MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7015 0640 0003 5695 1134

May 19, 2017

Mr. Matthew Fischer, Administrator
Bethany Home
1020 Lark Street
Alexandria, MN 56308

Re: Bethany Home - Independent Informal Dispute Resolution (IIDR)
CMS Certification Number (CCN): 245434
Project Number: S5434025

Dear Mr. Fischer:

In a letter dated August 11, 2016, Bethany Home requested removal of a deficiency cited at F323 as a result of a recertification survey completed on July 22, 2016 by the Licensing and Certification Program of the Minnesota Department of Health. The Statement of Deficiencies, CMS 2567, has been revised to reflect the Commissioner's decision as delineated in the letter dated March 24, 2017. The revised CMS 2567 is enclosed. The revisions reflect the deletion of several fall incidents for the affected resident, R87, which were noted to be duplicative as discussed at the IIDR review meeting.

In addition, the corresponding State licensing order issued under Minnesota Rule 4658.0520, Subp. 1 (St. - 2 - 0830), has been reviewed and revised. The revised Minnesota Department of Health State form is enclosed.

This concludes the Minnesota Department of Health Independent Informal Dispute Resolution Process.

Sincerely,

Holly Kranz

Holly Kranz, HFE NEII
Licensing and Certification Program
Health Regulation Division
Email: Holly.Kranz@state.mn.us
Minnesota Department of Health
Phone: (507) 334-2742 Fax: (507) 344-2723

cc: Office of Ombudsman for Long-Term Care
Mary Absolon, Program Manager
Pam Kerssen, Assistant Program Manager
Licensing and Certification File

IIDR Response Letter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

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F 000	INITIAL COMMENTS A survey was conducted by the Minnesota Department of Health on July 18,2016 through July 22, 2016. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to comprehensively assess and effectively implement fall interventions for a Merry walker which resulted in the high potential for harm or death. The IJ began October 24, 2015 and was removed on July 20, 2016 at 3:30 p.m. As a result of identification of the IJ at F323, an extended survey was conducted by the Minnesota Department of Health on July 21 and 22, 2016. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		8/9/16

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

Electronically Signed | 08/12/2016

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F 225	Continued From page 1 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure injuries of unknown origin were reported to the State agency (SA) for 1 of 3 residents (R87) reviewed. Findings include:	F 225	This plan of correction is submitted solely to comply with all applicable state and Federal regulatory requirements. These written responses do not constitute an Admission of non-compliance with any requirements nor an agreement with any	

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F 225	Continued From page 2 R87's annual Minimum Data Set (MDS) dated 5/11/16, identified long and short term memory problems with no recall ability, was rarely to never understood and required extensive assistance for all areas of daily living (ADL). The facility form titled Order Summary Report signed by the physician dated 6/27/16, identified R87's medical diagnoses to include dementia with Lewy Bodies, Parkinson's disease, and anxiety disorders. R87's care plan reviewed 7/13/16, indicated,"The resident is dependent upon staff etc. for emotional, intellectual, physical and social needs r/t [related to] Lewy Bodies, Physical Limitations" The care plan further indicated "The resident has physically abusive behaviors r/t dementia with Lewy Bodies, unspecified psychosis". A review of R87's nursing progress notes identified the following : -10/24/15-"Data: resident tipped merry walker over sideways and was found face down on floor, unable to move. Resident hit head/mouth on floor. residents mouth was bleeding from loosing a tooth. no one seen [sik] the incident so we don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift." -10/26/15," IDT (interdisciplinary team) review of fall from 10/24/15, Resident tipped over merry walker and landed on her face. Received a small abrasion under [R87's] nose and lost a tooth as a result of the fall." Study results of an x-ray (CT) of R87's brain dated 10/26/15, identified the following Clinical information: [R87] presents with a fall, initial encounter. Nurse states -facial pain with more confusion than usual. Conclusion: Nondisplaced fracture thorough the anterior	F 225	Findings. It is the policy of Ecumen Bethany Home that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical mental and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care. To assure continued compliance the following plan has been implemented. • Regarding cited residents: F225 Investigate Report allegations/individuals Per Abuse Prevention policy: An injury is considered an injury of unknown source and must be reported when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident. A. For R87 any further falls that result in a serious injury of unknown source that is unwitnessed and the resident is not able to explain, shall be reported to OHFC immediately per the abuse policy. B. All residents that are identified at risk for falls could be affected by not reporting immediately. For all incidents that result in a serious injury that are unwitnessed and the resident is not able to explain shall be reported to OHFC immediately per the abuse policy. C. Education to all licensed staff and individuals responsible for reporting provided on 8-9-16 via email. The education includes the Abuse and	

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F 225	Continued From page 3 superior most maxilla (upper jaw) at the base of the nose. Review of the facility form titled 2015 Vulnerable Adult Incident Log, which logged the facility reports to the SA, indicated a report had not been submitted related to R87's fractured jaw from an unwitnessed fall on 10/24/15. On 7/22/16, at 11:28 a.m. the director of nursing (DON) verified a report had not been submitted to the SA when R87 had an unwitnessed fall on 10/24/15. The DON indicated she had not considered it a major injury at the time because it was unknown that R87 had a fractured jaw until a day or two after the fall occurred. The DON verified she had not considered to report to the state agency when it became known that R87 had a fractured jaw from the fall; however, would typically report an injury related to an unwitnessed fall when the resident is not cognitively intact. When interviewed on 7/22/16, at 1:10 p.m. the social services director (SSD) verified the responsibility of oversight for abuse prevention and reporting to the SA. SSD indicated training had been completed for many staff to submit VA reports to OHFC (Office of Health Facility Complaints)/MAARC (Minnesota Adult Abuse Reporting Center) including nurse managers, social services and nurses who worked the floor. SSD indicated the initial report was to be made immediately for alleged or suspected abuse, neglect, exploitation, and all things that fall under the facility vulnerable adult (VA) policy. When given the scenario of an unwitnessed fall of a cognitively impaired resident resulting in a fracture, SSD stated "I would have to look at the guidelines." When reviewed on SSD's lap top	F 225	Prevention policy specifically in regards to reporting serious injuries of unknown origin due to unwitnessed falls and the resident not able to explain what happened. Nursing incident check list that now includes reporting serious injuries of unknown origin to OHFC, and education on the use of the Federal Long Term Care Report ability Under F225 injuries of unknown source. Face to face meetings were also held the week of 8-8-16 to provide education on reporting injuries of unknown origin. The policy, checklist and algorithm will be review at an all staff meeting on 8-23-16 as an additional education opportunity. D. Audits will be completed on all falls beginning 8-9-16 to assure any serious injury of unknown origin is reported to OHFC per policy. Audits will be completed after each reported fall for 4 weeks to assure compliance with the Abuse Prevention policy. E. Completion date 8-9-20-16. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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F 225	Continued From page 4	F 225		

computer and the incident included no observation, resident unable to explain and the resulting injury; SSD responded, "I would think so" regarding R87's fractured jaw due to an unwitnessed fall. SSD indicated the facility staff had discussed the incident and had not found it to be a reportable incident. SSD verified the usual procedure for reporting an injury of unknown origin by reading aloud the facility policy: An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury. SSD request more time to review the electronic record before answering any more questions.

On 7/22/16, at 1:56 p.m. SSD identified R87's fall had been reviewed with the interdisciplinary team (IDT) and stated,"we didn't think it was a serious injury." SSD further explained the fractured jaw did not result in a hospitalization or affect R87's quality of life; therefore it was not a serious injury.

When interviewed on 7/22/16, at 1:56 p.m. the administrator indicated the report would be brought to the Quality Assurance meeting to review procedures for reporting.

The facility policy titled Ecumen's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities updated 7/2015, identified " An injury is considered an injury of unknown source and must be reported when both of the following conditions are present
(1) The source of the injury was not observed by

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F 225	Continued From page 5 any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement abuse policies and procedures to include consistent, immediate reporting of injuries of unknown origin to the State Agency (SA) for 1 of 3 residents (R87) reviewed. Findings include: The facility policy titled Ecumen's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities updated 7/2015, identified " An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the	F 226	F226 Develop/Implement abuse/neglect etc. policies The facility does have a policy for reporting injury of unknown origin. Per Abuse Prevention policy: An injury is considered an injury of unknown source and must be reported when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident. A. For R87 any further injury of unknown origin per policy will be reported and reviewed by the IDT. All major injuries that are unwitnessed and the resident is not able to explain shall be reported to OHFC immediately per the abuse prevention	8/9/16

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F 226	Continued From page 6 injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." R87's annual Minimum Data Set (MDS) dated 5/11/16, identified long and short term memory problems with no recall ability, was rarely to never understood and required extensive assistance for all areas of daily living (ADL). The facility form titled Order Summary Report signed by the physician dated 6/27/16, identified R87's medical diagnoses to include dementia with Lewy Bodies, Parkinson's disease, and anxiety disorders. R87's care plan reviewed 7/13/16, indicated,"The resident is dependent upon staff etc. for emotional, intellectual, physical and social needs r/t [related to] Lewy Bodies, Physical Limitations" The care plan further indicated "The resident has physically abusive behaviors r/t dementia with Lewy Bodies, unspecified psychosis". A review of R87's nursing progress notes identified the following : -10/24/15-"Data: resident tipped merry walker over sideways and was found face down on floor, unable to move. Resident hit head/mouth on floor. residents mouth was bleeding from loosing a tooth. no one seen [sik] the incident so we don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift." -10/26/15," IDT (interdisciplinary team) review of fall from 10/24/15, Resident tipped over merry walker and landed on her face. Received a small abrasion under [R87's] nose and lost a tooth as a result of the fall." Study results of an x-ray (CT) of R87's brain dated 10/26/15, identified the	F 226	policy. B. All residents that are identified at risk for falls could be affected by not reporting immediately. For all falls that result in a serious injury, that are unwitnessed and the resident is not able to explain shall be reported to OHFC immediately per the abuse policy. C. Education to all licensed staff and individuals responsible for reporting provided on 8-9-16 via email. The education includes the Abuse and Prevention policy specifically in regards to reporting injuries of unknown origin due to unwitnessed falls and the resident not able to explain what happened. Nursing incident check list that now includes reporting serious injuries of unknown origin to OHFC, and education on the use of the Federal Long Term Care Report ability Under F225 injuries of unknown source. Face to face meetings were also held the week of 8-8-16 to provide education on reporting injuries of unknown origin. The policy, checklist and algorithm will be review at an all staff meeting on 8-23-16 as an additional education opportunity. D. Audits will be completed on all falls beginning 8-9-16 to assure any serious injury of unknown origin is reported to OHFC per policy. Audits will be completed after each reported fall for 4 weeks to assure compliance with the Abuse Prevention policy. E. Completion date 8-9-2016. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional	

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F 226	Continued From page 7 following Clinical information: [R87] presents with a fall, initial encounter. Nurse states -facial pain with more confusion than usual. Conclusion: Nondisplaced fracture thorough the anterior superior most maxilla (upper jaw) at the base of the nose. Review of the facility form titled 2015 Vulnerable Adult Incident Log, which logged the facility reports to the SA, indicated a report had not been submitted related to R87's fractured jaw from an unwitnessed fall on 10/24/15. On 7/22/16, at 11:28 a.m. the director of nursing (DON) verified a report had not been submitted to the SA when R87 had an unwitnessed fall on 10/24/15. The DON indicated she had not considered it a major injury at the time because it was unknown that R87 had a fractured jaw until a day or two after the fall occurred. The DON verified she had not considered to report to the state agency when it became known that R87 had a fractured jaw from the fall; however, would typically report an injury related to an unwitnessed fall when the resident is not cognitively intact. When interviewed on 7/22/16, at 1:10 p.m. the social services director (SSD) verified the responsibility of oversight for abuse prevention and reporting to the SA. SSD indicated training had been completed for many staff to submit VA reports to OHFC (Office of Health Facility Complaints)/MAARC (Minnesota Adult Abuse Reporting Center) including nurse managers, social services and nurses who worked the floor. SSD indicated the initial report was to be made immediately for alleged or suspected abuse, neglect, exploitation, and all things that fall under the facility vulnerable adult (VA) policy. When	F 226	education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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F 226	Continued From page 8	F 226		

given the scenario of an unwitnessed fall of a cognitively impaired resident resulting in a fracture, SSD stated "I would have to look at the guidelines." When reviewed on SSD's lap top computer and the incident included no observation, resident unable to explain and the resulting injury; SSD responded, "I would think so" regarding R87's fractured jaw due to an unwitnessed fall. SSD indicated the facility staff had discussed the incident and had not found it to be a reportable incident. SSD verified the usual procedure for reporting an injury of unknown origin by reading aloud the facility policy: An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury. SSD request more time to review the electronic record before answering any more questions.

