision Diagram instructed staff to obtain a physician's order for removal if criteria for the justification of an indwelling catheter was not met. The diagram further instructed staff to monitor and assess output for 72 hours to determine toileting plan. In addition the decision diagram directed staff to review quarterly for continued need for the indwelling catheter.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess the safe use of a mechanical device (EZ) for 1 of 1 resident (R96) reviewed for transfers; and failed to thoroughly investigate falls to determine causal factors for 1 of 3 residents (R113) who had falls.	F 323	F323 -Causal factors for falls have been identified for R113. R96 has had an assessment completed for safe use of a medical device for transfers. -All residents at risk for falls have the potential to be affected by the identified practice. -Nursing staff have been educated on identifying causal factors for residents with falls. Nursing staff have been educated on needed assessments for safe use of medical devices for transfers. -Education provided on 5/21 and 6/2.	

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F 323	Continued From page 52 Findings include: R96's significant change Minimum Data Set (MDS) dated 3/31/15, indicated R96 was cognitively intact, no behaviors, needs extensive assistance for transfers, bed mobility, activities of daily living and toileting. R96's care plan dated 2/18/15 indicated a diagnosis of paralysis agitans (paralysis agitans, which literally means shaking palsy, Parkinson disease is another term for this disease), acquired torsion dystonia (is a movement disorder in which a person's muscles contract uncontrollably). The care plan also listed a need for an assistive device (mechanical lift). When observed on 4/29/15, at 8:55 a.m. nursing assistant (NA)-G put R96's pants on her legs, assisted with her shirt and placed the mechanical lift in front of her, while R96 was seated on the shower chair. The wheelchair was located on the opposite side of the room. NA-G placed R96's feet onto the lift and placed a pillow between her legs and the lift. NA-G assisted R96 to a standing position on the lift with a strap around her trunk. NA-G instructed R96 to hold onto the handles. NA-G had put a blue pillow between R96's legs and the leg holder of the lift. She instructed R96 to push her hip foreword. R96 started falling, NA-G held onto R96 and told her again to bring her hips forward. R96's legs were not in the proper position on the leg holder due to the pillow being in between. NA-G pulled up R96's pants and rolled her around the room to wheelchair. R96 was leaning way backwards during this process. R96 was lowered into the chair.	F 323	-Random bi-weekly audits will be conducted of incident reports and Post Fall investigations, to ensure causal factors have been identified and proper transfer devices are being used for residents with falls. Audits will be reviewed at QAPI and action planned as needed. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015.	6/13/15

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F 323	Continued From page 53 An interview with NA-G on 4/29/15, at 9:05 a.m. said "she fits well, when she is pushing her legs forward it doesn't work as well." "Some people think it is because of medical reasons but I think it is because she is nervous." NA-G indicated R96 has gotten bruises from the lift, so we put the pillow in between the lift and her legs. An interview with NA-H on 4/29/15, at 2:03 p.m. indicated R96 is transferred with one staff and the EZ stand. NA-H stated a pillow is placed in front of her legs to protect her legs. When interviewed on 4/29/15, at 2:43 p.m. R96 said sometimes my legs get scratched on the lift machine. When interviewed on 4/30/15, at 8:42 a.m. unit manager/registered nurse (RN)-A indicated R96 doesn't want to utilize the Hoyer lift and the facility is a "no lift" facility so staff place a pillow between her (R96) legs and the leg holders. When questioned whether a pillow was the best choice, RN-A indicated the intervention was to pad it but the direction to use a pillow was never stated. It is the persons interpretation of padding when a pillow is utilized. RN-A was unable to determine whether this practice was safe as she had not observed the resident transfer in this manner. RN-A also said therapy discussed this and the use of padding was discussed at morning stand up meeting. There was no direction to use a pillow. When interviewed on 4/30/15, at 9:22 a.m. the occupational therapist (OT)-C and physical therapist (PT)-D indicated they were not entirely sure how the skin tear located on her leg happened; and were told with the tremors R96	F 323		

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F 323	Continued From page 54 caught her leg on the foot peddle of the wheelchair. OT-C and PT-D indicated padding was recommended but never directed staff to use a pillow in the manner used (between R96 and the lift). OT-C said they can't use a pillow with the EZ stand because it is against the manufacturer recommendations. Both agree an assessment had not occurred with the use of the pillow with the EZ stand. During an interview on 4/30/15, at 9:16 a.m. the director of nursing (DON) stated she was unaware of using the pillow when transferring R96. The manufacturer recommendations for EZ lift indicated "do not modify the lift unit." Care plan dated 2/18/15 lists "an assistive device (wc,mech lift)" but does not give any instructions to use a pillow. A lift mobility status assessment dated 2/5/15 indicated R96 was safe to use a "EZ lift." There was no notation on the assessment regarding modification to use a pillow. R113 experienced a fall on 4/16/15. A fall investigation to determine causal factors and on-going appropriateness of the care plan post fall was not evident in the medical record. R113 was admitted on 1/30/12, according to the facility admission record with diagnoses that included but was not limited to dementia, Alzheimer's disease, anxiety, depression, pain in joint pelvic region and thigh, osteoporosis, personal history of fall, hearing loss and difficulty in walking. R113's quarterly Minimum Data Set (MDS) dated 4/10/15, indicated severe cognitive impairment	F 323		

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F 323	Continued From page 55	F 323		

with a Brief Interview for Mental Status (BIMS) score of 6, was independent with ambulation and transfers after set up, balance was steady during transitions and walking, used a cane or crutch, and had sustained two falls without injury since the previous assessment date. The MDS also included R113 had an indwelling urinary catheter.

