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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W9DH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00968

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245281**

2.STATE VENDOR OR MEDICAID NO.
(L2) **198148100**

3. NAME AND ADDRESS OF FACILITY
(L3) **VALLEY CARE AND REHAB LLC**
(L4) **600 FIFTH STREET SOUTHEAST, BOX 129**
(L5) **BARNESVILLE, MN** (L6) **56514**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/01/2015**

6. DATE OF SURVEY **12/20/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)
13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(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 :
Tammy Williams, HFE - NE II 12/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 01/12/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
07/01/1985
(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.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/22/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 29, 2017

Mr. Mark Rustad, Administrator
Valley Care And Rehab LLC
600 Fifth Street Southeast, PO Box 129
Barnesville, MN 56514

RE: Project Number S5281028

Dear Mr. Rustad:

On November 7, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 19, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 20, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 30, 2017 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 October 19, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 28, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 19, 2017, effective November 28, 2017 and therefore remedies outlined in our letter to you dated November 7, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W9DH

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Facility ID: 00968

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(L3) **VALLEY CARE AND REHAB LLC**
(L4) **600 FIFTH STREET SOUTHEAST, BOX 129**
(L5) **BARNESVILLE, MN** (L6) **56514**

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) **11/01/2015**

6. DATE OF SURVEY **10/19/2017** (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**	
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04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

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To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE-NE II 11/30/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforecment Specialist 12/22/2017 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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07/01/1985
(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
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03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
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OTHER
07-Provider Status Change
00-Active

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(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/22/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered November 7, 2017

Mr. Mark Rustad, Administrator
Valley Care and Rehab LLC
600 Fifth Street Southeast
Barnesville, MN 56514

RE: Project Number S5281028

Dear Mr. Rustad:

On October 19, 2017, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required.

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

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

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

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

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 November 28, 2017, 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 November 28, 2017 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 19, 2018 (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 April 19, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

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
	245281	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(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 On 10/19, 2017, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance.	F 000		
F 156 SS=C	NOTICE OF RIGHTS, RULES, SERVICES, CHARGES CFR(s): 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication. (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section.	F 156		11/28/17

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

Electronically Signed | 11/17/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(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 156	Continued From page 1 The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245281	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(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 156	Continued From page 2 not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.	F 156		

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	245281	A. BUILDING _____ B. WING _____	10/19/2017

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F 156	Continued From page 3 (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community. (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.	F 156		

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F 156	Continued From page 4 (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and	F 156		

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F 156	Continued From page 5 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 156	F156	

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F 156	Continued From page 6 review, the facility failed to ensure the most current Combined Federal and State Bill of Rights for Residents(BOR) was available for the facility residents and resident representatives to view. This had the potential to affect all 34 residents currently residing in the facility. Findings include: On 10/15/17, at 12:37 p.m. the BOR was observed posted on the wall, in the main entry way adjacent to the bird aviary. The BOR posting was in a silver frame, and dated 11/28/16. The BOR posting lacked revised information which included email addresses for pertinent State agencies and advocacy groups. On 10/19/17 at 4:15 p.m. Adminstrator confirmed the BOR posting lacked the updated information including email addresses for pertinent State agencies and advocacy groups. A policy for the Bill of Rights was requested, but not provided.	F 156	1. The current combined Federal and State Bill of Rights is provided to resident and family at time of admission to include pertinent state agencies and advocacy groups with their contact information and email addresses. This document is also available in the Resident Council binder that is available for public viewing in Dining Area. Contact information and email addresses for pertinent state agencies and advocacy groups is also located at the entrance of each resident hallway on the front cover of Grievance Binders. Facility will also include pertinent state agencies and advocacy groups with their contact information and email addresses in front window of Business Office. 2. Re-education provided to all staff on locations of Resident Bill of Rights and pertinent state agencies and advocacy groups with their contact information and email addresses. Social Service Designee will provide updated Bill of Rights to residents and update facility postings if and when updates occur in the future. 3. Administrator will perform random audits of facility postings of Resident Bill of Rights and pertinent state agency information for 3 months to ensure it is available and current. The audit outcomes will be submitted to the QI/QA Committee for comment and/or review. 4. Corrective actions will be completed by November 28, 2017.	
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)	F 157		11/28/17

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F 157	Continued From page 7 CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-	F 157		

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F 157	Continued From page 8 (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician and resident representative of a significant weight loss for 1 of 2 resident (R11) reviewed for weight loss and for a change in suicidal ideation for 1 of 1 resident (R28) reviewed for suicidal ideation. Findings include: R11's admission Minimum Data Set (MDS) dated 5/1/17, identified R11 had severe cognitive impairment and required supervision with eating. R11's MDS identified diagnoses of dementia, depression and pressure ulcer. R11's MDS further identified an admission weight of 100 pounds, regular diet and did not identify weight loss. Due to not identifying a weight loss on R11's admission MDS, a Care Area Assessment (a compressive assessment) was not completed on nutrition. R11's quarterly MDS dated 8/1/17, identified R11 had severe cognitive impairment and required supervision with eating. R11's MDS identified diagnoses of dementia, depression and pressure ulcer. R11's MDS further identified weight of 92 pounds, regular diet and did not identify weight	F 157	F157 1. Resident, resident's physician, and, consistent with his/her authority, resident's representative were notified of change in resident's physical condition for R11 and resident, resident's physician, and, consistent with his/her authority, resident's representative were notified of change in resident's mental or psychosocial status and medication changes for R28. 2. All resident Weight Variance Reports, Risk Management incident reports, Psychotropic Trackers, and Behavior Monitoring notes were reviewed for change in health status that would result in notification of resident, physician, and consistent with his/her authority, resident's representative, by IDT consisting of MDS Coordinator, Social Service Designee, Activity Director, Registered Dietician, and DON to verify the resident, physician, and consistent with his/her authority, resident's representative were notified of such change in condition. 3. All resident records will be continuously reviewed by the IDT for requirements for change in condition and	

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F 157	Continued From page 9 loss. Review of R11's weekly weight records identified: -4/24/17, admission weight of 100 pounds. -5/5/17, 94 pounds. -7/21/17, 93 pounds. -7/28/17, 92 pounds. -9/22/17, 90 pounds. -10/6/17, weight of 88 pounds. -R11 had a significant weight loss (significant weight loss is defined as weight loss of 5% or greater over 30 days, 7.5% loss over 90 days, or 10% over 180 days) of 12% of her body weight (12 pounds from 4/24/17 to 10/6/17 a total of 165 days). On 10/18/17, at 2:55 p.m. FM-A stated R11's usual weight was always between 105-110 pounds. FM-A confirmed that R11 was 105 pounds two weeks prior to admission to the facility. FM-A stated she was R11's Power of Attorney for care and was unaware that R11 had refused the nutritional supplement and the order was discontinued, and that her weight had declined to 88 pounds. On 10/19/17, at 9:14 a.m. MDS coordinator stated R11 ate independently with supervision for encouragement from staff. He also confirmed R11's most recent weight of 88 pounds. MDS coordinator confirmed R11 was 92 pounds during her last MDS on 8/1/17. He confirmed R11 had a	F 157	to ensure that proper notification was completed. These records shall include but are not limited to Weight Variance Reports, Risk Management incident reports, Psychotropic Trackers, and Behavior Monitoring notes. DON or designee will utilize SBAR tool to ensure proper notification was provided to physician, resident or resident's representative. All nurses and IDT team were re-educated on facility policy and procedure for Notification of Change. 4. DON or designee will audit daily progress notes and/or physician communication notes for compliance. These daily audits will be done for 90 days or until 100% compliance is achieved. The audit outcomes will be submitted to the QI/QA Committee for comment &/or review. 5. Corrective actions will be completed by November 28, 2017.	

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12% decline in her weight since admission and was unaware if the dietician was updated, or if any further assessments were completed, or interventions put in place.

On 10/19/17, at 3:15 p.m. director of nursing (DON)stated that she completed R11's admission MDS section K. She was unaware that R11's usual weight was between 105-110 pounds or that R11's Admission Nursing Assessment stated she was 105 pounds two weeks prior to admission. DON confirmed that R11 had a 12% weight loss since admission, per her 10/6/17 weight of 88 pounds. DON stated she was unaware of any further assessments or interventions put in place for R11. She confirmed that R11's significant weight decline had not been reported to R11's physician or resident representative.

On 10/19/17, at 5:37 p.m. a telephone call was placed to office nurse of R11's primary physician, return call pending. On 11/2/17, at 10:03 a.m. primary physician returned call and stated he would expect the facility to update him on a significant weight loss. He confirmed he was not updated on R11's significant weight loss.

In addition:

R28's quarterly Minimum Data Set (MDS) dated 9/3/17, identified R28 had diagnoses which included: dementia, unspecified mood disorder and chronic kidney disease. The MDS identified R28 had severe cognitive impairment, required extensive staff assistance with dressing, toileting, limited assistance for bed mobility and transfers and supervision with walking and eating. R28 required assistance of one staff for bathing. The

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MDS identified R28 wandered daily, was on antipsychotic medication and did not reject care. R28's MDS indicated he had verbal behavior on 1-3 days and other behavior symptoms not directed towards others 1-3 days. Further, R28's MDS identified he expressed thoughts he would be better off dead or thoughts of hurting self. However, the MDS had not been completed accurately to include the frequency of the thoughts.

R28's significant change MDS dated 10/3/17, identified R28 had diagnoses which included: dementia, unspecified mood disorder and chronic kidney disease. The MDS identified R28 had severe cognitive impairment, required total staff assistance for bathing, extensive assistance with hygiene. R28's MDS also identified no behavioral symptoms, no rejection of care, an improvement in behaviors and the use of antipsychotic medication. R28's MDS identified he expressed thoughts he would be better off dead or thoughts of hurting self. The MDS identified the frequency of the thoughts were several days in the reference period for the MDS.

R28's Care Area Assessment (CAA) dated 10/10/17, was not congruent with the corresponding significant MDS dated 10/10/17. R28's MDS identified he had thoughts of being better off dead, or would hurt himself in some way, and had a diagnosis of dementia. R28's 10/10/17 CAA listed R28 did not have a diagnosis of dementia, could be resistive to redirection, and he had denied thoughts of hurting himself. The CAA indicated R28 showed evidence of decline, had a vacant look, difficulty with ADLs, did not ask for help or use his call light when toileting. The CAA identified R28 had negative thoughts when

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frustrated or confused and indicated the care plan would be developed to address meaningful activity in resident daily life to encourage him to focus on the positive and build self esteem. R28's CAA did not identify or address behaviors with bathing.

R28's progress notes from 9/1/17 to 9/28/17 revealed the following:

-9/1/17, R28's MDS reference period note revealed; R28 did not smile or interact as much anymore.

-9/27/17, R28 stated to staff, just leave him there to die, he just wanted to die.

-9/28/17, R28 had been incontinent and staff assisted with cares. R28 stated he wished he were dead and he was going to hang himself. He began crying and stated please shoot me.

On 10/18/17, at 11:19 a.m. phone interview with family member stated that R28 had verbalized suicidal ideation in the past year, but thought the last time he talked about self-harm was in June or July of 2017. FM-D stated that R28 would ask her to bring in a gun so he could shoot himself, or of walking out of the facility and lying down on the train tracks and waiting for the train. FM-D stated that the facility does not update her when R28 verbalizes suicidal ideation and she was under the impression that he no longer made those comments. FM-D stated she was not aware of R28 stating he wanted to hang himself during the night of 9/28/17 and would want to be updated if the self-harm comments started up again.

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F 157	Continued From page 13 On 10/19/17, at 3:39 p.m. director of nursing (DON) stated the facility was aware of R28's thoughts of self harm after the SSD completed R28's PHQ-9 for his quarterly MDS dated 9/3/17. DON stated that R28's primary physician was verbally updated regarding a statement of self harm, but could not specify a date. On 10/19/17, at 5:37 p.m. a telephone call was placed to office nurse of R28's primary physician, return call pending. On 11/2/17, at 10:03 a.m. primary physician returned call and stated he had not been aware of R28's statements from 9/28/17 regarding suicidal ideation. He indicated R28's change in ideation would concern him.	F 157		
F 164 SS=D	PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS CFR(s): 483.10(h)(1)(3)(i); 483.70(i)(2) 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records.	F 164		11/28/17

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F 164	Continued From page 14 (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to close curtains to the outside to ensure privacy during personal cares for 2 of 2 resident (R19, R35) observed during morning cares. Findings include: R19 R19's quarterly Minimum Data Set (MDS) dated 9/8/17, identified R19 had diagnoses which included arthritis, dementia, and cataracts. The MDS identified R19 had severe cognitive impairment, required total assistance with bed	F 164	F164 1. Curtains were closed to the outside to ensure privacy during personal cares for R19 and R35 on November 7, 2017. 2. All residents will have their curtains closed to the outside during personal cares. 3. Education was provided to nursing staff on facility policy and procedure regarding Resident Privacy and Dignity. All resident curtains were lowered to the bottom of the window. 4. DON or designee will audit randomly all shifts to ensure compliance. These audits will be done for a quarter or until	

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VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

(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 164	Continued From page 15 mobility, transfer, locomotion, dressing, eating, toileting and personal hygiene. R19's current computerized care plan revised 9/21/17, identified R19 had a self care deficit related to the diagnoses of dementia, osteoarthritis, general muscle weakness, and was dependent upon staff for all areas of daily living (ADL). On 10/17/2017, at 7:39 a.m. R19 was observed in bed in her room, in a gown and covered with bed linens up to her upper chest. Nursing assistant (NA)-B stood next to R19's bed, on the opposite side of the window. R19's bed was positioned parallel to the window, with a view to the outside of the building. R19's bed was raised, even with the bottom of the window and the window blinds remained partially lowered, with the bottom 1/3 of the window not covered with the blinds. NA-B folded back R19's covers and gown, which exposed R19's upper body including her breasts. NA-B washed R19's upper body with a washcloth and soapy water from a pink basin while R19 remained on the bed, with the window not covered with the blind. NA-B dried R19's upper body, applied deodorant and then covered R19's upper body with the bed linen. NA-B proceeded to fold the bed linen up and away from R19's lower body, unfastened her incontinent brief and attempted to wash R19's peri-area while she lay in view of the window. R19 resisted the peri-cares, and NA-B covered R19's lower body, lowered the bed to the floor and briefly exited the room. At 7:52 a.m. NA-B and NA-C entered the room, and each stood on a side of R19's bed with the window blind open. NA-B raised R19's bed up, even with the bottom edge of the window and with NA-C's assistance, washed and dried R19's	F 164	100% compliance is achieved. The audit outcomes will be submitted to the QI/QA Committee for comment &/or review. 5. Corrective actions will be completed by November 28, 2017.	

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peri-area, applied a new incontinent brief, applied R19's bra and the rest of her clothing. R19's window blind remained open, with a view to the outside, for the entire observation.

On 10/17/2017, at 10:22 a.m. NA-B verified the usual facility practice to close window blinds while providing personal cares to residents to ensure resident privacy. NA-B verified she had not closed the window blinds while providing R19's morning cares. At this time NA-B extended her arm toward the window blind pull string and was unable to reach it. NA-B verified she was unable to reach the pull string to close the window blind on R19's bedroom window.

R35

R35's quarterly MDS dated 9/24/17, identified R19 had moderate cognitive impairment, required extensive assistance with bed mobility, transfer, ambulation, dressing, toileting and personal hygiene.

R35's current computerized care plan revised 9/26/17, identified R35 had an ADL self care deficit related to, diagnoses of anemia, congestive heart disease (CHF) and A-Fib (atrial fibrillation), limited range of motion to shoulders and required extensive assistance with dressing and hygiene.

On 10/17/2017, at 8:36 a.m. R35 was observed lying on top of his bed, parallel with a window which faced the street near the entrance to the facility. The window blind was half closed and covered only the top half of the window. NA-F stood between R35's bed and the window partially obstructing the view of R35 from the front

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F 164	Continued From page 17	F 164		

of the building. NA-F assisted R35 to change from the overnight catheter bag to a leg bag for the day. NA-F moved to the foot of R35's bed and applied his stockings and shoes with R35's legs and feet exposed. NA-F obtained a gait belt from a hook on the door and place it around R35's waist while she told R35 to walk with her across the room to the bathroom. R35 was wearing only boxer type underwear and was in full view from the window to the front of the building, where visitors were observed to park cars and walked towards the building. At this time the surveyor intervened and NA-F closed the window blinds prior to completion of assistance with dressing for R35.

On 10/17/2017, at 8:45 a.m. NA-F verified the window blinds should be closed when providing resident care and indicated R35's window blinds were physically able to be closed while other residents blinds were not.

On 10/18/2017, at 3:19 p.m. registered nurse (RN)-A verified she expected staff to provide resident care with dignity and respect. RN-A verified window blinds should be closed for privacy to complete resident personal cares.

On 10/19/2017, at 11:00 a.m. the director of nursing (DON) indicated the window blinds should have been closed when staff performed resident personal cares in order to provide privacy. The DON indicated she was not aware of any problems with window shades.

The requested facility policy was not provided. On 10/19/17, at 5:43 p.m. the facility administrator identified no further policies were available.

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F 166	Continued From page 18	F 166		
F 166 SS=E	RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES CFR(s): 483.10(j)(2)-(4) (j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. (j)(3) The facility must make information on how to file a grievance or complaint available to the resident. (j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F 166		11/28/17

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F 166	Continued From page 19 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation	F 166		

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F 166	Continued From page 20 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly resolve resident grievances for 4 of 4 resident (R1, R2, R6, R22) with concerns of inadequate assistance with resident cares. Findings include: Review of Resident Council Minutes from 4/17 to 9/17 revealed the following: -4/17/17, residents voiced long wait times with call lights and nursing assistants (NA) turn off call lights without addressing needs and not returning in a timely fashion for assistance. -5/15/17, residents reported when facility had been short staffed cares were delayed and /or of lesser quality. The residents were encouraged to advocate for themselves and speak up regarding their preferences and report any issues to social service designee (SSD) or director of nursing (DON) regarding staff. They were also informed staff were to utilized their care guides. The minutes identified the DON would be invited to the July council meeting to address such matters.	F 166	F166 1. Interview completed with R1, R2, R6, R22 and copy of updated facility Grievance Policy provided. 2. All residents have the potential to be affected; therefore, the Grievance Policy and Procedure has been revised to ensure resident concerns have been addressed and follow-up has been conducted with the residents. All residents and/or family representative were provided a copy of updated policy. All residents and/or family representatives will be interviewed during resident care conferences held quarterly to address any concerns. IDT will review daily progress notes during regularly scheduled meetings for any potential grievances or resident concerns. 3. Education provided to interdisciplinary team about Grievance Policy and when to initiate grievance process. DON and Administrator will offer to attend November Resident Council meeting and will attend if allowed. 4. Administrator will review Resident	

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F 166	Continued From page 21 -6/17/17, the minutes lacked documentation the DON had attended the meeting and listed no concerns with nursing. -7/17/17, the minutes lacked documentation the DON had attended the meeting and the residents did not feel like there had been any changes regarding their concerns with staffing. -8/21/17, residents had been notified the facility had audited call lights and the audit showed call lights were responded to on an average of nine minutes. The resident noted differences of opinions to responsive service call light times and felt nine minutes was a long time to wait for assistance and indicated there was room for improvement. The facility informed the residents that in the evening when assisting residents for bedtime, residents who were unable to voice their needs were the priority. -9/18/17, the minutes listed there were no nursing concerns. R2's annual Minimum Data Set (MDS) dated 8/30/17, identified R2 was cognitively intact. On 10/19/17 at 9:31 a.m. R2 stated she attended resident council on a regular basis and had voiced several concerns related to long call light wait times, staff shutting off the call lights, not asking you what you need and not returning to answer the lights in a timely manner and the facility being short staffed. R2 indicated she had waited up to forty five minutes for assistance to go to the bathroom. R2 indicated she received a water pill, and made it difficult to wait for assistance. She stated waiting so long for	F 166	Council meeting minutes and any Resident Council Concern forms monthly for the next 3 months to ensure concerns are followed up on. All audit outcomes shall be presented to the QI/QA Committee for review &/or comment. 5. Corrective actions will be completed by November 28, 2017.	

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assistance made her upset. R2 indicated staff were always in a hurry and she felt there were more issues with staffing on the evening shift. R2 indicated these issues have been brought up many times at resident council and had been told the facility was looking into the staffing concerns, however, stated she had not seen much done with the complaints. R2 indicated she felt sometimes her needs were being met and other times they were not. R2 indicated the DON had not attended resident council meeting to address the issues of long call light times or staffing concerns. R2 indicated the administrator attended one time in the past and talked about wait times of no more than forty five minutes. R2 stated "I'm a patient person" but stated it took too long at night. During the interview R2 was talking very rapidly in a curt voice and to the point, with squinting facial expressions about call lights and staffing.

R6's annual MDS dated 8/8/17, identified R6 was cognitively intact.

On 10/19/17 at 9:46 a.m. R6 verified she attended resident council on a regular basis and had voiced several concerns related to long call light wait times and the facility being short staffed. R6 indicated she had waited at least a half hour to get help with putting her socks on, shoes on and getting into bed at night. R6 stated she felt the facility had been short staffed at times and mostly on the evening shift. R6 indicated when she has brought up her concerns at resident council in the past, the facility staff told the residents they were working on it. R6 indicated she does not know how the facility was trying to fix the problem. R6 indicated she felt the problem started when the school girls went back to school

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inn the summer and stated "they seem to be short now." R6 indicated she did not remember the facility even talking about call lights. She indicated she did not remember the DON ever coming to a resident council meeting to address the issues with long call light times or staffing. She stated "No, she never came in that I can remember." R6 indicated social service designee (SSD) had talked about call lights and staffing issues and indicated the residents had been told they needed to be more patient when the facility was short staffed.

R22's significant change MDS dated 9/13/17, identified R22 was cognitively intact.

On 10/19/17 at 10:32 a.m. R22 verified she attended resident council on a regular basis and had voiced several concerns related to call lights and staffing issues. R22 indicated she felt some staff do not have the manners to work with the elderly population. R22 indicated staff would get residents partially ready for bed, leave and then the resident had to wait for them to come back to finish. R22 indicated sometimes she had called for assistance 10 or 15 times before getting help and stated "Where is everybody." R22 indicated the problem had been getting the call lights answered and having to wait to get help. R22 indicated she had waited over fifteen minutes to get help with getting dressing in the morning, getting down to meals and getting to bed. R22 also indicated she felt the call lights and staffing seemed to be more of a problem on the evening shift. R22 indicated the DON had not been to resident council to address any concerns with staffing issues or call lights and stated "they have not talked about it a lot."

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R1's quarterly MDS dated 9/16/17, identified R1 was cognitively intact.

On 10/15/17, at 4:54 p.m. R1 stated she used to routinely attend the resident council meeting until she had an altercation with the SSD and was asked by the SSD not to return to the meeting. RI stated the council had voiced numerous complaints regarding long call wait times, staff not returning to resident rooms once a call light was shut off and concerns with overall staffing numbers. R1 indicated she felt her needs were not routinely met by the facility staff. R1 further indicated she no longer felt comfortable attending resident council.

On 10/19/17, at 10:32 a.m, the SSD indicated the facility currently did not have any grievances and she had not dealt with a resident grievance since she had been in the facility. The SSD indicated the facility practice was to complete a written grievance form once the facility had exhausted their means to address the issue. She would then move on to the grievance process and refer to the facility policy. The SSD indicated a grievance could be verbal or written, formal or informal. She confirmed residents had talked about issues in resident council such as: staffing, answering call lights and shutting them off and cares not being done. The SSD indicated she had educated the residents in regards to these issues of needs verses wants and felt the education was talking care of the concerns voiced by residents. The SSD indicated she felt it was a matter of perspective, the facility has been working on these issues and have shown the residents the call light audits. The SSD indicated when residents have to wait 15 minutes, it seems like an hour for them. The SSD indicated when

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residents have to wait 15 minutes, it's not good enough and they want their call lights answered sooner and doesn't seem like were showing improvement on call light times.

Further, SSD confirmed the resident council minutes and confirmed the residents met on a monthly basis. She stated the resident council meetings could be very intense. SSD verified residents had voiced concerns regarding call light times, short staffing issues and thought there was room for improvement. The SSD indicated that addressing these issues had been a challenge because she felt residents wanted assistance with things before their needs were met. The SSD indicated the facility had attempted to educate residents and set boundaries on wanting something verses needing something and stated they had attempted to educate on "your important to me but I have to meet everyone's needs." The SSD indicated she felt basic needs were more important than expressing resident wants and the residents needed to be mindful of this. The SSD indicated by meeting the wants of a few residents, the facility was not able to meet the needs of other residents and those boundaries needed to be set for other resident's wanting things. The SSD indicated she felt by setting boundaries professionally,was upsetting to the residents because their not getting what they want now. The SSD indicated some residents do not have the best boundaries to wait for what they want. The SSD indicated the facility was not able to meet every residents needs and wants and they would have to wait. The SSD confirmed the DON had not attended a resident council meeting to address the issues of call lights and short staffing concerns as indicated in the resident council minutes. The SSD indicated in the past

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F 166	Continued From page 26 the resident council had not been a place where positive things were talked about and in the past had tried to explain to residents that resident council was not just a place to come and complain about things going on in facility. SSD indicated she felt that call light and staffing would always be a concern and stated "this is health care." Review of facility policy titled, Grievance Policy revised on 12/9/16, indicated any person who has a personal complaint against the facility, an employee, staff member, resident, or visitor may file a grievance. Under resident rights: the resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and with out fear of discrimination or reprisal. The facility will respond initially to the residents verbal or written grievance with five working days and will respond in writing to grievances that are written. The facility will make every effort to resolve the problem as soon as possible, taking no longer than thirty days. Under resident council: future meeting will indicated progress made on each suggestion/ recommendation, and /or the reason (S) for rejection if changes suggested cannot be implemented. The social service designee has been appointed by the administrator to work with the resident council in obtaining services for resident's, including assisting them in voting, and to receive grievances and recommendations by residents and any group or individual designated by the resident or his/her representative.	F 166		
F 222 SS=D	RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS CFR(s): 483.10(e)(1), 483.12(a)(2)	F 222		11/28/17

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F 222	Continued From page 27 §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). 42 CFR § 483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must- (2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete an comprehensive assessment prior to the use of chemical restraints for 1 of 1 residents (R28) who received a routine dose of hydroxyzine	F 222	F222 1. Comprehensive assessment completed for R28 and care plan with appropriate diagnoses, interventions and goals for medical and nursing needs, as	

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F 222	Continued From page 28 (medication that reduces activity in the central nervous system) to ensure compliance with bathing due to behaviors. Findings include: R28's quarterly Minimum Data Set (MDS) dated 9/3/17, identified R28 had diagnoses which included: dementia, unspecified mood disorder and chronic kidney disease. The MDS identified R28 had severe cognitive impairment, required extensive staff assistance with dressing, toileting, limited assistance for bed mobility and transfers and supervision with walking and eating. R28 required assistance of one staff for bathing. The MDS identified R28 wandered daily, was on antipsychotic medication and did not reject care. R28's MDS indicated he had verbal behavior on 1-3 days and other behavior symptoms not directed towards others 1-3 days. Further, R28's MDS identified he expressed thoughts he would be better off dead or thoughts of hurting self. However, the MDS had not been completed accurately to include the frequency of the thoughts. R28's significant change MDS dated 10/3/17, identified R28 had diagnoses which included: dementia, unspecified mood disorder and chronic kidney disease. The MDS identified R28 had severe cognitive impairment, required total staff assistance for bathing, extensive assistance with hygiene. R28's MDS also identified no behavioral symptoms, no rejection of care, an improvement in behaviors and the use of antipsychotic medication. R28's MDS identified he expressed thoughts he would be better off dead or thoughts of hurting self. The MDS identified the frequency of the thoughts were several days in the	F 222	well as nutritional, psychosocial, and activity approaches was implemented for R28. 2. Care plans for all residents on a psychotropic medication were reviewed to ensure proper medication use for the diagnosis given. 3. Facility will comprehensively assess all residents prior to the use of chemical restraints and quarterly for continued need. Nursing staff educated on behavior reporting, non-pharmalogical interventions, and policy and procedure for Chemical Restraints and Unnecessary Medications. 4. Review of comprehensive care plan shall be reviewed at admission, quarterly, and/or with change in condition by IDT. DON or designee will audit psychotropic medication use monthly x3 months to ensure proper medication for current diagnoses and initiate GDR as indicated. QI/QA update quarterly with compliance findings. 5. Corrective actions will be completed by November 28, 2017	

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reference period for the MDS.