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F 226	Continued From page 9	F 226		
F 282 SS=D	. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the plan of care for 2 of 3 residents (R78, R28) reviewed who were dependent upon staff for shaving and oral cares and for 1 of 1 resident (R65) reviewed with bilateral hand contractures and required range of motion (ROM). Findings include: R78's admission Minimum Data Set (MDS) dated 7/1/16, identified R78 was moderately cognitively impaired, required extensive assistance for all areas of daily living (ADL)with exception of limited assistance to walk in corridor and diagnoses which included Parkinson's disease, dementia, arthritis and vision impairment. R78's undated care plan, identified R78 had a self	F 282	F282 Services by Qualified Persons/per care plan Policy: Nursing care standards: to ensure that every resident receives care to reach their highest practicable level of functioning. This includes: Assistance with or supervision of shaving residents as necessary to keep them clean and well groomed. Assistance as needed with oral hygiene to keep the mouth, teeth or dentures clean. Assistance with ROM or placement of a device. Residents do have the right to refuse care/assistance all refusals will be charted in the resident's record. A. For R78 shaving will be offered and provided by staff daily. Care plan for R78	8/9/16

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F 282	Continued From page 10 care deficit related to Parkinson's Disease, hypertension, diabetes, and dementia as evidenced by requiring assist with ADL's -The resident requires extensive assist of 1 staff with personal hygiene. The undated resident care sheet, indicated R78 required assist of one staff with dressing and grooming. On 7/19/16, at 9:28 a.m. R78 stated, " I can't shave because of my Parkinson, that is one thing they are a little lax on." At this time R78 has stubble on chin and upper lip. On 7/20/16, at 7:57 a.m. R78 was propelled from his room to the dining room by nursing assistant (NA)-H. R78 had facial hair stubble on the upper lip and chin area. On 7/20/16, at 1:00 p.m. R78 was seated in his room in a stationary chair in front of the television. R87 remained unshaven. On 7/21/16, at 9:26 a.m. R78 was seated in room dressed, has not had face shaved, mustache and beard heavy stubble. On 7/20/16, at 8:51 a.m. NA-H indicated R78 tries to shave independently and will ask staff when he needs help. NA-H indicated R78 was new to the facility and NA-H was unsure of whether R78 had behaviors or refused cares. When interviewed on 7/20/16, at 1:00 p.m. R78 verified if he was able to shave himself he would do it every day. R78 stated staff will shave his face each morning when they get him up with an electric razor but some times they forget. R78	F 282	has been reviewed with staff providing cares for R78 in regards to offering and providing shaving. For resident R28 oral cares will be offered and provided by staff at least 2 times per day. Care plan R28 has been updated to include resident does not wear dentures. The care plan has been reviewed with staff providing care for R28 in regards to providing oral cares at least 2 times per day. For R65 has had fixed contractures (irreversible) for years per OT evaluation 11-17-12. The kerlix rolls in hands are to prevent moisture related issues and not to prevent contractures. MD orders clarified and plan of care has been revised. All staff working with R56 will be provided education on placement of kerlix in hands. It will be the responsibility of all nursing staff to assure kerlix is in place. The care plan has been updated will be reviewed with staff providing care for R65 in regards to placement of gauze rolls in hands. B. All residents requiring assistance with cares have to potential to be affected by this same practice. C. Written Education was provided to all staff via email and on Point of Care messaging on 8-9-16 in regards to care expectations related to shaving, oral cares, placement of devices related to contractures and providing assistance to all resident per their plan of care. Face to face education was provided to staff the week of 8-8-16. Will also provide additional training opportunity at the 8-23-16 all staff meeting.	

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	245434	A. BUILDING _____ B. WING _____	07/22/2016

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F 282	Continued From page 11 verified his facial hair had not been shaved off today and was unable to recall when staff last shaved him. On 7/20/16, at 1:17 p.m. NA-I identified R78 had no behaviors and did occasionally refuse to go for a walk, however, it was usually for a reason, for example if his wife was here or if he was having pain in his hip. On 7/21/16, at 9:54 a.m. NA-E indicated R78 was unable to shave independently due to shaky hands. NA-E verified he/she had not shaved R78 this a.m. NA-E indicated R78 refused the offer to shave this a.m. and had a routine of shaving only "every so often." On 7/21/16, at 11:00 a.m. NA-F verified R78 had a good memory and what he says is accurate. NA-F indicated he/she did not provide cares for R78 often, however, did believe R78 was usually clean shaven. NA-F indicated staff usually assisted R78 with oral care and shaving. NA-F sated, " We would normally shave a person if they can't themselves." On 7/21/16, at 11:04 a.m. R78 verified he was not shaved this morning. R78 stated, " it (facial hair) isn't so hard to get off" if he is shaved every day. R78 further identified with a clean shaven face it was easier to keep clean as things get caught, stating "I drool." On 7/21/16, at 11:13 a.m. licensed practical nurse (LPN)-E verified R78 had facial stubble and had not been shaved. On 7/21/2016, at 11:14 a.m. registered nurse (RN)-A verified R78 required assistance with	F 282	D. Audits implemented beginning 8-9-16 on 4 residents per week x 4 weeks to assure shaving, oral cares, and application of kerlix/devices are provided per policy. Further education and audits will be provided/conducted if compliance is not met. E. Completion date 8-9-2016. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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F 282	Continued From page 12	F 282		

ADL's due to has Parkinson's Disease and although his abilities change from day to day, R78 was not able to shave independently with an electric razor. RN-A identified staff were expected to shave male residents daily and would not expect residents to have to ask for the assistance.

When interviewed on 7/22/16, at 11:25 a.m. the director of nursing (DON) verified the expectation that staff follow the care plan and residents who require assistance with ADL's be provided the care and not expected to ask for assistance.

R28's care plan dated 7/15/16, identified R28 required extensive assistance to total assistance with personal hygiene and oral cares. The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 mouth swab and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed.

The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28.

During observation of morning cares on 7/20/16, from 8:23 a.m. to 8:54 a.m. NA-A and NA-G assisted R28 with personal cares which included washing her face, perineal cares and dressing. During the observation, R28 was not assisted nor offered the opportunity for completion of oral cares. R28's oral cavity and lips appeared very dry.
-At 8:57 a.m. NA-A assisted R28 with breakfast while R28 was positioned in bed. R28 was not

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F 282	Continued From page 13	F 282		

wearing any dentures, and R28 refused the breakfast food items and juice offered. R28 did consume the strawberry supplement.
-At 9:01 a.m. NA-A gathered the breakfast tray, shut off the bedroom lights and stated some days are good with feeding, and some days are not, just like today. NA-A then delivered the breakfast tray to the kitchen, R28 was not assisted nor offered the opportunity for completion of oral cares.

During interview on 7/20/16, at 8:45 a.m. NA-A reported R28 no longer wears dentures, and stated she was going to wait until after R28 ate breakfast to provide oral cares which included swabbing out the mouth with a toothette.

At 9:07 a.m. NA-A confirmed R28 had finished with the breakfast meal and confirmed she had completed morning cares for R28. NA-A verified she did not complete nor offer oral cares which included swabbing the mouth with a toothette or mouthwash. Further, NA-A confirmed she did not inspect her mouth with cares.

During interview on 7/21/16, at 10:35 a.m. RN-B confirmed R28 no longer wore dentures. RN-B verified staff are expected to swab R28's mouth with morning cares, or at least attempting as R28 will at times refuse. RN-B confirmed R28 has a dry mouth and sleeps with the oral cavity open, therefore, oral care must be attempted.

During interview on 7/22/16, at 10:08 a.m. the DON confirmed staff are expected to provide or offer oral cares to all resident twice per day as indicated on the care plan.

The facility's Mouth Care Policy dated October

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F 282	Continued From page 14 2010, directed staff to review the resident's care plan for any special needs of the resident. and assemble the equipment and supplies as needed. Review of R65's quarterly Minimum Data Set (MDS) dated 4/27/16, identified R65 had severe cognitive impairment and had diagnoses which included Parkinson's disease, Alzheimer's disease and cerebravascular disease with hemiplegia . The MDS further identified R65 was totally dependent on staff for activities of daily living (ADL's) and had bilateral upper extremity contractures. Review of R65's annual Care Area Assessment (CAA) dated 8/19/15, identified R65 had severe cognitive impairment due to Alzheimer's disease, was totally dependent on staff for ADL's and had contractures. Review of R65's care plan print dated 2/25/16, identified R65 had bilateral contractures of the upper and lower extremities, was totally dependent on staff for all ADL's, required gentle range of motion with daily care, required gauze rolls in both hands 23/hrs/day: to be removed for 30 minutes twice daily for hygiene for bilateral hand contractures. On 7/18/16, at 5:38 p.m. R65 was seated in a tilt in space wheelchair across from the nurses station prior to the evening meal. Both of R65's hands were held in a fisted position, elbows were bent and hands rested on her chest, right hand rested near her heart and her left hand rested on her left upper chest. R65 did not have kerlix placed in her hands. At 6:55 p.m. R65 was seated in a tilt in space wheelchair near the nurses station following the evening meal. R65 remained without kerlix/gauze in both hands. On 7/19/16, from 8:45 a.m. to 10:55 a.m. R65	F 282		

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was lying in bed tilted to her right side with pillows against her back, blankets were observed to cover R65 to mid torso. R65's hands were in a fisted position , arms were bent at the elbow, fisted hands rested against her chest. R65 did not have kerlix in her hands.

On 7/21/16, at 4:57 p.m. R65 was seated in a tilt in space wheelchair with both arms bent at the elbows, hands were resting on her chest and were clenched fisted position. R65's right clenched hand was resting over her heart and her left clenched hand was resting on her upper left chest, no kerlix was observed in R65's hands.

When interviewed on 7/21/16, at 5:09 p.m. registered nurse manager (RN)-A confirmed R65 did not have kerlix in her contracted hands as care planned and was unsure why the kerlix was not in use. RN-A stated the medication nurses were responsible for checking to make sure R65's kerlix were in both hands for bilateral hand contractures. RN-A stated she felt R65 hands were too contracted for the kerlix to have fallen out, nor could R65 remove the kerlix independently. RN stated R65's hands were fully contracted and had been for years. RN-A directed a licensed practical nurse (LPN)-D to apply kerlix.