R113's care plan last reviewed on 3/10/15 read, "at risk for falls related to hx [history] of falls, use of Remeron." Interventions included but were not limited to encourage use of walker, give antianxiety medication per nurse practitioner (NP), use walker when ambulating as he is unsteady at times. The care plan also indicated R113 used a cane for ambulation.

R113's physician orders per the electronic medical record (EMR) included the use of Oxycodone 5 milligrams (mg) two times a day as needed for headaches not relieved by Tylenol; Remeron (anti-depressant medication) 15 mg daily at bedtime; Ativan (anti-anxiety medication) 0.5 mg as needed for agitation/or anxiety two times a day as needed; and Celexa (anti-depressant medication) 20 mg daily. All of these medications could contribute to falling.

R113 has experienced multiple falls between March 2015 and April 2015. R113 sustained two falls on 3/10/15 and one fall on 3/17/15 (Post Fall Analysis/plan had been completed). R113 also had a fall on 3/22/15 according to nursing progress notes but a post fall investigation was not evident in the medical record. The facility was requested to provide the most recent 3 months of fall investigations/incident reports and the investigation related to the 3/22/15, fall and/or report indicating the fall had occurred, and none

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was provided.

A nursing progress note dated 4/16/15 read, "Resident was walking down the hall with his cane and then he got into elevator and gently sat on the floor of the elevator... When up to 2nd floor nursing assistants assisted him to his room by pushing him in a wheelchair."

R113 was observed walking with a cane on 4/29/15, at 8:29 a.m., at 10:52 a.m. and at 11:32 a.m. R113 was not observed to walk with the use of a walker during the survey.

During an interview on 4/30/15, at 2:12 p.m. RN-A explained incidents were logged on a facility software system called DQI. RN-A stated the incident that occurred on 4/16/15 would be considered a fall and confirmed a follow up investigation or report had not been performed. RN-A stated a Post Fall Analysis/Plan should have been completed.

Facility policy Falls Management Guidelines last reviewed 1/22/15 read, "The licensed nurse initiates the DQI Quality Control Report" and "Residents are evaluated for fall risk" and "licensed nurse completes change of condition-Post Fall Analysis following a resident fall."

Facility policy Post Fall Analysis Summary and Guidelines for Completion last reviewed 11/13/14 read, "It is the policy of Living Center to complete the Post Fall Analysis Summary after every known resident fall to assess the individuals condition and to identify the reason and/or risk factor for fall in order to prepare a plan of care to reduce the potential for future falls." The policy included the definition of a fall as "A fall is a

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F 323	Continued From page 57 sudden change in position usually involving the floor or lowering/assisting a resident to the floor..."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure there were adequate indications for continued use of antidepressant medications and/or whether the	F 329	F329 -R4 and R104 have specific target behaviors and non-pharmacologic interventions identified and care planned. Monthly behavior tracking flow sheets have been completed with specific identified target behaviors and non-pharmacologic interventions. -All residents have the potential to be affected by the identified practice. -Nursing staff have been educated on the requirement to document behaviors and non-pharmacologic interventions on the monthly behavior tracking sheets as well as their effectiveness. SSD has been educated to ensure residents receiving psychotropic medication have appropriate documentation in place including appropriate diagnosis, specific target behaviors, non-pharmacologic interventions for the identified target behaviors, and appropriate GDR trials as needed.	

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F 329	Continued From page 58 medications could be gradually reduced with continued effectiveness for 2 of 2 residents (R4 and R104) who were reviewed for unnecessary medication use. Findings include: R4 was admitted to the facility 9/2/13, with diagnoses including depression, according to resident care plan printed 4/29/15. The facility identified R4 on a significant change Minimum Data Set (MDS)assessment dated 4/6/15, to have intact cognition, no behaviors, mood symptom of poor appetite, and required extensive assistance of two staff for activities of daily living. R4's Clinical Health Status form dated 3/9/15, revealed no indicators of depression, no behavioral symptoms, however indicated continued use of antidepressant medications. During interview on 5/1/15, at 10:58 a.m., the director of nursing stated she expected the facility depression scale and cognitive exams to be included on the facility Clinical Health Status form, although none was available. R4's care plan revised 10/8/14, included a focus area of potential for drug related complications related to anti-depressant medication. Interventions included to monitor for side effects, monthly pharmacy reviews, provide medications as ordered and monitor side effects, and risk/benefit and reduction plan as recommended by physician and pharmacist. During observations throughout the survey	F 329	-Random bi-weekly audits will be conducted to residents with an indwelling catheter have a medical need for ongoing use of same. Any required re-education will be conducted at that time Audits will be reviewed at QAPI and action planned as needed. -Education provided on 5/21, and 621. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015	6/13/15

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including, 4/27/15 in the evening, and 4/28/15 during the day, R4 was observed in her room and about the facility in her electric wheelchair. No mood symptoms were observed.

During interview on 4/29/15, at 7:52 a.m., nursing assistant (NA)-C stated R4 had mood symptoms of being irritable. NA-C stated interventions used that were sometimes effective included to talk with R4 and re-approach later.

Document review of physician orders signed 4/14/15, revealed orders for citalopram (celexa) an anti-depressant medication, 40 milligrams daily. The physician orders directed to observe for adverse reactions that included nausea, dry mouth, somnolence, insomnia, sweating, tremor, diarrhea, anxiety, and nervousness.

Document review from 4/1-4/30/15 revealed no symptoms of depression had been exhibited.

Although the facility had documentation of quarterly psychosocial progress note dated 1/20/15, which also revealed no moods and no behaviors except "occasionally feels down", there were no current notes regarding the resident's continued use of the antidepressant. There were no recommendations for an attempt at a gradual dose reduction of the antidepressant even though the resident was not exhibiting symptoms.