R28's Care Area Assessment (CAA) dated 10/10/17, was not congruent with the cooresponding significant MDS dated 10/10/17. R28's MDS identified he had thoughts of being better off dead, or would hurt himself in some way, and had a diagnosis of dementia. R28's 10/10/17 CAA listed R28 did not have a diagnosis of dementia, could be resistive to redirection, and he had denied thoughts of hurting himself. The CAA indicated R28 showed evidence of decline, had a vacant look, difficulty with ADLs, did not ask for help or use his call light when toileting. The CAA identified R28 had negative thoughts when frustrated or confused and indicated the care plan would be developed to address meaningful activity in resident daily life to encourage him to focus on the positive and build self esteem. R28's CAA did not identify or address behaviors with bathing.

R28's care plan dated 10/16/17, indicated R28 had dementia, decreased cognition, impaired safety awareness, impaired thought processes, identified target behaviors of directing derogatory language/rude comments towards staff, yelling at staff and making degrading comments to wife. The care plan listed various interventions for staff to utilize for the target behaviors, however, R28's care plan did not identify R28's behaviors with bathing or directions for non-pharmacological interventions when those behaviors occurred.

On 10/16/17, at 3:01 p.m. R28 was seated at a dining room table and played bingo with wife next to him. R28 was calm, smiling and talking with staff. At 3:25 p.m. R28 remained seated at dining room table after bingo ended to eat a cookie at

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F 222	Continued From page 30 Social Hour. On 10/17/17, at 8:43 a.m. until 9:08 a.m. R28 was observed completing activities of daily living (ADLs) with nursing assistant (NA)-E including washing with soap and water and changing clothes. R28 was smiling throughout the cares, he was calm, and no behaviors were observed. NA-E offered choices in cares and clothing, and he cooperated with cares. On 10/18/17, at 1:15 p.m. R28 was dressed in a coat and cowboy hat, seated on a couch in the facility's front entrance area near the aviary. His eyes were closed and he was slumped down and leaning to the left. R28 remained slumped over with eyes closed, on the couch approximately one hour. On 10/19/17, at 1:30 p.m. R28 was seated on a couch next to the front door of the facility. He was staring, with a flat affect, out the window across from where he was seated. On 10/19/17, at 3:50 p.m. R28 was seated quietly on the couch in the front door area of the facility. He was awake, quiet and looked out the windows. At 4:15 p.m. R28 remained seated on the couch with eyes closed and head tilted down. R28's progress note dated 9/13/17, indicated R28 was being assisted by nursing assistant (NA)-C into the tub. R28 stated he should put her in the tub and shove her head in the water. R28 then spat on her and told NA-C to shut up. The director of nursing, social worker and charge nurse were updated on the event. R28's progress note dated 9/15/17, indicated R28	F 222		

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was seen by the physician and hydroxyzine (Vistaril) was added before bath days. Bath aide noted that resident would not allow bath to be done once dressed for the day, but is angry when he is bathed early. Attempts to offer bath on PM shift also have been unsuccessful with similar aggressive behaviors. Will monitor to see if hydroxyzine is effective.

Review of R28's Physician Round Tool dated 9/15/17, indicated R28 was verbally abusive of staff, spitting at them, saying he was going to bomb facility, refusing medications and anxiety/anger with tub baths. The document included to give hydroxyzine 10mg by mouth 15-30 minutes before bath, if not effective increase to 2 tablets. Further, the document included an order to increase the Seroquel from 25 mg twice a day to 50 mg twice a day.

Review of R28's Medication Administration Records (MAR) for the months of September and October 2017 indicated:

-Hydroxyzine give 10 mg by mouth, every Wednesday, with start date of 9/20/17 . The MAR listed R28 had received the medication on 9/20/17, 9/27/17, 10/4/17, 10/11/17 and 10/18/17.

Review of R28's clinical record lacked documentation of monitoring the efficacy of the hydroxyzine for R28.

On 10/18/17, at 2:04 p.m. NA-A stated R28 was confused and wandered throughout the facility. NA-A stated R28's care sheet indicated he was an elopement risk, but the care sheet did not indicate he had behaviors or how to deal with any

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behaviors. NA-A stated she was not aware R28 had voiced thoughts of self harm or harm to others.

On 10/19/17, at 1:41 p.m. NA-C stated she regularly gave R28 his weekly bath and stated he did not like the idea of bathing. She stated R28 would routinely complain verbally about bathing, up until the tub door closed and filled with water, then "he loved it." NA-C stated staff had tried giving R28 his bath in the evenings and it did not work. She indicated he received his bath in the morning, and stated she was unaware of any other interventions that had been attempted to assist with R28's bathing. NA-C stated R28's verbal behaviors were long standing and she had not seen a decrease in them, only recently R28 was more tired and he slept longer on bath day. NA-C stated she had worked with R28 on 9/15/17 and had reported his verbal behavior to the nurse so that others attempting his bath would be aware. NA-C stated she was unaware R28 was taking a medication to attempt to decrease behaviors with bathing and denied that nursing staff had questioned her on R28's compliance with bathing in the recent past.

On 10/19/17, at 2:11 p.m. licensed practical nurse (LPN)-A stated R28 had a history of belittling his wife and hovering over her at meals. LPN-A stated staff redirected R28 during those situations. She also stated R28 fluctuate between being happy to stating he wants to die. LPN-A stated NA-C updated her about R28's verbal behaviors prior to bath on 9/13/17. LPN-A verified NA-C was able to assist R28 with his bath that day. LPN-A was unaware of any other non-pharmacological interventions for R28 and bathing. LPN-A was unaware of R28's order for

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F 222	Continued From page 33 hydroxyzine prior to bathing, and unaware what was the medication's action. On 10/19/17, at 3:39 p.m. director of nursing (DON) confirmed the facility had not assessed R28 for the use of a chemical restraint and confirmed Vistaril was ordered to assist in behaviors during bathing. DON confirmed no other interventions had been developed in an attempt to deal with R28's behaviors with bathing. On 10/19/17, at 4:55 p.m. during a telephone interview with consultant pharmacist (CP), she stated she was aware of the addition of hydroxyzine (Vistaril) for agitation during bathing and stated it was a better alternative than use of Ativan (an antianxiety medication). No further information was offered regarding the use of the hydroxyzine. A policy regarding restraint use, psychotropic drug use and behavior/mood monitoring was requested from the facility and not provided.	F 222		
F 244 SS=E	LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION CFR(s): 483.10(f)(5)(iv)(A)(B) (f)(5) The resident has a right to organize and participate in resident groups in the facility. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response.	F 244		11/28/17

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F 244	Continued From page 34 (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly resolve resident grievances for 4 of 4 resident (R1, R2, R6, R22) voiced during resident council meetings. Findings include: Review of Resident Council Minutes from 4/17 to 9/17 revealed the following: -4/17/17, residents voiced long wait times with call lights and nursing assistants (NA) turn off call lights without addressing needs and not returning in a timely fashion for assistance. -5/15/17, residents reported when facility had been short staffed cares were delayed and /or of lesser quality. The residents were encouraged to advocate for themselves and speak up regarding their preferences and report any issues to social service designee (SSD) or director of nursing (DON) regarding staff. They were also informed staff were to utilized their care guides. The minutes identified the DON would be invited to the July council meeting to address such matters. -6/17/17, the minutes lacked documentation the DON had attended the meeting and listed no concerns with nursing. -7/17/17, the minutes lacked documentation the DON had attended the meeting and the residents did not feel like there had been any changes	F 244	F244 1. Interview completed with R1, R2, R6, R22 and copy of updated facility Grievance Policy provided. 2. All residents have the potential to be affected; therefore, the Grievance Policy and Procedure has been revised to ensure resident concerns have been addressed and follow-up has been conducted with the residents. All residents and/or family representative were provided a copy of updated policy. 3. Education provided to interdisciplinary team about Grievance Policy and when to initiate grievance process. DON and Administrator will offer to attend November Resident Council meeting and will attend if allowed. 4. Administrator will review Resident Council meeting minutes and any Resident Council Concern forms monthly for the next 3 months to ensure concerns are followed up on. All audit outcomes shall be presented to the QI/QA Committee for review &/or comment. 5. Corrective actions will be completed by November 28, 2017	

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F 244	Continued From page 35 regarding their concerns with staffing. -8/21/17, residents had been notified the facility had audited call lights and the audit showed call lights were responded to on an average of nine minutes. The resident noted differences of opinions to responsive service call light times and felt nine minutes was a long time to wait for assistance and indicated there was room for improvement. The facility informed the residents that in the evening when assisting residents for bedtime, residents who were unable to voice their needs were the priority. -9/18/17, the minutes listed there were no nursing concerns. R2's annual Minimum Data Set (MDS) dated 8/30/17, identified R2 was cognitively intact. On 10/19/17 at 9:31 a.m. R2 stated she attended resident council on a regular basis and had voiced several concerns related to long call light wait times, staff shutting off the call lights, not asking you what you need and not returning to answer the lights in a timely manner and the facility being short staffed. R2 indicated she had waited up to forty five minutes for assistance to go to the bathroom. R2 indicated she received a water pill, and made it difficult to wait for assistance. She stated waiting so long for assistance made her upset. R2 indicated staff were always in a hurry and she felt there were more issues with staffing on the evening shift. R2 indicated these issues have been brought up many times at resident council and had been told the facility was looking into the staffing concerns, however, stated she had not seen much done with the complaints. R2 indicated she felt	F 244		

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sometimes her needs were being met and other times they were not. R2 indicated the DON had not attended resident council meeting to address the issues of long call light times or staffing concerns. R2 indicated the administrator attended one time in the past and talked about wait times of no more than forty five minutes. R2 stated "I'm a patient person" but stated it took too long at night. During the interview R2 was talking very rapidly in a curt voice and to the point, with squinting facial expressions about call lights and staffing.

R6's annual MDS dated 8/8/17, identified R6 was cognitively intact.

On 10/19/17 at 9:46 a.m. R6 verified she attended resident council on a regular basis and had voiced several concerns related to long call light wait times and the facility being short staffed. R6 indicated she had waited at least a half hour to get help with putting her socks on, shoes on and getting into bed at night. R6 stated she felt the facility had been short staffed at times and mostly on the evening shift. R6 indicated when she has brought up her concerns at resident council in the past, the facility staff told the residents they were working on it. R6 indicated she does not know how the facility was trying to fix the problem. R6 indicated she felt the problem started when the school girls went back to school inn the summer and stated "they seem to be short now." R6 indicated she did not remember the facility even talking about call lights. She indicated she did not remember the DON ever coming to a resident council meeting to address the issues with long call light times or staffing. She stated "No, she never came in that I can remember." R6 indicated social service designee

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(SSD) had talked about call lights and staffing issues and indicated the residents had been told they needed to be more patient when the facility was short staffed.

R22's significant change MDS dated 9/13/17, identified R22 was cognitively intact.

On 10/19/17 at 10:32 a.m. R22 verified she attended resident council on a regular basis and had voiced several concerns related to call lights and staffing issues. R22 indicated she felt some staff do not have the manners to work with the elderly population. R22 indicated staff would get residents partially ready for bed, leave and then the resident had to wait for them to come back to finish. R22 indicated sometimes she had called for assistance 10 or 15 times before getting help and stated "Where is everybody." R22 indicated the problem had been getting the call lights answered and having to wait to get help. R22 indicated she had waited over fifteen minutes to get help with getting dressing in the morning, getting down to meals and getting to bed. R22 also indicated she felt the call lights and staffing seemed to be more of a problem on the evening shift. R22 indicated the DON had not been to resident council to address any concerns with staffing issues or call lights and stated "they have not talked about it a lot."

R1's quarterly MDS dated 9/16/17, identified R1 was cognitively intact.

On 10/15/17, at 4:54 p.m. R1 stated she used to routinely attend the resident council meeting until she had an altercation with the SSD and was asked by the SSD not to return to the meeting. RI stated the council had voiced numerous

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complaints regarding long call wait times, staff not returning to resident rooms once a call light was shut off and concerns with overall staffing numbers. R1 indicated she felt her needs were not routinely met by the facility staff. R1 further indicated she no longer felt comfortable attending resident council.

On 10/19/17, at 10:32 a.m, the SSD confirmed residents had talked about issues in resident council such as: staffing, answering call lights and shutting them off and cares not being done. The SSD indicated she had educated the residents in regards to these issues of needs verses wants and felt the education was talking care of the concerns voiced by residents. The SSD indicated she felt it was a matter of perspective, the facility has been working on these issues and have shown the residents the call light audits. The SSD indicated when residents have to wait 15 minutes, it seems like an hour for them. The SSD indicated when residents have to wait 15 minutes, it's not good enough and they want their call lights answered sooner and doesn't seem like were showing improvement on call light times.

Further, SSD confirmed the resident council minutes and confirmed the residents met on a monthly basis. She stated the resident council meetings could be very intense. SSD verified residents had voiced concerns regarding call light times, short staffing issues and thought there was room for improvement. The SSD indicated that addressing these issues had been a challenge because she felt residents wanted assistance with things before their needs were met. The SSD indicated the facility had attempted to educate residents and set boundaries on wanting something verses needing something and stated

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they had attempted to educate on "your important to me but I have to meet everyone's needs." The SSD indicated she felt basic needs were more important than expressing resident wants and the residents needed to be mindful of this. The SSD indicated by meeting the wants of a few residents, the facility was not able to meet the needs of other residents and those boundaries needed to be set for other resident's wanting things. The SSD indicated she felt by setting boundaries professionally,was upsetting to the residents because their not getting what they want now. The SSD indicated some residents do not have the best boundaries to wait for what they want. The SSD indicated the facility was not able to meet every residents needs and wants and they would have to wait. The SSD confirmed the DON had not attended a resident council meeting to address the issues of call lights and short staffing concerns as indicated in the resident council minutes. The SSD indicated in the past the resident council had not been a place where positive things were talked about and in the past had tried to explain to residents that resident council was not just a place to come and complain about things going on in facility. SSD indicated she felt that call light and staffing would always be a concern and stated "this is health care."

Review of facility policy titled, Grievance Policy revised on 12/9/16, indicated any person who has a personal complaint against the facility, an employee, staff member, resident, or visitor may file a grievance. Under resident rights: the resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and with out fear of discrimination or reprisal. The

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F 244	Continued From page 40 facility will respond initially to the residents verbal or written grievance with five working days and will respond in writing to grievances that are written. The facility will make every effort to resolve the problem as soon as possible, taking no longer than thirty days. Under resident council: future meeting will indicated progress made on each suggestion/ recommendation, and /or the reason (S) for rejection if changes suggested cannot be implemented. The social service designee has been appointed by the administrator to work with the resident council in obtaining services for resident's, including assisting them in voting, and to receive grievances and recommendations by residents and any group or individual designated by the resident or his/her representative.	F 244		
F 250 SS=D	PROVISION OF MEDICALLY RELATED SOCIAL SERVICE CFR(s): 483.40(d) (d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary medically related social services s for 1 of 1 resident (R28) with dementia and voiced suicidal ideations. In addition, the facility failed to provide an environment free of chemical restraints and to develop non pharmacological interventions for 1 of 1 resident (R28) who voiced injury/harm to others during bath time. Findings include:	F 250	F250 1. Comprehensive assessment completed for R28 and care plan with appropriate diagnoses, interventions and goals for medical and nursing needs, as well as nutritional, psychosocial, suicidal ideation, behavioral, and activity approaches was implemented for R28. 2. Care plans for all residents with psychosocial disorder were reviewed to ensure resident specific	11/28/17

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F 250	Continued From page 41 R28's quarterly Minimum Data Set (MDS) dated 9/3/17, identified R28 had diagnoses which included: dementia, unspecified mood disorder and chronic kidney disease. The MDS identified R28 had severe cognitive impairment, required extensive staff assistance with dressing, toileting, limited assistance for bed mobility and transfers and supervision with walking and eating. R28 required assistance of one staff for bathing. The MDS identified R28 wandered daily, was on antipsychotic medication and did not reject care. R28's MDS indicated he had verbal behavior on 1-3 days and other behavior symptoms not directed towards others 1-3 days. Further, R28's MDS identified he expressed thoughts he would be better off dead or thoughts of hurting self. However, the MDS had not been completed accurately to include the frequency of the thoughts. R28's significant change MDS dated 10/3/17, identified R28 had diagnoses which included: dementia, unspecified mood disorder and chronic kidney disease. The MDS identified R28 had severe cognitive impairment, required total staff assistance for bathing, extensive assistance with hygiene. R28's MDS also identified no behavioral symptoms, no rejection of care, an improvement in behaviors and the use of antipsychotic medication. R28's MDS identified he expressed thoughts he would be better off dead or thoughts of hurting self. The MDS identified the frequency of the thoughts were several days in the reference period for the MDS. R28's Care Area Assessment (CAA) dated 10/10/17, was not congruent with the corresponding significant MDS dated 10/10/17.	F 250	non-pharmalogical interventions are identified and utilized as well as proper medication use for the diagnosis given. Review of all resident daily progress notes and completed resident PHQ-9 assessments for thoughts of death or harm to self. 3. Facility will comprehensively assess all residents prior to the use of chemical restraints and quarterly for continued need. Nursing staff educated on behavior reporting, non-pharmalogical interventions, and policy and procedure for Chemical Restraints and Unnecessary Medications. 4. Review of comprehensive care plan shall be reviewed at admission, quarterly, and/or with change in condition by IDT. DON or designee will audit daily progress notes and PHQ-9 assessments weekly for any indications of suicidal ideations or self-harm for 90 days. QI/QA update quarterly with compliance findings. 5. Corrective actions will be completed by November 28, 2017.	

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R28's MDS identified he had thoughts of being better off dead, or would hurt himself in some way, and had a diagnosis of dementia. R28's 10/10/17 CAA listed R28 did not have a diagnosis of dementia, could be resistive to redirection, and he had denied thoughts of hurting himself. The CAA indicated R28 showed evidence of decline, had a vacant look, difficulty with ADLs, did not ask for help or use his call light when toileting. The CAA identified R28 had negative thoughts when frustrated or confused and indicated the care plan would be developed to address meaningful activity in resident daily life to encourage him to focus on the positive and build self esteem. R28's CAA did not identify or address behaviors with bathing.

R28's care plan dated 10/16/17, indicated R28 had dementia, decreased cognition, impaired safety awareness, impaired thought processes, identified target behaviors of directing derogatory language/rude comments towards staff, yelling at staff and making degrading comments to wife. The care plan listed various interventions for staff to utilize for the target behaviors, however, R28's care plan did not identify R28's suicidal ideation, thoughts of self harm, behaviors with bathing or directions for staff to utilize non-pharmacological interventions to utilize when those behaviors occurred.

On 10/16/17, at 3:01 p.m. R28 was seated at a dining room table and played bingo with wife next to him. R28 was calm, smiling and talking with staff. At 3:25 p.m. R28 remained seated at dining room table after bingo ended to eat a cookie at Social Hour.

On 10/17/17, at 8:43 a.m. until 9:08 a.m. R28 was

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observed completing activities of daily living (ADLs) with nursing assistant (NA)-E including washing with soap and water and changing clothes. R28 was smiling throughout the cares, he was calm, and no behaviors were observed. NA-E offered choices in cares and clothing, and he cooperated with cares.

On 10/18/17, at 1:15 p.m. R28 was dressed in a coat and cowboy hat, seated on a couch in the facility's front entrance area near the aviary. His eyes were closed and he was slumped down and leaning to the left. R28 remained slumped over with eyes closed, on the couch approximately one hour.

On 10/19/17, at 1:30 p.m. R28 was seated on a couch next to the front door of the facility. He was staring, with a flat affect, out the window across from where he was seated.

On 10/19/17, at 3:50 p.m. R28 was seated quietly on couch in the front door area of the facility. He was awake, quiet and looked out the windows. At 4:15 p.m. R28 remained seated on the couch with eyes closed and head tilted down.

On 10/17/17, at 11:15 a.m. nursing assistant (NA)-E stated R28 was confused at times and could be "feisty" at times. NA-E stated R28's only behavior she was aware of was stating belittling comments to his wife and that he was easily redirected by music, or his harmonica. NA-E stated she was aware R28 had made negative remarks such as if I had a gun I would shoot you, or if I had a bomb I would blow this place up. NA-E stated she was aware of R28 making comments weekly. NA-E stated R28 had stated If I had a gun I would shoot myself, what was the

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point of this life, I wish I could just lay down and die, or blowing up the facility and he had questioned the point of his life.

On 10/17/17, at 1:38 p.m. NA-F stated that R28 got weepy at times, but did not get angry. When R28 got weepy, she offered him a snack and visited with him one on one. NA-F stated that if R28 was redirected away from his wife, then R28 would state he was going to leave and take his wife with him. NA-F stated R28 was easily redirectable, and had never heard R28 bring up harming himself or others.

On 10/17/17, at 1:59 p.m. NA-B stated R28 made belittling comments to his wife, especially at meals and that was why R28 did not sit with her at meals. NA-B also stated R28 spit in inappropriate places in the facility and could be rude. NA-B stated R28 was very easy to redirect and had never heard R28 bring up harming himself or others.

On 10/18/17, at 10:40 a.m. registered nurse (RN)-A stated R28 had behaviors that included: being rude to his wife, rude to staff, nastiness and spitting. RN-A stated she had not seen a lot of behaviors from R28, but when she did see them, redirection worked well with him. RN-A stated that it was all in the approach to R28. RN-A confirmed she had heard R28 state that he wished he were dead at least 4-5 times over the past six months. RN-A stated she had not assessed R28 for a plan to carry out the suicidal ideation on any of the past verbalizations of wishing he were dead. RN-A confirmed she had updated the director of nursing (DON) on some of the occasions, but not all. RN-A stated R28 was very mobile and walked without assistance and spent a lot of time alone in

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his room. RN-A was unaware if R28's care plan addressed his suicidal ideation or interventions in place for staff to follow when R28 verbalized thoughts of self-harm.

On 10/18/17, at 11:19 a.m. during telephone interview with family member (FM)-D, FM-D indicated R28's cognition had recently declined, and also had a decline in his urinary continence. FM-D stated R28 had verbalized suicidal ideation in the past year, but thought the last time he talked about self-harm was in June or July of 2017. FM-D stated R28 would ask her to bring in a gun so he can shoot himself, or of walking out of the facility and lying down on the train tracks and waiting for the train. FM-D stated the facility had not contacted her in the past when R28 verbalized thoughts of self harm or harm to others had occurred and she was under the impression that he no longer made those comments. FM-D stated she was not aware of R28 stating he wanted to hang himself during the night of 9/28/17 and would want to be updated if the self-harm comments started up again. FM-D stated she felt the antipsychotic medication he was receiving was making him have the suicidal ideation. She stated it seemed like when the facility got more aggressive with the dosing of Seroquel (antipsychotic), R28 would verbalize the suicidal ideation more. FM-D stated she was unaware R28's dose of antipsychotic medication had been increased in the recent past (9/15/17) and stated that the facility staff had promised her they would cut back the Seroquel dose.

Review of R28's progress notes from 4/14/17 to 10/17/17 revealed the following:

-4/14/17, provider was updated R28 becomes

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agitated after redirection from wife at meals, where he will return to wife to belittle her or tell her to stop eating. Staff unable to redirect resident on 12.5 mg dose of Seroquel. Provider increased Seroquel to 25 mg.

-5/16/17, R28's behaviors of spitting, hovering over wife at meals, or pulling her away from table stating she doesn't need to eat were discussed with provider. Asked provider about possible medication that would decrease secretions and need to spit. Orders were written to increase Seroquel to 25 mg twice a day.

-6/3/17, R28 was tearful throughout the day.

-7/12/17, R 28's monthly behavior note listed R28's past behavior includes: rude to staff/wife, yelling at staff, calling staff names, hovering over wife, wandering into other rooms and tearfulness. R28 lacked behavior notes charted by nurses. NAs noted disorganized thinking x 4, delusions x 1 and rejection of care x 1. NAs also noted negative self-talk, short tempered/easily annoyed, comments such as "life isn't worth living", anxious comments/concerns, and negative statements. Staff review, R28's behaviors occur on a daily basis. Staff state he redirects easily with positivity, though sometimes the redirection is not well received.

-8/29/17, R28 was asked questions for PHQ-9 (a questionnaire that monitors/measures the severity of depression) and he was unable to reference the past two weeks. R28 stated he has thought about being better off dead. He denied any thoughts of harming or killing self. R28 was confused which season it was.

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-8/29/17, R28's monthly behavior monitoring revealed wandering occurred on a daily basis. At times R28 would refuse his medications whole, he continued to hover over wife and being tearful. Redirection was challenging at times.

-9/1/17, R28's MDS reference period note revealed R28 did not smile or interact as much anymore.

-9/15/17, R28's provider was updated regarding recent increased verbal abuse towards staff, spitting at staff and refusal of medication. On interview with provider R28 was cheerful and denied frustrations with living in the facility. Bath aide notes R28 will not allow bath to be done once dressed for the day, but was angry when he was bathed early. Attempts to bath on evening shift were unsuccessful with similar aggressive behaviors. R28's provider increased his Seroquel and made an addition of hydroxyzine (medication that reduces activity in the central nervous system) before baths.

-9/27/17, R28 stated to staff to just leave him there to die, he just wanted to die.

-9/28/17, R28 had been incontinent and staff assisted with cares. R28 stated he wished he were dead and he was going to hang himself. He began crying and stated please shoot me.