On 7/21/16, at 5:13 p.m. LPN-D attempted to open R65's right hand fingers from the contracted, fisted position and apply approximately an inch in diameter cotton kerlix roll into R65's hand. R65 stated it hurt and she was hurting her fingers, LPN-D immediately stopped opening R65's hand. At that time, LPN-D stated there were times when R65's hands needed to be soaked in warm water to help open the hands up. RN-A and NA-B then wheeled

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R65's to her room and NA-B wheeled R65 into her bathroom, while RN-A started to run the water out of the faucet. NA-B took R65's right hand, held it under the warm water while RN-A slowly opened R65's hand, washed, dried and applied the kerlix. NA-B then took R65's left hand, held it under the water while RN-A opened R65's hand, washed, dried and applied another roll of kerlix. NA-B assisted R65 back out of the bathroom in her wheelchair and wheeled R65 back to nursing station.

On 7/21/16, at 5:12 p.m. NA-B stated R65 was supposed to have the kerlix in both of her hands at all times. NA-B stated the nurses usually put them in after R65's hands were washed. NA-B stated she felt about 3-4 times a week R65's kerlix were not in her hands and she would then place the kerlix into R65's hands and often had a hard time doing so. NA-B further stated she felt R65's hands were fisted very tightly so the kerlix could not fall out and she felt R65 would be unable to remove the kerlix herself. NA-B stated she felt R65's hands had not worsened over the last few years.

On 7/22/16, at 10:23 a.m. NA-C stated R65 required total assistance with all ADL's, NA-C stated on average a few days a week R65 would not have the cloth rolls, (kerlix) in her hands and NA-C would then place the kerlix in R65's contracted hands.

On 7/22/16, at 10:37 a.m. RN-A stated R65 had not had a recent occupational therapy evaluation, though had one a few years ago which identified R65 had complete contractures of both hands. RN-A confirmed R65's current physician orders directed nursing staff to ensure R65 had kerlix

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F 282	Continued From page 17 placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated R65 had fully contracted hands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing (DON) stated she expected resident care plans to be implemented as directed. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. The facility policy titled Resident MDS 3.0 Assessment and Plan of Care revised 03/12, indicated the care plan was to provide continuity of care from admission to discharge. The facility's Care Plan Policy dated September 2010, indicated the care plan would be used to enhance the optimal functioning of the resident, and/or aid in preventing or reducing decline in resident's functional status and/or functional levels.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		8/12/16

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F 312	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral care and removal of facial hair for 2 of 3 residents (R78, R28) reviewed who were dependent upon staff for grooming and personal cares. Findings include: R78's admission Minimum Data Set (MDS) dated 7/1/16, identified R78 was moderately cognitively impaired, required extensive assistance for all areas of daily living (ADL)with exception of limited assistance to walk in corridor and diagnoses which included Parkinson's disease, dementia, arthritis and vision impairment. R78's undated care plan, identified R78 had a self care deficit related to Parkinson's Disease, hypertension, diabetes, and dementia as evidenced by requiring assist with ADL's -The resident requires extensive assist of 1 staff with personal hygiene. The undated resident care sheet, indicated R78 required assist of one staff with dressing and grooming. On 7/19/16, at 9:28 a.m. R78 stated, " I can't shave because of my Parkinson, that is one thing they are a little lax on." At this time R78 has stubble on chin and upper lip. On 7/20/16, at 7:57 a.m. R78 was propelled from his room to the dining room by nursing assistant (NA)-H. R78 had facial hair stubble on the upper	F 312	F312 ADL care provided for dependent residents Policy: Nursing care standards: to ensure that every resident receives care to reach their highest practicable level of functioning. This includes: Assistance with or supervision of shaving residents as necessary to keep them clean and well groomed. Assistance as needed with oral hygiene to keep the mouth, teeth or dentures clean. Assistance with ROM or placement of a device. Residents do have the right to refuse care/assistance all refusals will be charted in the resident's record. A. For R78 shaving has been offered and provided by staff daily. Care plan for R78 has been reviewed with staff providing cares for R78 in regards to offering and providing shaving. a. For R28 oral cares will be offered and provided by staff at least 2 times per day. Care plan R28 has been updated to include resident does not wear dentures. The care plan has been reviewed with staff providing care for R28 in regards to providing oral cares at least 2 times per day. b. R65 has had fixed contractures (irreversible) for years per OT evaluation 11-17-12. The kerlix rolls in hands are to prevent moisture related issues and not to prevent contractures. MD orders clarified	

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F 312	Continued From page 19 lip and chin area. On 7/20/16, at 1:00 p.m. R78 was seated in his room in a stationary chair in front of the television. R87 remained unshaven. On 7/21/16, at 9:26 a.m. R78 was seated in room dressed, has not had face shaved, mustache and beard heavy stubble. On 7/20/16, at 8:51 a.m. NA-H indicated R78 tries to shave independently and will ask staff when he needs help. NA-H indicated R78 was new to the facility and NA-H was unsure of whether R78 had behaviors or refused cares. When interviewed on 7/20/16, at 1:00 p.m. R78 verified if he was able to shave himself he would do it every day. R78 stated staff will shave his face each morning when they get him up with an electric razor but some times they forget. R78 verified his facial hair had not been shaved off today and was unable to recall when staff last shaved him. On 7/20/16, at 1:17 p.m. NA-I identified R78 had no behaviors and did occasionally refuse to go for a walk, however, it was usually for a reason, for example if his wife was here or if he was having pain in his hip. On 7/21/16, at 9:54 a.m. NA-E indicated R78 was unable to shave independently due to shaky hands. NA-E verified he/she had not shaved R78 this a.m. NA-E indicated R78 refused the offer to shave this a.m. and had a routine of shaving only "every so often." On 7/21/16, at 11:00 a.m. NA-F verified R78 had	F 312	and plan of care has been revised. All staff working with R56 have been provided education on placement of kerlix in hands. It will be the responsibility of all nursing staff to assure kerlix is in place. The care plan has been updated will be reviewed with staff providing care for R65 in regards to placement of kerlix rolls in hands. B. All residents requiring assistance with care have been reviewed to determine if they have been affected by the same practice. C. Written education has been provided to all staff via email and on Point of Care messaging on 8-9-16 in regards to care expectations related to shaving, oral cares, placement of devices related to contractures and providing assistance to all resident per their plan of care. Face to face education was also provided to staff the week of 8-8-16. Will also provide additional training opportunity at the 8-23-16 all staff meeting. D. Audits will be implemented beginning 8-9-16 on 4 residents per week x 4 weeks to assure shaving, oral cares, and application of kerlix/devices are provided per policy. E. Completion date 8-12-2016. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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a good memory and what he says is accurate. NA-F indicated he/she did not provide cares for R78 often, however, did believe R78 was usually clean shaven. NA-F indicated staff usually assisted R78 with oral care and shaving. NA-F sated, " We would normally shave a person if they can't themselves."

On 7/21/16, at 11:04 a.m. R78 verified he was not shaved this morning. R78 stated, " it (facial hair) isn't so hard to get off" if he is shaved every day. R78 further identified with a clean shaven face it was easier to keep clean as things get caught, stating "I drool."

On 7/21/16, at 11:13 a.m. licensed practical nurse (LPN)-E verified R78 had facial stubble and had not been shaved.

On 7/21/2016, at 11:14 a.m. registered nurse (RN)-A verified R78 required assistance with ADL's due to has Parkinson's Disease and although his abilities change from day to day, R78 was not able to shave independently with an electric razor. RN-A identified staff were expected to shave male residents daily and would not expect residents to have to ask for the assistance.

When interviewed on 7/22/16, at 11:25 a.m. the director of nursing (DON) verified the expectation that staff follow the care plan and residents who require assistance with ADL's be provided the care and not expected to ask for assistance.

The requested facility personal hygiene policy was not provided.

R28's quarterly Minimum Data Set (MDS) dated

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F 312	Continued From page 21 6/15/16, identified R28 was moderately cognitively impaired and diagnoses which included: Alzheimer's, psychotic disorder and arthritis. The MDS indicated R28 required extensive assistance for completion of personal hygiene tasks. R28's care plan dated 7/15/16, identified R28 required extensive assistance to total assistance with personal hygiene and oral cares. The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 mouth swab and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed. The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28. The nursing oral assessment dated 6/13/16, indicated R28 had no natural teeth or tooth fragments, and indicated R28 chose not to wear dentures. The assessment identified R28 had a chewing and swallowing problem and received a pureed diet. During observation of morning cares on 7/20/16, from 8:23 a.m. to 8:54 a.m. NA-A and NA-G assisted R28 with personal cares which included washing her face, perineal cares and dressing. During the observation, R28 was not assisted nor offered the opportunity for completion of oral cares. R28's oral cavity and lips appeared very dry. -At 8:57 a.m. NA-A assisted R28 with breakfast while R28 was positioned in bed. R28 was not	F 312		

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	245434	A. BUILDING _____ B. WING _____	07/22/2016

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F 312	Continued From page 22 wearing any dentures, and R28 refused the breakfast food items and juice offered. R28 did consume the strawberry supplement. -At 9:01 a.m. NA-A gathered the breakfast tray, shut off the bedroom lights and stated some days are good with feeding, and some days are not, just like today. NA-A then delivered the breakfast tray to the kitchen, R28 was not assisted nor offered the opportunity for completion of oral cares. During interview on 7/20/16, at 8:45 a.m. NA-A reported R28 no longer wears dentures, and stated she was going to wait until after R28 ate breakfast to provide oral cares which included swabbing out the mouth with a toothette. At 9:07 a.m. NA-A confirmed R28 had finished with the breakfast meal and confirmed she had completed morning cares for R28. NA-A verified she did not complete nor offer oral cares which included swabbing the mouth with a toothette or mouthwash. Further, NA-A confirmed she did not inspect her mouth with cares. During interview on 7/21/16, at 10:35 a.m. RN-B confirmed R28 no longer wore dentures. RN-B verified staff are expected to swab R28's mouth with morning cares, or at least attempting as R28 will at times refuse. RN-B confirmed R28 has a dry mouth and sleeps with the oral cavity open, therefore, oral care must be attempted. During interview on 7/22/16, at 10:08 a.m. the DON confirmed staff are expected to provide or offer oral cares to all resident twice per day as indicated on the care plan. The facility's Mouth Care Policy dated October	F 312		

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F 312	Continued From page 23 2010, directed staff to review the resident's care plan for any special needs of the resident. and assemble the equipment and supplies as needed. The purpose is to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions for identified contractures for 1 of 1 resident (R65) reviewed for range of motion (ROM.) Findings include: Review of R65's quarterly Minimum Data Set (MDS) dated 4/27/16, identified R65 had severe cognitive impairment and had diagnoses which included Parkinson's disease, Alzheimer's disease and cerebrovascular disease with hemiplegia . The MDS further identified R65 was totally dependent on staff for activities of daily living (ADL's) and had bilateral upper extremity contractures.	F 318	F318 Increase/Prevent decrease in Range of Motion Per Policy: to promote each resident's ability to adapt to attain his or her maximum functional potential. To promote each resident's highest practicable level of physical, mental and psychosocial functioning. A. R65 admitted to Bethany with contractures. Per OT assessment 11-17-12 contractures in hands are in a fixed position. Kerlix placed in hands daily is to prevent moisture associated damage and/or skin breakdown. MD order has been clarified to state such and R65 plan of care has been updated.	8/12/16

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F 318	Continued From page 24 Review of R65's annual Care Area Assessment (CAA) dated 8/19/15, identified R65 had severe cognitive impairment due to Alzheimer's disease, was totally dependent on staff for ADL's and had contractures. Review of R65's care plan print dated 2/25/16, identified R65 had bilateral contractures of the upper and lower extremities, was totally dependent on staff for all ADL's, required gentle range of motion with daily care, required gauze rolls in both hands 23/hrs/day: to be removed for 30 minutes twice daily for hygiene for bilateral hand contractures. Review of R65's current physician orders signed 7/19/16, revealed an order with a start date of 10/21/2015, directed nursing staff to check R65's kerlix roll in bilateral hands for placement every shift, should have kerlix in hands at all times and additional gauze between thumb, change kerlix and gauze when soiled and as needed every shift for contractures. The orders also directed nursing staff to wash R65's hands twice daily per instruction sheet. Review of R65's provider progress note dated 5/27/16, revealed R65 had been seen for a routine visit in which R65 was assessed to have contractures which were most notably in her arms and hands. Review of R65's most recent occupational therapy (OT) assessment dated 11/17/12, revealed R65 had bilateral hand contractures which were in a fixed flexed position. The evaluation directed staff to implement ROM exercises and in hand splints for bilateral hand	F 318	B. All resident's with devices for ROM and or contractures has the potential to be affected by the same practice. C. All resident's that have devices for ROM and/or contractures will be reviewed to assure the device is being used for the appropriate reasons and that the devices are being placed per MD orders, and that the care plan and care sheets are current. D. Audits for devices to assure MD order is correct, care plan is correct, devices are being applied and care sheets are current will be done on each resident with a device until all residents with a device have been reviewed. E. Completion date 8-12-16. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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contractures.