According to the Admission Record, R104 had

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been admitted to the facility 10/21/11with diagnoses including: depressive type psychosis, depressive disorder and dementia with behavioral disturbance. A review of the Physician Orders revealed an order for the use of Zoloft 75 milligrams (mg) daily for "behavior dyscontrol related to depressive disorder." The Pharmacist Medication Review Summary indicated the Zoloft had been increased in September of 2014.

R104's 2/3/15, quarterly MDS identified the resident as severely cognitively impaired; displayed no mood indicators; however had experienced behavioral symptoms directed at others including wandering 1-3 days during the assessment period. The quarterly MDS indicated R104 was dependent on staff to perform activities of daily living.

A Clinical Status Health form dated 2/3/15, indicated the resident wandered but had no indicators of depression.

A quarterly Psychosocial Progress Note dated 2/17/15, also indicated R104 displayed no mood indicators.

R104's care plan dated 2/22/15, noted the resident had dementia, was at risk for an alteration in behaviors, and had an alteration in her mood.

A review of the Resident Behavior Log & Behavior Detail Report for R104 from 4/1-5/1/15 revealed only wandering behaviors had occurred.

There was no documentation in the record to indicate whether the resident continued to have depressive symptoms which would require the

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F 329	Continued From page 61 continued use of the increased dose of Zoloft. During interview on 5/1/15, at 10:58 a.m. director of nursing stated she expected staff to complete appropriate monitoring for depression and cognition, as well as pertinent medication side effect monitoring. During interview on 4/29/15, at 7:19 a.m., the director of nursing (DON) verified the facility lacked consistent monitoring of mood symptoms and target behaviors for residents who received mood and behavior medications. The DON verified behavior and mood monitoring was inconsistently documented in order to determine the continued need for the use of psychoactive medications, including antidepressants, at the current dose. On 5/4/15 at 4:40 p.m. via telephone, the consultant pharmacist reported it was his expectation facility staff would consistently monitor residents' mood and or behaviors to determine the continued need for the medications. The facility's Mood/Behavior Management policy read, "The social services coordinator, as facilitator, will ensure that the Behavior Committee utilizes the existing systems of monitoring the frequency and circumstances surrounding behaviors, including Care Tracker, MAR (medication administration record), 24 hour report, Incident Reports to assist in determining the following: symptoms, cause, patterns, and severity of the behavior."	F 329		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS	F 334		

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GOLDEN LIVINGCENTER - ROCHESTER EAST	501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904

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F 334	Continued From page 62 The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334	F334 -Flu consent has been completed for R7. -All residents receiving influenza vaccine have the potential to be affected by the identified practice. -Licensed nursing staff have been educated to obtain consent prior to administration of influenza vaccine and provide vaccine information to resident/families. -Audits will be completed on new admissions for proper consent prior to vaccine administration. Audits will be reviewed at QAPI and action planned as needed. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015	6/13/15

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F 334	Continued From page 63 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain influenza consent prior to administering the influenza vaccine for 1 of 5 residents (R7) reviewed for influenza immunizations. Findings include: R7 lacked evidence that they had been educated regarding the risks and benefits and potential side effects prior to receiving the immunization on	F 334		

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F 334	Continued From page 64 10/22/14. An influenza immunization form, which documented informed consent, was not available in the medical record of R7. Documentation in the medical chart identified that R7 received an influenza vaccine while in the facility on 10/22/14. On 4/30/15, at 5:48 p.m. the administrator provided an influenza consent form dated 3/26/13 but verified the consent form provided prior to the 10/22/14 influenza vaccine was not available. Influenza/Pneumococcal immunization guideline last updated 12/1/14, read, "The Resident Annual Consent or Declination Form will be signed each year as proof that education of risk/benefits was provided on the influenza vaccine. Verbal consents that are documented will suffice...The original copy of the immunization consent or declination form will be maintained on each resident's current medical record in the same section as the Immunization log. Verify that consent was given for the resident to receive the vaccine and that education of the risks and benefits was provided."	F 334		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services	F 425	F425 -R203 no longer resides in the facility. R63 is receiving pain medications as ordered by the physician. -All residents receiving medication have the potential to be affected. -Licensed staff have been educated on medication errors and medication administration to include obtaining ordered medications and timely administration. -Education provided on 5/21 and 6/2. -Daily review of medication administration will be conducted for timely administration and/or potential medication errors.	

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F 425	Continued From page 65 (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain medications for pain management in a timely manner for 2 of 2 residents (R203, R63) reviewed for pain. Findings include: During an interview with R203 on 4/27/15 at 3:03 p.m., she reported to the surveyor that her narcotic pain medications had not been received by the facility on the day of admission. The Admission Record sheet indicated R203 had been admitted to the facility on 4/17/15 with orders for Oxycodone 15 milligrams (mg) one tablet daily by mouth and Oxycodone 15 mg one half a tablet by mouth every four hours as needed for pain. According to facility documentation including a fax Transmission Verification Report, the prescriptions had been faxed to Alixa (pharmacy) on 4/17/15 at 4:16 p.m.	F 425	Negative findings will be addressed at that time. Results will be reviewed at QAPI. -DNS/Designee will be responsible party. Corrective action will be completed by 6-13-2015	6/13/15