-9/28/17, R28's monthly behavior monitoring revealed: frequent crying x 4, repeated movement x 1, yelling x 1, spitting x 1, abusive language x 2, threatening behaviors x 2, indicated bad feeling of self x 4, short-tempered/easily annoyed x 4, wishing for death x 4, repetitive anxious complaints/concerns x 2, negative statements x

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4, self deprecation x 3, behavior significantly disrupt care or environment x 1. Redirection could be a challenge. Current psychoactive medication included: Seroquel 50 mg twice daily and hydroxyzine 10 mg every Wednesday for aggressive behaviors at bath time.

-10/3/17, R28 answered questions with confusion and difficulty. R28 denied thoughts of hurting himself, but stated sometimes he had thoughts he'd be better off dead. Staff noted tearful with incontinence or confusion. Nursing noted negative statements x 2 when he is cared for or confused. Wandered daily with one occasion with potential to put him in danger. R28 had a tendency to refuse medications but re-approach was effective. No behaviors noted in charting by NAs.

Review of R28's Medication Administration Records for the months of August, September and October 2017 revealed the following:

-Hydroxyzine (medication that reduces activity in the central nervous system) give 10 mg by mouth every Wednesday with a start date of 9/20/17. He had received the medication on 9/20/17, 9/27/17, 10/4/17, 10/11/17 and 10/18/17.

-Seroquel (antipsychotic medication) give 50 mg by mouth twice a day related to dementia in other diseases classified elsewhere with behavioral disturbance; unspecified mood (affective) disorder with a start date of 9/15/17 given at 6:30 a.m. and 4:00 p.m. R28 received all doses except refused one dose on 10/16/17.

On 10/18/17, at 3:29 p.m. social services

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designee (SSD) stated the usual facility practiced was for the nursing assistants to chart resident behaviors each shift in Point of Care (electronic health record). The computerized program had standard categories which included: frequent crying, repeats movement, yelling/screaming, kicking/hitting, pushing, grabbing, pinching/scratching/spitting, biting, wandering, abusive language, threatening behavior, sexually inappropriate, rejection of care, none of the above observed, resident not available, resident refused and not applicable. SSD stated she reviewed these categories and completed a Monthly Behavior Review (MBR)

Further, SSD indicated behaviors were monitored for all residents in the facility and monitor behaviors for MDS completion. She confirmed R28's behaviors had included voicing self harm, and she stated she had asked R28 if he had a plan for self harm and he denied a plan. She stated he had indicated he did not know why he had said that and felt he was having a good life. She stated her usual practice would be to notify the director of nursing if she had a concern with a resident's mood and indicated she was aware R28's daughter had commented she felt he said things like that for attention. SSD indicated when R28 was confused he would get very upset with the negative thoughts and voiced a wish for death. She indicated she was not aware how long he had thoughts of self harm or dying. SSD indicated R28's for his mood for music/reminiscing, was not aware of other care plan interventions. She stated interventions to deal with self harm should be addressed on R28's care plan.

On 10/18/17, at 2:04 p.m. NA-A stated R28 was

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confused and wandered throughout the facility. NA-A stated R28's care sheet indicated he was an elopement risk, but the care sheet did not indicate he had behaviors or how to deal with any behaviors. NA-A stated she was not aware R28 had voiced thoughts of self harm or harm to others.

On 10/18/17, at 2:27 p.m. NA-H stated she was not aware R28 talked about self harm. NA-H stated she was aware R28 had stated in the past, if he had a bomb he'd blow the place up, or that he would get a car and leave there. NA-H stated he made comments like this approximately monthly and the last time she heard him make the statements was three weeks ago. NA-H stated R28 was confused and would become annoyed when staff attempted redirection with him.

On 10/19/17, at 10:17 a.m. during follow up interview, SSD indicated she felt redirection was a challenge with him and felt approach was key. She stated she felt music, sunshine and stories of the past were effective for R28. She stated she felt he could not formulate a plan for self harm or harm to others, because he did not have the capacity to carry it out. She stated R28 was very religious and suicide was a mortal sin. SSD indicated the present plan for his self harm/harm to others was to build his self esteem and keep him busy. She stated she felt R28 was an "alpha male" and indicated with R28's cognitive loss, the current interventions possibility were not effective. SSD confirmed she had notified the DON of R28's voicing thoughts of self harm/ harm to others at the times the quarterly and significant change MDS had been completed.

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On 10/19/17, at 1:41 p.m. NA-C stated she regularly gave R28 his weekly bath and stated he did not like the idea of bathing. She stated R28 would routinely complain verbally about bathing, up until the tub door closed and filled with water, then "he loved it." NA-C stated staff had tried giving R28 his bath in the evenings and it did not work. She indicated he received his bath in the morning, and stated she was unaware of any other interventions that had been attempted to assist with R28's bathing. NA-C stated R28's verbal behaviors were long standing and she had not seen a decrease in them, only recently R28 was more tired and he slept longer on bath day. NA-C stated she had worked with R28 on 9/15/17, and had reported his verbal behavior to the nurse so that others attempting his bath would be aware. NA-C stated she was unaware R28 was taking a medication to attempt to decrease behaviors with bathing and denied nursing staff had questioned her on R28's compliance with bathing in the recent past.

On 10/19/17, at 2:11 p.m. licensed practical nurse (LPN)-A stated R28 had a history of belittling his wife and hovering over her at meals. LPN-A stated staff redirected R28 during those situations. She also stated R28 fluctuated between being happy to stating he wants to die. LPN-A stated NA-C updated her about R28's verbal behaviors prior to bath on 9/13/17. LPN-A verified NA-C was able to assist R28 with his bath that day. LPN-A was unaware of any other non-pharmacological interventions for R28 and bathing. LPN-A was unaware of R28's order for hydroxyzine prior to bathing, and unaware what was the medication's action.

On 10/19/17, at 3:39 p.m. director of nursing

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VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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F 250	Continued From page 52 (DON) stated the facility was aware of R28's thoughts of self harm after the SSD completed R28's PHQ-9 for his quarterly MDS dated 9/3/17. DON confirmed R28's care plan did not identify or address R28's suicidal ideation or interventions for suicidal ideation. DON also confirmed the medication Vistaril was added to assist in behaviors with the activity of daily living of bathing. DON confirmed R28 lacked an assessment for a chemical restraint. On 10/19/17, at 4:55 p.m. during a telephone interview with consultant pharmacist (CP), she stated she was aware of the black box warning for Seroquel, and suicidal ideation. CP stated she felt suicidal ideation could be due to an increased feeling of anxiety people feel during the first couple of weeks after initiation of Seroquel or increase in dosage. CP stated she was unaware of R28's suicidal ideation. CP stated she was aware of the addition of Vistaril for agitation during bathing and stated she felt it was a better alternative than Ativan (an antianxiety medication). A policy titled Suicidal Ideation dated 11/1/15, indicated any resident that stated or indicated suicidal tendencies needed immediate intervention to prevent potential harm or death to self. A policy titled Care Plan Policy and Procedure dated 11/1/15, indicated resident care plans would ensure the appropriate care required to maintain the resident's highest level of functioning possible. The policy also indicated that the care plan will change with the resident's needs and that any temporary problems will be added to the care plan if no resolution in 30 days.	F 250		

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F 250	Continued From page 53 A policy regarding restraint use, psychotropic drug use and behavior/mood monitoring was requested from the facility and not provided.	F 250		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g)-(j) (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.	F 278		11/28/17

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F 278	Continued From page 54 (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately reflect resident status related to presence of pressure ulcers on the Minimum Data Set (MDS) for 1 of 3 residents (R5) reviewed for pressure ulcers and accurately reflect significant weight loss for 1 of 2 residents (R11) reviewed for weight loss. Findings include: R5's annual MDS dated 5/1/17, indicated R5 had a stage 1 pressure ulcer, described by the MDS as intact skin with non-blanchable redness of a localized area usually over a bony prominence. The corresponding Care Area Assessment (CAA) identified R5 had a stage one pressure ulcer on the left buttock on admission. Review of R5's progress notes included the following: -4/26/17, "2 open wounds on buttock coccyx." -4/27/17, " left buttock, sloughing skin, dry, about 2 cm (centimeters) X 2 cm." -4/28/17,"Red small open area, no drainage, partial loss of dermis." -4/29/17,"Red small open area, no drainage, partial loss of dermis." -4/30/17,"Red small open area, no drainage, partial loss of dermis." The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2017, identified instructions for completing the MDS used in nursing homes. The section	F 278	F278 1. Modification MDS completed for R5 to accurately reflect pressure ulcer at admission and modification MDS completed for R11 to accurately reflect weight loss at admission. 2. MDS audit completed for new admissions in last 30 day to verify accuracy of weight loss/gain history. Random audit completed of remaining residents to ensure MDS accuracy. 3. Education provided to DON and MDS Coordinator on the importance of MDS accuracy and rules and regulations in RAI manual. Facility will interview resident and/or family at admission to obtain weight history and make appropriate comparison to current medical record. 4. DON or designee will audit randomly all MDS submission to ensure compliance. These audits will be done for a quarter or until 100% compliance is achieved. The audit outcomes will be submitted to the QI/QA Committee for comment &/or review. 5. Corrective actions will be completed by November 28, 2017.	

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labeled, "Section M: Skin conditions," identified an intent which included, to document the current number of unhealed pressure ulcers at each stage. The section listed several, Coding Instructions, to be followed for staging a residents' pressure ulcer, which included:

- "Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence." and;

- "Stage 2: Partial thickness loss of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. May also present as an intact or open/ruptured serum filled blister." and;

- "Stage 3: Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling."

On 10/19/2017, at 10:04 a.m. the MDS coordinator stated he completed the MDS skin section with review of all the resident skin notes, assessments and a visual skin assessment, however; indicated the visual inspection was not always possible. After review of R5's progress notes from 4/26/17 to 4/30/17, the MDS coordinator indicated the initial progress notes did not have enough information to determine if the open area was a pressure ulcer or scratches. The MDS coordinator identified he did not work with wounds every day and indicated the progress notes indicate the wound was small and stated, he would not think there would be any depth to it. MDS coordinator stated he had missed the notes regarding partial loss of the dermis. The MDS

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F 278	Continued From page 56 coordinator identified the resident assessment manual did give direction to help determine a pressure ulcer's stage and he did refer to the manual for staging pressure ulcers. The MDS coordinator agreed the ulcer should have been coded as a stage two pressure ulcer. On 10/19/2017, at 10:51 a.m. the director of nursing (DON) verified the MDSC was responsible to complete resident MDS assessments. DON indicated she expected the resident MDSs to be accurate. The DON indicated the facility reviewed MDS assessments and followed up with discrepancies. The DON reviewed R5's progress notes and admission MDS and stated,"it really should have been a stage two." R11's admission Minimum Data Set (MDS) dated 5/1/17, identified R11 had severe cognitive impairment and required supervision with eating. R11's MDS identified diagnoses which included dementia, depression and pressure ulcer. R11's MDS further identified an admission weight of 100 pounds, regular diet and did not identify weight loss. Due to not identifying a weight loss on R11's admission MDS, a Care Area Assessment (a compressive assessment) was not completed on nutrition. R11's quarterly MDS dated 8/1/17, identified R11 had severe cognitive impairment and required supervision with eating. R11's MDS identified diagnoses which included dementia, depression and pressure ulcer. R11's MDS further identified weight of 92 pounds, regular diet and question K0300 did not identify weight loss of 5 percent or	F 278		

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F 278	Continued From page 57 more in 30 days, or 10 percent or more in 180 days. The Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual dated 10/2017, identified instructions for completing the MDS used in nursing homes. The RAI indicated instructions to calculate weight loss for section K question 0300: - 1. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 30 days ago. - 2. If the current weight is less than the weight in the observation period 30 days ago, calculate the percentage of weight loss. -3. From the medical record, compare the resident's weight in the current observation period to his or her weight in the observation period 180 days ago. -4. If the current weight is less than the weight in the observation period 180 days ago, calculate the percentage of weight loss. RAI indicated to calculate a 10% weight loss in 180 days: -Start with the resident's weight closest to 180 days ago and multiply it by .90 (or 90%). The resulting figure represents a 10% loss from the weight 180 days ago. If the resident's current weight is equal to or less than the resulting figure, the resident has lost 10% or more body weight. R11's Admission Nursing Assessment dated	F 278		

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4/24/17, indicated a weight of 105 pounds two weeks prior to her admission on 4/24/17. R11's weight closest to 180 days prior to her admission was a weight of 105 pounds recorded two weeks prior to admission. So, 105 x 0.90 = 94.5 pounds. R11's recorded weight of 92 pounds represented a greater than 10% weight loss.

R11's Admission Nursing Assessment dated 4/24/17, identified R11's weight as 100 pounds. She had mild left arm non-pitting edema and no edema in her bilateral lower extremities. R11's Admission Nursing Assessment further identified R11 could feed self, and had recent unintentional weight loss; family member (FM)-A reported R11 was 105 pounds two weeks ago.

On 10/19/17, at 9:14 a.m. MDS coordinator (MDSC) confirmed R11's weight two weeks prior to admission was 105 pounds. He confirmed R11's weight during the 8/1/17, quarterly MDS assessment reference date was 92 pounds. MDSC confirmed R11's MDS had been completed incorrectly.

On 10/19/17, at 3:15 director of nursing (DON) confirmed she completed R11's section K on her admission MDS. DON stated MDSC took over MDS duties in June of 2017 and the dietary manager (DM) now completed section K of the MDS. DON confirmed R11 had a significant weight change of greater than 10 percent and R11's MDS was coded incorrectly.

The facility policy titled MDS and Resident Assessment Policy, revised 1/12/17, identified comprehensive assessments of resident's functional capacity are accurate, standardized (state approved) and reproducible.

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F 278	Continued From page 59 Comprehensive assessments describe the resident's capability to perform daily life functions and significant impairment in functional capacity to provide the facility with the information necessary to develop a care plan and to provide appropriate care and services for each resident. The policy further identified the registered nurse coordinating each assessment shall sign and certify the accuracy of that portion of the assessment.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d);483.21(b)(1) 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 279		11/28/17

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F 279	Continued From page 60 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan for 1 of 1 resident (R28) with suicidal ideation and 1 of 2 residents (R11) with significant weight loss.	F 279	F279 1. Care plans with appropriate diagnoses, interventions and goals for medical and nursing needs, as well as nutritional, psychosocial, suicidal	

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F 279	Continued From page 61 Findings include: R28's quarterly Minimum Data Set (MDS) dated 9/3/17, identified R28 had diagnoses which included: dementia, unspecified mood disorder and chronic kidney disease. The MDS identified R28 had severe cognitive impairment, required extensive staff assistance with dressing, toileting, limited assistance for bed mobility and transfers and supervision with walking and eating. R28 required assistance of one staff for bathing. The MDS identified R28 wandered daily, was on antipsychotic medication and did not reject care. R28's MDS indicated he had verbal behavior on 1-3 days and other behavior symptoms not directed towards others 1-3 days. Further, R28's MDS identified he expressed thoughts he would be better off dead or thoughts of hurting self. However, the MDS had not been completed accurately to include the frequency of the thoughts. R28's care plan last revised 10/16/17, identifies target behaviors of directing derogatory language/rude comments towards staff, yelling at staff, hovering over wife during meals, crying related to misconception of wife's condition and making degrading comments towards wife. R28's care plan did not address his thoughts he would be better off dead, or of hurting himself in some way. Review of R28's progress notes from 4/14/17 to 10/17/17 revealed the following: -6/3/17, R28 was tearful throughout the day. -7/12/17, nursing assistants note R28 displayed	F 279	ideations, and activity approaches were implemented for R11 and R28. 2. All resident care plans were reviewed and updated by IDT consisting of MDS Coordinator, Social Service Designee, Activity Director, Registered Dietician, and DON to include appropriate diagnoses, interventions and goals for medical and nursing needs, as well as nutritional, psychosocial, suicidal ideations, and activity approaches. 3. Comprehensive care plan development will begin on day of admission and be completed no later than 7 days after the completion of the admission MDS and CAA. This shall include input from all disciplines including but not limited to Nursing, Social Services, Activities, Dietary, Rehab, Pharmacy, Physician, Resident & Family. 4. Review of comprehensive care plan shall be completed on day 21 after admission, quarterly, and with significant change in health status by MDS Coordinator and DON. All disciplines will receive ongoing education on initiating and updating care plans to reflect new orders and change in status. Monthly audits x3 of MARS and care guides, with any discrepancies reported to MDS Coordinator. QI/QA update quarterly with compliance findings. 5. Corrective action will be completed by November 28, 2017.	

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negative self-talk, short tempered/easily annoyed, comments such as "life isn't worth living", anxious comments/concerns, and negative statements. Staff review, R28's behaviors occur on a daily basis.

-8/29/17, R28 was asked questions for PHQ-9 (a questionnaire that monitors/measures the severity of depression) he was unable to reference the past two weeks. R28 stated he has thought about being better off dead. He denied any thoughts of harming or killing self. R28 was confused which season it was.

-8/29/17, R28's monthly behavior monitoring revealed; wandering occurred on a daily basis. At times R28 would refuse his medications whole, he continued to hover over wife and being tearful. Redirection was challenging at times.

-9/1/17, R28's MDS reference period note revealed; R28 did not smile or interact as much anymore.

-9/27/17, R28 stated to staff, just leave him there to die, he just wanted to die.

-9/28/17, R28 had been incontinent and staff assisted with cares. R28 stated he wished he were dead and he was going to hang himself. He began crying and stated please shoot me.

-9/28/17, R28's monthly behaivors monitoring revealed; frequent crying x 4, repeated movement x 1, yelling x 1, spitting x 1, abusive language x 2, threatening behaviors x 2, indicated bad feeling of self x 4, short-tempered/easily annoyed x 4, wishing for death x 4, repetitive anxious complaints/concerns x 2, negative statements x

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F 279	Continued From page 63 4,self deprecation x 3, behavior significantly disruptive to care or environment x 1. Redirection could be a challenge. -10/3/17, R28 answered questions with confusion and difficulty. R28 denied thoughts of hurting himself, but stated sometimes he had thoughts he'd be better off dead. Staff noted tearful with incontinence or confusion. Nursing noted negative statements x 2 when he is cared for or confused. Wandered daily with one occasion with potential to put him in danger. On 10/18/17, at 10:40 a.m. registered nurse (RN)-A stated R28 had behaviors that included: being rude to his wife, rude to staff, nastiness and spitting. RN-A confirmed she had heard R28 state that he wished he were dead at least 4-5 times over the past six months. RN-A stated she had not assessed R28 for a plan to carry out the suicidal ideation on any of the past verbalizations of wishing he were dead. RN-A confirmed she had updated the director of nursing (DON) on some of the occasions, but not all. RN-A stated R28 was very mobile and walked without assistance and spent a lot of time alone in his room. RN-A was unaware if R28's care plan addressed his suicidal ideation or interventions in place for staff to follow when R28 verbalized thoughts of self-harm. On 10/19/17, at 3:39 p.m. director of nursing (DON) stated that the facility was aware of R28's thoughts of self harm after the SSD completed R28's PHQ-9 for his quarterly MDS dated 9/3/17. DON confirmed R28's care plan did not identify R28's suicidal ideation or interventions for suicidal ideation.	F 279		

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F 279	Continued From page 64 R11 R11's admission Minimum Data Set (MDS) dated 5/1/17, identified R11 had severe cognitive impairment and required supervision with eating. R11's MDS identified diagnoses of dementia, depression and pressure ulcer. R11's MDS further identified an admission weight of 100 pounds, regular diet and did not identify weight loss. Due to not identifying a weight loss on R11's admission MDS, a Care Area Assessment (a compressive assessment) was not completed on nutrition. R11's quarterly MDS dated 8/1/17, identified R11 had severe cognitive impairment and required supervision with eating. R11's MDS further identified weight of 92 pounds, regular diet and did not identify weight loss. However, R11's weight loss had been incorrrectly calculated from prior to admission weight of 105 pounds. Review of Registered Dietician (RD)-A's dietician nutrition note dated 5/6/17, indicated R11 had diagnoses of dementia, depression and pressure ulcer, weight was 94 pounds and on a regular diet. RD-A's note further indicated R11 was receiving a house supplement three times per day, would benefit from additional protein to heal pressure ulcer, poor oral intake (with at least one meal daily where consumption is between 1-25%), weight is down 6 pounds since admission, and her Body Mass Index (BMI) is 17.8, which is too low. Review of RD-A's dietician nutrition note dated 8/1/17, indicated R11 had diagnoses of dementia, depression and pressure ulcer, weight was 92 pounds and on a regular diet. RD-A's notes	F 279		

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F 279	Continued From page 65 further indicated, R11 was receiving a house supplement three times per day, her oral intake had improved since admission (eating 75-[1]00% at meals but overall averaging 50-75%). RD-A's note indicates her weight is down from admission and her weight has triggered for significant weight change, her weight is too low. Her BMI was 17, which was classified as underweight, recommend a BMI of 22. R11's care plan, dated 8/16/17, identified R11 required supervision and cues by staff with eating related to weakness and confusion. R11's care plan listed various interventions which included to monitor R11's intake, provide protein powder one scoop daily, and invite the resident to activities that promote additional intake. R11's care plan further identified staff were to monitor, record and report to medical doctor signs and symptoms of malnutrition: emaciation (being abnormally thin, weak), muscle wasting and significant weight loss. R11's care plan identified a registered dietician to evaluate and make diet change recommendations as needed and her nutrition needs were 1200 calories and 50 grams of protein [daily]. R11's care plan did not identify significant weight and did not identify interventions in an attempt to deal with R11's weight loss. On 10/17/17, at 1:44 p.m. during a phone interview, RD-A confirmed she was not aware that R11's weight declined to 88 pounds on 10/6/17. RD-A stated that R11's order for nutritional supplement was discontinued on 8/28/17, due to R11's refusal to drink the supplement. RD-A was not aware of any further assessments or interventions for R11's nutritional status.	F 279		

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On 10/17/17, at 2:06 p.m. dietary manager (DM)-A stated that she completes the dietary assessments on admission and quarterly. DM-A stated that the dietician checks resident weights and intakes in the electronic health record. DM-A stated that the dietician would assess a resident with a significant weight loss and give recommendations for interventions. DM-A confirmed that the dietary department did not prepare any specific snacks for R11, and that activities department passed out a snack for all residents as an activity at 3:15 p.m. daily.

On 10/19/17, at 11:31 a.m. during a follow up interview of DM-A, she indicated that DM-A spoke with R11 today and R11 stated she did not like dairy products or strawberry or vanilla nutritional supplements. DM-A indicated that this was the first she had heard this information and would order chocolate supplements, as the facility did not carry chocolate nutritional supplements.

On 10/19/17, at 3:15 p.m. DON stated that she completed R11's admission MDS section K. She was unaware that R11's usual weight was between 105-110 pounds or that R11's Admission Nursing Assessment stated she was 105 pounds two weeks prior to admission. DON confirmed that R11 had a 12% weight loss since admission, per her 10/6/17 weight of 88 pounds. DON stated she was unaware of any further assessments or interventions put in place for R11. She confirmed that R11's significant weight decline had not been reported to R11's physician or resident representative.

A policy titled Care Plan Policy and Procedure dated 11/1/15, indicated resident care plans

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F 279	Continued From page 67 would ensure the appropriate care required to maintain the resident's highest level of functioning possible. The policy also indicated that the care plan will change with the resident's needs and that any temporary problems will be added to the care plan if no resolution in 30 days.	F 279		
F 282 SS=E	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 implement care plan interventions related to toileting for 3 of 3 (R5, R27, R29) and repostioning for 3 of 3 (R5, R27,R29) reviewed for pressure ulcers. In addition, the facility failed to implement interventions to provided oral cares for 1 of 1 resident (R19) reviewed who was dependent on staff for assistance with oral cares. Findings include: R5: R5's care plan revised 8/15/17, identified R5 had impaired cognitive function/dementia or impaired though processes related to dementia and history of previous stroke, difficulty with ADL (activities of	F 282	F282 1. R5, R27, R19, and R29 NAR care sheets & care plans have been reviewed and updated as needed to include but not limited to addressing toileting, repositioning, and oral cares. 2. All resident care plans and NAR care sheets have been reviewed and updated as needed to assure individualized approaches are outlined to include but not limited to toileting, repositioning, and oral cares. 3. All nursing staff providing direct cares to residents has been educated on use and compliance of NAR care guide use to include but not limited to toileting, repositioning, and oral cares. 4. The DON or designee will	11/28/17

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F 282	Continued From page 68 daily living) self care performance, weakness, and potential for pressure ulcer development related to immobility. The care plan identified R5 required staff assistance with a mechanical lift to transfer, required repositioning and toileting every two hours, use of pressure relieving cushion when in chair, and was frequently incontinent of bowel and bladder. The facility's undated nursing assistant care guide identified R5 required assistance of one to two staff to use the commode for toileting and was at risk to left buttock for pressure ulcer, the care guide lacked direction for repositioning. On 10/17/2017, during continous observations from 6:59 a.m. to 11:47 a.m. R5 was observed seated in a wheel chair for total of four hours and 48 minutes without repositioning or off loading, the following was observed: -at 6:59 a.m. R5 was fully dressed and seated in a wheel chair in his room near the sink, independently using an electric razor. -at 7:06 a.m. R5 remained seated in the wheel chair in his room. -at 7:18 a.m. R5 remained the same, nursing assistant (NA)B walked down the hall past R5's room with a mechanical lift and waved to R5 as she walked past his room. -at 7:27 a.m. R5 remained in the wheel chair in his room and watched the television (TV). -at 7:32 a.m. R5 remained in the wheel chair and continued to watch TV in his room. -at 7:37 a.m. NA-B entered R5's room, asked if he wanted a ride down to the dining room and then propelled R5 to a dining room table near the window. -at 8:08 a.m. R5 remained seated in the wheel	F 282	review/audit all care sheet documentation daily for 7 days; then, 2X a week for 30 days or until 100% compliance is achieved to assure compliance. Additionally, the DON or designee will do unannounced, observational audits on select residents daily to assure consistency in documentation for 7 days. All audit outcomes shall be presented to the QAA Committee for review &/or comment. 5. Corrective actions will be completed by November 28, 2017.	