- R65's medical record lacked any further OT evaluations for hand contractures.

Review of R65's July 2016, treatment administration record (TAR) revealed a check mark for R65's treatment of kerlix rolls in both hands three times a day. The TAR revealed a chart code legend which a check mark indicated the treatment was in place on all days.

Review of R65's care conference note dated 5/17/16, revealed R65 continued to have contractures of her hands and extremities. The note further revealed staff were to continue to apply gauze to R65's hands daily. The note indicated that was to continue.

Review of R65's progress notes from 1/23/16, to 7/13/16, revealed the following:

-1/24/16, revealed R65 had contractures to bilateral hands and required vigilant monitoring and gauze rolls placed in both hands, extra care to keep R65's hands clean.

-2/5/16, revealed R65 received passive range of motion (PROM) to both upper and lower extremities due to contractures, staff continued to apply gauze rolls in both contracted hands daily.

-3/5/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's.

-4/6/16, revealed a monthly charting note which identified R65 had bilateral hand contractures

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and required total assistance from staff for all ADL's.

-4/23/16, revealed a ADL note which identified R65 required total assistance with all ADL's due to contractures and blindness.

-4/27/16, revealed a restorative program note which identified R65 had bilateral hand contractures and staff was to put gauze rolls in both hands to help her contractures and maintain skin integrity.

-5/20/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's.

-5/28/16, revealed a order administration note which revealed staff was unable to place kerlix in R65's hands due to resident not able to open her hands. R65's progress notes lacked any follow up regarding inability to place gauze in R65's hands.

-5/29/16, revealed a order administration note which revealed staff was unable to place kerlix in R65's hands due to resident not able to open her hands. R65's progress notes lacked any follow up regarding inability to place gauze in R65's hands.

-6/20/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's.

-6/27/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's.

-7/13/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and

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F 318	Continued From page 27 required total assistance from staff for all ADL's. On 7/18/16, at 5:38 p.m. R65 was seated in a tilt in space wheelchair across from the nurses station prior to the evening meal. Both of R65's hands were held in a fisted position, elbows were bent and hands rested on her chest, right hand rested near her heart and her left hand rested on her left upper chest. R65 did not have kerlix placed in her hands. At 6:55 p.m. R65 was seated in a tilt in space wheelchair near the nurses station following the evening meal. R65 remained without kerlix/gauze in both hands. On 7/19/16, from 8:45 a.m. to 10:55 a.m. R65 was lying in bed tilted to her right side with pillows against her back, blankets were observed to cover R65 to mid torso. R65's hands were in a fisted position , arms were bent at the elbow, fisted hands rested against her chest. R65 did not have kerlix in her hands. On 7/21/16, at 4:57 p.m. R65 was seated in a tilt in space wheelchair with both arms bent at the elbows, hands were resting on her chest and were clenched fisted position. R65's right clenched hand was resting over her heart and her left clenched hand was resting on her upper left chest, no kerlix was observed in R65's hands. When interviewed on 7/21/16, at 5:09 p.m. registered nurse manager (RN)-A confirmed R65 did not have kerlix in her contracted hands as care planned and was unsure why the kerlix was not in use. RN-A stated the medication nurses were responsible for checking to make sure R65's kerlix were in both hands for bilateral hand contractures. RN-A stated she felt R65 hands were too contracted for the kerlix to have fallen out, nor could R65 remove the kerlix	F 318		

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independently. RN stated R65's hands were fully contracted and had been for years. RN-A directed a licensed practical nurse (LPN)-D to apply kerlix.

On 7/21/16, at 5:13 p.m. LPN-D attempted to open R65's right hand fingers from the contracted, fisted position and apply approximately an inch in diameter cotton kerlix roll into R65's hand. R65 stated it hurt and she was hurting her fingers, LPN-D immediately stopped opening R65's hand. At that time, LPN-D stated there were times when R65's hands needed to be soaked in warm water to help open the hands up. RN-A and NA-B then wheeled R65's to her room and NA-B wheeled R65 into her bathroom, while RN-A started to run the water out of the faucet. NA-B took R65's right hand, held it under the warm water while RN-A slowly opened R65's hand, washed, dried and applied the kerlix. NA-B then took R65's left hand, held it under the water while RN-A opened R65's hand, washed, dried and applied another roll of kerlix. NA-B assisted R65 back out of the bathroom in her wheelchair and wheeled R65 back to nursing station.

On 7/21/16, at 5:12 p.m. NA-B stated R65 was supposed to have the kerlix in both of her hands at all times. NA-B stated the nurses usually put them in after R65's hands were washed. NA-B stated she felt about 3-4 times a week R65's kerlix were not in her hands and she would then place the kerlix into R65's hands and often had a hard time doing so. NA-B further stated she felt R65's hands were fisted very tightly so the kerlix could not fall out and she felt R65 would be unable to remove the kerlix herself. NA-B stated she felt R65's hands had not worsened over the last few years.

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F 318	Continued From page 29 On 7/22/16, at 10:23 a.m. NA-C stated R65 required total assistance with all ADL's, NA-C stated on average a few days a week R65 would not have the cloth rolls, (kerlix) in her hands and NA-C would then place the kerlix in R65's contracted hands. On 7/22/16, at 10:37 a.m. RN-A stated R65 had not had a recent occupational therapy evaluation, though had one a few years ago which identified R65 had complete contractures of both hands. RN-A confirmed R65's current physician orders directed nursing staff to ensure R65 had kerlix placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated R65 had fully contracted hands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing (DON) stated she expected physician orders and resident care plans to be implemented. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. Review of a facility policy titled, Restorative Nursing Program reviewed 5/2011, revealed a facility procedure to promote each residents highest practicable well being. A policy was requested regarding following	F 318		

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F 318	Continued From page 30 physician orders, treatments and contractures; none were provided.	F 318		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, ensure adequate supervision and implement interventions, to decrease the risk of further falls for 1 of 3 residents (R87) reviewed who sustained multiple falls. R87 experienced an injury while utilizing a Merry walker (a walker/chair combination type device), resulting in an immediate jeopardy (IJ) situation. The facility failed to investigate and comprehensively assess the resident's falls while utilizing the Merry walker to determine whether new interventions should have been implemented, and the facility failed to ensure interventions currently in place were adequate and consistently implemented to minimize the risk for further falls. The immediate jeopardy (IJ) began on 10/24/15, when R87 sustained a fall with injury while walking in the Merry walker. The facility's administrator and director of nursing (DON) were	F 323	F323 Free of accident hazards/supervision/devices A. On 7-20-2016 the following was implemented immediately for R87. 1. Current Merry Walker was discontinued; 1-1 staff implemented and was in place until all assessments were completed and new plan for safety was initiated. 2. We immediately implemented a new written assessment for all falls. The Post-Fall assessment includes root cause analysis and intervention options to prevent further falls. A new Progress note type was created in the electronic chart and titled fall which triggers the user to review the care plan and make modifications and revise interventions as needed.	8/12/16

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F 323	Continued From page 31 notified of the immediate jeopardy (IJ) situation on 7/19/16, at 7:05 p.m. The IJ was removed on 7/20/16, however, noncompliance remained at a lower level of G, isolated scope, with severity of actual harm that is not immediate jeopardy. Findings include: R87 was observed on 7/18/16, at 5:31 p.m. with a gait belt fastened around her waist, standing in a Merry walker made of PVC pipe. Cloth weights had been fastened with zip ties to the bottom of the walker on three sides and a cloth type strap was attached to the seat of the walker. The strap attached to the front of the walker and was located between R87's legs. R87 independently wandered about the Darling Springs unit utilizing the Merry walker. R87 was observed to walk with a shuffling gait and was noted to have an abrasion near her right eye. When she got to the doorway to the dining room, R87 couldn't move the Merry walker forward. R87 remained stationery in the doorway to the dining room until nursing assistant (NA)-D assisted R87 to turn around in the Merry walker so R87 could ambulate in the opposite direction. R87 continued to move around the area of the Darling Springs nurses' desk, bumping into walls and doorways. R87 was again observed on 7/18/16, at 6:48 p.m. walking in the Merry walker in the Darling Springs hallway with a shuffled gait. R87 was observed bumping into walls, doorways and residents in wheelchairs while walking down the hallway in the Merry walker device. The administrator was observed at that time to grasp a corner of the Merry walker to straighten R87's navigation. A few minutes later, R87 was observed to walk/bump into the right front corner of the Merry	F 323	3. Physician reviewed the current status and provided directives for care. Consulting pharmacy reviewed medication regime. Physical Therapy reviewed and assessed for recommendations. 4. Interventions for all falls that occur in the facility will be reviewed each time for appropriateness at IDT meeting. 5. Education was provided to all licensed staff on new written assessment and progress note types on 7-20-16, verbally, via email and postings at nurse's stations. Alert messages with new plan of care was sent to direct care givers via PCC. 6. R87 will be audited for any falls that occur in the next 6 week to assure that written assessments and interventions have been implemented. Will report to QAPI monthly. Will continue to audit as needed. B. All resident who are at risk for falls have the potential to be affected. C. The new fall note and post fall assessment was put in place on 7-20-16 for all residents in the facility that sustain a fall. Education was provided on 7-20-16. Face to face education provided the week of 8-8-16. Additional educational opportunity will be provide at the 8-23-16 all staff meeting. Will also have Ecumen QI nurse provide education on this topic on 8-25-16. Ecumen QI nurse will also Audit notes and assessments 1 x per	

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F 323	Continued From page 32 walker, bounced backward and came to rest on the seat of the Merry walker with half of her buttock positioned on the seat of the walker. R87 then stood and continued to wander throughout the hallway while attempting to navigate the Merry walker. On 7/19/16, at 10:42 a.m. NA-E was observed to guide R87, who was in the Merry walker, out of her room to the hallway. NA-E then left R87 to independently walk in the Merry walker. R87 was observed to walk with a shuffled gait. She was located in the short hall outside of her room, but not within staff view. While in the Merry walker in the corner of the short hall, R87 was able to grasp the door handle to the bathroom door labeled B-13 and jiggle the handle. R87 then turned her body to the right side of the Merry walker, moved the walker in a sideways direction out from the corner and moved toward the nurses' desk located on the opposite side from the dining room. At 10:46 a.m. R87 continued to move about in the Merry walker with a shuffled gait. She navigated to and from the short hallway located near her room which was located on the side of the nurses' station desk without staff in the area. At 10:47 a.m. a lab (laboratory) tech (technician) and two facility staff walked near the side of the nurses' station facing the dining room. None of these three staff looked in the direction of R87 as they walked past this area. At 10:47 a.m. licensed practical nurse (LPN)-C returned to the nurses' station area and approached the medication cart which faced the opposite direction from R87. LPN-C did not move to an area where R87 could be supervised. During this time, R87 was observed to have turned herself within the Merry walker to face backwards, and was observed to have lifted her right knee onto	F 323	month x 3 months. D. 8-9-16 we will begin auditing fall note and post fall assessment to assure staff are appropriately completing the note/assessment and adding new interventions as needed. Audits will be done on all falls x4 weeks to assure compliance. E. Completion date for 8-12-16. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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the Merry walker seat.