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F 425	Continued From page 66 Medication adminsitration record and nursing notes reviews for R203 verified there had been no receipt of the Oxycodone 4/17/15. Although MAR documentation revealed staff had provided R203 with Tylenol 500 mg 2 tablets, and Ibuprofen 400 mg, during the evening of 4/17/15, and that the resident had received some relief; the facility had ultimately sent R203 to the emergency room to receive the Oxycodone they'd been unable to receive from the pharmacy. According to the hospital Emergency Record Clinical Note from 4/18/15, "She [R203] had not received her narcotics for pain since she arrived at the NH [nursing home] yesterday afternoon, ultimately this is what is causing her low grade tactile temps, chills, flushing, and abdominal pain. Narcotic pain prescriptions were rewritten and given to the patient to carry back to the NH and calls [by ER nurse] were placed to reinforce the staff awareness of the written prescriptions that were accompanying the patient back to the NH setting." On 4/28/15 at 9:00 a.m. the Director of Nursing (DON) stated she was aware of the pain medication issue. She verified it had been an issue with the fax scripts for Alixa pharmacy. During a telephone interview with consultant pharmacist on 5/4/15 at 4:40 p.m. he stated he expected the facility to have emergency medications available in the facility and to use the emergency medications that are in the facility. Policy titled, Medication Administration--Preparation and General Guidelines section 7.2 dated 5/12 section A #11	F 425		

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F 425	Continued From page 67 indicates; if a medication with a current, active order cannot be located, the pharmacy was contacted or medication was to be removed from the night box/emergency kit. Policy titled, Miscellaneous Special Situations Unavailable Medications section 6.10 dated 5/12 indicates; "the facility must make every effort to ensure that medications are available to meet the needs of each resident. Section B indicates nursing staff shall 1) notify the attending physician of the situation and explain the circumstances, expected availability and optional therapy(ies) that are available. 2) Obtain a new order and cancel/discontinue the order for the non-available medication. 3) Notify the pharmacy of the replacement order. " R63 had chronic pain and physician ordered Lidoderm patch (slow release pain medication) was not available due to not reordering the medication timely which decreased pain control for R63. R63 had diagnosis of shoulder region join pain, pain in soft tissues in limb, backache, difficulty with walking, osteoporosis, and osteoarthrosis according to the facility admission record. R63's quarterly Minimum Data Set (MDS) dated 3/3/15 indicated moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of eight, and R63 frequently had pain during the assessment period and received scheduled pain medication. Signed physician orders dated 2/23/15 included Lidoderm patch 5% (lidocaine) apply to neck/shoulder/rib topically every 12 hours for	F 425		

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F 425	Continued From page 68 pain, leave on for 12 hours in a 24 hour period then remove. During an observation of a medication pass on 4/29/15, at 7:37 a.m. LPN-Z stated R63 did not have any Lidoderm patches left in his supply and she would have to contact pharmacy to order more. During an interview on 4/29/15, at 12:00 p.m. LPN-Z stated the pharmacy had been contacted and would be delivered the Lidoderm patch later that evening. R63's Medication Administration Record (MAR) instructed staff to apply the Lidoderm patch at 8:00 a.m. and remove the patch at 8:00 p.m. The MAR further indicated Lidoderm patch was not applied on 4/29/15 and referred to a nursing progress note. Nursing progress note dated 4/29/15 read, "Medication not available will be delivered tonight per pharmacy." During an interview on 4/29/15, at 5:19 p.m. R63 reported he had not had an increase in pain and was not aware what the pain patch was for, however stated the patch was for his shoulders. R63 stated the patch was on (with the resident's consent, the patch was observed not to be on by this writer). R63 did not recall being informed by the nurse the patches were not available. During an interview on 4/30/15, at 8:26 a.m. registered nurse (RN)-A stated a medication error report had not been filled out for the omission of the Lidoderm Patch. RN-A stated a medication error report should have been filled out and reported to the physician. During an observation of a medication pass on 4/30/15, at 8:26 a.m. licensed practical nurse (LPN)-C was asked if the Lidoderm had been	F 425		

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F 425	Continued From page 69 delivered for R63. LPN-C took out a box of Lidoderm patches, the pharmacy label on the box was not for R63. The box also had a plastic bag that contained 4 Lidoderm patches, the label on the bag was not for R63. Then LPN-C took out the last few patches in the box that were behind the bag and stated the patches belonged to R63, and explained they had been taken out of the original packages and put with the other ones. LPN-C stated she had put a new Lidocain patch on R63 earlier today. During an interview on 4/30/15, at 9:42 a.m. director of nursing (DON) stated it was not good practice to remove medication from the original packaging with the pharmacy label. DON stated the medication should have been re-ordered at least two or three days prior to the medication running out. Staff administered additional Ativan (anti-anxiety medication) doses; and did not follow the order prescribed by the physician. In addition a medication error report was not completed, and physician notification of medication error was not evident.	F 425		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F428 -Consultant pharmacist has reviewed medication regimen for R4 and R104. Recommendations have been addressed by primary MD. -All residents receiving medication have the potential to be affected. -Consultant pharmacist has been educated on reviewing medication regimen for unnecessary medications.	

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F 428	Continued From page 70 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the consultant pharmacist identified irregularities in medication regimen review 2 of 5 residents (R104, R4) reviewed for unnecessary medications. Findings include: On 5/4/15 at 4:40 p.m. via telephone, the consultant pharmacist reported it was his expectation facility staff would consistently monitor residents' mood and or behaviors to determine the continued need/effectiveness of the medications. The facility's Mood/Behavior Management policy included: "The social services coordinator, as facilitator, will ensure that the Behavior Committee utilizes the existing systems of monitoring the frequency and circumstances surrounding behaviors, including Care Tracker, MAR (medication administration record), 24 hour report, Incident Reports to assist in determining the following: symptoms, cause, patterns, and severity of the behavior." According to the Admission Record, R104 had been admitted to the facility 10/21/11with diagnoses including: depressive type psychosis, depressive disorder and dementia with behavioral disturbance. A review of the Physician Orders revealed an order for the use of Zoloft 75 milligrams (mg) daily for "behavior dyscontrol related to depressive disorder." The Pharmacist	F 428	-Monthly audit will be conducted after pharmacist medication review. Negative findings will be reviewed at QAPI. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015	6/13/15