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chair in the dining room.
-at 8:13 a.m. R5 remained seated in the wheel chair in the dining room. R5 independently ate two hard boiled eggs, toast with grape jelly, and drank orange juice, milk and coffee.
-at 8:34 a.m. R5 finished all of the food items and continued to independently drink the fluids.
-at 9:05 a.m. R5 remained in the dining room with his head hanging forward towards his chest and eyes closed.
-at 9:20 a.m. R5 remained the same.
-at 9:26 a.m. R5 awoke, and propelled self in the wheel chair with his feet to the activity area.
-at 9:36 a.m. R5 remained seated in the wheel chair playing balloon ball with a yellow fly swatter shaped like a hand and the blue balloon.
-at 9:48 a.m. R5 remained seated paying balloon ball.
-at 9:52 a.m. R5 self propelled the wheel chair with his feet to the Heritage hall, toward the resident council meeting.
-at 9:55 a.m. R5 continued to propelled self slowly in the direction of the resident council meeting.
-at 9:59 a.m. R5 remained seated in the wheel chair in the hall. R5's wife entered the building, approached R5, visited with him briefly and then left R5 who remained seated in the wheel chair waiting for the resident council meeting to begin.
-at 10:02 a.m. the social services designee (SSD) asked R5 if he wanted to go into resident council meeting and assisted R5 to the beauty shop where the resident council meeting was held. R5 sat to the left of the beauty shop door. R5 was visible from the hall through the window of the beauty shop door.
-at 10:11 a.m. R5 remained seated in his wheel chair in the beauty shop.
-at 10:29 a.m. R5 remained in the resident

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council meeting in the beauty shop.
-at 10:48 a.m. R5 remained seated in the wheel chair. R5's eyes were closed head hanging forward.
-at 11:18 a.m. R5 was propelled out of the beauty shop to the hall by the SSD. The MDS coordinator then propelled R5 down the hall to the nurses desk. The MDS coordinator left R5 seated in the wheel chair at the nurses desk and returned down the hall to assist another resident with his catheter leg bag.
-at 11:23 a.m. R5 propelled his wheel chair around the nurses desk independently with the use of his feet.
-at 11:27 a.m. R5 propelled his wheel chair to the dining room table near the window in the dining room.
-at 11:30 a.m. R5 remained seated in the wheel chair in the dining room and looked out the window.
-at 11:40 a.m. R5 propelled his wheel chair to the nurses desk and toward the Serenity hall.
-at 11:45 a.m. NA-B propelled R5's wheel chair in to the hall, bent down to R5's ear and asked if he needed to use the bathroom, then asked if he needed to use the commode or be checked and changed. R5 responded, he needed to, "pee."
-at 11:47 a.m. in R5's room, NA-B utilized a mechanical standing lift and stood R5 up out of the wheelchair, removed his wet incontinent brief. R5's bottom and scrotum were bright red in color.

On 10/17/2017, at 10:55 a.m. NA-E indicated R5 was forgetful and needed assistance with a mechanical lift to transfer. NA-E indicated she used a care guide sheet for direction on how to care for a resident.

On 10/17/2017, at 11:12 a.m. NA-C indicated

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she would usually ask R5 if he needed to go to the bathroom and he was able to make his needs known.

On 10/17/2017, at 11:49 a.m. NA-B verified she had assisted R5 with cares this morning and R5 and had been in the wheel chair prior to 7:00 a.m. NA-B verified R5 had not been assisted out of the wheel chair until he was assisted on to the commode at 11:47 a.m. (greater than 4 hours and forty seven minutes).

On 10/18/2017, at 3:19 p.m. registered nurse (RN)-A verified she expected staff to to follow the resident care guides. RN-A identified R5 required staff assistance to toilet and reposition. RN-A identified the facility protocol for residents who require assistance or prompting is to approach the resident and offer every two hours. RN-A indicated staff would not be expected to interrupt an activity such as the resident council meeting to offer toileting. RN-A identified she had not been aware R5 had been without toileting or repositioning three hours before the resident council meeting was held.

On 10/19/2017, at 10:04 a.m. the MDS coordinator identified R5 required varying levels of care due to weakness and a lower level of alertness in the early morning and later evening. The MDS coordinator indicated R5 did not have behaviors, required staff assistance with a mechanical standing lift to transfer, was not able to not stand independently and did not attempt to stand independently.

On 10/19/2017, at 10:51 a.m. the director of nursing (DON) verified R5's care plan to be current as of August and R5 had not had changes

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in care since that time. The DON verified R5 should have been repositioned and offered toileting every two hours. The DON verified R5 required assistance for transfers with a lift and required repositioning every two hours related to a history of pressure ulcers. The DON verified it would be a problem if R5 had not been repositioned with in approximately two hours of being placed in the wheel chair. The DON further explained if R5 was not transferred with the lift to the commode, R5 should have used the lift to stand in place for a while or be transferred to the recliner.

R19:

R19's computerized care plan revised 9/21/17, identified R19 had a self care deficit related to dementia and was dependent upon staff . R19's undated facility form titled Admission/Annual Nursing Assessment for Oral/Dental identified R19 had natural teeth present. The care plan directed staff to provide oral care, brush teeth, rinse dentures, clean gums with toothette and rinse mouth with mouth wash in the morning, after meals and before bed.

On 10/17/2017, at 7:39 a.m. R19 was provided morning cares by nursing assistant (NA)B . R19 was not provided oral cares prior to being propelled in her wheel chair to the dining room at 8:02 a.m. Following the breakfast meal, R19 remained in the dining room until she was propelled to her room by the director of nursing at 10:06 a.m.

On 10/17/2017, at 10:03 a.m. The DON verified she had assisted R19 to lie down after breakfast,

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and checked her brief, and confirmed no other cares were completed at that time.

On 10/17/2017, at 10:22 a.m. NA-B verified she had not completed R19's oral cares that morning. NA-B indicated the usual facility protocol is to provide oral care prior to breakfast but if unable to, staff would try to provide oral care after breakfast.

On 10/19/2017, at 11:00 a.m. The DON verified R19's computerized care plan was correct and R19 was dependent on staff for all ADLs. The DON verified staff would need to brush R19's teeth and she expected staff to provide oral care prior to breakfast or be taken back to her room following breakfast to provide oral care.

R29:

R29's current care plan revised on 7/11/17, identified R29 had potential/actual impairment to skin integrity related to incontinence, contact dermatitis and fragile skin. The care plan listed various interventions including directing staff to turn/reposition and check/change R29 every two hours, keep body parts from excessive moisture and keep skin dry, clean and assist with toileting as needed with each incontinent episodes, monitor for any skin breakdown related to incontinence and provide pericare after each incontinent episode.

R29's nursing assistance care guide, undated, identified R29 was to be repositioned by two staff and check/change every two hours by one staff. The care plan also indicated R29 was high risk

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for skin breakdown and to alert nurse to any changes.

During observations on 10/17/17 at 8:14 a.m. NA-E was observed next to R29's bed, and assisted R29 with morning cares.
-at 8:26 a.m. NA-E and administrator were present in R29's room and assisted her to transfer from her bed to her black tilt and space wheelchair via total mechanical lift. After the transfer, NA-E wheeled R29 out to the dining room for breakfast.
-at 9:03 a.m. R29 seated at a table in the dining room, independently eating breakfast.
-at 9:24 a.m. R29 remained seated in the dining room area, visiting with other residents at her table.
-at 9:30 a.m. R29 was actively participating in activity in the den area.
-at 9:50 a.m. activity staff wheeled R29 down the north hallway towards the beauty shop. R29 was seated in her wheel chair and waited in the hallway lined up with other residents for resident council to begin. R29 was not observed to be offered assistance with toileting or repositioning and remained in the same position in the wheelchair.
-at 10:05 a.m. R29 was wheeled into the beauty shop by the social service designee (SSD) for resident council meeting. R29 remained in the resident council meeting until 11:21 a.m. when the SSD pushed R29 via wheel chair back to her room. SSD placed her call light within reach and immediately left the room. R29 was not offered to reposition or check/change and remained in the same seated position in her wheel chair.
-at 11:23 a.m. NA-C briefly entered R29's room, and discussed assistance with her bath, after lunch and exited the room. NA-C did not offer to

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reposition or check/change R29 and R29 remained in the same seated position in her wheel chair. .
-at 11:28 a.m. registered nurse (RN)-A briefly entered R29's room, visited with R29 and immediately exited the room. RN-A had not offered to reposition or check/change R29.
-at 11:29 a.m. NA-C and NA-F entered R29's room to assist R29 to transfer from the wheelchair to her bed.
-at 11:31 a.m., NA-C and NA-F transferred R29 into bed via a total mechanical lift.

During observations on 10/17/17, R29 had not been repositioned from 8:26 a.m. to 11:31 a.m., a total of 3 hours and 6 minutes.

On 10/17/17 at 11:28 a.m. NA-C confirmed R29 needed to be repositions every 2 hours, and was high risk for skin breakdown. NA-C was unaware when R29 had last been repositioned and or checked/changed. NA-C indicated she had just now helped R29, prior to that she had not toileted or repositioned R29. NA-C indicated staff try to reposition R29 every hour. NA-C indicated R29 was not repositioned and checked/change due to being at the resident council meeting today. NA-C indicated R29 was to have a bath this morning, but it did not go as planned due to it being a busy morning. NA-C indicated reclining R29 back in her tilt and space wheel chair was not repositioning her and indicated that was not properly repositioning R29. NA-C indicated R29 should be laid down to be reposition and checked/changed and indicated she had heard it was wrong to tilt R29 back in wheel chair. NA-C indicated this was not repositioning R29 she felt and she would report any concerns to the nurse if cares were not getting done in a timely fashion.

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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 282	Continued From page 76 On 10/17/17 at 11:53 a.m. NA-F confirmed R29 was routinely incontinent of bowel and bladder and needed to be repositions every two hour, checked/changed due to skin issues. NA-F indicated this was the first time she had worked with R29 today and indicated she had not repositioned or toileted R29 before this. NA-F also indicated R29 was a high risk for skin breakdown and was not sure why R29 had not been repositioned and checked/changed and stated she felt R29 was busy with activities. NA-F indicated she had heard R29 was in resident council and felt that was the reason she had not been repositioned timely. NA-F indicated she would report any concerns to the nurse if cares were not getting done in a timely fashion. On 10/17/17 at 11:56 a.m. R29 indicated staff had not offered or asked her if she wanted to be repositioned or checked/changed before she went to resident council meeting today and stated "they did tip me back a little in my chair but not all the way back, just a little." On 10/17/17 at 11:59 a.m. NA-E stated R29 needed to be repositioned every hour to hour and half. NA-E confirmed R29 had not been repositioned or checked/changed since this morning when she got up in her wheel chair for breakfast and indicated other staff had repositioned and checked/changed her just a little bit ago. NA-E indicated R29 had a chair that reclines and indicated R29 was reclined in her tilt and space wheel chair before she went to resident council meeting NA-E indicated she prefers to have R29 lie down to reposition and stated she felt it was not proper repositioning by lying R29 back in her wheel chair.	F 282		

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F 282	Continued From page 77 On 10/18/17 at 2:05 p.m. RN-A stated R29 needed to be repositioned and checked/changed every two hours by staff. RN-A indicated she would expect staff to follow the care plan as written and to make sure cares are getting done on time. RN-A indicated she did not feel tilting R29 back in her wheel chair was repositioning her and indicated she personally did not think this was repositioning R29 properly. On 10/19/17 at 11:29 a.m. DON confirmed R29 needed to be repositioned and checked/changed every two hours by staff. The DON indicated her expectations of staff would be to offer R29 to be repositioned and to be checked/changed every two hours and stated she felt staff understood the importance of this for R29 and should be repositioning, check/changing her on time. The DON also indicated R29 had a history with her skin and high risk of skin breakdown due to moisture. DON confirmed R29's care plan and indicated she had given her staff and family education on the importance of this and stated "staff should offer and encourage R29." The DON indicated staff should be following the care plan and tilting R29 back in her wheel chair was not offloading or repositioning her properly and preferred staff lay her down in her bed to reposition and check/change her.	F 282		

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F 282	Continued From page 78	F 282		

Review of R27's quarterly MDS) dated 9/4/17, identified R27 had severe cognitive impairment and had diagnoses which included; dementia and malnutrition. The MDS identified R27 was totally dependent on facility staff for all activities of daily living (ADL's.) R27's MDS indicated she was totally incontinent of bowel and bladder, was not on a toileting program and identifed R27 was at risk for pressure ulcer development and was on a turn and repositioning program.

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F 282	Continued From page 79	F 282		

Review of R27's care plan revised 9/20/17, revealed R27 was totally incontinent of bladder and bowel, wore an incontinent brief and required every two hour checking and changing and repositioning by facility staff.

On 10/17/17, during continuous observations from 7:05 a.m. to 10:35 a.m. R27 remained seated in her wheelchair without being offered assistance with repositioning, the following was observed:
- at 7:05 a.m. R27 was lying in bed on her back, her eyes were closed and the blankets were covered up to her chin and the television was on in her room.
-at 7:23 a.m. R27 remained lying on her back in her bed with her mouth open, eyes were closed and the blankets were covered her body up to her chin.
-at 7:30 a.m. R27 remained lying on her back in bed, with her eyes closed, at that time nursing assistant (NA)-F entered her room and pulled back the blankets which had covered R27. R27 was lying in bed fully dressed, NA-F donned R27's shoes and placed the lift sling underneath R27, at 7:32 a.m. NA-B entered R27's room with a full mechanical lift. At that time NA-F indicated she had dressed R27 at approximately 6:30 a.m. and had laid R27 back into bed to rest before breakfast.
-at 7:35 a.m. R27 was lying in her bed fully dressed and NA-F and NA-B assisted from her bed to her wheelchair with a full mechanical lift. NA-B immediately left R27's room after assisting with the transfer, NA-F combed R27's hair and then left the room. R27 remained seated in her wheelchair in her room with the television on. Neither NA-F or NA-B were observed to offered R27 assistance with checking and changing her

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F 282	Continued From page 80 incontinent brief. -at 8:19 a.m. R27 remained seated in a wheelchair in her room, NA-F entered her room and wheeled R27 to the dining room. R27 was not offered assistance with repositioning. -at 8:43 a.m. R27 remained seated in a wheelchair in the dining room at a circular table with approximately three other residents with the seated next to her, assisting her to eat her morning meal. -at 9:13 a.m. R27 remained seated in a wheelchair in the dining room with her breakfast meal in front of her. At that time FA stood and walked away from R27. R27 remained at the circular dining room table with her breakfast plate of eggs and toast in front of her. -at 9:23 a.m. R27 remained seated in a wheelchair in the dining room with her breakfast meal in front of her. At that time MDS coordinator (MDSC) sat between R27 and another resident. MDSC handed R27 a piece of toast and encouraged her to eat. -at 9:33 a.m. R27 remained seated in a wheelchair in the dining room and held a piece of toast in her hand. At that time MDSC stood from the table and walked away. R27 was not offered assistance with check and change or repositioning. - at 9:37 a.m. R27 remained seated in a wheelchair at the dining room table with her toast in her hand, plate of eggs and a full cups of milk and orange juice. NA-F briefly walked over to R27, verbally cued her to finish her breakfast meal and immediately walked away from R27. -at 9:51 a.m. R27 remained seated at the dining room table with a piece of toast in her hand. NA-G briefly sat next to R27, asked her if she wanted more to eat and proceeded to stand and walk away. R27 was not offered assistance with	F 282		

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F 282	Continued From page 81 cares such as repositioning or checking and changing her incontinent brief. -at 10:00 a.m. R27 remained seated at the dining room table in her wheelchair with a piece of toast in her hand. RN-A approached R27 and administered her oral medications with water. RN-A walked away immediately following administering R27's medications and was not observed to offer assistance to check and change of incontinent brief. -at 10:10 a.m. R27 remained seated at the dining room table in her wheelchair with a piece a toast in her hand. NA-G sat next to R27 and assisted her to eat the remainder of her breakfast, the piece of toast, plate of eggs and the cup of milk and juice. R27 remained seated in her wheelchair in the dining room with NA-G until 10:26 a.m. when NA-B approached. -at 10:27 a.m. R27 had remained seated in her wheelchair, NA-G placed R27's feet on the footrests of the wheelchair and proceeded to wheel R27 back to her room. NA-B approached R27's room with a full mechanical lift and both NA-F and NA-B assisted R27 out of her wheelchair and into bed at 10:35 a.m. -at 10:35 a.m. R27 was assisted to lay on her bed with the mechanical lift. NA-G was on R27's right side and NA-B was on R27's left side. NA-G removed R27's shoes and proceeded to turn R27 to her left side and then to her right side. NA-G pulled R27's slacks down to her ankles which revealed R27 had a blue incontinent brief on. R27's brief was soiled with a large amount of urine and a small amount of soft bowel. R27's buttocks was wet and her entire buttocks skin was wrinkled with deeply lines crevices from the incontinent brief. NA-B assisted to remove R27 soiled brief, cleanse her skin and donned a clean, dry brief.	F 282		

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F 282	Continued From page 82 R27 was observed for a total of four hours and five minutes without being checked and changed for incontinence. On 10/17/17, at 10:35 a.m. NA-G stated R27 was supposed to be checked and changed every two hours with repositioning. NA-G indicated she was unsure of when R27 was last assisted with repositioning and had felt since she was done with breakfast she should assist R27 to lay down. NA-G stated she was with other residents down the other wing and was not sure why R27 was not repositioned or checked and changed timely. On 10/17/17, at 10:36 a.m. NA-B indicated she had assisted R27 with the mechanical lift to get up for breakfast and had not checked and changed R27 prior to the transfer. NA-B indicated she had thought R27 had already been changed prior to her entering R27's room and before the transfer. NA-B further indicated she had not returned to assist R27 with repositioning or check and change within two hours as she had been assisting other residents with cares. NA-B stated R27 needs must be anticipated by staff and she was unable to reposition herself in bed or in the wheelchair. On 10/17/17, at 11:36 a.m. NA-F indicated she had assisted R27 with morning cares at approximately 6:30 a.m. and had at that time checked and changed R27's incontinent brief. NA-F stated R27 was supposed to be assisted with repositioning and checking and changing for incontinence every two hours and as needed. NA-F indicated she had been working with other residents at the time R27 should have been repositioned.	F 282		

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F 282	Continued From page 83	F 282		

On 10/17/17, at 1:55 p.m. NA- E stated R27 needs must be anticipated and was totally dependent on staff for all ADL's. NA-E indicated R27 required assistance every two hours checking and changing for incontinence.

On 10/18/17, at 2:16 p.m. NA-D stated R27 was unable to verbalize her needs or wishes and she was totally dependent on facility staff for all ADL's. NA-D indicated R27 required assistance with every two hour checking and changing for incontinence.

On 10/18/17, at 2:50 p.m. RN-A confirmed R27's care plan directed facility staff to turn and reposition R27 every two hours and check and change for incontinence every two hours. RN-A indicated she was not notified R27 had not received repositioning in a timely manner on 10/17/017, though would expect to be notified if residents cares were not done according to their care plans, such as R27. RN-A further indicated as recently as last week, NA's had reported to her residents cares were not done timely due to not enough NA's.

On 10/19/17, at 1:42 p.m. MDSC confirmed R27 was totally dependent on facility staff for all ADL's including checking and changing every two hours for both bowel and bladder incontinence. MDSC stated he expected staff to follow resident care plans and would expect R27 to be repositioned and checked and changed every two hours as directed by her care plan.

On 10/19/17, at 2:41 p.m. director of nursing (DON) stated she would expect facility staff to follow R27's care plan, which included checking

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F 282	Continued From page 84 and changing incontinent product every two hours. DON further indicated it was not acceptable for R27 to go four hours and five minutes without being checked or changed. The requested facility policy was not provided. On 10/19/17, at 5:43 p.m the facility administrator identifed no further policies were available.	F 282		
F 312 SS=D	ADL CARE PROVIDED FOR DEPENDENT RESIDENTS CFR(s): 483.24(a)(2) (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide timely assistance with incontinence cares for 2 of 3 residents (R29, R27) who were dependent upon staff for personal cares with a check and change program. In addition, the facility failed to ensure oral care was provided for 1 of 1 resident (R19) reviewed who was dependent on staff for assistance with oral cares. Findings include: R29's quarterly Minimum Data Set (MDS) dated 9/2/17, identified R29 had diagnoses which included bladder disorder, full incontinence of feces and unspecified urinary incontinence. The MDS identified R29 was cognitively intact and required extensive assist of two staff for bed mobility, personal hygiene, dressing and was totally dependent on two staff for transfers and	F 312	F312 1. R19, R27, and R29 NAR care sheets & care plans have been reviewed and updated as needed. 2. All resident care plans and NAR care sheets have been reviewed and updated as needed to assure individualized approaches are outlined to include but not limited to turn and repositioning, timely toileting, check and change, and oral cares. 3. All staff providing direct cares to residents has been educated on use and compliance of NAR care guide use. 4. The DON or designee will review/audit all care sheet documentation daily for 7 days; then, 2X a week for 30 days or until 100% compliance is achieved to assure compliance. Additionally, the DON or designee will do	11/28/17

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F 312	Continued From page 85 toileting. Further, the MDS identified R29 was always incontinent of bowel and bladder, and was not on a urinary toileting or bowel toileting program. R29's Bowel and Bladder assessment dated 9/1/17, indicated R29 had urge bladder incontinence, was always incontinent of bowel and bladder, was not on a toileting program and was to be provided scheduled incontinent care as defined on care plan (check and change). R29's current care plan revised 7/11/17, identified R29 had bowel incontinence related to colitis and physical limitations. R29 also had mixed bladder incontinence related to limited mobility and disease process. The care plan directed staff to check and change R29 every two hours, assist with toileting as needed with each incontinent episodes, monitor for any skin breakdown related to incontinence and provide pericare after each incontinent episode. Review of the facility's nursing assistant care guide undated, identified R29 was to be checked/changed by one staff and repositioned every two hours by two staff. The care guide also indicated R29 was high risk for skin breakdown and to alert nurse to any changes. During observations conducted on 10/17/17 from 7:43 a.m. to 11:31 a.m. At 7:43 a.m., R29 was observed with eyes closed, covered with a blanket, lying on her back in bed, with the head of bed elevated approximately 30 degrees. -at 7:55 a.m. nursing assistant (NA)- E entered R29's room to assist R29 with morning cares. -at 8:11 a.m. R29 was noted to have a green incontinent pad draped under her mid buttocks	F 312	unannounced, observational audits on select residents daily to assure consistency in documentation for 7 days. All audit outcomes shall be presented to the QAA Committee for review &/or comment. 5. Corrective actions will be completed by November 28, 2017.	

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area. NA-E unhooked R29's brief straps, washed her peri area, dried, assisted R29 roll to her left side. NA-E removed the soiled incontinent brief, R29 was noted to be incontinent of urine and have a small soft brown bowel movement in her incontinent brief. At 8:14 a.m. NA-E applied a clean incontinent brief under R29's buttocks, applied barrier cream to rectal area and buttocks, and closed the tabs of R29's clean incontinent brief. NA-E continued to get R29's lower body dressed.
-at 8:26 a.m. NA-E and administrator were present in R29's room and assisted R29 to transfer from her bed to her black tilt and space wheelchair via total mechanical lift. After the transfer, NA-E wheeled her out to the dining room for breakfast.
-at 9:03 a.m. R29 seated at a table in the dining room, independently eating breakfast.
-at 9:24 a.m. R29 remained seated in the dining room area, visiting with other residents at her table.
-at 9:30 a.m. R29 was actively participating in activity in the den area.
-at 9:50 a.m. activity staff wheeled R29 down the north hallway towards the beauty shop. R29 was seated in her wheel chair and waited in the hallway lined up with other residents for resident council to begin. R29 was not observed to be offered assistance with toileting.
-at 10:05 a.m. R29 was wheeled into the beauty shop by the social service designee (SSD) for resident council meeting. R29 remained in the resident council meeting until 11:21 a.m. when the SSD pushed R29 via wheel chair back to her room. SSD placed her call light within reach and immediately left the room. R29 was not offered to reposition or check/change.
-at 11:23 a.m. NA-C briefly entered R29's room,

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and discussed assistance with her bath, after lunch and exited the room. NA-C did not offer to reposition or check/change R29.
-at 11:28 a.m. registered nurse (RN)-A briefly entered R29's room, visited with R29 and immediately exited the room. RN-A had not offered to reposition or check/change R29.
-at 11:29 a.m. NA-C and NA-F entered R29's room to assist R29 to transfer from the wheelchair to her bed.
-at 11:31 a.m., NA-C and NA-F transferred R29 into bed via a total mechanical lift.
-at 11:35 a.m. NA- C and NA-F assisted R29 with change of incontinent brief and peri cares. R29 had a medium, brown soft bowel movement and urine in her incontinent brief.

During observations on 10/17/17, R29 had not been check and changed from 8:26 a.m. to 11:31 a.m., a total of 3 hours and 6 minutes. R29 was unable to reposition herself independently and was not assisted by staff to be checked or changed for incontinence every two hours per her current care plan.

On 10/17/17, at 11:28 a.m. NA-C confirmed R29 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours, was to be checked/changed, wore a green brief and was high risk for skin breakdown. NA-C was unaware when R29 had last been repositioned and or checked/changed. NA-C indicated she had just now helped R29, prior to that she had not toileted or repositioned R29. NA-C indicated R29 had not been checked/change due to being at the resident council meeting today. NA-C indicated R29 was to have a bath this morning, but it did not go as planned due to it being a busy morning.

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F 312	Continued From page 88 On 10/17/17 at 11:53 a.m. NA-F confirmed R29 was routinely incontinent of bowel and bladder and needed to be repositioned every two hours, checked/changed due to skin issues. NA-F indicated this was the first time she had worked with R29 for the 11:31 a.m. check and change and indicated she had not repositioned or toileted R29 before this. NA-F also indicated R29 was a high risk for skin breakdown and was not sure why R29 had not been repositioned and checked/changed and stated maybe busy with activities. NA-F indicated she had heard R29 was in resident council and that was the reason she had not been repositioned and checked/changed. On 10/17/17 at 11:56 a.m. R29 indicated staff had not offered or asked her if she wanted to be repositioned or checked/changed before she went to resident council meeting today. On 10/17/17 at 11:59 a.m. NA-E confirmed R29 was routinely incontinent of bowel and bladder and needed to be repositioned and checked/changed every hour to hour and half. NA-E confirmed R29 had not been repositioned or checked/changed since this morning when she got up in her wheel chair for breakfast and indicated other staff had repositioned and checked/changed her just a little bit ago. On 10/18/17 at 2:05 p.m. RN-A confirmed R29 was routinely incontinent of bowel and bladder and needed to be repositioned and checked/changed every two hours by staff. The RN-A indicated she would expect staff to follow the care plan as written and to make sure cares were getting done on time and stated she was not aware R29's care plan was not being followed consistently.	F 312		

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F 312	Continued From page 89 On 10/19/17 at 11:29 a.m. director of nursing (DON) confirmed R29 was routinely incontinent of bowel and bladder and needed to be repositioned and checked/changed every two hours by staff. The DON indicated her expectations of staff would be to offer R29 to be repositioned and to be checked/changed every two hours and stated she felt staff understood the importance of this for R29 and should be repositioning, check/changing her on time. The DON also indicated R29 had a history with her skin and high risk of skin breakdown due to moisture. The DON confirmed R29's care plan and indicated she had given her staff and family education on the importance of this and stated "staff should offer and encourage R29." .	F 312		

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Review of R27's quarterly MDS dated 9/4/17,

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identified R27 had severe cognitive impairment and had diagnoses which included; dementia and malnutrition. The MDS identified R27 was totally dependent on facility staff for all activities of daily living (ADL's.) R27's MDS indicated she was totally incontinent of bowel and bladder and further indicated R27 was not on a toileting program.