On 7/19/16, at 10:50 a.m. two NAs were observed in the hallway to propel a cart while water mugs were removed from resident rooms. Neither NA looked in the direction of R87 as she once again maneuvered the Merry walker into the corner of the hall and was unable to propel it forward. At 10:51 a.m. R87 stood backwards in the Merry walker. The front and one side of the Merry walker were located against the corner walls in the short hallway. No staff were in the vicinity nor in view of R87 to provide supervision. At 10:55 a.m. R87 remained unable to move from the corner with the Merry walker. R87 raised her feet, one at a time, placing them onto the bottom bar of the Merry walker. She then placed her right knee onto the seat of the walker. At 10:57 a.m. R87 shuffled the Merry walker towards the location of the nurses' desk, leaned over the Merry walker bar, spit on the floor and continued forward with little shuffled steps in the direction of the corner located near the bathroom. NA-E was observed in the hall to be delivering water mugs to resident rooms but did not walk in R87's direction. At 11:00 a.m. R87 continued to ambulate with small steps, navigating the Merry walker toward the nurses' station. R87 stopped the movement of the walker when it butted up against the nurses' station desk. At 11:08 a.m. R87 stood up in the Merry walker while it was caught against the nurses' station. Staff were noted on the dining room side of the desk.

At 11:11 a.m. on 7/19/16, R87 and another female resident seated in a wheelchair were in the vicinity of the nurses' desk. At 11:14 a.m. R87 pushed her Merry walker into the other female resident's wheel chair. When R87 could not

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propel forward, she grasped the top bar of the walker and shook it back and forth. At 11:17 a.m., while R87 continued to shake the Merry walker, the resident located in the wheel chair grasped R87's left wrist and stated "go tell your mother". R87 made no response but continued to shake the walker. At 11:18 a.m. facility staff walked through the area pushing a housekeeping cart onto the elevator, without looking in the direction of R87. At 11:19 a.m. R87 finally seated herself in the Merry walker with only the right side of her buttock seated on the Merry walker seat. The Merry walker remained in contact with the other resident's wheel chair. At 11:19 a.m. R87 stood from the seat, and again began shaking the walker. The resident in the wheelchair stated, "do you want me to spank you?" and grasped R87's wrist. At that time, the surveyor summoned staff. At 11:22 a.m. registered nurse (RN)-A separated the two residents.

R87's annual Minimum Data Set (MDS) dated 5/11/16, identified R87 had long and short term memory problems with no recall ability, was rarely to never understood, and required extensive assistance for all activities of daily living (ADL). A facility form, Order Summary Report signed by the physician 6/27/16, indicated R87's medical diagnoses included: dementia with Lewy Bodies, Parkinson's disease and anxiety disorders.
R87's Care Area Assessment (CAA) dated 5/11/16, included: "Cognitive loss /Dementia: severe impairment w(with)/cognition triggered CAA r/t [related to] dx [diagnosis] of dementia with Lewy bodies, Parkinson's and depression..
ADL functional /Rehabilitation Potential: Requires assist with ADL's and mobilities r/t Parkinson's Disease, Dementia with Lewy Bodies, HTN [hypertension], osteoarthritis and Hx [history of

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falls]. See CP [care plan] for details. Safety interventions are in place to prevent falls/injuries. Noted to have 2 falls since previous MDS. Will monitor and implement safety interventions PRN [as needed]. Resident does wander about unit. At times will wander into other resident's rooms. Wander guard is in place to alert staff if resident attempts to wander outside. Velcro sashes are put across other residents' doorways to detour resident of entering room. Does help detour at times. Is at risk for impaired communication r/t [related to] Dementia and Parkinson's Disease. Speech is mumbled and has difficulty finding the right words. Response does not always make sense. Is sometimes understood and sometimes understands communication. No referral needed at this time." Behavioral Symptoms: "Observed to have behaviors of physical abuse towards others and wandering. Staff will provide [R87] with PRN pain meds [medications] when is showing aggression in her face. [R87] will also ram into things with her Merry walker repetitively. PRN pain meds have shown to redirect this behaviors."

R87's care plan reviewed 7/13/16, indicated the resident was "at risk for falls due to dementia with Lewy Bodies, and Parkinson's disease." Interventions included: "Ensure [R87] is wearing appropriate footwear when ambulating or mobilizing in wheel chair. Follow facility fall protocol. Physical therapy eval [evaluation] and treat as ordered or as needed. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident/family/caregivers/ IDT [interdisciplinary team] as to causes. Safety interventions: (1) Low bed and safety mats when in bed. (2) Shoes or gripper slippers to be worn when in Merry walker. (3) Close dining room and

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F 323	Continued From page 36 activity doors in the evening when [R87] is in Merry walker. Bathroom door to be closed when resident is not using the bathroom. (4) Weights on base of Merry walker to increase stability. (5) Keep an extra set up [SIK] slippers in Merry walker in case one falls off. (6) 1:1 staff assist/ supervision when in the dining room. (7) Clip call light to resident at NOC [night] to alert staff when she moves or gets up (has soft touch call light). (8) Staff will monitor whereabouts every 30 minutes and PRN. (9) Bring to bathroom before sitting in recliner." R87's NA care sheet (a reference NAs used regarding specific care for residents) undated, identified safety interventions for R87 to include: (1) to ensure to take R87 to the bathroom before assisting to the recliner, (2) keep bathroom door closed, (3) clip call light on R87 at bed time, (4) low bed and safety mat (put mat against wall when not in bed), (5) keep gait belt on walker (close to resident), (6) Follow with wheel chair when ambulating, one to one assist when in dining room, use body pillow to position in bed, wanderguard worn. The NA care sheet also indicated in the comment section: "Merry Walker [see purple sheet in NA book]." The purple sheet directed staff to "observe frequently." Although the NA care sheet directed staff to observe R87 in the Merry walker, no specific time frame was given even though the care plan indicated staff to monitor R87's whereabouts every 30 minutes and PRN. When interviewed on 7/19/16, at 11:22 a.m. RN-A stated R87 was safe to be unsupervised in the Merry walker and stated, "we check on her every half hour". On 7/19/16, at 1:35 p.m. NA-E indicated it was	F 323		

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usual practice to allow R87 to walk around while in the Merry walker unsupervised. NA-E stated, "We try to keep her safe, the nurses do a good job of keeping her close." NA-E verified that although she had not witnessed R87's falls involving the Merry walker, she'd heard that R87 had stepped on the bottom of the walker causing it to fall over and causing a cut to R87's face. NA-E pointed to the temple area.

A review of R87's clinical record identified the following 20 documented fall incidents which involved the use of the Merry walker since R87 was admitted on March 2015:

(1) 5/10/15- found on floor underneath Merry walker; No apparent injuries
Care plan and multiple safety interventions were being followed at time of fall. Spoke with family member (F)-A. Discussed the risk vs. benefits of the Merry walker, F-A feels at this time, the merry walker continues to benefit greatly and feels is at a greater risk of injury if she was not using the Merry walker and self transferring without it. Staff will continue with 30 minute checks and follow Merry Walker guidelines as listed in CP (care plan).

(2) 5/17/15- found on floor, had tipped over Merry walker; head up against the wall on right side; bruising on RUE (right upper extremity) from previous fall; No other noted injuries. Resident was crying but able to voice if she was hurt. Unwitnessed. Will place safety mat against wall when not in bed to prevent resident from tripping on mat or wheeling over it with Merry walker. Will also continue Q (every) 30 minute checks.

(3) 5/20/15- found by a staff member laying on

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F 323	Continued From page 38 the floor with one leg still around the strap of Merry walker around 4:00 p.m. Resident assisted back into Merry walker with 2 staff and EZ (mechanical device) lift. No further documentation of IDT (interdisciplinary team) review of fall. (4) 6/20/15- found sitting opposite direction in Merry walker. Sitting on floor. No apparent injuries. (4) 6/23/15- found on floor in Merry walker. When staff removed Merry walker to assist off the floor, resident began scooting on her butt on the floor. No injuries noted. CP being followed. (6) 6/28/15- in Merry walker, stumbled to the left and right leg crossed over left leg and resident grabbed for medication cart to catch herself and this caused [R87] and Merry walker to fall to the left. Right hip pain and right foot rotated inward. Lump on left side of head and above left eye. Pupils sluggish. Guarded movement to the right leg. Ice applied to head abrasion and lump. Sent to the emergency department (ED). (7) 8/1/15- found on floor in Merry walker in room. Got up with assist of 2 staff. Resident was uninjured (8) 8/4/15- found on floor at 11:30 a.m. in another resident's room with no injuries or hitting head. Was wearing slippers and in Merry walker at time of occurrence. Action: Up off floor and back in Merry walker. (9) 8/4/15- found on floor in front of nurses' station in Merry walker and slipper on. No injuries noted. Continue current CP.	F 323		

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F 323	Continued From page 39 (10) 9/15/15- found sitting on floor backwards in Merry walker in her room, leg strap still attached between legs; shirt off at this time, gripper socks in place; R87 agitated at the time. Staff last checked in on R87 shortly before, less than hour prior to fall. (11) 9/19/15- observed on floor next to bed in room, was lying under the Merry walker. The Merry walker was intact, was assisted to the toilet and into the Merry walker at 2:20 p.m. No lumps bumps or bruising noted to her head. (12) 9/22/15- found in room on the floor underneath Merry walker at 7:00 p.m. The strap was hooked around R87's foot and was lying on her back. A small quarter sized bruise was found on right buttock. Brought to the bathroom and returned to bed. (13) 10/24/15- Resident tipped merry walker over sideways and was found face down on floor, unable to move. [R87] hit head/mouth on floor; mouth bleeding from losing a tooth. No one seen [sik] the incident so don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift. A follow up nursing note dated 10/26/15 at 11:41 a.m. included, IDT reviewed fall from 10/24/15. Resident tipped over merry walker and landed on her face. Received a small abrasion under nose and lost a tooth as a result of the fall. Seroquel (antipsychotic medication) was recently decreased last Wednesday, [R87] more active since then. Per daughter's request, she would like Seroquel increased to the previous dose, she states she has seen her mom have more added behaviors and would like her mom to be more tired than anxious and falling. Referral filled out	F 323		

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for MD (medical doctor). Also, weights added to the back of the merry walker to balance it. (The intervention of added weights to the base of the merry walker was initiated after R87 had sustained a fall on 6/28/15). A nurses' note dated 10/26/15, at 13:39 (1:39 p.m.) included:..."Res. face continues to be swelled and abrasion is scabbed. Call placed to [MD] to inquire about xray to face. RN UC [registered nurse unit coordinator] aware. [MD's] nurse will call back after talking to CNP [certified nurse practitioner]. Subsequent nursing notes indicated the physician had ordered a head CT scan [computed tomography X-ray] for that date. Documentation from 16:53 (4:53 p.m.) 10/26/15 indicated CT scan results from that date, indicated the resident had presented with facial pain and more confusion than usual. The report further included: Conclusion: 1. Nondisplaced fracture through the anterior superior most maxilla (upper jaw) at the base of the nose. Additionally, a nurse's note from 10:49 a.m. on 10/27/15 indicated the resident required an oral surgery consult.