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F 428	Continued From page 71 Medication Review Summary indicated the Zoloft had been increased in September of 2014. R104's 2/3/15, quarterly MDS identified the resident as severely cognitively impaired; displayed no mood indicators; however had experienced behavioral symptoms directed at others including wandering 1-3 days during the assessment period. The quarterly MDS indicated R104 was dependent on staff to perform activities of daily living. A Clinical Status Health form dated 2/3/15, indicated the resident wandered but had no indicators of depression. A quarterly Psychosocial Progress Note dated 2/17/15, also indicated R104 displayed no mood indicators. R104's care plan dated 2/22/15, noted the resident had dementia, was at risk for an alteration in behaviors, and had an alteration in her mood. A review of the Resident Behavior Log & Behavior Detail Report for R104 from 4/1-5/1/15 revealed only wandering behaviors had occurred. There was no documentation in the record to indicate whether the resident continued to have depressive symptoms which would require the continued use of the increased dose of Zoloft. During interview on 5/1/15, at 10:58 a.m. director of nursing stated she expected staff to complete appropriate monitoring for depression and cognition, as well as pertinent medication side effect monitoring.	F 428		

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F 428	Continued From page 72 During interview on 4/29/15, at 7:19 a.m., the director of nursing (DON) verified the facility lacked consistent monitoring of mood symptoms and target behaviors for residents who received mood and behavior medications. The DON verified behavior and mood monitoring was inconsistently documented in order to determine the continued need for the use of psychoactive medications, including antidepressants, at the current dose. R4 was admitted to the facility 9/2/13, with diagnoses including depression, according to resident care plan printed 4/29/15. The facility identified R4 on a significant change Minimum Data Set (MDS)assessment dated 4/6/15, to have intact cognition, no behaviors, mood symptom of poor appetite, and required extensive assistance of two staff for activities of daily living. R4's Clinical Health Status form dated 3/9/15, revealed no indicators of depression, no behavioral symptoms, however indicated continued use of antidepressant medications. During interview on 5/1/15, at 10:58 a.m., the director of nursing stated she expected the facility depression scale and cognitive exams to be included on the facility Clinical Health Status form, although none was available. R4's care plan revised 10/8/14, included a focus area of potential for drug related complications related to anti-depressant medication. Interventions included to monitor for side effects,	F 428		

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F 428	Continued From page 73 monthly pharmacy reviews, provide medications as ordered and monitor side effects, and risk/benefit and reduction plan as recommended by physician and pharmacist. During interview on 4/29/15, at 7:52 a.m., nursing assistant (NA)-C stated R4 had mood symptoms of being irritable. NA-C stated interventions used that were sometimes effective included to talk with R4 and re-approach later. Document review of physician orders signed 4/14/15, revealed orders for citalopram (celexa) an anti-depressant medication, 40 milligrams daily. The physician orders directed to observe for adverse reactions that included nausea, dry mouth, somnolence, insomnia, sweating, tremor, diarrhea, anxiety, and nervousness. Document review from 4/1-4/30/15 revealed no symptoms of depression had been exhibited. Although the facility had documentation of quarterly psychosocial progress note dated 1/20/15, which also revealed no moods and no behaviors except "occasionally feels down", there were no current notes regarding the resident's continued use of the antidepressant. There were no recommendations for an attempt at a gradual dose reduction of the antidepressant even though the resident was not exhibiting symptoms.	F 428	F431 -R36 no longer resides in the facility. R4 insulin has been replaced. Expired medication has been removed from the medication carts and medication rooms. Medications are being disposed of properly. Controlled medications are being documented when dispensed. -All residents receiving medications have the potential to be affected by this deficient practice.	
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all	F 431		

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F 431	Continued From page 74 controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to remove insulin pens that were expired for 2 of 9 residents (R36, R4) receiving insulin on the 2nd floor; failed to remove expired stock medications from potential use from 2 of 2 medication carts, 1 of 1	F 431	-Licensed staff have been educated on checking expiration dates prior to dispensing, proper disposition of medications, and documentation of administration. -Random audits will be performed on medication carts weekly to check for expired medications, proper disposition of medications, and documentation of administration. Negative findings will be reviewed at QAPI. -DNS/Designee is the responsible party. -Corrective action will be completed by 6-13-2015.	6/13/15

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F 431	Continued From page 75 medication storage room located on the 2nd floor and from 1 of 1 medication storage room located on the 3rd floor when reviewed during medication storage observation. In addition, the facility staff failed to dispose of contaminated medication properly, during medication storage observation on 1 of 3 facility floors. In addition, the facility failed to ensure controlled medications were documented when dispensed from 1 of 2 medication carts located on the 2nd floor when reviewed. This had the potential to affect all 86 residents who reside on the second and third floors. Findings include: During the medication review of the 3rd floor medication storage room on 4/28/15, at 10:00 a.m. an opened stock bottle of Bisacodyl (medication to treat constipation) was noted with an expiration date of 12/2014. It was currently available for use. During the medication storage review of the 2nd floor East medication cart on 4/29/15, at 7:40 a.m. with trained medication assistant (TMA)-A, the following was noted: (1) A Novolog (insulin used to treat diabetes) multidose pen for R36 had a dispensed date from the pharmacy of 2/20/15 and was labeled with an opened date of 3/7/15. R36's physician orders directed staff to give Novolog solution 100 unit/milliliter (ml) per sliding scale, before meals and at bedtime. (2) A Novolog Flex multidose pen for R4 had a dispensed date from the pharmacy of 3/10/15 and was labeled with an opened date of 3/21/15.	F 431		