Review of R27's Care Area Assessment (CAA) dated 6/4/17, lacked any documentation of R27's cognition, ADL status or incontinence.

Review of R27's Bladder assessment dated 9/1/17, revealed R27 had severe cognitive impairment, was dependent on facility staff for transfers and was totally incontinent of bladder and bowel. The assessment revealed R27 would be placed on a check and change program to keep dry.

Review of R27's care plan revised 9/20/17, revealed R27 was totally incontinent of bladder and bowel, wore an incontinent brief and required every two hour checking and changing by facility staff.

On 10/17/17, during continuous observations from 7:05 a.m. to 10:35 a.m. R27 remained seated in her wheelchair without being offered assistance with repositioning, the following was observed:

-at 7:05 a.m. R27 was lying in bed on her back, her eyes were closed and the blankets were covered up to her chin and the television was on in her room.
-at 7:23 a.m. R27 remained lying on her back in her bed with her mouth open, eyes were closed

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and the blankets were covered her body up to her chin.
-at 7:30 a.m. R27 remained lying on her back in bed, with her eyes closed, at that time nursing assistant (NA)-F entered her room and pulled back the blankets which had covered R27. R27 was lying in bed fully dressed, NA-F donned R27's shoes and placed the lift sling underneath R27, at 7:32 a.m. NA-B entered R27's room with a full mechanical lift. At that time NA-F indicated she had dressed R27 at approximately 6:30 a.m. and had laid R27 back into bed to rest before breakfast.
-at 7:35 a.m. R27 was lying in her bed fully dressed and NA-F and NA-B assisted from her bed to her wheelchair with a full mechanical lift. NA-B immediately left R27's room after assisting with the transfer, NA-F combed R27's hair and then left the room. R27 remained seated in her wheelchair in her room with the television on. Neither NA-F or NA-B were observed to offered R27 assistance with checking and changing her incontinent brief.
-at 8:19 a.m. R27 remained seated in a wheelchair in her room, NA-F entered her room and wheeled R27 to the dining room. R27 was not offered assistance with repositioning.
-at 8:43 a.m. R27 remained seated in a wheelchair in the dining room at a circular table with approximately three other residents with the seated next to her, assisting her to eat her morning meal.
-at 9:13 a.m. R27 remained seated in a wheelchair in the dining room with her breakfast meal in front of her. At that time FA stood and walked away from R27. R27 remained at the circular dining room table with her breakfast plate of eggs and toast in front of her.
-at 9:23 a.m. R27 remained seated in a

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wheelchair in the dining room with her breakfast meal in front of her. At that time MDS coordinator sat between R27 and another resident. MDS coordinator handed R27 a piece of toast and encouraged her to eat.
-at 9:33 a.m. R27 remained seated in a wheelchair in the dining room and held a piece of toast in her hand. At that time MDS coordinator stood from the table and walked away. R27 was not offered assistance with check and change or repositioning.
-at 9:37 a.m. R27 remained seated in a wheelchair at the dining room table with her toast in her hand, plate of eggs and a full cups of milk and orange juice. NA-F briefly walked over to R27, verbally cued her to finish her breakfast meal and immediately walked away from R27.
-at 9:51 a.m. R27 remained seated at the dining room table with a piece of toast in her hand. NA-G briefly sat next to R27, asked her if she wanted more to eat and proceeded to stand and walk away. R27 was not offered assistance with cares such as repositioning or checking and changing her incontinent brief.
-at 10:00 a.m. R27 remained seated at the dining room table in her wheelchair with a piece of toast in her hand. RN-A approached R27 and administered her oral medications with water. RN-A walked away immediately following administering R27's medications and was not observed to offer assistance to check and change of incontinent brief.
-at 10:10 a.m. R27 remained seated at the dining room table in her wheelchair with a piece a toast in her hand. NA-G sat next to R27 and assisted her to eat the remainder of her breakfast, the piece of toast, plate of eggs and the cup of milk and juice. R27 remained seated in her wheelchair in the dining room with NA-G until 10:26 a.m.

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F 312	Continued From page 94 when NA-B approached. -at 10:27 a.m. R27 had remained seated in her wheelchair, NA-G placed R27's feet on the footrests of the wheelchair and proceeded to wheel R27 back to her room. NA-B approached R27's room with a full mechanical lift and both NA-F and NA-B assisted R27 out of her wheelchair and into bed at 10:35 a.m. -at 10:35 a.m. R27 was assisted to lay on her bed with the mechanical lift. NA-G was on R27's right side and NA-B was on R27's left side. NA-G removed R27's shoes and proceeded to turn R27 to her left side and then to her right side. NA-G pulled R27's slacks down to her ankles which revealed R27 had a blue incontinent brief on. R27's brief was soiled with a large amount of urine and a small amount of soft bowel. R27's buttocks was wet and her entire buttocks skin was wrinkled with deeply lines crevices from the incontinent brief. NA-B assisted to remove R27 soiled brief, cleanse her skin and donned a clean, dry brief. R27 was observed for a total of four hours and five minutes without being checked and changed for incontinence. On 10/17/17, at 10:35 a.m. NA-G stated R27 was supposed to be checked and changed every two hours with repositioning. NA-G indicated she was unsure of when R27 was last assisted with repositioning and had felt since she was done with breakfast she should assist R27 to lay down. NA-G stated she was with other residents down the other wing and was not sure why R27 was not repositioned or checked and changed timely. On 10/17/17, at 10:36 a.m. NA-B indicated she had assisted R27 with the mechanical lift to get	F 312		

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up for breakfast and had not checked and changed R27 prior to the transfer. NA-B indicated she had thought R27 had already been changed prior to her entering R27's room and before the transfer. NA-B further indicated she had not returned to assist R27 with repositioning or check and change within two hours as she had been assisting other residents with cares. NA-B stated R27 needs must be anticipated by staff and she was unable to reposition herself in bed or in the wheelchair.

On 10/17/17, at 11:36 a.m. NA-F indicated she had assisted R27 with morning cares at approximately 6:30 a.m. and had at that time checked and changed R27's incontinent brief. NA-F stated R27 was supposed to be assisted with repositioning and checking and changing for incontinence every two hours and as needed. NA-F indicated she had been working with other residents at the time R27 should have been repositioned.

On 10/17/17, at 1:55 p.m. NA- E stated R27 needs must be anticipated and was totally dependent on staff for all ADL's. NA-E indicated R27 required assistance every two hours checking and changing for incontinence.

On 10/18/17, at 2:16 p.m. NA-D stated R27 was unable to verbalize her needs or wishes and she was totally dependent on facility staff for all ADL's. NA-D indicated R27 required assistance with every two hour checking and changing for incontinence.

On 10/18/17, at 2:50 p.m. RN-A confirmed R27's care plan directed facility staff to turn and reposition R27 every two hours and check and

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change for incontinence every two hours. RN-A indicated she was not notified R27 had not received repositioning in a timely manner on 10/17/017, though would expect to be notified if residents cares were not done according to their care plans, such as R27. RN-A further indicated as recently as last week, NA's had reported to her residents cares were not done timely due to not enough NA's.

On 10/19/17, at 1:42 p.m. MDS coordinator confirmed R27 was totally dependent on facility staff for all ADL's including checking and changing every two hours for both bowel and bladder incontinence. MDS coordinator stated he expected staff to follow resident care plans and would expect R27 to be repositioned and checked and changed every two hours as directed by her care plan.

On 10/19/17, at 2:41 p.m. director of nursing (DON) stated she would expect facility staff to follow R27's care plan, which included checking and changing incontinent product every two hours. DON further indicated it was not acceptable for R27 to go four hours and five minutes without being checked or changed.

A facility policy and procedure titled "Bowel and Bladder Assessment, Retraining and Toileting", revised 5/1/17, identified it was the facility's policy for those residents assessed as requiring a check and change program, be done so every two hours.

R19's annual MDS dated 6/8/17, identified R19

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had severe cognitive impairment, had diagnoses which included arthritis, dementia, and cataracts. The MDS identified R19 required total assistance with bed mobility, transfer, locomotion dressing, eating, toileting and personal hygiene.

R19's computerized care plan revised 9/21/17, identified R19 had a self care deficit related to dementia and was dependent upon staff . R19's undated facility form titled Admission/Annual Nursing Assessment for Oral/Dental identified R19 had natural teeth present. The care plan directed staff to provide oral care, brush teeth, rinse dentures, clean gums with toothette and rinse mouth with mouth wash in the morning, after meals and before bed.

On 10/17/2017, at 7:39 a.m. R19 was provided morning cares by nursing assistant (NA)B . R19 was not provided oral cares prior to being propelled in her wheel chair to the dining room at 8:02 a.m. Following the breakfast meal, R19 remained in the dining room until she was propelled to her room by the director of nursing at 10:06 a.m.

On 10/17/2017, at 10:03 a.m. The DON verified she had assisted R19 to lie down after breakfast, and checked her brief, and confirmed no other cares were completed at that time.

On 10/17/2017, at 10:22 a.m. NA-B verified she had not completed R19's oral cares that morning. NA-B indicated the usual facility protocol is to provide oral care prior to breakfast but if unable to, staff would try to provide oral care after breakfast.

On 10/19/2017, at 11:00 a.m. The DON verified

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F 312	Continued From page 98 R19's computerized care plan was correct and R19 was dependent on staff for all ADLs. The DON verified staff would need to brush R19's teeth and she expected staff to provide oral care prior to breakfast or be taken back to her room following breakfast to provide oral care. The facility policy titled Oral Cares revised 11/1/15, identified oral hygiene provided twice a day is best to maintain good oral health.	F 312		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely repositioning for 3 of 3 residents (R5, R29, R27) who were identified at risk for pressure ulcer development.	F 314	F314 1. R5, R27, and R29 NAR care sheets & care plans have been reviewed and updated as needed. 2. All resident care plans and NAR care	11/28/17

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F 314	Continued From page 99 Findings include: R5's annual Minimum Data Set (MDS) dated 5/1/17, identified R5 had moderate cognative impairement, had diagnoses which included diabetes, arthritis and dementia, required extensive assist for bed mobility, transfer locomotion on and off of unit, dressing, hygiene, and toileting. The MDS indicated R5 was at risk for pressure ulcers and had a current stage one pressure ulcer. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual dated 10/2017, defined a Stage 1: Intact skin with non-blanchable redness of a localized area usually over a bony prominence. The corresponding care area assessment (CAA) dated 5/1/17, identified R5 required extensive assistance related to limited mobility, used a mechanical lift and was to be repositioned every two hours. The CAA identifed R5 had been admitted with a left buttocks pressure ulcer. The CAA further revleaed R5's pressure ulcer was reoccuring and R5 remained at risk for pressure ulcers. R5's quarterly MDS dated 7/27/17, identified R5 had moderate cognative impairment, had diagnoses which included diabetes, arthritis and dementia, required extensive assist for bed mobility, transfer locomotion on and off of unit, dressing, hygiene, and toileting and at risk for pressure ulcers and did not have any pressure ulcers at the time of the assessment. R5's Braden Scale/Skin Risk Assessment for Pressure Ulcers effective date 7/27/17, identified R5 had slightly limited sensory perception, skin	F 314	sheets have been reviewed and updated as needed to assure individualized approaches are outlined to include but not limited to turn and repositioning, timely toileting, check and change, and oral cares. 3. All staff providing direct cares to residents has been educated on use and compliance of NAR care guide use. 4. The DON or designee will review/audit all care sheet documentation daily for 7 days; then, 2X a week for 30 days or until 100% compliance is achieved to assure compliance. Additionally, the DON or designee will do unannounced, observational audits on select residents daily to assure consistency in documentation for 7 days. All audit outcomes shall be presented to the QAA Committee for review &/or comment. 5. Corrective actions will be completed by November 28, 2017.	

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was very moist, was chair fast, had very limited mobility, had adequate nutritional intake, and a potential problem with friction and shear. The assessment identified R5 had a moderate risk of developing pressure ulcers.

R5's care plan revised 8/15/17, identified R5 had impaired cognitive function/dementia or impaired though processes related to dementia and history of previous stroke, difficulty with ADL (activities of daily living) self care performance, weakness, and potential for pressure ulcer development related to immobility. The care plan identified R5 required staff assistance with a mechanical lift to transfer, required repositioning and toileting every two hours, use of pressure relieving cushion when in chair, and was frequently incontinent of bowel and bladder.

The facility's undated nursing assistant care guide identified R5 required assistance of one to two staff to use the commode for toileting and was at risk to left buttock for pressure ulcer, the care guide lacked direction for repositioning.

On 10/17/2017, during continous observations from 6:59 a.m. to 11:47 a.m. R5 was observed seated in a wheel chair for total of four hours and 48 minutes without repositioning or off loading, the following was observed:

-at 6:59 a.m. R5 was fully dressed and seated in a wheel chair in his room near the sink, independently using an electric razor.
-at 7:06 a.m. R5 remained seated in the wheel chair in his room.
-at 7:18 a.m. R5 remained the same, nursing assistant (NA)B walked down the hall past R5's room with a mechanical lift and waved to R5 as

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she walked past his room.
-at 7:27 a.m. R5 remained in the wheel chair in his room and watched the television (TV).
-at 7:32 a.m. R5 remained in the wheel chair and continued to watch TV in his room.
-at 7:37 a.m. NA-B entered R5's room, asked if he wanted a ride down to the dining room and then propelled R5 to a dining room table near the window.
-at 8:08 a.m. R5 remained seated in the wheel chair in the dining room.
-at 8:13 a.m. R5 remained seated in the wheel chair in the dining room. R5 independently ate two hard boiled eggs, toast with grape jelly, and drank orange juice, milk and coffee.
-at 8:34 a.m. R5 finished all of the food items and continued to independently drink the fluids.
-at 9:05 a.m. R5 remained in the dining room with his head hanging forward towards his chest and eyes closed.
-at 9:20 a.m. R5 remained the same.
-at 9:26 a.m. R5 awoke, and propelled self in the wheel chair with his feet to the activity area.
-at 9:36 a.m. R5 remained seated in the wheel chair playing balloon ball with a yellow fly swatter shaped like a hand and the blue balloon.
-at 9:48 a.m. R5 remained seated paying balloon ball.
-at 9:52 a.m. R5 self propelled the wheel chair with his feet to the Heritage hall, toward the resident council meeting.
-at 9:55 a.m. R5 continued to propelled self slowly in the direction of the resident council meeting.
-at 9:59 a.m. R5 remained seated in the wheel chair in the hall. R5's wife entered the building, approached R5, visited with him briefly and then left R5 who remained seated in the wheel chair waiting for the resident council meeting to begin.

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F 314	Continued From page 102 -at 10:02 a.m. the social services designee (SSD) asked R5 if he wanted to go into resident council meeting and assisted R5 to the beauty shop where the resident council meeting was held. R5 sat to the left of the beauty shop door. R5 was visible from the hall through the window of the beauty shop door. -at 10:11 a.m. R5 remained seated in his wheel chair in the beauty shop. -at 10:29 a.m. R5 remained in the resident council meeting in the beauty shop. -at 10:48 a.m. R5 remained seated in the wheel chair. R5's eyes were closed head hanging forward. -at 11:18 a.m. R5 was propelled out of the beauty shop to the hall by the SSD. The MDS coordinator then propelled R5 down the hall to the nurses desk. The MDS coordinator left R5 seated in the wheel chair at the nurses desk and returned down the hall to assist another resident with his catheter leg bag. -at 11:23 a.m. R5 propelled his wheel chair around the nurses desk independently with the use of his feet. -at 11:27 a.m. R5 propelled his wheel chair to the dining room table near the window in the dining room. -at 11:30 a.m. R5 remained seated in the wheel chair in the dining room and looked out the window. -at 11:40 a.m. R5 propelled his wheel chair to the nurses desk and toward the Serenity hall. -at 11:45 a.m. NA-B propelled R5's wheel chair in to the hall, bent down to R5's ear and asked if he needed to use the bathroom, then asked if he needed to use the commode or be checked and changed. R5 responded, he needed to, "pee." -at 11:47 a.m. in R5's room, NA-B utilized a mechanical standing lift and stood R5 up out of	F 314		

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the wheelchair, removed his wet incontinent brief. R5's bottom and scrotum were bright red in color.

On 10/17/2017, at 10:55 a.m. NA-E indicated R5 was forgetful and needed assistance with a mechanical lift to transfer. NA-E indicated she used a care guide sheet for direction on how to care for a resident.

On 10/17/2017, at 11:12 a.m. NA-C indicated she would usually ask R5 if he needed to go to the bathroom and he was able to make his needs known.

On 10/17/2017, at 11:49 a.m. NA-B verified she had assisted R5 with cares this morning and R5 and had been in the wheel chair prior to 7:00 a.m. NA-B verified R5 had not been assisted out of the wheel chair until he was assisted on to the commode at 11:47 a.m. (greater than 4 hours and forty seven minutes).

On 10/18/2017, at 3:19 p.m. registered nurse (RN)-A verified she expected staff to to follow the resident care guides. RN-A identified R5 required staff assistance to toilet and reposition. RN-A identified the facility protocol for residents who require assistance or prompting is to approach the resident and offer every two hours. RN-A indicated staff would not be expected to interrupt an activity such as the resident council meeting to offer toileting. RN-A identified she had not been aware R5 had been without toileting or repositioning three hours before the resident council meeting was held.

On 10/19/2017, at 10:04 a.m. the MDS coordinator identified R5 required varying levels of care due to weakness and a lower level of

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alertness in the early morning and later evening. The MDS coordinator indicated R5 did not have behaviors, required staff assistance with a mechanical standing lift to transfer, was not able to not stand independently and did not attempt to stand independently.

On 10/19/2017, at 10:51 a.m. the director of nursing (DON) verified R5's care plan to be current as of August and R5 had not had changes in care since that time. The DON verified R5 should have been repositioned and offered toileting every two hours. The DON verified R5 required assistance for transfers with a lift and required repositioning every two hours related to a history of pressure ulcers. The DON verified it would be a problem if R5 had not been repositioned with in approximately two hours of being placed in the wheel chair. The DON further explained if R5 was not transferred with the lift to the commode, R5 should have used the lift to stand in place for a while or be transferred to the recliner.

The facility policy titled Prevention and Treatment of Wounds, revised 3/4/17, identified the policy objective to identify and assess residents whose clinical conditions increase the risk for impaired skin integrity and pressure ulcers and to implement preventative measures.

R29's quarterly MDS dated 9/2/17, identified R29 had diagnoses which included bladder disorder, full incontinence of feces and unspecified urinary incontinence. The MDS also identified R29 was cognitively intact and required extensive assist of two staff for bed mobility, personal hygiene, dressing and was totally dependent on two staff for transfers and toileting. Further, the MDS

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identified R29 was at risk for the development of pressure ulcers and listed various treatments which included turning and repositioning.

R29's Braden Scale for Predicting Pressure Sore Risk form, dated 9/1/17, identified R29 was at risk for the development of pressure ulcers, and indicated R29 was very limited in making frequent or significant changes independently, and could not bear weight.

R29's Tissue Tolerance Data Collection Sheet, dated 5/16/17 identified R29 had history of pressure ulcers in the last six months and listed reposition every 1.5 hours.

R29's current care plan revised on 7/11/17, identified R29 had potential/actual impairment to skin integrity related to incontinence, contact dermatitis and fragile skin. The care plan listed various interventions including directing staff to turn and reposition R29 every two hours, keep body parts from excessive moisture and keep skin dry and clean.

R29's nursing assistance care guide, undated, identified R29 was to be repositioned every two hours by two staff. The care plan also indicated R29 was high risk for skin breakdown and to alert nurse to any changes.

During observations on 10/17/17 at 8:14 a.m. NA-E was observed next to R29's bed, and assisted R29 with morning cares.
-at 8:26 a.m. NA-E and administrator was present in R29's room and assisted her to transfer from her bed to her black tilt and space wheelchair via total mechanical lift. After the transfer, NA-E wheeled her out to the dining room for breakfast.

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F 314	Continued From page 106 -at 9:03 a.m. R29 seated at a table in the dining room, independently eating breakfast. -at 9:24 a.m. R29 remained seated in the dining room area, visiting with other residents at her table. -at 9:30 a.m. R29 was actively participating in activity in the den area. -at 9:50 a.m. activity staff wheeled R29 down the north hallway towards the beauty shop. R29 was seated in her wheel chair and waited in the hallway lined up with other residents for resident council to begin. R29 was not observed to be offered assistance with toileting or repositioning and remained in the same position in the wheelchair. -at 10:05 a.m. R29 was wheeled into the beauty shop by the social service designee (SSD) for resident council meeting. R29 remained in the resident council meeting until 11:21 a.m. when the SSD pushed R29 via wheel chair back to her room. SSD placed her call light within reach and immediately left the room. R29 was not offered to reposition or check/change and remained in the same seated position in her wheel chair. -at 11:23 a.m. NA-C briefly entered R29's room, and discussed assistance with her bath, after lunch and exited the room. NA-C did not offer to reposition or check/change R29 and R29 remained in the same seated position in her wheel chair. . -at 11:28 a.m. registered nurse (RN)-A briefly entered R29's room, visited with R29 and immediately exited the room. RN-A had not offered to reposition or check/change R29. -at 11:29 a.m. NA-C and NA-F entered R29's room to assist R29 to transfer from the wheelchair to her bed. -at 11:31 a.m., NA-C and NA-F transferred R29 into bed via a total mechanical lift.	F 314		

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F 314	Continued From page 107 During observations on 10/17/17, R29 had not been repositioned from 8:26 a.m. to 11:31 a.m., a total of 3 hours and 6 minutes. On 10/17/17 at 11:28 a.m. NA-C confirmed R29 needed to be repositions every 2 hours, and was high risk for skin breakdown. NA-C was unaware when R29 had last been repositioned and or checked/changed. NA-C indicated she had just now helped R29, prior to that she had not toileted or repositioned R29. NA-C indicated staff try to reposition R29 every hour. NA-C indicated R29 was not repositioned and checked/change due to being at the resident council meeting today. NA-C indicated R29 was to have a bath this morning, but it did not go as planned due to it being a busy morning. NA-C indicated reclining R29 back in her tilt and space wheel chair was not repositioning her and indicated that was not properly repositioning R29. NA-C indicated R29 should be laid down to be reposition and checked/changed and indicated she had heard it was wrong to tilt R29 back in wheel chair. NA-C indicated this was not repositioning R29 she felt and she would report any concerns to the nurse if cares were not getting done in a timely fashion. On 10/17/17 at 11:53 a.m. NA-F confirmed R29 was routinely incontinent of bowel and bladder and needed to be repositions every two hour, checked/changed due to skin issues. NA-F indicated this was the first time she had worked with R29 today and indicated she had not repositioned or toileted R29 before this. NA-F also indicated R29 was a high risk for skin breakdown and was not sure why R29 had not been repositioned and checked/changed and stated she felt R29 was busy with activities. NA-F	F 314		

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indicated she had heard R29 was in resident council and felt that was the reason she had not been repositioned timely. NA-F indicated she would report any concerns to the nurse if cares were not getting done in a timely fashion.

On 10/17/17 at 11:56 a.m. R29 indicated staff had not offered or asked her if she wanted to be repositioned or checked/changed before she went to resident council meeting today and stated "they did tip me back a little in my chair but not all the way back, just a little."

On 10/17/17 at 11:59 a.m. NA-E stated R29 needed to be repositioned every hour to hour and half. NA-E confirmed R29 had not been repositioned or checked/changed since this morning when she got up in her wheel chair for breakfast and indicated other staff had repositioned and checked/changed her just a little bit ago. NA-E indicated R29 had a chair that reclines and indicated R29 was reclined in her tilt and space wheel chair before she went to resident council meeting NA-E indicated she prefers to have R29 lie down to reposition and stated she felt it was not proper repositioning by lying R29 back in her wheel chair.

On 10/18/17 at 2:05 p.m. RN-A stated R29 needed to be repositioned and checked/changed every two hours by staff. RN-A indicated she would expect staff to follow the care plan as written and to make sure cares are getting done on time. RN-A indicated she did not feel tilting R29 back in her wheel chair was repositioning her and indicated she personally did not think this was repositioning R29 properly.

On 10/19/17 at 11:29 a.m. DON confirmed R29

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F 314	Continued From page 109 needed to be repositioned and checked/changed every two hours by staff. The DON indicated her expectations of staff would be to offer R29 to be repositioned and to be checked/changed every two hours and stated she felt staff understood the importance of this for R29 and should be repositioning, check/changing her on time. The DON also indicated R29 had a history with her skin and high risk of skin breakdown due to moisture. DON confirmed R29's care plan and indicated she had given her staff and family education on the importance of this and stated "staff should offer and encourage R29." The DON indicated staff should be following the care plan and tilting R29 back in her wheel chair was not offloading or repositioning her properly and preferred staff lay her down in her bed to reposition and check/change her.	F 314		

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R27
Review of R27's quarterly MDS dated 9/4/17, identified R27 had severe cognitive impairment and had diagnoses which included; dementia and malnutrition. The MDS identified R27 was totally dependent on facility staff for all activities of daily living (ADL's.) R27's MDS indicated she was at risk for pressure ulcer development and had interventions in place to prevent pressure ulcer development which included a turn and repositioning program.

Review of R27's Care Area Assessment (CAA) dated 6/4/17, lacked any documentation of R27's cognition, ADL status, incontinence and risk for pressure ulcer development and/or skin breakdown.

Review of R27's Braden scale/Skin risk assessment for pressure ulcer (a tool used to identify risk for pressure ulcer development,) dated 8/30/17, identified was at moderate risk for pressure ulcer development.

Review of R27's care plan revised 9/20/17, revealed R27 was at risk for pressure ulcer development and directed facility staff to turn and reposition every two hours and as needed.