Despite the number of falls and fracture while utilizing the Merry walker, the facility failed to reassess R87's fall risk and interventions.

(14) 1/6/16- found on the floor in the bathroom still in Merry-walker, under the bar with leg strap intact. Resident was found leaning against the wall in the bathroom. No other injuries present. Resident was assisted with 3 and ez-lift (mechanical full body lift) off of the floor and into bed. Then placed in merry walker for meals. No further review of the fall by the IDT.

(15) 1/8/16- found on the bathroom floor, still in Merry walker; Merry walker did not tip over. No

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injuries from fall. CP was being followed. Was assisted to the bathroom less than 2 hours prior to the fall, not attempting to go to the bathroom at the time of the fall. Action: intervention to keep the bathroom door closed when not using it, [R87] wanders into her room through out the day. No further IDT review of the fall documented.

(16) 2/2/16- on floor in front of nurses' station at 7:30 a.m. in Merry walker. No injuries noted. Had foot wear on at time of occurrence. Continue CP.

(17) 4/16/16- found sitting on the floor in the activity room close to Turtle Beach (resident unit) still in the Merry walker; walker was still upright; assisted back into the Merry walker with the EZ lift and 3 staff assist. Continue with CP; Family continue to feel the Merry walker is safest option and continues to be appropriate.

A physician visit form dated 4/18/16, identified R87 was seen for a "regularly scheduled visit." "Nursing has no concerns with [R87], she has been stable."

(18) 5/13/16- found on right side, Merry walker was tipped over on the floor, laying on gray mat next to bed, feet still inside tipped Merry walker. Was trying to get to Herbergers, climbed on Merry walker and flipped Merry walker onto side. Aide found resident on floor. No injuries from fall. Staff educated to make sure the mat is not on the floor when [R87] not in bed. Sign placed on wall to remind staff to pick up the mat when not in bed.

(19) 6/26/16- found on floor of other resident's room in Merry Walker on floor with feet on the seat. No injuries noted. Merry walker discussed

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with family at all care conferences and they feel this is her safest option to avoid injury and also gives her the freedom to ambulate and be more independent. Will continue with current interventions. CP followed.

(20) 6/27/16- found lying on floor underneath Merry walker outside of room in hallway, lying on back and holding head up, appeared to be sleeping. No injuries. CP being followed;Will continue with these interventions.

When interviewed on 7/19/16, at 2:55 p.m. the director of nursing (DON) identified an IDT reviewed resident falls to identify the cause of the fall, current interventions in place, previous interventions and possible new interventions. This IDT review is added to the nurse's progress notes in the electronic record and documented onto a Falls log.

Review of the facility form titled Resident Incidents, printed for the dates of January 2016 to July 2016 included the following falls involving the Merry walker for R87:
-2/2/16- witness-none, interventions-Continue current interventions-no injury.
-4/16/16- witness-none, interventions-Continue current interventions.
-5/13/16- witness- none, interventions-Continue current interventions.
-6/26/16-witness-none, interventions-Will continue with current interventions.
-6/27/16-witness-none, interventions-No maltreatment, care plan was being followed. Resident has numerous fall interventions in place. Will continue with theses interventions.

The Incident Log did not include all the

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documented falls that occurred during the selected time frame. The log also lacked documentation of a comprehensive re-assessment of R87 and lacked documentation of any additional interventions implemented to prevent re-occurrence of falls.

R87's electronic and written records lacked any evidence of physical (PT) or occupational therapy (OT) evaluations and/or treatment. In addition, Morse Fall Scale documents completed on 8/28/15, 10/26/15, 11/20/15, 11/22/15 and 5/9/16, each identified R87's risk for falling, the use of a walker, and identified the resident as having a weak gait, stooped posture and described gait with, "steps are short, resident may shuffle." Each of these Morse Fall Scale documents indicated the resident had a score of 80 with anything above 45 indicating a high risk for falls. None of the documents identified any other specific assessment information.

On 7/19/16, at 4:19 p.m. registered nurse (RN)-A reviewed the progress notes and verified R87's falls involved the Merry walker and that assessments and new interventions were not consistently completed and/or implemented. RN-A identified the usual process after a fall as follows: (1) review the nurse's progress notes, (2) interview staff to see what [R87] was trying to do, (3) if interviewable, ask the resident, (4) reassess fall risk and whether planned interventions are effective. RN-A indicated these assessment findings would have been documented as a follow-up note after each fall. RN-A verified that R87 was cognitively impaired and that it was difficult to identify a cause for each fall because R87 could not express her needs or actions. RN-A further identified there were so

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many planned interventions it was difficult to identify any new ones, and RN-A also stated fall assessments were completed quarterly, not after each fall. A facility document was provided titled Restraint/ Physical (Quarterly/Annual Evaluation) dated 2/17/16. RN-A verified this was the most current assessment form and verified there were no other assessment forms related to a fall risk assessment for R87. RN-A stated therapy had been involved with the assessment for the use of a Merry walker and had been assessed when admitted. RN-A also stated the current CP included all of the current interventions and confirmed it was an expectation that staff follow the care plan. RN-A also stated the nurse was responsible to check on R87 every 30 minutes and to document such. RN-A explained the Merry walker currently utilized by R87 had been obtained from storage in the basement of the facility, and stated she did not believe they had a written copy of the manufacturer's instructions/recommendations. RN-A indicated she may have to complete a "Google" search to obtain the instructions.

On 7/19/16, at 4:57 p.m. the DON identified the nurse manager was responsible to complete an assessment for resident use of a Merry walker and explained the assessment involved standing the resident in the Merry walker to see whether it was safe. The DON further explained this was not an actual written assessment, but included more of an observation to see whether the Merry walker was appropriate. The DON verified this was the only Merry walker assessment completed. The DON further explained the staff and family were aware that R87 was not safe and remained at risk for falls while in the Merry walker. The DON confirmed they were honoring

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the family wishes since R87 was not utilizing a Merry walker, she would have to be placed into a Geri Chair (a reclining wheel chair). The DON also indicated implementation of interventions after a fall would be completed if staff identified problems with the Merry walker, identifying examples such as not walking with it, or not using it properly. The DON further indicated the expectation for care of a resident utilizing a Merry walker included frequent observations by all staff when walking by. The DON said if a resident were trying to crawl out of the Merry walker, staff may lay the resident in bed with a safety mat placed next to the bed. The DON reiterated staff were expected to follow the CP. The DON indicated they had tried numerous interventions but would follow family wishes related to the continued use of the Merry walker. The DON stated the manufacturer's recommendations for use of the Merry walker was located in the storage area.

On 7/19/16 at 5:50 p.m. RN-A provided manufacturer's recommendations for use of a Merry Walker print out from the Internet. These printed out recommendations included: "The walker is constructed of metal and weighted at the bottom and each one should be individually fitted to the resident. The height of the top frame should be at the height of the pelvis to promote good posture." However, the Merry walker R87 currently utilized was constructed of PVC pipe to which three fabric type weights with zip ties were secured to the bottom bar of the walker. In addition, it was noted the height of the top frame of the Merry walker R87 utilized was not at the height of the pelvis but above the pelvis.

On 7/20/2016, at 9:33 a.m. physical therapist (PT)-A was interviewed. PT-A confirmed therapy

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duties included screening and treatment of residents related to transfers, balance,walking and determination of the most appropriate lifts for individual residents. PT-A stated, "[Merry walker] is not something we recommend, we want it to be functional walking with a walker or cane." PT-A identified resident considerations for use of a Merry walker would include: look safe, maintain balance and strength, have a good gait pattern and ability to propel forward without tripping. PT-A also verified that Merry walkers were able to tip over. PT-A indicated that when R87 was admitted to the facility, a quick screen to evaluate if therapy services were required was conducted. PT-A indicated that at that time services had not been determined to be needed so no physician order for treatment had been requested. PT-A confirmed R87 had not been provided therapy services any time since admission (March 2015) and confirmed R87 had not been evaluated by PT for the use of the Merry walker.

The facility policy titled, Falls- Clinical Protocol revised September 2012, Assessment and Recognition identified the following: #5 The staff will evaluate and document falls that occur while the individual is in the facility: for example, when and where they happen, and observations of the events, ect. Treatment/Management: #1- Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.

The immediate jeopardy that began on 10/24/15, and identified on 7/19/16, at 7:05 p.m, was removed on 7/20/16, at 3:30 p.m. when it could be verified by observation, record review and staff interviews, the the facility had implemented

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F 323	Continued From page 47 interventions including: -discontinuing the use of the Merry walker for R87 - 1:1 staffing implemented for R87 until appropriate assessments could be completed and a new safety plan initiated - the consultant pharmacist reviewed R87's medications - a PT assessment was conducted and a combination wheelchair/walker with 18" wheels for stability was ordered - PT also planned re-assessment of the new device upon arrival to determine appropriateness for R87 - a physician review was conducted - a comprehensive fall assessment was developed and staff were educated to implement appropriately; a post fall assessment, including required progress note, was created in the electronic chart to trigger a review of the care plan to include modifications and review of interventions; all staff were educated either verbally, via e-mail and/or by written postings at nurses' stations; NAs, RNs, case managers, LPNs, activity staff, and PT staff were interviewed to confirm implementation of the plan. Although numerous interventions were initiated, noncompliance remained at the lower scope and severity of a G, isolated scope with severity of actual harm that is not immediate jeopardy, because the facility had failed to ensure ongoing assessment and staff compliance with identified interventions to maintain resident safety.	F 323		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that --	F 334		8/30/16

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F 334	Continued From page 48 (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse	F 334		

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F 334	Continued From page 49 immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Pneumococcal Conjugate Vaccine-13 (PCV13) vaccines were offered to 4 of 5 residents (R20, R71, R91, R94) as recommended by the Centers for Disease Control (CDC) whose vaccination histories were reviewed and failed to develop guidelines for PCV13 as recommended by the CDC. Findings include: R20's Immunization Audit Report dated 7/22/16, indicated the 91 year old had received Pneumovax dose 1 on 1/1/07; however, the	F 334	F334 Influenza and Pneumococcal immunization Guidelines for administration of the use of PCV13 have been obtained. Medical Director's order obtained, and staff education on new guidelines completed on 8-4-16. A. R20, R71, R91, R94 will be offered PVC13 according to the CDC guidelines. B. All resident have the potential to be affected by this practice. Upon admission residents will be assessed for the need of	

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F 334	Continued From page 50 medical record lacked evidence R20 was also offered the PCV-13 vaccination as recommended by the CDC. R71's Immunization Audit Report dated 7/22/16, indicated the 95 year old had received Pneumovax dose 1 on 6/22/11; however, the medical record lacked evidence R71 was also offered the PCV-13 vaccination as recommended by the CDC. R91's Immunization Audit Report dated 7/22/16, indicated the 102 year old had received Pneumovax dose 1 on 10/1/90; however, the medical record lacked evidence R 91 was also offered the PCV-13 vaccination as recommended by the CDC. R94's Immunization Audit Report dated 7/22/16, indicated the 96 year old had received Pneumovax dose 1 on 9/17/09; however, the medical record lacked evidence R94 was also offered the PCV-13 vaccination as recommended by the CDC. When interviewed on 7/22/16, at 1:42 p.m. registered nurse (RN)-D who was responsible for the facility's infection control program confirmed the facility was aware of the CDC recommendation related to PCV13 and stated it was not a standard of practice to offer/administer the vaccination to the residents, only if the physician specifically ordered it. Further, RN-D verified the CDC's recommendations were not reflected in the facility's pneumococcal policy. The facility's Pneumococcal Vaccine Policy dated December 2012, indicated all resident would be offered the Pneumovax (pneumococcal vaccine)	F 334	the pneumococcal vaccination (PCV13) as per the CDC guidelines. PCV13 will be offered first per the CDC guidelines and administrated if the resident so desires. Education will be given at the time of the offer of the vaccination explaining the risk VS benefits of the vaccination. Will follow up with the PPSV23 vaccination per guidelines. All residents currently residing in the building and that have previously had the PPSV23 vaccination, will be offered PCV13 according to the guidelines. All residents who qualify for the PCV 13 vaccination will be offered and vaccination will be administered if the resident so desires. C. Audits on all new residents for the administration of the PCV13 will be completed on the next 20 admissions, to assure guidelines are being followed. D. Audits on all current LTC residents to assure the PVC13 was given/offered if they qualify according to the CDC guidelines. E. Completion for the administration of the PVC 13 8-30-16. Results will be reported to monthly QAPI meeting. DON or designee responsible.	