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	245184	A. BUILDING _____ B. WING _____	05/04/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 76 R4's physician orders directed staff to give Novolog PenFill solution cartridge 100 unit/ml per sliding scale, before meals. When interviewed on 4/29/15, at 7:40 a.m. TMA-A indicated multidose insulin pens were "Generally good for 30 days after being opened." TMA-A verified the insulin pens were past the 30 days and were expired and indicated the nurses were responsible for taking care of and giving the insulin. A review of R36's medication administration record (MAR), revealed R36 received insulin from the insulin pen, four times a day, for 25 days, after the insulin pen was expired. A review of R4's MAR, revealed R4 received insulin from the insulin pen, three times a day, for 11 days, after the insulin pen was expired. (3) A stock bottle of One Daily multivitamins had an expiration date of 3/15. The bottle was labeled as opened on 4/23/15. TMA-A verified although the multivitamins were expired, the bottle remained in the cart, ready for use. TMA-A indicated all staff who administered medications were responsible for checking expiration dates and removing expired medications from the cart. During an observation on 4/29/15, at 8:07 a.m., licensed practical nurse (LPN)-C moved the location of the 2nd floor West medication cart, to retrieve an unidentified pill on the floor, located underneath the cart. LPN-C retrieved the pill from the floor, placed it inside a plastic bag, crushed it and threw the small plastic bag with the crushed pill into the trash bin located on the side of the medication cart. When interviewed immediately after the incident, LPN-C stated she dropped the pill on the floor so she, "Crushed it	F 431		

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F 431	Continued From page 77 and put it in the trash." When asked about the process for disposing contaminated medications, LPN-C shrugged her shoulders, and indicated she didn't know. LPN-C stated, "I'm just a temp...I had one day of orientation. I don't know what their policy is." During the medication storage review, on 4/29/15, at 2:11 p.m. of the 2nd floor West medication cart with LPN-C the following was noted: (1) A stock bottle of One Daily multivitamins with an expiration date of 3/15. LPN-C verified, although the multivitamins were expired, the bottle remained in the cart, ready for use. (2) When reviewing and reconciling narcotics located on the 2nd floor West medication cart, LPN-C took the narcotic book, flipped the pages one by one and signed her name to some of the pages. When asked about her practice, LPN-C stated she signed all of the narcotics she had given throughout the day, at the end of her shift. LPN-C stated, "That's what I do." When reconciling R82's Morphine Sulfate 60 milligrams (mg), there were 87 pills in the punch pack, although the narcotic book revealed there were 88 pills. LPN-C stated, "That's because I gave one and haven't signed it out yet." When reconciling R82's Morphine Sulfate 30 mg, there were 80 in the punch pack, although the narcotic book revealed there were 83 pills. LPN-C stated, "That's because I gave him three today, and I haven't signed them out yet." When asked how she knows the narcotic count is accurate, LPN-C stated, "I like to count them by myself before I count with the nurse at shift change." During the medication storage review of the medication storage room located on the 2nd floor on 4/29/15, at 2:40 p.m. with LPN-C, three stock	F 431		

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F 431	Continued From page 78 bottles of One Daily multivitamins were noted with an expiration date of 3/15. LPN-C verified, although the multivitamins were expired, the bottle remained on the shelf, ready for use. A vial of Aplisol tuberculin was noted in the medication refrigerator. The vial was opened, but not dated. LPN-C indicated she didn't know when it was opened and verified that it should have been dated. LPN-C verified the Aplisol was used for new admissions to the facility and was stored in the refrigerator, ready for use. During an interview on 4/30/15, at 1:39 p.m., director of nursing (DON) concurred expired medications should not be used and medications should be labeled with the date opened. DON stated, "They're not rotating our stock [medications] in our central supply," and she indicated she had removed all of the expired medications. DON stated, "Medications should not be thrown in the garbage," but stated she didn't how the facility disposed of unused or contaminated medications. DON also stated, "Narcotics should be signed [in the narcotics book] when given." A review of the package insert for Novolog cartridges revealed, "Once a cartridge or Novolog FlexPen or Novolog FlexTouch is punctured, it should be kept at temperatures below 30°C (86°F) for up to 28 days..." A review of the facility's Medication Administration Preparation and General Guidelines policy, dated 5/12, included, during medication administration, "The expiration date on the packaging/container is checked." A review of the facility's Medication Destruction	F 431		

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F 431	Continued From page 79 policy, dated 5/12, included, "Unused, unwanted and non-returnable medications should be removed...Mix drugs with an undesirable substance, such as cat litter or used coffee grounds...The provider pharmacy is contacted if the facility is unsure of proper disposal methods for a medication..." A review of the facility's Storage of Medications policy, dated 5/12, included, "Certain medications or package types, such as...multiple dose injectable vials..., once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency." Also included, "When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. ..The nurse will check the expiration date of each medication before administering it...No expired medication will be administered to resident...All expired medication will be removed from the active supply and destroyed in the facility, regardless of amount remaining..." A review of the facility's Controlled Substances policy, dated 5/12, included, "Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled drug is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration... 2) Amount administered...3) Remaining quantity...4) Initials of the nurse administering the dose, completed after the medication is actually administered..."	F 431		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=F	Continued From page 80 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their 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.	F 441	F441 -Infection control program has been established to include surveillance of infections and antibiotic use including monitoring, outcome, and data analysis. R51 wound is being protected from contamination. -All residents have the potential to be affected by the deficient practice. -Licensed staff have been educated on infection control measures. DNS has been educated on infection control program components. -Random audits of infection reports will be completed bi-weekly. Bi-weekly wound rounds will be conducted to insure wounds are protected from contamination. Audit results will be reviewed at QAPI. -Education provided on 5/21 and 6/2. -DNS/Designee will be responsible party. -Corrective action will be completed by 6-13-2015	6/13/15