On 10/17/17, during continuous observations from 7:35 a.m. to 10:35 a.m. R27 remained seated in her wheelchair without being offered assistance with repositioning, the following was observed:

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-at 7:05 a.m. R27 was lying in bed on her back, her eyes were closed and the blankets were covered up to her chin and the television was on in her room.
-at 7:23 a.m. R27 remained lying on her back in her bed with her mouth open, eyes were closed and the blankets were covered her body up to her chin.
-at 7:30 a.m. R27 remained lying on her back in bed, with her eyes closed, at that time nursing assistant (NA)-F entered her room and pulled back the blankets which had covered R27 and R27 was observed fully dressed in bed. At that time NA-F indicated she had dressed R27 at approximately 6:30 a.m. and had assisted R27 back into bed to rest before breakfast. NA-F donned R27's shoes and placed the lift sling underneath R27, at 7:32 a.m. NA-B entered R27's room with a full mechanical lift.
-at 7:35 a.m. R27 was lying in her bed fully dressed and was assisted from her bed to her wheelchair with a full mechanical lift and assistance from nursing assistant (NA)-F and NA-B. NA-B immediately left R27's room after assisting with the transfers, NA-F combed R27's hair and then left the room. R27 remained seated in her wheelchair in her room with the television on. Neither NA-F or NA-B were observed to offered R27 assistance with checking and changing her incontinent brief.
-at 8:19 a.m. R27 remained seated in a wheelchair in her room, NA-F offered to bring R27 to the dining room for breakfast. At that time, NA wheeled R27 to the dining room. R27 was not offered assistance with repositioning.
-at 8:43 a.m. R27 remained seated in a wheelchair in the dining room at a circular table with approximately three other residents and at that time the administrator assisted R27 with her

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F 314	Continued From page 112 morning meal. -at 9:13 a.m. R27 remained seated in a wheelchair in the dining room with her breakfast meal in front of her. At that time the administrator stood and walked away from R27. R27 remained at the circular dining room table with her breakfast plate of eggs and toast in front of her. -at 9:23 a.m. R27 remained seated in a wheelchair in the dining room with her breakfast meal in front of her. At that time MDS coordinator sat between R27 and another resident. MDS coordinator handed R27 a piece of toast and encouraged her to eat. -at 9:33 a.m. R27 remained seated in a wheelchair in the dining room and held a piece of toast in her hand. At that time MDS coordinator stood from the table and walked away. R27 was not offered assistance with repositioning. -at 9:37 a.m. R27 remained seated in a wheelchair at the dining room table with her toast in her hand, plate of eggs and a full cups of milk and orange juice. NA-F briefly walked over to R27, verbally cued her to finish her breakfast meal, and immediately walked away from R27. -at 9:51 a.m. R27 remained seated at the dining room table with a piece of toast in her hand, at that time NA-G sat next to R27 and asked if she wanted any more to eat, in which R27 shook her head. NA-G then stood up and left R27's table. R27 was not offered assistance with repositioning or checking and changing her incontinent brief. -at 10:00 a.m. R27 remained seated at the dining room table in her wheelchair with a piece of toast in her hand. RN-A approached R27 and administered her oral medications with water. RN-A walked away immediately following administering R27's medications. RN-A did not offer R27 assistance with repositioning or with eating.	F 314		

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-at 10:10 a.m. R27 remained seated at the dining room table in her wheelchair with a piece a toast in her hand. NA-G sat next to R27 and assisted her to eat the remainder of her breakfast, the piece of toast, plate of eggs and the cup of milk and juice. R27 remained seated in her wheelchair in the dining room with NA-G until 10:26 a.m. when NA-B approached.
-at 10:27 a.m. R27 had remained seated in her wheelchair, NA-G placed R27's feet on the footrests of the wheelchair and proceeded to wheel R27 back to her room. NA-B approached R27's room with a full mechanical lift and both NA-F and NA-B assisted R27 out of her wheelchair and into bed at 10:35 a.m.
-at 10:35 a.m. R27 was assisted to lay on her bed with the mechanical lift. NA-G was on R27's right side and NA-B was on R27's left side. NA-G removed R27's shoes and proceeded to turn R27 to her left side and then to her right side. NA-G pulled R27's slacks down to her ankles which revealed R27 had a blue incontinent brief on. R27's brief was soiled with a large amount of urine and a small amount of soft bowel. R27's buttocks was wet and her entire buttocks skin was wrinkled with deeply lines crevices from the incontinent brief. NA-B assisted to remove R27 soiled brief, cleanse her skin and donned a clean, dry brief.

R27 was observed seated in her wheelchair for a total of three hours without being offered repositioning.

On 10/17/17, at 10:35 a.m. NA-G stated R27 was supposed to be checked and changed every two hours with repositioning. NA-G indicated she was unsure of when R27 was last assisted with repositioning and had felt since she was done

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VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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with breakfast she should assist R27 to lie down. NA-G stated she was with other residents down the other wing and was and was not sure why R27 was not repositioned or checked and changed.

On 10/17/17, at 10:36 a.m. NA-B indicated she had assisted R27 with the mechanical lift to get up for breakfast and indicated she had not returned to assist R27 with repositioning within two hours as she had been assisting other residents with cares. NA-B stated R27 needs must be anticipated by staff and she was unable to reposition herself in bed or in the wheelchair.

On 10/17/17, at 11:36 a.m. NA-F indicated she had assisted R27 with morning cares at approximately 6:30 a.m. and had at that time checked and changed R27's incontinent brief. NA-F stated R27 was supposed to be assisted with repositioning and checking and changing for incontinence every two hours and as needed. NA-F indicated she had been working with other residents at the time R27 should have been repositioned.

On 10/17/17, at 1:55 p.m. NA- E stated R27 needs must be anticipated and was totally dependent on staff for all ADL's. NA-E indicated R27 required assistance every two hours with repositioning.

On 10/18/17, at 2:16 p.m. NA-D stated R27 was unable to verbalize her needs or wishes and she was totally dependent on facility staff for all ADL's. NA-D indicated R27 required assistance with repositioning every two hours.

On 10/18/17, at 2:50 p.m. RN-A confirmed R27's

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care plan directed facility staff to turn and reposition R27 every two hours and check and change for incontinence every two hours. RN-A indicated she was not notified R27 had not received repositioning in a timely manner on 10/17/017, though would expect to be notified if residents cares were not done according to their care plans, such as R27. RN-A further indicated as recently as last week, NA's had reported to her residents cares were not done timely due to not enough NA's.

On 10/19/17, at 1:42 p.m. MDS coordinator confirmed R27 was at risk for skin breakdown and was totally dependent on facility staff for all ADL's including repositioning. MDS coordinator stated he expected staff to follow resident care plans and would expect R27 to be repositioned and checked and changed every two hours as directed by her care plan.

On 10/19/17, at 2:41 p.m. director of nursing (DON) stated she would expect facility staff to follow R27's care plan, which included repositioning every two hours and checking and changing incontinent product every two hours. DON indicated R27 was at risk for pressure ulcer development and had a history of a pressure ulcer to her left foot earlier in the year. DON further indicated it was not acceptable for R27 to go three hours without repositioning.

The facility policy titled Prevention and Treatment of Wounds, revised 3/4/17, identified the policy objective to identify and assess residents whose clinical conditions increase the risk for impaired skin integrity and pressure ulcers and to implement preventative measures.

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F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(e)(1)-(3) (e) Incontinence. (1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. (2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. (3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal	F 315		11/28/17

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F 315	Continued From page 117 bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting to reduce or prevent incontinence for 1 of 1 residents (R5) reviewed for urinary incontinence. Findings include: R5's annual minimum data set (MDS) dated 5/1/17, identified R5 had moderate cognitive impairment, required extensive assist for bed mobility, transfer locomotion on and off of unit, dressing, hygiene, and toileting. The MDS identified R5 was frequently incontinent of bowel and bladder and did not have a toileting plan. The corresponding care area assessment (CAA) identified R5 had functional incontinence related to limited mobility and directed staff to offer toileting every two hours to promote continence. The facility form titled Bladder Assessment effective date 7/27/17, identified R5 currently was not continent of bladder, had impaired mobility/dependent transfer and severe cognitive impairment. The assessment summary indicated R5 was able to to be dry/continent during much of the day with staff toileting him on schedule. The assessment identified R5 did not request toileting. R5's current/computerized care plan identified R5 had difficulty with ADL (activities of daily living) self care performance related to a history of stroke, polyarthritis and weakness, required staff assistance with a mechanical lift to transfer, required toileting every two hours and was	F 315	F315 1. R5 NAR care sheets & care plans have been reviewed and updated as needed. 2. All resident care plans and NAR care sheets have been reviewed and updated as needed to assure individualized approaches are outlined to include but not limited to turn and repositioning, timely toileting, check and change, and oral cares. 3. All staff providing direct cares to residents has been educated on use and compliance of NAR care guide use. 4. The DON or designee will review/audit all care sheet documentation daily for 7 days; then, 2X a week for 30 days or until 100% compliance is achieved to assure compliance. Additionally, the DON or designee will do unannounced, observational audits on select residents daily to assure consistency in documentation for 7 days. All audit outcomes shall be presented to the QAA Committee for review &/or comment. 5. Corrective actions will be completed by November 28, 2017.	

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frequently incontinent of bowel and bladder.

The undated nursing assistant care guide identified R5 required assistance of one to two staff to use the commode for toileting, the care guide did not address toileting frequency.

On 10/17/2017, during continuous observations from 6:59 a.m. to 11:47 a.m. R5 was observed seated in a wheel chair for total of four hours and 48 minutes without toileting, repositioning of off-loading, the following was observed:

-at 6:59 a.m. R5 was fully dressed and seated in a wheel chair in his room near the sink independently using an electric razor.
-at 7:06 a.m. R5 remained seated in the wheel chair in his room.
-at 7:18:42 a.m. R5 remained the same, nursing assistant (NA)B walked down the hall past R5's room with a mechanical lift, but did not stop or talk to R5.
-at 7:27 a.m. R5 remained in the wheel chair and watched the Lone Ranger on the television (TV).
-at 7:32 a.m. R5 remained in the wheel chair and continued to watch TV in his room.
-at 7:37 a.m. NA-B entered R5's room, asked if he wanted a ride down to the dining room and then propelled R5 to a dining room table near the window.
-at 8:08 a.m. R5 remained seated in the wheel chair in the dining room.
-at 8:34 a.m. R5 had consumed all of the food items and continued to independently drink the fluids.
-at 9:05 a.m. R5 remained in the dining room with his head hanging forward towards his chest and eyes closed.
-at 9:26 a.m. R5 awoke, and propelled self in

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the wheel chair with his feet forward to the activity area.
-at 9:36 a.m. R5 remained seated in the wheel chair playing balloon ball with a yellow fly swatter shaped like a hand and the blue balloon.
-at 9:48 a.m. R5 remained seated paying balloon ball.
-at 9:52 a.m. R5 self propelled the wheel chair with his feet in to the Heritage hall, toward the resident council meeting.
-at 9:55 a.m. R5 continued to propelled self slowly in the direction of the resident council meeting.
-at 9:59 a.m. R5 remained seated in the wheel chair in the hall. R5's wife entered the building, approached R5, visited with him briefly and then left R5, who remained seated in the wheel chair waiting for the resident council meeting to begin.
-at 10:02 a.m. the social services designee (SSD) assisted R5 to the beauty shop where the resident council meeting was held. R5 sat to the left of the beauty shop door.
-at 10:11 a.m. R5 remained seated in his wheel chair in the beauty shop.
-at 10:48 a.m. R5 remained seated in the wheel chair in the beauty shop. R5's eyes were closed head hanging forward.
-at 11:18 a.m. R5 was propelled out of the beauty shop to the hall by the SSD. The MDS coordinator then propelled R5 down the hall to the nurses desk. The MDS coordinator left R5 seated in the wheel chair at the nurses desk and returned down the hall to assist another resident.
-at 11:27 a.m. R5 propelled his wheel chair to the dining room table near the window in the dining room.
-at 11:40 a.m. R5 propelled his wheel chair to the nurses desk and toward the Serenity hall.
-at 11:45 a.m. NA-B approached R5 and

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propelled his wheel chair in to the hall. NA-B bent down to R5's ear and asked if he needed to use the bathroom, then asked if he needed to use the commode or be checked and changed. R5 responded, he needed to, "pee."
-at 11:47 a.m. NA-B propelled R5 into his room, utilized a mechanical standing lift, stood R5 and removed his wet incontinent brief and lowered R5 on to the commode.

On 10/17/2017, at 10:55 a.m. NA-E indicated R5 was forgetful and needed assistance with a mechanical lift to use to transfer on and off the commode. NA-E indicated she used a care guide sheet for direction on how to care for a resident.

On 10/17/2017, at 11:12 a.m. NA-C indicated she would usually ask R5 if he needed to go to the bathroom and he was able to make his needs known.

On 10/17/2017, at 11:49 a.m. NA-B verified R5's brief was wet when she assisted R5 with toileting. NA-B indicated R5's usual daily routine was to use the commode in the morning and then before lunch. NA-B indicated R5 used the commode a little later than usual today because of the resident council meeting. NA-B verified R5's care plan directed R5 was to use the commode every 2 hours, however; stated R5 was usually able to tell staff when he needed to use the commode during the day. NA-B verified she had assisted R5 with cares this morning and R5 and had been in the wheel chair prior to 7:00 a.m. NA-B verified R5 had not been assisted with toileting until he was assisted on to the commode at 11:47 a.m. (greater than 4 hours and forty seven minutes).

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On 10/18/2017, at 3:19 p.m. registered nurse (RN)A verified she expected staff to to follow the resident care guides, and keep them safe and clean. RN-A identified R5 required staff assistance to toilet. RN-A indicated R5 was at times able to request assistance with toileting but was not always aware of his needs. RN-A identified the facility protocol for residents who require assistance or prompting is to approach the resident and offer every two hours. RN-A indicated staff would not be expected to interrupt an activity such as the resident council meeting to offer toileting.

On 10/19/2017, at 10:04 a.m. the MDS coordinator identified R5 required varying levels of care due to weakness and a lower level of alertness in the early morning and later evening. The MDS coordinator indicated R5 did not have behaviors, required staff assistance with a mechanical standing lift to transfer. He indicated R5 was dependent on staff for his toileting needs and was able to maintain urinary continence when he was routinely assisted with toileting.

On 10/19/2017, at 10:51 a.m. the director of nursing (DON) verified R5's care plan to be current as of August and R5 had not had changes in care since that time. The DON verified R5 required assistance for transfers with a lift and should have been offered toileting every two hours.

The facility policy titled Bowel and Bladder Assessment - Retraining - Toileting, revised 5/1/17, identified a systemic evaluation of the resident was completed to assist in determining the most effective and appropriate treatment and management of bowel and bladder function.

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F 323 SS=E	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure facility mattresses appropriately and securely fit the facility bed frames to prevent possible entrapment for 14 of 14 residents (R13, R20, R23, R1, R39, R2, R19, R35, R29, R5, R27, R10, R6) who required assistance with transfer and/or bed mobility.	F 323	F323 1. Mattress guards and mattress bolsters were added to resident bed of R13, R20, R23, R1, R39, R2, R19, R35, R29, R5, R27, R10, R6 to ensure mattress security. 2. All remaining residents had mattress guards and mattress bolsters added to resident beds to ensure mattress security.	11/28/17

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F 323	Continued From page 123 Findings Include: On 10/18/17, at 10:30 a.m. a walk through of the facility was completed with the environmental services director (ESD). Resident beds were observed to have spaces between the head board and the mattress or the foot board and the mattress. R6's firm foam like mattress lay on top of the chrome colored bed frame with wood look head and foot boards. R6's mattress measured five inches between the mattress and head of the bed and one inch between the mattress and the foot board of the bed. R6's mattress was easily moved within the bed frame. R37's firm foam like mattress lay on top of the chrome colored bed frame with wood look head and foot boards. R37's mattress easily moved within the bed frame and created a space between the mattress and the head or the foot board of six inches. R29's mattress was inflated with air by an electrical box mounted to the foot board of the bed. R29's mattress lay on the chrome colored bed frame mattress rested against the brown wood look foot board, the top of R29's bed measured six inches between the mattress and the head board. R19 lay on top of her bed with a blanket over her legs. R19's mattress was inflated with air by an electrical box mounted to the foot board of the bed. R19's mattress rested against the brown wood look foot board, the top of R19's bed measured six inches between the mattress and the head board. The United Stated Food and Drug Administration (FDA) Guide for Modifying Bed Systems and Using Accessories to Prevent Entrapment dated 6/21/2006, defined entrapment as an event in which a patient is caught, trapped or entangled in the spaces in or about the bed rail, mattress or	F 323	3. The United States Food and Drug Administration Guide for Modifying Bed Systems and Using Accessories to Prevent Entrapment dated 6/21/2006 was provided to Environmental Services Director. Education also provided to direct care staff and environmental service staff about the importance of the items added. 4. ESD or designee will monitor weekly for first month and then monthly x2 to ensure FDA guidelines are being followed. All audit outcomes shall be presented to the QI/QA Committee for review &/or comment. 5. Corrective actions will be completed by November 28, 2017.	

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bed frame. Entrapment can result in serious injury or death.

The FDA guide identified entrapment events have occurred in openings within the bed rails, between the bed rails and mattresses, under bed rails, between split rails, and between the bed rails and head or foot boards. The population most vulnerable to entrapment are elderly patients and residents.

The identified the body part dimensions used to develop FDA's dimensional limit recommendation for the specific body parts include:
Head 4 3/4 inches.
Neck 2 3/8 inches.
Chest 12 1/2 inches.

R13's quarterly Minimum Data Set (MDS) dated 9/8/17, identified R13 was cognitively intact and required physical assistance from facility staff for ADL's including transfers and bed mobility.

R20's admission MDS dated 8/20/17, identified R20 was cognitively impaired and required physical assistance from facility staff for ADL's including extensive assistance for transfers and limited assistance for bed mobility

R23's quarterly MDS dated 7/17/17, identified R23 was cognitively intact, required extensive physical assistance from facility staff for ADL's including bed mobility and total assistance for transfers.

R1's quarterly MDS dated 9/16/17, identified R1 was cognitively intact, required extensive physical assistance from facility staff for ADL's including transfer and bed mobility.

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F 323	Continued From page 125 R39's 14-day perspective payment systems (PPS) MDS dated 10/09/17, identified R39 was cognitively intact, required extensive physical assistance from facility staff for ADL's transfer and bed mobility. Review of R2's quarterly MDS dated 8/30/17, identified R2 was cognitively intact, required extensive physical assistance from facility staff for ADL's including transfers and bed mobility. Review of R19's quarterly MDS dated 9/8/17, identified R19 was cognitively impaired, required total physical assistance from facility staff for ADL's including transfers and bed mobility. Review of R35's quarterly MDS dated 9/24/17, identified R35 was moderately cognitively impaired, required extensive physical assistance from facility staff for ADL's including transfers and bed mobility. R29's quarterly MDS dated 9/2/17, identified R29 was cognitively intact, required extensive physical assistance of from staff for bed mobility and total dependent for transfers. R5's annual MDS dated 5/1/17, identified R5 was moderately cognitively impaired, required extensive physical assistance from facility staff for ADL's including transfers and bed mobility. R27's quarterly MDS dated 9/4/17, identified R27 was cognitively impairment, required total physical assistance from staff for all ADL's including bed mobility and transfer. R37's significant change MDS dated 9/6/17 ,	F 323		

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identified R37 was cognitively impaired, required extensive physical assistance for ADL's including bed mobility, and total assistance with transfer.

R10's significant change MDS dated 8/9/17, identified R10 was cognitively intact, required limited physical assistance from facility staff for ADL's including transfers and bed mobility.

R6's annual MDS dated 8/8/17, identified R6 was cognitively intact, required extensive physical assistance from facility staff for ADL's including bed mobility and limited assistance with transfer.

On 10/16/17, at 9:49 a.m. R10 identified her mattress moved on the bed frame and caused her pillow to fall between the head board and the mattress. R10 stated every so often she needed to ask staff to move the mattress back into place to ensure the pillow would not fall into the space between the mattress and head board.

On 10/18/17, at 10:30 a.m. during the environmental tour R6 identified her mattress moved on the bed frame when getting in to bed, however; stated she had not slipped or fallen because of it.

On 10/18/2017, at 9:50 a.m. the environmental services director (ESD) verified the facility had recently purchased new bed frames and mattresses for facility residents. The ESD identified the facility had purchased two different styles/brands of mattresses in the recent past and both types had the potential to move on the frame and create a space at the head or foot of the bed measuring up to 6 inches. He indicated the facility had purchased new mattresses and beds but had not considered how the mattresses

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F 323	Continued From page 127 fit onto the bed frame. The ESD indicated the facility had relied on the company to send the appropriate mattresses. The ESD verified it was concerning to have mattresses which were not secure on the beds and identified he was not aware of the Federal Drug Administration (FDA) bed mattress spacing guide lines. On 10/19/2017, at 2:40 p.m. the administrator indicated he worked together with the maintenance director as a team to ensure the facility was maintained for the residents. The administrator indicated the facility had recently purchased new bed frames and mattresses, however; was unaware of the Federal Drug Administration (FDA) regulations regarding mattress spacing from the head and foot board. The administrator indicated he was not aware of any entrapment problems with the new beds, however; the potential problem would be taken care of. The requested facility policy was not provided.	F 323		
F 325 SS=D	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(g)(1)(3) (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless	F 325		11/28/17

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F 325	Continued From page 128 the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; (3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to comprehensively assess a significant weight loss for 1 of 2 residents (R11) reviewed for nutrition. Findings include: R11's admission Minimum Data Set (MDS) dated 5/1/17, identified R11 had severe cognitive impairment and required supervision with eating. R11's MDS identified diagnoses of dementia, depression and pressure ulcer. R11's MDS further identified an admission weight of 100 pounds, regular diet and did not identify weight loss. Due to not identifying a weight loss on R11's admission MDS, a Care Area Assessment (a compressive assessment) was not completed on nutrition. R11's quarterly MDS dated 8/1/17, identified R11 had severe cognitive impairment and required supervision with eating. R11's MDS identified diagnoses of dementia, depression and pressure ulcer. R11's MDS further identified weight of 92 pounds, regular diet and did not identify weight loss. R11's care plan, dated 8/16/17, identified R11's care plan goals were to comply with recommended diet daily through 11/8/17. R11's	F 325	F325 1. Comprehensive assessment completed for R11 and care plan with appropriate diagnoses, interventions and goals for medical and nursing needs, as well as nutritional, psychosocial, and activity approaches was implemented for R11. 2. Care plans for all residents at risk for change in nutritional status or significant weight loss were reviewed for but not limited to goals, interventions, resident choices, and dietary recommendations. 3. Facility will comprehensively assess all residents for change in nutritional status and/or significant weight loss monthly to monitor if nutritional goals are being met. Education provided to RNs, LPNs, and MDS Coordinator on nutritional status parameters. 4. Comprehensive care plan shall be reviewed at admission, quarterly, and/or with change in condition by IDT. DON or designee will review nutritional parameters monthly for first quarter or until 100% compliant. QI/QA update quarterly with compliance findings. 5. Corrective actions will be completed by November 28, 2017	

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care plan identified R11 required supervision and cues by staff with eating related to weakness and confusion. R11's care plan directed staff to monitor R11's intake, provide protein powder one scoop daily, and invite the resident to activities that promote additional intake. R11's care plan further identified staff were to monitor, record and report to medical doctor signs and symptoms of malnutrition: emaciation (being abnormally thin, weak), muscle wasting and significant weight loss: 3lbs. in one week, greater than 5% in 1 month, greater than 7.5% in 3 months, greater than 10% in 6 months. R11's care plan identified a registered dietician to evaluate and make diet change recommendations as needed and her nutrition needs were 1200 calories and 50 grams of protein [daily].

R11's Admission Nursing Assessment dated 4/24/17, identified R11's weight as 100 pounds. She had mild left arm non-pitting edema and no edema in her bilateral lower eremites. R11's Admission Nursing Assessment further identified R11 could feed self, and had recent unintentional weight loss; family member (FM)-A reported R11 was 105 pounds two weeks ago.

R11's admission Dietary Assessment dated 4/28/17, identified a regular diet order, usual body weight of 100 pounds and no preference for snacks and nourishments.

R11's quarterly Dietary Assessment dated 7/28/17, identified a regular diet order, usual body weight of 95 pounds and no preference for snacks and nourishments. In addition, R11's quarterly dietary assessment, additional comments section identified R11 does not have an appetite.

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F 325	Continued From page 130 Review of Registered Dietician (RD)-A's dietician nutrition note dated 5/6/17, indicated R11 had diagnoses of dementia, depression and pressure ulcer, weight was 94 pounds and on a regular diet. RD-A's note further indicated R11 was receiving a house supplement three times per day, would benefit from additional protein to heal pressure ulcer, poor oral intake (with at least one meal daily where consumption is between 1-25%), weight is down 6 pounds since admission, and her Body Mass Index (BMI) is 17.8, which is too low. Review of RD-A's dietician nutrition note dated 8/1/17, indicated R11 had diagnoses of dementia, depression and pressure ulcer, weight was 92 pounds and on a regular diet. RD-A's notes further indicated, R11 was receiving a house supplement three times per day, her oral intake had improved since admission (eating 75-[1]00% at meals but overall averaging 50-75%). RD-A's note indicates her weight is down from admission and her weight has triggered for significant weight change, her weight is too low. Her BMI was 17, which was classified as underweight, recommend a BMI of 22. Review of R11's weekly weight records identified: -R11 had a significant weight loss (significant weight loss is defined as weight loss of 5% or greater over 30 days, 7.5% loss over 90 days, or 10% over 180 days) of 12% of her body weight (12 pounds from 4/24/17 to 10/6/17 a total of 165 days). -4/24/17, admission weight of 100 pounds.	F 325		

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F 325	Continued From page 131 -5/5/17, 94 pounds. -7/21/17, 93 pounds. -7/28/17, 92 pounds. -9/22/17, 90 pounds. -10/6/17, weight of 88 pounds. Review of R11's meal consumption from 6/16/17 to 10/17/17, identified: -61 meals had an intake of 0-25% -71 meals had an intake of 26-50% -105 meals had an intake of 51-75% -119 meals had an intake of 76-100% Review of R11's progress notes from 4/24/17 to 10/17/17, revealed: -5/19/17, R11 is protein deficient, currently taking dietary supplement x 3 and ProHeal (protein supplement) with contains 15 grams of protein. R11 does not always finish all of these fluids and prefers to just drink water. Will ask dietary for any suggestions for increased protein in diet. -6/15/17, R11's weight triggered for significant weight change. Weight at admit 100 pounds, current weight is 94 pounds which is a six pound weight loss. Her BMI was underweight. Her oral intake had been improving recently; she was averaging around 50% at meals. Is noted to be walking more and eating better.	F 325		

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-7/31/17, R11 is frail with cachectic appearance. Intake is inadequate to maintain her weight.

-8/1/17, R11 was asked about her appetite, R11 stated she was "always hungry".

-8/12/17, R11 stated that she did not like the house supplements, because they were thick and make her have bowel movements.

Review of R11's August 2017, medication administration record shows an order for house supplement three times a day for weight loss. This order has a start date of 4/24/17, and a discontinue date of 8/28/17. In the month of August R11 completed this intervention 11 out of the possible 83 times.

Review of R11's current signed physician orders indicated an order for a regular diet and protein powder one scoop daily.

On 10/16/17, from 3:07 p.m. to 3:42 p.m. R11 was observed lying on her back in bed with eyes opened, glasses on and a blanket pulled up to her shoulders. R11's shoes sat on the floor next to the bed, with her four-wheeled walker positioned next to the head of the bed. No staff were noted to enter R11's room to offer the afternoon activity of Social Hour, which started at 3:15 p.m.