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F 334	Continued From page 51 to aid in preventing pneumococcal infections. The policy, however, did not incorporate the new CDC guidelines to ensure residents were offered timely immunizations.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the cleanliness of the walk-in cooler to promote sanitation and food safety in the main kitchen. This practice had the potential to affect all 80 who received food from the kitchen. Findings include: During the initial kitchen tour with cook (C)-A on 7/18/16, at 1:14 p.m. it was noted the outside of the walk-in refrigerator was wet. The frame of the door to the refrigerator had a thick layer of white frost and the stainless steel door frame had a dark brown substance evident when opened. A strong sour odor and garbage smell was evident inside the unit. Along the south wall of the cooler there was a significant number of irregular shaped areas of black colored substance located	F 371	F371 Food Procure, Store/Prepare/Serve-Sanitary • The Walk in cooler has been fully cleaned and sanitized by dietary staff in order to store, prepare and distribute food under sanitary conditions per regulation. • Current walk in cooler will be fully replaced with an entirely brand new unit as of 10/1/2016 by Alexandria Refrigeration. • A full cleaning schedule to include the entire current walk in cooler has been put into place to allow for and promote sanitation and food safety. • All dietary staff have been educated as of 8/11/2016 on the proper cleaning schedule and process per Ecumen Bethany cleaning policy.	8/11/16

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F 371	Continued From page 52 between the second and third shelves. Fresh vegetables (leaf lettuce, cabbage, spinach and tomatoes) were stored on these shelves. The tomatoes and leaf lettuce were open to air, without any covering of these food items. Throughout the entire unit large areas of missing and chipped paint were noted. It appeared the interior walls of the walk-in cooler had been silver but the walls had been painted a white color. This was evident as the paint was peeling from the interior walls. Located adjacent to the shelves of stored vegetables were stored fresh oranges and apples. These fruit items were next to the areas of the dark colored substance. On 7/21/16, at 1:55 p.m. dining director (DD) stated she had a designated staff person, dietary aid (DA)-A who cleaned the walk-in cooler on Monday which included the walls but if not completed, the cooks clean the walls of this refrigerator. DD stated DA-A worked this past Monday and should have cleaned the walls as she saw DA-A in the unit. DD stated if any kitchen equipment required any repairs, a work order would be entered into the computer. The DD confirmed the most recent work order entered had been related to a storage pallet sent last week. It was observed on 7/21/16, at 2:05 p.m. that C-A was placing groceries onto the shelves located in the walk-in cooler/refrigerator when the DD and the surveyor re-entered the unit to confirm the presence of the mold identified on 7/18/16. C-A and DD indicated the humidity level was so high in the walk-in cooler that the refrigerator unit could not keep up with the excessive humidity. C-A stated it had been discussed with the maintenance manager (MM) approximately a	F 371	• Audits of Cleaning schedule completeness and cleanliness of walk in cooler will be completed by Certified Dietary Manger or designee for 4 weeks, results will be provided to QAPI team for review.	

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F 371	Continued From page 53 week ago, indicating the door seal was not working properly. The MM had confirmed the broken gray seal had separated from the door, thus not working properly to maintain the conditions inside the cooler. The MM stated he was responsible for cleaning the door seals and confirmed that mold was evident along the door frame. He stated they just had to be careful to make sure the door was shut tight but verified the door was sweating and consequently, moisture was evident due to the broken seal and the humidity level. When C-A removed the shelving away from the wall, both C-A and DD confirmed there was black colored mold extending across the length of the shelving and down the entire length of the wall. It extended from above the level of the second shelf down to the floor. There were several irregular shaped black colored mold patches and streaks on the wall with several, up to 1-1/2 inches around or long. DD wiped a large black patch of the black substance (mold) with her fingers. A dark residue remained on her fingers. Both C-A and DD confirmed a strong odor was evident while in the cooler. C-A stated they did not have baking soda in the cooler anymore, but used to use it to control the odor. C-A also confirmed there was standing liquid in front of the shelf where a pork roast was thawing in a cardboard box. He confirmed the frozen roast had leaked liquid onto the floor during thawing. C-A indicated both the pork and fish tend to leak onto the floor. C-A stated they have a galvanized floor in the walk-in cooler, which was damaged and had rusted. He confirmed the floor had significant rust located in front of the meat thawing rack which extended approximately 6 in. from the rack. On 7/21/16, at 2:10 p.m. C-A removed the	F 371		

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F 371	Continued From page 54 vegetables from the shelving and placed them on top of a stainless steel cart located in the cooler. It was observed that C-A was inside the walk-in cooler on his knees and had a small white plastic bucket containing bleach solution and a cleaning rag. C-A indicated he had never washed the walls inside the cooler, and was unsure of the last time it had been washed. He stated the black substance was present due to the high humidity level in the cooler. C-A indicated he had never noticed the black mold substance until the surveyor made them aware. As C-A wiped the black substance off the wall of the cooler with the bleach solution, gray colored water ran down the wall as it was washed. On 7/21/16, at 3:45 p.m. DA-A stated she was scheduled to clean on Mondays from 9-11:30 a.m. but confirmed she had not washed the walls inside the walk-in cooler this past Monday during her scheduled hours. DA-A verified she doesn't wash the wall and was unsure how long it's been since they had been washed. She was unsure who was assigned this cleaning task and indicated only recently started sanitizing the shelf racks. DA-A explained she only conducted random checks of the cooler cleanliness as she had too many other tasks. DA-A stated she had noticed the black substance on the racks in the past but was unsure how the mold returned as bleach kills it. When interviewed on 7/21/16, at 5:30 p.m. the MM and the administrator (A) confirmed they were unaware of the mold (black substance) in the walk-in cooler and agreed they needed to develop a system, procedure and cleaning schedule for the walk-in cooler. The administrator stated staff need to remove all of the food items	F 371		

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F 371	Continued From page 55 and wash/clean the unit, including the shelves prior to returning the stored food items. Review of the undated facility policy, Sanitation of the Food Service Department identified the food service staff shall maintain the sanitation of the food service department through compliance with the cleaning schedule. Review of the dietary cleaning schedule , dated 4/08 identified refrigerators would be cleaned weekly.	F 371		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the condition of the walk-in cooler located in the dietary kitchen was properly maintained to control the humidity level and ensure the proper storage of perishable food. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: During the initial kitchen tour with cook (C)-A on 7/18/16, at 1:14 p.m. it was noted the outside of the walk-in refrigerator was wet. The frame of the door to the refrigerator had a thick layer of white frost and the stainless steel door frame had a dark brown substance evident when opened. A	F 456	F456 Essential Equipment, Safe Operating Condition • The Walk in cooler has been fully cleaned, sanitized and maintained by dietary staff in order to store, prepare and distribute food under sanitary conditions and safe operation condition per regulation. • Current walk in cooler will be fully replaced with an entirely brand new unit as of 10/1/2016 by Alexandria Refrigeration. • A full cleaning schedule to include the entire current walk in cooler has been put into place to allow for and promote sanitation and food safety.	8/11/16

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F 456	Continued From page 56 strong sour odor and garbage smell was evident inside the unit. Along the south wall of the cooler there was a significant number of irregular shaped areas of black colored substance located between the second and third shelves. Fresh vegetables (leaf lettuce, cabbage, spinach and tomatoes) were stored on these shelves. The tomatoes and leaf lettuce were open to air, without any covering of these food items. Located adjacent to the shelves of stored vegetables were stored fresh oranges and apples. These fruit items were next to the areas of the dark colored substance. On 7/21/16, at 1:55 p.m. dining director (DD) stated if any kitchen equipment required any repairs, a work order would be entered into the computer. The DD confirmed the most recent work order entered had been related to a storage pallet sent the previous week. It was observed on 7/21/16, at 2:05 p.m. that C-A was placing groceries onto the shelves located in the walk-in cooler/refrigerator when the DD and the surveyor re-entered the unit to confirm the presence of the mold identified on 7/18/16. C-A and DD indicated the humidity level was so high in the walk-in cooler that the refrigerator unit could not keep up with the excessive humidity. C-A stated it had been discussed with the maintenance manager (MM) approximately a week ago, indicating the door seal was not working properly. The MM had confirmed at that time that the broken gray door seal had separated from the door, thus not working properly to maintain the conditions inside the cooler. MM had instructed they just had to be careful to make sure the door was shut tight but verified the door was sweating and consequently,	F 456	• All dietary staff have been educated as of 8/11/2016 on the proper cleaning schedule and process per Ecumen Bethany Community cleaning policy. • Audits of Cleaning schedule completeness and cleanliness of walk in cooler will be completed by Certified Dietary Manger or designee for 4 weeks, results will be provided to QAPI team for review.	

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	245434	A. BUILDING _____ B. WING _____	07/22/2016

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F 456	Continued From page 57 moisture was evident due to the broken seal and the humidity level. C-A confirmed the mold was evident between the shelves and when he pulled the shelving away from the refrigerator wall, areas of dark colored substance extended down the wall from the area above the second shelf to the floor of the refrigerator. He stated they have a galvanized floor in the walk-in cooler, which damaged and had rusted. On 7/21/16, at 2:10 p.m. C-A removed the vegetables from the shelving and placed them on top of a stainless steel cart located in the cooler. He stated the black substance was present due to the high humidity level in the cooler. On 7/21/16, at 3:45 p.m. DA-A stated she had noticed the black substance on the racks in the past. When interviewed on 7/21/16, at 5:30 p.m. the MM stated he was unaware of the broken seal on the door to the walk-in cooler and confirmed the evidence of the humidity/moisture problem on the walk-in cooler door and walls inside the cooler door.	F 456		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, document review and	F 465	F465	8/11/16

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F 465	Continued From page 58 interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: On 7/18/216, at 1:14 p.m. during the initial kitchen tour with cook (C)-A it was noted that the floor covering underneath and surrounding the affixed steamer and oven located in the food preparation area had an area of missing maroon floor tile, which measured approximately 18 inches (in) by 18 in. The area was filled with dark and light gray dust and dirt particles. In addition, there was another irregular shaped area directly under the steamer and next to the missing tile area that was a dark brown, sticky, sludge material which measured approximately 6 in by 4 in. The entire floor in the food preparation area was soiled with food particles and dirty. On 7/21/16, at 1:55 p.m. the dining director (DD) confirmed the damage and dirty kitchen floor. She indicated the floor had steadily gotten worse this past year. DD also stated the floor is old and needed to be replaced. DD indicated they had purchased another oven, moved equipment around and had problems with water leaking from the steamer which caused the floor damage. DD stated the brown sticky substance was not grease but was compacted food material, dirt and grime. She confirmed the floor was no longer a cleanable surface, thus dirty. She stated housekeeping staff scrubbed the floor every other week, otherwise dietary was responsible for washing the floor.	F 465	Safe/Functional/Sanitary/Comfortable Environment • Kitchen Floor Tile has been fully cleaned throughout entire Kitchen area to provide a safe, functional, sanitary and comfortable environment for residents and staff. • Damaged Tile in kitchen has been replaced and repaired as of 8/23/2016 • A full floor cleaning schedule to include the entire kitchen area floors has been put into place • All dietary staff have been educated as of 8/11/52016 on the proper cleaning schedule and process per Ecumen Bethany Community cleaning policy. • Audits of cleaning schedule completeness and cleanliness of kitchen floors with be completed by Certified Dietary Manger or designee for 4 weeks, results will be provided to QAPI team for review.	