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F 441	Continued From page 81 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility infection control program lacked evidence that resident infections were monitored so that surveillance and investigation to prevent the spread of infection occurred through an active infection control program and failed to ensure an open wound was protected from contamination for 1 of 5 residents (R51) with wound treatments. This had the potential to affect staff, visitors and all residents who reside in the facility. Findings include: Lack of a functioning infection control program: Infection control documentation provided to surveyors included documentation for the months of February, March and April 2015. When the Line Listing of Resident Infections form was reviewed for February, March and April 2015, documentation lacked any tracking, analyzing and outcome surveillance process that consisted of collecting/documenting data on individual cases and comparing the collected data. The infections on the log did not have documentation that a culture of the infection was completed to identify the correct antibiotic was prescribed or whether the infection resolved. Documentation related to the analysis of resident infections to determine whether the treatment was effective to reduce the spread of infection was requested but none provided. On 4/27/15 at 2:53 p.m. the director of nursing	F 441		

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F 441	Continued From page 82 (DON) stated the following regarding infection control documentation, " I'm working on April [2015] now. I just got February and March done now." When questioned who would be knowledgeable about infection control surveillance and activity prior to February 2015, the DON replied, "There probably isn't anyone. There has been like a 30 day turnover here." On 5/1/15 at 10:27 a.m. the DON verified there was no documentation of infection control surveillance. The DON also stated, "Normally we would put a map in the infection control book. It's too late to analyze, so mapping will have to start doing in May. We were doing one thing at a time one line at a time to get what we could done." "We make sure they have a culture if they need one to make sure it is the right antibiotic, no allergies, and if they have been on it [antibiotic] in the last 30 days so they don't have a pattern, is it working or not working. Before the antibiotic [for urinary tract infections] try cranberry tabs, fluids, and vitals. Sometimes we do a follow up if they have no more signs and symptoms, depends on the doctor's orders, the NP [nurse practitioner] usually evaluates when they are here. Symptoms to look at, vitals every day and their patterns. Look at the confusion, is it from meds, possibly neuro checks, intake and output." R51 was observed to have open wounds and was seated on a soiled pad with wound in contact with soiled pad: During an observation on 4/29/15, at 2:15 p.m. licensed practical nurse (LPN)-A pulled off a brown adhesive dressing from R51's right buttock while he was standing on the mechanical lift. The surrounding skin of the bilateral open wounds was deep red with some excoriation and irritation present. Without completion of the dressing	F 441		

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F 441	Continued From page 83 change, R51 was then lowered unto a soiled pad located on the recliner. During an interview on 4/29/15, at 5:57 p.m. nursing assistant (NA)-B stated she had worked the day shift and had provided morning cares to R51 around 7:00 a.m. which included peri care and a partial bed bath. NA-B indicated that during morning cares the dressings had come off from the wounds located on the buttock and wounds had not been redressed before seating back in chair. NA-B stated she assisted R51 at 12:00 p.m. and there was blood evident on the protective pad. NA-B explained a nurse shortly afterwards applied dressings to the wounds, after it had been requested at 12:00 p.m.. NA-B stated there had not been dressings on the wounds since they had fallen off that morning. During an interview on 5/4/15, at 4:40 p.m. the DON concurred that sitting in a chair with no dressing covering the wound would cause contamination to the wounds. In addition, the DON indicated that if the dressing change could not be completed, the open areas should have been covered with something.	F 441		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment	F 520		

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F 520	Continued From page 84 and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to hold quarterly Quality Assurance and Process Improvement committee meetings. This had the potential to affect all 99 residents in the facility. Findings include: Quality Assurance and Process Improvement [QAPI] committee documentation provided to surveyors lacked documentation for the months of 8/2014 through 2/2015 for having had a QAPI meeting. On 5/1/15 at 1:02 p.m. the Director of Nursing (DON) stated,"There is nothing in between there [QAPI meetings]. I put them in motion when I was here last, you have to ask [the] administrator maybe he has information for you." On 5/1/15 at 1:08 p.m. the administrator stated, "We had ad-hoc meetings but not a full QAPI	F 520	F520 -QAPI meetings are being held per regulatory guidelines. -QAPI members have been educated on the requirements for meetings. -Education will be provided by 6/13/2015. -Audits will be completed monthly to insure QAPI meetings are being held per regulatory requirements. -ED/Designee will be responsible party. -Corrective action will be completed by 6-13-2015.	6/13/15

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F 520	Continued From page 85 meeting. The former DON and medical director did attend but we didn't document." The administrator verified there was no documentation of QAPI meetings from 8/2014 through 2/2015. On 5/4/15 at 4:30 p.m. the administrator stated, the QAPI committee had not written action plans to direct the quality improvement projects.	F 520		

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Golden Livingcenter - Rochester East was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or	K 000	POCok 6-5-15 RECEIVED JUN - 4 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 6-13-15

EXIT: 5-4-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawn Mutch — TITLE: Executive Director — (X6) DATE: 6-3-15

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Golden Livingcenter - Rochester East, is a 3-story building with a full basement. The facility was built in 1968 and was determined to be of Type II(222) construction. The facility is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 116 beds and had a census of 100 beds at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000	K 000 Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in the response and Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 054		

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GOLDEN LIVINGCENTER - ROCHESTER EAST	**501 EIGHTH AVENUE SOUTHEAST ROCHESTER, MN 55904**