On 10/17/17, at 9:26 a.m. R11 was seated at dining room table. At 9:36 a.m., nursing assistant (NA)-F sat down at same table as R11 and began assisting another resident to eat. At 9:37 a.m., R11 received her breakfast meal that consisted of eggs, toast, banana, coffee, orange juice and toast. R11 opened a jelly container and applied to

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her toast and began to feed herself. At 9:38 a.m. DON approached R11 with a medication cup. DON explained the medications in the cup. DON left table after R11 took her medications and did not encourage or cue her meal intake. At 9:48 a.m. NA-F moves around table and sat next to R11 to assist the resident to her left with a bite of food. NA-F then returns to her original seat at the table. NA-F did not encourage or cue R11 to complete her meal. At 9:51 a.m. NA-F stands and leaves the table, while NA-G sat down in the chair NA-F was seated in. NA-G continues to assist other residents seated at the table with eating. At 9:57 a.m. NA-G asked R11 if she was drinking her coffee, but did not encourage or cue R11 with her food intake. At 10:13 a.m., dietary assistant (DA)-A approached R11 and took her plate with a piece of toast still remaining without asking R11 if she was finished or encouraging her to eat it. DA-A disposed of toast and plate and returned to the table and asked R11 if she was finished with her orange juice as she was reaching to take R11's glass, R11 stated she was not finished with the juice. At 10:22 a.m. R11 finished her fluids and was assisted back to her bed by staff.

On 10/17/16, at 1:10 p.m.NA-E stated R11 was able to eat by herself, but did require verbal prompts to continue to eat. She stated R11 will refuse to eat some meals and staff will offer a nutritional supplement, but she will refuse the supplement because they make her go to the bathroom.

On 10/17/17, at 1:44 p.m. during a phone interview, RD-A confirmed she was not aware that R11's weight declined to 88 pounds on 10/6/17. RD-A stated that R11's order for nutritional supplement was discontinued on

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8/28/17, due to R11's refusal to drink the supplement. RD-A was not aware of any further assessments or interventions for R11's nutritional status.

On 10/17/17, at 2:06 p.m. dietary manager (DM)-A stated that she completes the dietary assessments on admission and quarterly. DM-A stated that the dietician checks resident weights and intakes in the electronic health record. DM-A stated that the dietician would assess a resident with a significant weight loss and give recommendations for interventions. DM-A confirmed that the dietary department did not prepare any specific snacks for R11, and that activities department passed out a snack for all residents as an activity at 3:15 p.m. daily.

On 10/18/17, at 10:19 a.m. activities director (AD)-A stated R11 was very quiet and reserved. AD-A confirmed R11 had participated in Social Hour only eight times over the past month, and was unaware that Social Hour was a care planned intervention for R11 to potentially increase her intake.

On 10/18/17, at 2:55 p.m. FM-A stated R11's usual weight was always between 105-110 pounds.FM-A confirmed that R11 was 105 pounds two weeks prior to admission to the facility, and was admitted at 100 pounds. FM-A stated she was R11's Power of Attorney for care and was unaware that R11 was refusing the nutritional supplement and the order was discontinued, and that her weight had declined to 88 pounds. FM-A stated, R11 likes chocolate nutritional supplements, and did not like strawberry or vanilla.

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On 10/18/17, at 10:32 a.m. registered nurse (RN)- A stated that R11 required supervision with eating for encouragement. She stated R11's weight had steadily declined since admission. RN-A indicated that if R11 were to refuse a meal that a nutritional supplement would then be offered.

On 10/18/17, at 2:11 p.m. NA-A confirmed that R11 can eat independently, but sat at a table with staff for encouragement to eat. NA-A stated R11 would refuse meals and staff will encourage her to eat something on her plate. NA-D confirmed R11 did not receive a nutritional supplement daily, but would have one from time to time.

On 10/18/17, at 2:20 p.m. NA-H stated R11 eats independently, but requires encouragement. She described R11 as a picky eater that often refuses meals. She stated R11 receives a protein powder each morning that was mixed into her orange juice, NA-H stated she never drinks it, and the most NA-H had ever seen her drink is half.

On 10/19/17, at 9:14 a.m. MDS coordinator stated R11 ate independently with supervision for encouragement from staff. He also confirmed R11's most recent weight of 88 pounds was recorded on 10/6/17. MDS coordinator confirmed R11 was 92 pounds during her last MDS on 8/1/17. He stated that R11's albumin was 2.9 grams per deciliter and that R11 received a daily protein powder. MDS coordinator stated that R11 was on a nutritional supplement three times per day, but the order was discontinued on 8/28/17 due to R11's refusal to drink. He confirmed R11 had a 12% decline in her weight since admission and was unaware if the dietician was updated, or if any further assessments were completed, or

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F 325	Continued From page 136 interventions put in place. On 10/19/17, at 10:54 a.m. dietary assistant (DA)-A stated she inserted the meal intakes after meals into the electronic medical record and does not have a specific routine to update nursing if a resident had no/poor intake. On 10/19/17, at 11:31 a.m. during a follow up interview of DM-A, she indicated that DM-A spoke with R11 today and R11 stated she did not like dairy products or strawberry or vanilla nutritional supplements. DM-A indicated that this was the first she had heard this information and would order chocolate supplements, as the facility did not carry chocolate nutritional supplements. On 10/19/17, at 3:15 p.m. DON stated that she completed R11's admission MDS section K. She was unaware that R11's usual weight was between 105-110 pounds or that R11's Admission Nursing Assessment stated she was 105 pounds two weeks prior to admission. DON confirmed that R11 had a 12% weight loss since admission, per her 10/6/17 weight of 88 pounds. DON stated she was unaware of any further assessments or interventions put in place for R11. She confirmed that R11's significant weight decline had not been reported to R11's physician or resident representative. On 10/19/17, at 5:37 p.m. a telephone call was placed to office nurse of R11's primary physician, return call pending. On 11/2/17, at 10:03 a.m. primary physician returned telephone call and stated he would expect the faciltiy to update him on a significant weight loss. He confirmed he was not updated on R11's significant weight loss.	F 325		

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F 325	Continued From page 137 A policy for nutrition was requested from the facility and not provided.	F 325		
F 329 SS=D	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;	F 329		11/28/17

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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 329	Continued From page 138 (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure non-pharmacological interventions were identified for use of an antihistamine medication prior to bathing for 1 of 1 residents (R28) reviewed for chemical restraint. In addition the facility failed to ensure an Abnormal Involuntary Movement Scale (AIMS)-(an assessment used to assess involuntary movements associated with the use of anti-psychotic medication) was completed to monitor for side effects for 3 of 5 resident (R3, R14, R28) who received antipsychotic medication. Findings include: R3's significant change Minimum Data Set (MDS) assessment dated 8/14/17, indicated R3 had diagnosis which included dementia with behavioral disturbance, unspecified psychosis and mood affect disorder. The MDS identified R3 had both short term and long term memory problems, severely impaired daily decision making skills and had no behaviors. The MDS further indicated R3 was using an antipsychotic (AP) medication for a psychotic disorder. R3's current order summary report, indicated an order for Seroquel (antipsychotic medication) 200 milligrams (mg) by mouth three times a day for mood affective disorder and unspecified psychosis.	F 329	F329 1. Comprehensive assessment completed for R28 and care plan with appropriate diagnoses, interventions and goals for medical and nursing needs, as well as nutritional, psychosocial, and activity approaches was implemented for R28. AIMS completed for R3, R14, and R28. 2. Care plans for all residents on a psychotropic medication were reviewed to ensure proper medication use for the diagnosis given. 3. Facility will comprehensively assess all residents prior to the use of chemical restraints and quarterly for continued need. All residents on anti-psychotropic medication will have AIMS completed every 6 months to monitor for side effects. Nursing staff educated on behavior reporting, non-pharmalogical interventions, and policy and procedure for Chemical Restraints and Unnecessary Medications. 4. Review of comprehensive care plan shall be reviewed at admission, quarterly, and/or with change in condition by IDT. DON or designee will coordinate monthly with pharmacy consultant to track completion of all future AIMS. QI/QA update quarterly with compliance findings. 5. Corrective actions will be completed	

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F 329	Continued From page 139 Review of monthly medication administration record (MAR) from 9/1/17 to 10/19/17, revealed R3 received Seroquel (antipsychotic medication) 200 mg by mouth three times a day for mood affective disorder and unspecified psychosis on a daily basis. R3's current care plan revised on 7/10/17, indicated R3 used psychoactive medications related to behavior management. The care plan listed various interventions which included: administer psychoactive medications as ordered by physician, monitor for side effects and effectiveness, and monitor/document/report any adverse reactions of psychotropic medications such as: unsteady gait, tardive dyskinesia and extraprimadal symptoms (shuffling gait, rigid muscles, shaking). Review of R3's clinical chart on 10/19/17, revealed a quarterly AIMS assessment had been completed to monitor the side effects of the AP medication on 2/8/17. The AIMS revealed R3 had no facial or oral movements, no extremity movements, no trunk movements, no global movements, no problems with dental status and movements in sleep disappeared. No further assessments were found in the clinical chart. On 10/19/17, at 4:04 p.m. director of nursing (DON) confirmed R3's was currently taking an AP medication and the last AIMS assessment had been completed on 2/8/17, to monitor for side effects of AP medications. The DON indicated the usual facility practice was for the pharmacy consultant to review resident records, note the assessment had not been completed and would then give the facility a reminder to complete the	F 329	by November 28, 2017	

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F 329	Continued From page 140 AIMS assessment. The DON also indicated the AIMS assessments usually are done quarterly by her or the MDS coordinator. On 10/19/17, at 4:31 p.m. left a voice message via phone call for the pharmacy consultant (PC). At 6:15 p.m. the PC called back and confirmed R3 had not had an AIMS assessment completed since 2/8/17. The PC indicated she would expect the facility staff to complete the AIMS assessment every six months. The PC confirmed she had not made a recommendation to have the facility complete the AIMS assessment for R3. R14's quarterly MDS assessment dated 9/17/17, indicated R14 had diagnosis which included dementia with behavioral disturbance, major depression disorder with psychotic symptoms and mood disorder due to unknown physiological condition. The MDS indicated R14 was cognitively intact and used an AP medication for a psychotic disorder. R14's current order summary report, indicated an order for Seroquel (antipsychotic medication) 50 mg by mouth in the morning and 100 mg by mouth in the evening and Risperidone (antipsychotic medication) 0.5 mg by mouth two times a day for mood affective disorder and depression with psychotic symptoms. Review of monthly medication administration record (MAR) from 9/1/17, to 10/19/17, R14 received Seroquel 50 mg by mouth in the morning and 100 mg by mouth in the evening and Risperidone 0.5 mg by mouth two times a day for mood affective disorder and depression with psychotic symptoms on a daily basis.	F 329		

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F 329	Continued From page 141 R14's current care plan revised on 10/3/17, indicated R14 used psychotropic medications related to dementia with behavioral disturbance. The care plan listed various interventions which included: administer psychotropic medications as ordered by physician, monitor for side effects and effectiveness, and monitor/document/report any adverse reactions of psychotropic medications such as: unsteady gait, tardive dyskinesia and extraprimadal symptoms (shuffling gait, rigid muscles, shaking). Review of 14's clinical chart on 10/19/17, revealed a quarterly AIMS assessment had been completed to monitor the side effects of the AP medication on 3/14/17. The AIMS revealed R14 had no facial or oral movements, no extremity movements, no trunk movements, no global movements, no problems with dental status and movements in sleep disappeared. No further assessments were found in the clinical chart, Review of R14's Thrifty White Pharmacy Summary Reports, from 2/17, to 9/17, revealed no recommendations were made by pharmacy to have AIMS assessment completed to monitor for side effects of AP medications. On 10/19/17, at 4:04 p.m. DON confirmed R14's was currently taking an AP medications and the last AIMS assessment had been completed on 3/14/17 to monitor for side effects of AP medications. The DON indicated the pharmacy consultant will see the assessment had not been completed and will give them a reminder to complete the AIMS assessment. The DON also indicated the AIMS assessments usually are done quarterly by her or the MDS coordinator.	F 329		

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F 329	Continued From page 142 On 10/19/17, at 4:31 p.m. left a voice message via phone call for the PC. At 6:15 p.m. the PC called back and confirmed R14 had not had a AIMS assessment done since 3/14/17. The PC indicated she would expect the facility to complete an AIMS assessment every six months. The PC indicated she would usually wait a month after the AIMS should have been completed before giving the facility reminders to complete the AIMS assessment. The PC confirmed she had not made a recommendation to have the facility complete the AIMS assessment for R14.	F 329		

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Based on observation, interview and record review, the facility failed to develop non-pharmacological interventions prior to the use of an antihistamine medication, hydroxyzine (Vistaril), used to ensure compliance with bathing for 1 of 1 resident (R28) with dementia and verbalized thoughts of self harm/harm to others. In addition, the facility failed to ensure ongoing monitoring of side effects for 3 of 5 (R3, R14, R28) residents who recieved Seroquel (antipsychotic) medication.

Findings include:

R28's quarterly Minimum Data Set (MDS) dated 9/3/17, identified R28 had diagnoses which included: dementia, unspecified mood disorder and chronic kidney disease. The MDS identified R28 had severe cognitive impairment, required extensive staff assistance with dressing, toileting, limited assistance for bed mobility and transfers and supervision with walking and eating. R28 required assistance of one staff for bathing. The MDS identified R28 wandered daily, was on antipsychotic medication and did not reject care. R28's MDS indicated he had verbal behavior on 1-3 days and other behavior symptoms not directed towards others 1-3 days. Further, R28's MDS identified he expressed thoughts he would be better off dead or thoughts of hurting self. However, the MDS had not been completed accurately to include the frequency of the thoughts.

R28's significant change MDS dated 10/3/17, identified R28 had diagnoses which included: dementia, unspecified mood disorder and chronic

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kidney disease. The MDS identified R28 had severe cognitive impairment, required total staff assistance for bathing, extensive assistance with hygiene. R28's MDS also identified no behavioral symptoms, no rejection of care, an improvement in behaviors and the use of antipsychotic medication. R28's MDS identified he expressed thoughts he would be better off dead or thoughts of hurting self. The MDS identified the frequency of the thoughts were several days in the reference period for the MDS.

R28's Care Area Assessment (CAA) dated 10/10/17, was not congruent with the cooresponding significant MDS dated 10/10/17. R28's MDS identified he had thoughts of being better off dead, or would hurt himself in some way, and had a diagnosis of dementia. R28's 10/10/17 CAA listed R28 did not have a diagnosis of dementia, could be resistive to redirection, and he had denied thoughts of hurting himself. The CAA indicated R28 showed evidence of decline, had a vacant look, difficulty with ADLs, did not ask for help or use his call light when toileting. The CAA identified R28 had negative thoughts when frustrated or confused and indicated the care plan would be developed to address meaningful activity in resident daily life to encourage him to focus on the positive and build self esteem. R28's CAA did not identify or address behaviors with bathing.

R28's care plan dated 10/16/17, indicated R28 uses psychotropic medication related to dementia with behavioral disturbance. The care plan listed various interventions which included: administer psychoactive medications as ordered by physician, monitor for side effects and effectiveness, and monitor/document/report any

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adverse reactions of psychotropic medications such as: unsteady gait, tardive dyskinesia and extraprimadal symptoms (shuffling gait, rigid muscles, shaking). R28's care plan did not identify R28's behaviors with bathing or siucidal ideations and lacked any non-pharmacological interventions to deal with suicidal ideation or bathing.

Review of R28's Physician Round Tool dated 9/15/17, indicated R28 was verbally abusive of staff, spitting at them, saying he was going to bomb facility, refusing medications and anxiety/anger with tub baths. The document included to give hydroxyzine 10mg by mouth 15-30 minutes before bath, if not effective increase to 2 tablets. Further, the document included an order to increase the Seroquel from 25 mg twice a day to 50 mg twice a day.

Review of monthly medication administration record (MAR) from 9/1/17 to 10/19/17, revealed R28 received Vistaril 10 mg every Wednesday morning from 9/20/17 to 10/18/17. R28's MAR indicated he was receiving Seroquel (antipsychotic medication) 50 mg by mouth two times a day for mood affective disorder on a daily basis since 9/15/17. Prior to 9/15/17, R28 was receiving Seroquel 25 mg twice a day for mood (affective) disorder with an original start date of 5/30/17. R28's clinical record identified, prior to 4/14/17 R28 had received a daily dose of Seroquel 12.5 mg, then increased to 25 mg daily on 4/14/17.

Review of R28's computerized report of behaviors, completed on a daily basis by the nursing assistants, from 9/20/17 to 10/19/17 revealed R28 had one day with reported

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behaviors of frequent crying and abusive language, but did not significantly disrupt care or living environment. The computerized nursing assistant documentation indicated R28 had some disorganized thinking, that he felt bad for himself/is a failure, or let his family down. Further, he was easily annoyed, that he stated life isn't worth living/wishing for death, or attempting to harm himself, he had repetative anxious complaints/concerns, that he made negative statements, and was self deprecative. There was no further documentation of any further behaviors for the remaining 29 days.

Review of R28's clinical chart on 10/18/17 revealed a quarterly Abnormal Involuntary Movement Scale (AIMS) assessment had been completed to monitor the side effects of the AP medication on 2/28/17. No further AIMS assessments were found in the clinical chart.

Review of R28's progress notes from 4/14/17 to 10/17/17:

-4/14/17, provider was updated R28 becomes agitated after redirection from wife at meals, where he will return to wife to belittle her or tell her to stop eating. Staff unable to redirect resident on 12.5 mg dose of Seroquel. Provider increased Seroquel to 25 mg.

-5/16/17, R28's behaviors of spitting, hovering over wife at meals, or pulling her away from table stating she doesn't need to eat were discussed with provider. Asked provider about possible medication that would decrease secretions and need to spit. Orders were written to increase Seroquel to 25 mg twice a day.

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F 329	Continued From page 147 -6/3/17, R28 was tearful throughout the day. -7/12/17, R28's past behaivor includes: rude to staff/wife, yelling at staff, calling staff names, hovering over wife, wandering into other rooms and tearfulness. R28 lacked behavior notes charted by nurses. NA's noted disorganized thinking x 4, delusions x 1 and rejection of care x 1. NAs also noted negative self-talk, short tempered/easily annoyed, comments such as "life isn't worth living", anxious comments/concerns, and negative statements. Staff review, R28's behaviors occur on a daily basis. Staff state he redirects easily with positivity, though sometimes the redirection is not well received. -8/29/17, R28 was asked questions for PHQ-9 (a questionnaire that monitors/measures the severity of depression) he was unable to reference the past two weeks. R28 stated he has thought about being better off dead. He denied any thoughts of harming or killing self. R28 was confused which season it was. -8/29/17, R28's monthly behavior monitoring revealed; wandering occured on a daily basis. At times R28 would refuse his medications whole, he continued to hover over wife and being tearful. Redirection was challenging at times. -9/1/17, R28's MDS reference period note revealed; R28 did not smile or interact as much anymore. -9/15/17, R28's provider was updated regarding; recent increased verbal abuse towards staff, spitting at staff and refusal of medication. On interview with provider R28 was cheerful and denied frustrations with living in the facility. Bath	F 329		

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aide notes R28 will not allow bath to be done once dressed for the day, but was angry when he was bathed early. Attempts to bath on evening shift were unsuccessful with similar aggressive behaviors. R28's provider increased his Seroquel and made an addition of hydroxyzine (medication that reduces activity in the central nervous system) before baths.

-9/27/17, R28 stated to staff, just leave him there to die, he just wanted to die.

-9/28/17, R28 had been incontinent and staff assisted with cares. R28 stated he wished he were dead and he was going to hang himself. He began crying and stated please shoot me.

-9/28/17, R28's monthly behaivor monitoring revealed; frequent crying x 4, repeated movement x 1, yelling x 1, spitting x 1, abusive language x 2, threatening behaviors x 2, indicated bad feeling of self x 4, short-tempered/easily annoyed x 4, wishing for death x 4, repetitive anxious complaints/concerns x 2, negative statements x 4,self deprecation x 3, behavior significantly disruptrf care or environment x 1. Redirection could be a challenge. Current psychoactive medication included; Seroquel 50 mg twice daily and hydroxyzine 10 mg every Wednesday for aggressive behaviors at bath time.

-10/3/17, R28 answered questions with confusion and difficulty. R28 denied thoughts of hurting himself, but stated sometimes he had thoughts he'd be better off dead. Staff noted tearful with incontinence or confusion. Nursing noted negative statements x 2 when he is cared for or confused. Wandered daily with one occasion with potential to put him in danger. R28

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had a tendency to refuse medications but re-approach was effective. No behaviors noted in charting by NAs.

R28's Physician Round Tool dated 9/15/17, indicated R28 was verbally abusive to staff, spitting at them, stating he will bomb the facility and refusing medications. R28's physician replied: Anxiety/Anger with tub baths. 1. dementia with behaviors/mood disorder. (A) increase Seroquel from 25 mg twice a day to 50 mg twice a day. (B) Hydroxyzine 10 mg 15-30 minutes before bath, if not effective increase to 20 mg. (C) Follow up in one month.

On 10/16/17, at 3:01 p.m. R28 weas seated at a dining room table playing bingo with wife next to him. R28 is smiling and talking with staff. No noted behaivors.

On 10/17/17, at 8:43 a.m. R28 was completing activities of daily living (ADLs) with nursing assistant (NA)-E including washing with soap and water and changing clothes. R28 is gvien choices and participates fully with NA-E. He was smiling and had no problems following short commands. No noted target behaviors of derogatory language/rude comments towards staff or crying.

On10/18/2017, at 1:15 p.m. R28 was seated on a couch in the facilities front enterance area near the aviary, wearing a cowboy hat that is tilted down on his head and had on his coat. His eyes are closed and he is slumped down and leaning to the left. R28 remains seated on couch approximately one hour.

On 10/19/17, at 1:30 p.m. R28 was seated on a couch next to the front door of the facility. He was

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staring, with a flat affect, out the window across from where he was seated.

On 10/19/17, at 3:50 p.m. R28 was seated quietly on couch in the front door area of the facility. He was awake, quiet and looked out the windows. At 4:15 p.m. R28 remained seated on the couch with eyes closed and head tilted down.

On 10/19/17, at 1:41 p.m. NA-C stated she regularly gives R28 his weekly bath and he does not like the idea of bathing. R28 will complain verbally up until the tub door closes and fills with water, then he loves it. NA-C stated staff tried giving the bath in the evenings and it did not work. NA-C was unaware of any other attempted interventions for R28. NA-C stated R28's verbal behaviors are long standing and had not seen a decrease in them, only that R28 is more tired and he sleeps longer. NA-C stated she was the bath aide that is referenced in the 9/15/17 progress note to the provider and only reported his verbal behavior to the nurse so that others attempting his bath would be aware. NA-C stated she was unaware R28 was taking a medication to attempt to decrease behaviors with bathing and denied that nursing staff had questioned her on R28's compliance with bathing in the recent past.

On 10/19/17 at 3:39 p.m. director of nursing (DON) confirmed R28's was currently taking an AP medication and the last AIMS assessment had been completed on 2/28/17 to monitor for side effects of AP medications. The DON indicated the AIMS assessment should have been completed at least every six months, but are normally done quarterly by herself or the MDS coordinator. DON confrimed the medication hydroxyzine (Vistaril) was added to assist in

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VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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F 329	Continued From page 151 behaivors with the activity of daily living of bathing. DON confirmed that R28 lacked an assessment for a chemical restraint. On 10/19/17, at 4:55 p.m. a phone interview with consultant pharmacist (CP) was conducted. CP confirmed that R28 was currently taking an AP medication and that tardive dyskinesia (TD) assessments should be completed at least every six months. CP confirmed that she made a recommendation to the facility on 9/28/17, to complete a TD assessment due to R28's last TD assessment was from 2/2017. CP was aware of the addition of hydroxyzine (Vistaril) for agitation during bathing and stated it was a better alternative than ativan (an antianxiety medication). A facility policy for AIMS monitoring was requested, and but not provided.	F 329		
F 353 SS=F	SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS CFR(s): 483.35(a)(1)-(4) 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will	F 353		11/28/17

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F 353	Continued From page 152 be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing for timely assistance to answer call lights, and provide assistance with activities of daily living for 6 of 6 residents (R 13, R1, R2, R15, R39, R23) who resided on the Heritage and	F 353	F353 1. R19, R27, R11, R13, R1, R2, R15, R39, and R23 have needs being met. 2. Medication carts will be relocated down resident halls allowing nurse/TMA to assist with resident cares as needed.	

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F 353	Continued From page 153 Serenity wings and 2 of 3 family member (FM-B and FM-C) who voiced concerns. In addition, the facility failed to provide sufficient staffing for meals for 3 of 3 (R19, R27, R11) residents who required assistance with eating. This deficient practice had the potential to affect all 34 residents in the facility at the time of the survey. Findings include: Dining Observation On 10/15/17, from 5:36 p.m. to 6:01 p.m. during the evening meal the following was observed: -At 5:36 p.m. R19 was seated in a geri-chair, at a table in the dining room. Nursing assistant (NA)-F was seated on a wheeled stool next to R19, while NA-F assisted her to eat. -At 5:41 p.m. without standing up, NA-F wheeled her stool over to a table on her left, cued R27 at the other table to continue eating and then rolled the stool back over to the other table with R19 and proceeded to give R19 another bite of food. -At 5:42 p.m. NA-F stood from the wheeled stool, walked away from R19 who remained seated in a geri chair at the dining room table, and immediately walked over to the table on her left and sat in a stationary chair between two residents, R27 and R11. NA-F verbally cued R27 and R11 to eat, stood from the chair, walked over to R19's table, sat on the wheeled stool, gave R19 one bite of food, stood walked two tables away, opened a container for another resident (R42), and immediately walked back to the wheeled stool next to R19 and sat down again. NA-F then proceeded to scoot herself on the stool	F 353	Medication administration to residents will be completed prior to meal times allowing this staff member to either assist in dining room or in resident wing with direct resident cares. Customer Service Rounds will continue to offer a proactive approach to meeting resident needs. 3. Education provided to direct care staff on meeting the needs of the resident. 4. DON or designee will complete weekly audits x5 to ensure residents are receiving care and treatment needed per care plan. QI/QA update quarterly with compliance findings. 5. Corrective actions will be completed by November 28, 2017	

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back and forth between the two tables, R19 at one table and R27 and R11 at the other table and assisted both residents to eat.

-At 5:48 p.m. NA-F stood from the wheeled stool next to R19, walked over to the table on her left, sat in a stationary chair between R27 and R11 and proceeded to feed both residents.

-At 5:51 p.m. NA-F stood from the chair between R27 and R11, walked over to another resident (R8) across the same table and knelt on the floor, gave R8 a drink from a cup, immediately stood and walked back over to the stationary chair between R27 and R11 until 5:52 p.m. when NA-F stood from the chair and left the dining room.

-At 5:52 p.m. NA-G sat down in a stationary chair between R27 and R11 and fed both residents. R19 had remained seated in a geri chair at the dining room table with her plate of food in front of her, R19 received no further assistance with the evening meal.

-At 6:01 p.m. NA-G stood from the chair, walked over to R19 and wheeled her out of the dining room.