(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 054	Continued From page 2 All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed maintain the fire alarm system in accordance with the requirements of 2000 NFPA 101, Chapters 19.3.4.1, 9.6.1.4, 1999 NFPA 72, Section 7. The deficient practice could affect all 100 residents. Findings include: On facility tour between 8:30 AM and 12 noon on 04/28/2015, the review of the annual fire alarm inspection and testing report from Custom Alarm, dated 02/16/2015, indicated that the following was found: 1. Count of devices and devices tested did not equal each other; 2. There is a separate fire alarm panel for elevator recall but no report for that panel 3. Unknown if both fire alarm panels (4002 & 4010 simplex) are interconnect for monitoring purposes These deficient practices were confirmed by the Facility Maintenance Director (RE) at the time of discovery.	K 054	K54 Custom Alarm reports will be reviewed by Custom Alarm and corrected for smoke alarm and sensitivity testing numbers to reflect true results. Anew report has been generated and issued to facility which include test results of the elevator panel. Custom Alarm, All City Elevator and State Fire Marshall Gary Schroeder verified on Friday, May 15th that both panels and all systems are properly functioning per life safety code. 6-13-15	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating	K 062		

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	245184	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/28/2015**

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K 062	Continued From page 3 condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to maintain the fire sprinkler system in accordance with the requirements of 2000 NFPA 101, Sections 19.3.4.1 and 9.6, as well as 1998 NFPA 25. This deficient practice could affect all 30 out of 100 residents Findings include: On facility tour between 8:30 AM and 12 noon on 04/28/2015, observation revealed that the following were found: 1. 3rd floor - elevator lobby, quick response and standard response fire sprinkler heads are intermixed; 2. Review of the annual inspection report from Viking, dated 8/22/14 stating "it appears there maybe (2) dry sidewall heads in front entry that are over 10 years old and need to be replaced" at this time and date this hasn't been verified or corrected. These deficient practices were confirmed by the Facility Maintenance Director (RE) at the time of discovery.	K 062	K62 Viking Sprinkler has replaced the standard response sprinkler heads with quick response heads that were intermixed in the smoke compartment. The dry sidewall sprinkler heads that appeared to be over 10 years old have been replaced with new dry sidewall sprinkler heads. 6-13-15	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		

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K 069	Continued From page 4 with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility's kitchen gas piping was not installed accordance with 2000 NFPA 101 - Sections 19.3.5 and 9.7 and 1998 NFPA 96 section 9-1.2. The deficient practice could affect all 100 residents. Findings include: On facility tour between 8:30 AM and 12 noon on 04/28/2015, observation revealed that the main horizontal gas line feeding the kitchen appliances under the kitchen hood is being supported by a chain connect to a piece of conduit running across the bottom of the kitchen hood. This deficient practice was confirmed by the Facility Maintenance Director (RE) at the time of discovery.	K 069	K69 The main horizontal gas liine for the kitchen appliances has been affixed in a proper way to an upright that has been bolted to the kitchen floor.	6-13-15
K 143 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and	K 143	K143 The oxygen transfill room will have the current exhaust fan taken out of service and the opening to building ductwork will be sealed off from the oxygen room. The window in the transfill room will be removed and the op0ening will be closed with fire resistant materials. A new continuous running exhaust fan will be installed in the room that will be directly vented to the exterior of the building.	6-28-15 ~~7-30-15~~

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K 143	Continued From page 5 (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to assure oxygen transfill room is vented as required by 1999 NFPA 99. The deficient practice could affect all 100 residents. Findings include: On facility tour between 8:30 AM and 12 noon on 04/28/2015, the Maintenance Director (RE) when asked could not verify that the oxygen transfill room was directly vented to the outside. Upon further investigation it was found not to be vented outside. This deficient practice was confirmed by the Facility Maintenance Director (RE) at the time of discovery.	K 143	K143 The oxygen transfill room will have the current exhaust fan taken out of service and the opening to building ductwork will be sealed off from the oxygen room. The window in the transfill room will be removed and the op0ening will be closed with fire resistant materials. A new continuous running exhaust fan will be installed in the room that will be directly vented to the exterior of the building. 6-13-15	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144	K144 A new generator transfer switch that is programmable has been installed to replace older defective transfer switch. This new switch has been programmed to run an additional 5 minutes of cool down time after transfer of load back to utility power to reflect life safety code requirements. In addition, our generator text sheet has had an additional test result added to show how many minutes the generator has been run during cool down time during monthly testing. 6-13-15	

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K 144	Continued From page 6 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6.- 4.4(d). The deficient practice could affect all 100 residents. Findings include: On facility tour between 8:30 AM and 12 noon on 04/28/2015, documentation review of the past 12 monthly generator logs, revealed that (5 out 12 months) there was no documentation for cool down time of emergency generator. This deficient practice was confirmed by the Facility Maintenance Director (RE) at the time of discovery.	K 144	K144 A new generator transfer switch that is programmable has been installed to replace older defective transfer switch. This new switch has been programmed to run an additional 5 minutes of cool down time after transfer of load back to utility power to reflect life safety code requirements. In addition, our generator text sheet has had an additional test result added to show how many minutes the generator has been run during cool down time during monthly testing.	6-13-15
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain electrical outlets in accordance with the requirements of 2000 NFPA 101 - 19.5.1, 9.1.2, 1999 NFPA 70 and 2007 MSFC. The deficient practice could affect 25 out of 100 residents.	K 147	K147 The electrical outlet has been affixed in a proper way to an upright that has been bolted to the kitchen floor.	6-13-15

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K 147	Continued From page 7 Findings include: On facility tour between 8:30 AM and 12 noon on 04/28/2015, observation revealed, that in the 1st floor kitchen -behind the cooking stove is an electrical outlet on flex conduit that is attached to another pipe by electrical tape. This deficient practice was confirmed by the Facility Maintenance Director (RE) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 147	K147 The electrical outlet has been affixed in a proper way to an upright that has been bolted to the kitchen floor. 6-13-15	