On 10/15/17, at 7:54 p.m. NA-G stated it the usual facility practice to sit on a wheeled stool during the meals and move between tables in order to assist resident(s) with eating. NA-G indicated routinely during meals NAs had to help a resident outside the dining room. She indicated the NA left in the dining room would then have to cover that NA's table, which would lead to wheeling back and forth between tables. NA-G further indicated the usual staffing pattern during the meal was to have one staff member per table,

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F 353	Continued From page 155 assisting with three to four residents at the table. On 10/19/17, at 10:54 a.m. dietary aide (DA)-A indicated it was the usual routine facility practice for NA's to sit on a wheeled stool and scoot between tables, to assist residents with eating when there was not enough staff in the facility. On 10/19/17, at 3:55 p.m. the director of nursing (DON) stated it was not the usual facility practice during meals for staff to wheel between tables feeding residents. She indicated if an NA was pulled from the dining room to assist with cares the NA was expected to notify the office staff or the nurse on duty they were leaving the dining room. Resident Interviews: Review of R13's quarterly Minimum Data Set (MDS) dated 9/8/17, identified R13 was cognitively intact and required physical assistance from facility staff for ADL's including toileting. The MDS revealed R13 was frequently incontinent of urine and was continent of bowel. On 10/16/17, at 9:16 a.m. R13 stated she felt there were not enough staff available to answer her call light timely. She indicated she has had to wait up to 30 minutes for her call light to be answered to get off of the toilet. R13 stated she felt there were not enough staff since school had started up and some of the NAs had gone back to school. She indicated she and other residents had voiced their concerns about staffing in care conferences and at resident council and had not seen any resolution at the time of the survey. Review of R23's quarterly MDS dated 7/17/17,	F 353		

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identified R23 was cognitively intact, required extensive physical assistance from facility staff for ADL's including toileting. The MDS revealed R23 was frequently incontinent of urine and always incontinent of bowel.

On 10/15/17, at 6:40 p.m. R23 stated she had to wait for quite a long time for staff to answer her call light and had indicated afternoons were the worst. She stated she had been incontinent of urine on a daily basis due to her call light not being answered timely. R23 indicated she had not spoken specifically with the facility staff directly about her concerns with her call light answered timely. R23 indicated there had been discussion during resident council meetings about long call light wait times and indicated she felt the facility staff were not responsive to concerns or complaints.

During a follow up interview on 10/18/17, at 9:19 a.m. R23 indicated she would have to wait on average for 10-15 minutes, sometimes over 20 minutes for her call light to be answered in the afternoons and in the evenings. R23 stated this was a routine occurrence.

Review of R1's quarterly MDS dated 9/16/17, identified R23 was cognitively intact, required extensive physical assistance from facility staff for ADL's including toileting. The MDS revealed R1 was always incontinent of urine and frequently incontinent of bowel.

On 10/15/17, at 4:54 p.m. R1 stated she felt there were not enough staff in the facility on a consistent basis. She stated she routinely had to wait for her call light to be answered on the night shift and indicated there were usually one nurse

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and two NAs on the night shift. During a follow up interview on 10/17/17, at 10:54 a.m. R1 stated she did not feel like her needs were routinely getting met and had been looking into other facilities to move to, though had been unable to find one. She stated she felt there were not enough qualified staff and has had the NAs talk to her about being short staffed and having to stay longer. R1 indicated she felt the NA's would become flustered when they were not fully staffed and she would hesitate to put on her call light and add to their work. She indicated she would void in her incontinent brief other then call for help as she felt it was easier for the NAs to change her brief versus taking her to the bathroom. She stated she tried not to be incontinent of bowel, though at times she has had to wait up to 20 minutes for her call light to be answered and as a result has been incontinent of bowel. R1 could not recall the most recent time she had been incontinent of bowel due to waiting for the her call light to be answered.

Review of R39's 14-day perspective payment systems (PPS) MDS dated 10/09/17, identified R39 was cognitively intact, required extensive physical assistance from facility staff for ADL's including toileting. The MDS revealed R39 was frequently incontinent of urine and always continent of bowel.

On 10/16/17, at 9:18 a.m. R39 indicated she would routinely wait for more than 30 minutes for staff to answer her call light and as a result would have frequent urinary incontinence. During a follow up interview on 10/18/17, at 9:52 a.m. R39 stated as recently as last week, she had had to wait over 30 minutes for staff to answer her call light. She indicated this would usually occur in the

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evenings and overnight. R39 stated she had not spoken to staff about her concerns and felt it would do no good as staff would stop and tell her they would be right back and not come back for another 30 minutes. She indicated she would become anxious when she had to use her call light and when she waited for her light to be answered.

Review of R2's quarterly MDS dated 8/30/17, identified R2 was cognitively intact, required extensive physical assistance from facility staff for ADL's.

On 10/19/17, at 9:31 a.m. R2 indicated she had voiced grievances at several resident council meetings. R2 stated she attended resident council on a regular basis and had voiced several concerns related to long call light wait times, staff shutting off the call lights, staff not asking what was needed, staff not returning to answer the lights in a timely manner and the facility being short staffed. R2 indicated she had waited up to forty five minutes to go to the bathroom. R2 indicated she routinely received a water pill, which made it hard to wait sometimes and stated she would get upset when she had to wait so long for her call light to be answered. R2 indicated she felt staff were always in a hurry and she felt there were more issues with staffing on the evening shift. R2 indicated those issues have been brought up many times at resident council and stated she felt the facility staff were aware of the long wait times. R2 indicated the facility staff had told residents they were looking into staffing concerns. She further indicated she had not witnessed any changes or any response from the facility regarding resident complaints about staffing. R2 stated she felt the staffing conditions

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worsened since school started again. She indicated the resident council had been told the DON would come to speak with them regarding staffing, however, the DON had not attended. R2 stated there were times she felt her needs were not getting met.

Family Interviews:

On 10/16/17, at 11:46 a.m. during a telephone interview R20's family member (FM)-B indicated she felt the facility did not have enough staff on a consistent basis. She stated R20 would often be brought out to the dining room approximately an hour before the meal service and would fall asleep in her wheelchair. She indicated R20 would have a hard time waking up to eat the meal, once it was served and often ate cold food. FM-B indicated she had witnessed this more so on the weekends, and at the noon and evening meal. During a telephone follow up interview on 10/19/17, at 2:20 p.m. FM-B indicated on several occasions and as most recently as the past weekend, she had witnessed R20 sleeping during the meal time and had felt R20 would be able to feed herself if a staff member woke her up or if the staff would wait until closer to the meal to assist R20 to the dining room. FM-B further indicated she would come to the facility at various times of the day to see what was going on. She indicated the facility administrator and the office people would help with the breakfast meal during the week, however, not for the noon or evening meal, or on the weekends.

On 10/15/17, at 7:27 p.m. during a telephone interview R8's FM-C indicated while she had visited R20 on the evening shift, R20 would have

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to wait approximately 20 minutes for her call light to be answered. FM-C stated she felt R20 was the last resident the facility staff would help to bed and often times R20 would have fallen asleep in her wheelchair. FM-C indicated she felt there were not enough staff during meals and she would often see one NA feeding four to five residents. During a follow up telephone interview on 10/19/17, at 9:16 a.m. FM-C indicated she often visited R20 in the evenings twice a week, she would wheel R20 down to her room following the evening meal and would try to catch an NA on the way back to R20's room. FM-C further indicated R20 would fall asleep shortly after the meal and if she did not catch an NA on the way back to her room, R20 would end up having to wait, while sleeping, in her wheelchair and be woken by staff to be assisted to bed. FM-C stated she had mentioned her concerns regarding staffing to the facility social service designee, DON and the facility administrator during R20's last care conference. FM-C stated she had been told the facility was working on staffing, though R20 continued to fall asleep in her wheelchair and facility staff continued to wake R20 to assist her to bed.

Staff Interviews:

On 10/18/17, at 2:59 p.m. registered nurse (RN)-A indicated in the last couple of months a fourth NA had been added to the day shift, though at the time of the survey, it was not a routine occurrence to have a fourth NA on the day shift. RN-A stated she felt during the week the facility administrator and administrator intern would both help on the floor with feeding, answering call lights and assisting with transfers. She indicated the DON would routinely help with the medication

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pass during the day and evening med pass. RN-A also indicated the DON would come in to help for a med pass in the evening if needed and that had occurred as most recently as a few weeks ago. She stated she would routinely monitor residents during the meals, however, she did not monitor whether resident cares were done according to individualized care plans on a routine basis. She indicated she expected the NAs to complete cares timely and if they were unable to, she would expect to be notified. RN-A stated she was unaware of any residents cares that were not completed in a timely manner due to staffing shortages. She stated she was unaware of any specific resident or family complaints regarding insufficient staffing, however, she did indicate she had heard generalized complaints from staff when there were only three NAs as they had gotten used to having four NAs.

On 10/19/17, at 10:32 a.m. NA-C indicated she had recently received education about resident needs versus wants from the facility administrator (FA), DON and Minimum Data Set (MDS) coordinator approximately a month ago. She indicated some residents wanted their "wants" met immediately and she felt they did not like to wait for another residents "need" to be taken care of first. NA-C stated she had been educated an example of a need would be toileting, or needing water and a "want" would be reaching a newspaper and wanting staff to get it for them. NA-C indicated she felt R1 and R21 were residents which wanted their "wants" met before others "needs" were met.

On 10/19/17, at 11:13 a.m. NA-A indicated the usual facility staffing patterns was to have two NAs down each hall, and one of each NA was

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responsible for floating to the other hall to help during breaks. She stated during the week the office staff would come out and assist with meals and with wheeling residents back and forth if needed. She also indicated the facility administrator and intern both had their NA certification and would help with transfers during the week if needed. NA-A indicated at times they could get a little behind with time sensitive cares such as repositioning and checking and changing, though was not a routine occurrence. She further indicated the usual incidents that would cause them to get behind included; meals, two assist transfers with a full mechanical lift and the am cares.

On 10/19/17, at 1:49 p.m. the MDS coordinator indicated he felt the facility had adequate staffing to meet the needs of the residents. He stated he did not routinely monitor resident cares for timeliness or if their cares were provided according to resident care plans. He indicated his primary role was to complete the MDS in a timely fashion. MDS coordinator stated he would assist with feeding dependent residents during the week, though he could not speak to the weekends as he was not in the facility. He indicated he felt an acceptable wait time for a residents call light to be answered should not exceed five minutes. MDS coordinator stated he was unaware of any residents call lights not being answered for 45 minutes and stated the facility administrator monitored call light time. He further indicated he felt the facility had some residents who wanted their "wants" met before other residents' "needs" were met. MDS coordinator stated he had provided education to staff and residents on "needs" versus "wants," with defining a need as a basic human need such as toileting

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and eating. He further stated an example of a want would be visiting with someone or obtaining an object for a resident which was out of reach. MDS coordinator stated the facility did not have a process in place for determining individual residents' needs and wants. He further indicated it was up to the staff member who answered the residents' call light to determine if the residents request was a need or a want. He indicated he had not received any complaints from residents, family members or staff regarding insufficient staffing.

On 10/19/17, at 2:45 p.m. the DON stated she was responsible for developing the schedule and based the facility staffing needs on resident care needs. She indicated there were no open positions at the time of the survey, though she stated she would like to have two nurses for each shift to ensure individualized cares were provided for the residents. DON stated she had not received any complaints from residents, family members or staff regarding insufficient staffing. She had indicated she spoke with the NAs following complaints from resident council a few months ago and had educated her staff to stop and check with residents with call lights on and inform them of when they would plan to return and at that time, to hit the rounding button on the call box system in order to take credit for checking on the resident. She also indicated she had been aware of residents complaints of short staffing during resident council in April of 2017, and had added a fourth NA to the day and evening shift. She stated she understood the residents continued to complain at the resident council meeting. DON indicated she was unaware residents and family members had specific complaints about the evening shift. She stated

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	245281	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VALLEY CARE AND REHAB LLC	600 FIFTH STREET SOUTHEAST, BOX 129 BARNESVILLE, MN 56514

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she personally had not needed to stay longer in the day or come in on her off days to help with cares. She further stated she did not have a formal system in place to audit whether resident cares were being completed according to resident care plans in a timely manner and on a routine basis and indicated the most recent time spot checks had been completed was in July of 2017.

On 10/18/17, at 10:06 a.m. the facility administrator indicated he was well aware of staffing concerns in the facility. He indicated facility staff were monitoring resident call light times monthly and have discussed the results with the interdisciplinary team which consisted of himself, DON, SSD, MDS coordinator and occasionally an RN charge nurse. Administrator stated he had not personally heard any complaints from residents, family members or staff regarding not enough staff. He stated the facility had educated facility staff to encourage independence and to set boundaries with residents. He indicated staff had been told if they could not do something for everyone, then they could not do it for one resident. He further stated he felt facility staff would spend too much time with residents and he had felt some residents were a challenge as he felt these residents wanted to be pampered. Administrator stated he felt certain residents such as R2, R1 and R26 were demanding and felt they had the mentality of always wanting to be first.

During a follow up interview on 10/19/17, at 3:11 p.m. call light audits for the last month were reviewed with the facility administrator. He stated the facility staffing patterns were a collaborative effort of the interdisciplinary team (IDT) based on conversations and with helping on the floor with

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resident cares. He stated the facility had added a fourth NA in the spring and a full time bath aide last year. Administrator indicated they had been able to add more staff since they would get fully reimbursement and they were able to get dollar to dollar for direct care services. He indicated the facility's goal was to have a fourth aide scheduled consistently on the day shift. Administrator indicated residents had voiced complaints about staffing in resident council and he had indicated at times he felt some of the residents acted like 2 yr old, fighting over the facility copy of the newspaper. He stated his review of the call light wait times has ebbed and would flow up and down. He indicated the office staff such as himself, SSD and administrator intern would routinely help on the floor when they were in the building. Administrator confirmed office staff was in the building Monday through Friday during business hours. He indicated any long call light times were isolated events and he felt the facility had residents who routinely complained. He indicated facility staff and residents had been educated on needs versus wants and the staff were directed to meet the residents needs before wants. Administrator also indicated the facility staff had been instructed to inform residents their "wants" would be met after other residents' "needs" were met. He further indicated residents had not been asked what they personally had considered a need and a want. FA stated he felt the facility did not have a quantity staffing problem, but an "expectation" problem. He also stated residents waiting for 45 minutes for their call light to be answered was not acceptable. FA stated he was not aware residents and family members had specific concerns about getting their needs met on the evening and night shift, nor was he aware residents had incontinent

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episodes while waiting for staff to answer their call light.

Review of Resident Council Minutes from 4/17 to 9/17 revealed the following:

-4/17/17, residents voiced long wait times with call lights and nursing assistants (NA) turn off call lights without addressing needs and not returning in a timely fashion for assistance.

-5/15/17, residents reported when facility had been short staffed cares were delayed and /or of lesser quality. The residents were encouraged to advocate for themselves and speak up regarding their preferences and report any issues to social service designee (SSD,) DON regarding staff. They were also informed staff were to utilize their care guides. The minutes identified the DON would be invited to the July council meeting to address such matters.

-6/17/17, the minutes lacked documentation the DON had attended the meeting and listed no concerns with nursing.

-7/17/17, the minutes lacked documentation the DON had attended the meeting and the residents did not feel like there had been any changes regarding their concerns with staffing.

-8/21/17, residents had been notified the facility had audited call lights and the audit showed call lights were responded to on an average of nine minutes. The resident noted differences of opinions to responsive service call light times and felt nine minutes was a long time to wait for assistance and indicated there was room for

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improvement. The facility informed the residents that in the evening when assisting residents for bedtime, residents who were unable to voice their needs were the priority.

-9/18/17, the minutes listed there were no nursing concerns.

Review of facility detailed event report dated 10/18/17, revealed a summary of call light times from 9/17/17 to 10/18/17. The report revealed a total of 4,970 events (over 1,000 events were a service entrance door alarm), with the longest response time of 93 minutes, shortest response time of 1 minute and an average of 5 minute response time. Further review of the detailed report revealed numerous call light times over 20, 30 and 40 minutes.

Review of the facility's master nursing schedule from 9/4/17, to 10/19/17, revealed out of 46 total days reviewed for the day, evening and night staffing patterns, 40 of the days did not have the staffing pattern identified by the DON for licensed and registered nursing staff.

On 10/19/17, at 2:45 p.m. the DON stated she was responsible for developing the schedule and based the facility staffing needs on resident care needs. She stated the usual staffing pattern would be two licensed nurses (one RN) on the day shift, both 12 hour shift, 4 NA's, one bath aid, 1 licensed nurse and one trained medication assistant (TMA) on the evening shift from 4:00 p.m. to 7:00 p.m., four NAs 2 for the entire evening shift and 2 short shift NAs (one from 4:00 p.m. to 9:30 p.m. and one form 5:00 p.m. to 9:00 p.m. and the night shift had one RN and 2 NAs.

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F 353	Continued From page 168 A staffing policy was requested and was not provided.	F 353		
F 428 SS=D	DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON CFR(s): 483.45(c)(1)(3)-(5) c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a	F 428		11/28/17

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F 428	Continued From page 169 minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify irregularities and make recommendations for use of an antipsychotic medication in the presence of suicidal ideation and the use of an anti-anxiety medication prior to bathing for 1 of 1 resident (R28) reviewed for suicidal ideation and chemical restraints. In addition the facility failed to ensure the consultant pharmacist identified that the Abnormal Involuntary Movement Scale (AIMS)-(an assessment used to assess involuntary movements associated with the use of antipsychotic medication) was not completed to monitor for side effects for 3 of 5 resident (R3, R14, R28) reviewed for unnecessary medications. Findings include:	F 428	F428 1. Drug review and AIMS assessment completed for R3, R14, and R28. 2. Drug review completed for all residents on October 20, 2017. DON coordinated with pharmacy consultant to ensure completion of upcoming AIMS. 3. DON or designee will track AIMS due dates and completion thereof on Psychotropic Tracker spreadsheet. 4. DON or designee will monitor assessment completion monthly for the next 3 months or until 100% compliance is achieved. QI/QA update quarterly with compliance findings. 5. Corrective actions will be completed by November 28, 2017	

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F 428	Continued From page 170 Review of R3's clinical chart on 10/19/17 revealed a quarterly AIMS assessment had been completed to monitor the side effects of the AP medication on 2/8/17. The AIMS revealed R3 had no facial or oral movements, no extremity movements, no trunk movements, no global movements, no problems with dental status and movements in sleep disappeared. No further assessments were found in the clinical chart. R3's current order summary report, indicated an order for Seroquel (antipsychotic medication) 200 milligrams (mg) by mouth three times a day for mood affective disorder and unspecified psychosis initiated on 9/30/16. Review of R3's Thrifty White Pharmacy Summary Reports, from 2/17 to 9/17. Pharmacy reviews were done on 2/23/17, 3/22/17, 4/27/17, 5/24/17, 6/29/17, 7/27/17, 8/29/17 and 9/28/17 revealed no recommendations were made by pharmacy to have AIMS assessment completed to monitor for side effects of AP medications. On 10/19/17 at 4:31 p.m. left a voice message via phone call for the pharmacy consultant (PC). At 6:15 p.m. the PC called back and confirmed R3 had not had a AIMS assessment done since 2/8/17. The PC indicated she would expect the facility staff to complete an AIMS assessment every six months for R3. The PC also indicated she did not prompt the facility to compete a current AIMS assessment during her visits to the facility. The PC confirmed she had not made a recommendation to have the facility complete the AIMS assessment. Review of 14's clinical chart on 10/19/17,	F 428		

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F 428	Continued From page 171 revealed a quarterly AIMS assessment had been completed to monitor the side effects of the AP medication on 3/14/17. The AIMS revealed R14 had no facial or oral movements, no extremity movements, no trunk movements, no global movements, no problems with dental status and movements in sleep disappeared. No further assessments were found in the clinical chart, R14's current order summary report, indicated an order for Seroquel (antipsychotic medication) 100 mg by mouth in the evening and Risperidone (antipsychotic medication) 0.5 mg by mouth two times a day for mood affective disorder and depression with psychotic symptoms Review of R14's Thrifty White Pharmacy Summary Reports, from 2/17 to 9/17. Pharmacy reviews were done on 2/23/17, 3/22/17, 4/27/17, 5/24/17, 6/29/17, 7/27/17, 8/29/17 and 9/28/17 revealed no recommendations were made by pharmacy to have AIMS assessment completed to monitor for side effects of AP medications. On 10/19/17 at 4:31 p.m. left a voice message via phone call for the PC. At 6:15 p.m. the PC called back and confirmed R14 had not had a AIMS assessment done since 3/14/17. The PC indicated she would expect the facility staff to complete an AIMS assessment every six months for R14. The PC indicated she will usually wait a month after the AIMS should be completed before giving the facility reminders to complete the AIMS assessment. The PC confirmed she had not made made a recommendation to have the facility complete the AIMS assessment.	F 428		

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Review of R28's medication administration records(MAR) for the months of August, September and October 2017:

-Hydroxyzine give 10 mg by mouth every Wednesday, with a start date of 9/20/17. The MAR listed R28 had received the medication on 9/20/17, 9/27/17, 10/4/17, 10/11/17 and 10/18/17.

-Seroquel 25 mg by mouth twice a day, started 5/16/17 for unspecified mood, affective disorder. On 9/15/17, the dose of Seroquel increased to 50 mg by mouth twice a day.

Review of R28's clinical record revealed R28 had received a daily dose of Seroquel 12.5 mg until 4/14/17. At that time, the dose was increased to 25 mg daily.

Review of R28's clinical chart on 10/18/17 revealed a quarterly Abnormal Involuntary Movement Scale (AIMS) assessment had been completed to monitor the side effects of the AP

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F 428	Continued From page 173 medication on 2/28/17. No further AIMS assessments were found in the clinical record. Review of R28's Thrifty White Pharmacy Summary Reports, from 2/17 to 9/17 revealed pharmacy reviews were completed on 2/23/17, 3/22/17, 4/27/17, 5/24/17, 6/30/17, 7/27/17, 8/29/17, and 9/28/17. R28's pharmacy review dated 8/29/17 revealed no recommendation for completetion of tardive dyskinesia (TD) monitoring. R28's pharmacy review dated 9/28/17, indicated that R28's AIMS assessment was last completed on 2/2017, and that it was already a month past due. R28's irregularity indicated that anyone taking antipsychotic medications should be monitored for tardive dyskinesia (TD) at least every six months. On 10/19/17, at 4:55 p.m. a phone interview with consultant pharmacist (CP) was conducted. CP confirmed that R28 was currently taking an AP medication and that tardive dyskinesia (TD) assessments should be completed at least every six months. CP confirmed that she made a recommendation to the facility on 9/28/17, to complete a TD assessment due to R28's last TD assessment was from 2/2017. The CP indicated she will usually wait a month after the AIMS should be completed before giving the facility reminders to complete the AIMS assessment. On 10/19/17, requested facility policy for pharmacy consultant, one was not provided.	F 428		

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Valley Care and Rehab was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date.	K 000	EPOC	

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

Electronically Signed | 11/17/2017

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 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Valley Care and Rehab is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1980, a Sun Room addition was added to the south of the Dining Room/Day Room that was determined to be of Type V(000) construction. In 1994 an addition to the main entrance, to the west was constructed and was determined to be of Type II(111) construction. The building is completely protected by an automatic fire sprinkler system installed and also has a fire alarm system with smoke detection in the corridors and areas open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 35 beds and a census of 34 at the time of the survey..	K 000		
K 321 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is **NOT MET** as evidenced by: Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure 2012 EXISTING Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4-hour	K 321		10/23/17

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K 321	Continued From page 2 fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain 1 hazardous room in accordance with the 2012 Life Safety Code, (NFPA 101) section 19.3.2.1. This deficient practice could allow for smoke or fire to enter the corridor making it untenable for exiting, affecting an undetermined amount of staff and visitors. Findings include: At 11:09 am on 10/17/2017 observations revealed	K 321	K321 Boiler room door was adjusted to allow door to positively latch. Repair was completed on 10-23-2017 Environmental Services Director repaired door and will monitor periodically during the day to ensure that all doors with closures positively latch.	

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	245281	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/16/2017**

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K 321	Continued From page 3 the boiler room door did not positively latch. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director	K 321		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the 2012 Life Safety Code (NFPA 101) and NFPA 25 section 5.2.1.1.2. The standard for testing and maintenance of sprinkler systems. This deficient condition could cause the sprinkler system not to function properly and allow for the spread of fire. This could affect all of the 34 residents and an	K 353	K353 Education provided to Environmental Services Director (10-16-2017) Fire Marshal about the required intervals (Quarterly) of sprinkler system. Administrator will audit quarterly for the next two quarters to ensure compliance.	10/16/17

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K 353	Continued From page 4 undetermined amount of staff and visitors. Findings include: At 9:00 am on 10/17/2017 record review revealed there was no documentation for a flow test in the 2nd quarter of 2017. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 353		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to maintain one of two smoke barriers as required by the 2012 Life Safety Code (NFPA 101) section 19.3.7.3, 8.8.7.1 (1). This deficient practice could allow smoke to transfer from one smoke compartment to another affecting the exiting of 17 of the 34 residents and an undetermined amount of staff and visitors.	K 372	K372 Fire stop was applied around conduit above the ceiling in the smoke barrier of the Serenity wing. Repair was completed on 10-19-2017 Environmental Services Director applied fire stop and will inspect smoke barrier areas when any new work is done in	10/19/17

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K 372	Continued From page 5 Findings include: At 10:40 am on 10-17-2017 observations revealed the annular space around a conduit was not properly fire stopped above the ceiling in the smoke barrier of the serenity wing . This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 372	building that may have penetrated smoke barrier.	
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to conduct fire drills under varied conditions on each shift as required by the Life Safety Code (NFPA 101) 2012 edition, section 19.7.1.4 to 19.7.1.7. This deficient practice could reduce the ability of staff to conduct a safe and timely response to a fire emergency, which would	K 712	K712 Education provided to Environmental Services Director (10-16-2017)by Fire Marshal about the requirements of conducting fire drills under varied conditions i.e vary the times the drill are conducted on each shift. Administrator	10/16/17

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K 712	Continued From page 6 affect all 34 residents and an undetermined amount of staff and visitors. Findings include: At 8:45 on 10/17/2017 record review revealed that the fire drills were not conducted under varied conditions. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 712	will audit monthly for the next quarter to ensure compliance.	
K 923 SS=D	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2.	K 923		10/23/17

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K 923	Continued From page 7 A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to store oxygen tanks in accordance with NFPA 99 (Health Care Facilities Code) 2012 edition section 5.1.3.3.2. This deficient practice could create an oxygen filled atmosphere and accelerate the spread of fire. This condition could affect an undetermined amount of staff and visitors. Findings include: At 11:45 am on 10-17-2017 observations revealed a carpeted floor in the enclosure, near the front entry, where oxygen was being stored. This deficient condition was confirmed by the Facility Administrator and the Environmental Services Director.	K 923	K923 Environmental Services Director removed carpet from area where O2 tanks are stored. Removal was completed on 10-23-2017	