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F 465	Continued From page 59 On 7/21/16, at 5:30 the maintenance manager (MM) and the administrator (A) confirmed the condition of the damaged floor tile and the dirty floor. MM knelt to the floor, wiped his hand across the area and visible gray dust was evident on his hand. MM and A confirmed the floor surface need to be repaired and/or replaced and agreed the damaged tile surface was unclean. MM and A confirmed a dark brown sticky material was evident on the floor behind steamer and stated it would be cleaned. Review of the undated facility policy, Sanitation of the Food Service Department identified the food service staff shall maintain the sanitation of the food service department through compliance with the cleaning schedule.	F 465		

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/18/2016, through 7/22/2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the plan of care for 2 of 3 residents (R78, R28) reviewed who were dependent upon staff for shaving and oral cares and for 1 of 1 resident (R65) reviewed with bilateral hand contractures and required range of motion (ROM). Findings include: R78's admission Minimum Data Set (MDS) dated 7/1/16, identified R78 was moderately cognitively impaired, required extensive assistance for all areas of daily living (ADL)with exception of limited assistance to walk in corridor and diagnoses which included Parkinson's disease, dementia, arthritis and vision impairment. R78's undated care plan, identified R78 had a self care deficit related to Parkinson's Disease, hypertension, diabetes, and dementia as evidenced by requiring assist with ADL's -The	2 565	Corrected 8/9/2016 per Director of Nursing	8/9/16

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2 565	Continued From page 3	2 565		

resident requires extensive assist of 1 staff with personal hygiene.

The undated resident care sheet, indicated R78 required assist of one staff with dressing and grooming.

On 7/19/16, at 9:28 a.m. R78 stated, " I can't shave because of my Parkinson, that is one thing they are a little lax on." At this time R78 has stubble on chin and upper lip.

On 7/20/16, at 7:57 a.m. R78 was propelled from his room to the dining room by nursing assistant (NA)-H. R78 had facial hair stubble on the upper lip and chin area.

On 7/20/16, at 1:00 p.m. R78 was seated in his room in a stationary chair in front of the television. R87 remained unshaven.

On 7/21/16, at 9:26 a.m. R78 was seated in room dressed, has not had face shaved, mustache and beard heavy stubble.

On 7/20/16, at 8:51 a.m. NA-H indicated R78 tries to shave independently and will ask staff when he needs help. NA-H indicated R78 was new to the facility and NA-H was unsure of whether R78 had behaviors or refused cares.

When interviewed on 7/20/16, at 1:00 p.m. R78 verified if he was able to shave himself he would do it every day. R78 stated staff will shave his face each morning when they get him up with an electric razor but some times they forget. R78 verified his facial hair had not been shaved off today and was unable to recall when staff last shaved him.

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2 565	Continued From page 4 On 7/20/16, at 1:17 p.m. NA-I identified R78 had no behaviors and did occasionally refuse to go for a walk, however, it was usually for a reason, for example if his wife was here or if he was having pain in his hip. On 7/21/16, at 9:54 a.m. NA-E indicated R78 was unable to shave independently due to shaky hands. NA-E verified he/she had not shaved R78 this a.m. NA-E indicated R78 refused the offer to shave this a.m. and had a routine of shaving only "every so often." On 7/21/16, at 11:00 a.m. NA-F verified R78 had a good memory and what he says is accurate. NA-F indicated he/she did not provide cares for R78 often, however, did believe R78 was usually clean shaven. NA-F indicated staff usually assisted R78 with oral care and shaving. NA-F sated, " We would normally shave a person if they can't themselves." On 7/21/16, at 11:04 a.m. R78 verified he was not shaved this morning. R78 stated, " it (facial hair) isn't so hard to get off" if he is shaved every day. R78 further identified with a clean shaven face it was easier to keep clean as things get caught, stating "I drool." On 7/21/16, at 11:13 a.m. licensed practical nurse (LPN)-E verified R78 had facial stubble and had not been shaved. On 7/21/2016, at 11:14 a.m. registered nurse (RN)-A verified R78 required assistance with ADL's due to has Parkinson's Disease and although his abilities change from day to day, R78 was not able to shave independently with an electric razor. RN-A identified staff were expected to shave male residents daily and would	2 565		

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2 565	Continued From page 5 not expect residents to have to ask for the assistance. When interviewed on 7/22/16, at 11:25 a.m. the director of nursing (DON) verified the expectation that staff follow the care plan and residents who require assistance with ADL's be provided the care and not expected to ask for assistance. R28's care plan dated 7/15/16, identified R28 required extensive assistance to total assistance with personal hygiene and oral cares. The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 mouth swab and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed. The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28. During observation of morning cares on 7/20/16, from 8:23 a.m. to 8:54 a.m. NA-A and NA-G assisted R28 with personal cares which included washing her face, perineal cares and dressing. During the observation, R28 was not assisted nor offered the opportunity for completion of oral cares. R28's oral cavity and lips appeared very dry. -At 8:57 a.m. NA-A assisted R28 with breakfast while R28 was positioned in bed. R28 was not wearing any dentures, and R28 refused the breakfast food items and juice offered. R28 did consume the strawberry supplement. -At 9:01 a.m. NA-A gathered the breakfast tray, shut off the bedroom lights and stated some days are good with feeding, and some days are not,	2 565		

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2 565	Continued From page 6	2 565		

just like today. NA-A then delivered the breakfast tray to the kitchen, R28 was not assisted nor offered the opportunity for completion of oral cares.

During interview on 7/20/16, at 8:45 a.m. NA-A reported R28 no longer wears dentures, and stated she was going to wait until after R28 ate breakfast to provide oral cares which included swabbing out the mouth with a toothette.

At 9:07 a.m. NA-A confirmed R28 had finished with the breakfast meal and confirmed she had completed morning cares for R28. NA-A verified she did not complete nor offer oral cares which included swabbing the mouth with a toothette or mouthwash. Further, NA-A confirmed she did not inspect her mouth with cares.

During interview on 7/21/16, at 10:35 a.m. RN-B confirmed R28 no longer wore dentures. RN-B verified staff are expected to swab R28's mouth with morning cares, or at least attempting as R28 will at times refuse. RN-B confirmed R28 has a dry mouth and sleeps with the oral cavity open, therefore, oral care must be attempted.

During interview on 7/22/16, at 10:08 a.m. the DON confirmed staff are expected to provide or offer oral cares to all resident twice per day as indicated on the care plan.

The facility's Mouth Care Policy dated October 2010, directed staff to review the resident's care plan for any special needs of the resident. and assemble the equipment and supplies as needed.

Review of R65's quarterly Minimum Data Set (MDS) dated 4/27/16, identified R65 had severe cognitive impairment and had diagnoses which

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included Parkinson's disease, Alzheimer's disease and cerebravascular disease with hemiplegia . The MDS further identified R65 was totally dependent on staff for activities of daily living (ADL's) and had bilateral upper extremity contractures. Review of R65's annual Care Area Assessment (CAA) dated 8/19/15, identified R65 had severe cognitive impairment due to Alzheimer's disease, was totally dependent on staff for ADL's and had contractures.

Review of R65's care plan print dated 2/25/16, identified R65 had bilateral contractures of the upper and lower extremities, was totally dependent on staff for all ADL's, required gentle range of motion with daily care, required gauze rolls in both hands 23/hrs/day: to be removed for 30 minutes twice daily for hygiene for bilateral hand contractures.

On 7/18/16, at 5:38 p.m. R65 was seated in a tilt in space wheelchair across from the nurses station prior to the evening meal. Both of R65's hands were held in a fisted position, elbows were bent and hands rested on her chest, right hand rested near her heart and her left hand rested on her left upper chest. R65 did not have kerlix placed in her hands. At 6:55 p.m. R65 was seated in a tilt in space wheelchair near the nurses station following the evening meal. R65 remained without kerlix/gauze in both hands. On 7/19/16, from 8:45 a.m. to 10:55 a.m. R65 was lying in bed tilted to her right side with pillows against her back, blankets were observed to cover R65 to mid torso. R65's hands were in a fisted position , arms were bent at the elbow, fisted hands rested against her chest. R65 did not have kerlix in her hands.

On 7/21/16, at 4:57 p.m. R65 was seated in a tilt

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2 565	Continued From page 8 in space wheelchair with both arms bent at the elbows, hands were resting on her chest and were clenched fisted position. R65's right clenched hand was resting over her heart and her left clenched hand was resting on her upper left chest, no kerlix was observed in R65's hands. When interviewed on 7/21/16, at 5:09 p.m. registered nurse manager (RN)-A confirmed R65 did not have kerlix in her contracted hands as care planned and was unsure why the kerlix was not in use. RN-A stated the medication nurses were responsible for checking to make sure R65's kerlix were in both hands for bilateral hand contractures. RN-A stated she felt R65 hands were too contracted for the kerlix to have fallen out, nor could R65 remove the kerlix independently. RN stated R65's hands were fully contracted and had been for years. RN-A directed a licensed practical nurse (LPN)-D to apply kerlix. On 7/21/16, at 5:13 p.m. LPN-D attempted to open R65's right hand fingers from the contracted, fisted position and apply approximately an inch in diameter cotton kerlix roll into R65's hand. R65 stated it hurt and she was hurting her fingers, LPN-D immediately stopped opening R65's hand. At that time, LPN-D stated there were times when R65's hands needed to be soaked in warm water to help open the hands up. RN-A and NA-B then wheeled R65's to her room and NA-B wheeled R65 into her bathroom, while RN-A started to run the water out of the faucet. NA-B took R65's right hand, held it under the warm water while RN-A slowly opened R65's hand, washed, dried and applied the kerlix. NA-B then took R65's left hand, held it under the water while RN-A opened R65's hand, washed, dried and applied another roll of kerlix. NA-B assisted R65 back out of the bathroom in	2 565		

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2 565	Continued From page 9	2 565		

her wheelchair and wheeled R65 back to nursing station.

On 7/21/16, at 5:12 p.m. NA-B stated R65 was supposed to have the kerlix in both of her hands at all times. NA-B stated the nurses usually put them in after R65's hands were washed. NA-B stated she felt about 3-4 times a week R65's kerlix were not in her hands and she would then place the kerlix into R65's hands and often had a hard time doing so. NA-B further stated she felt R65's hands were fisted very tightly so the kerlix could not fall out and she felt R65 would be unable to remove the kerlix herself. NA-B stated she felt R65's hands had not worsened over the last few years.

On 7/22/16, at 10:23 a.m. NA-C stated R65 required total assistance with all ADL's, NA-C stated on average a few days a week R65 would not have the cloth rolls, (kerlix) in her hands and NA-C would then place the kerlix in R65's contracted hands.

On 7/22/16, at 10:37 a.m. RN-A stated R65 had not had a recent occupational therapy evaluation, though had one a few years ago which identified R65 had complete contractures of both hands. RN-A confirmed R65's current physician orders directed nursing staff to ensure R65 had kerlix placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated R65 had fully contracted hands and fingers.

On 07/22/16, at 11:13 a.m. the director of nursing

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2 565	Continued From page 10 (DON) stated she expected resident care plans to be implemented as directed. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. The facility policy titled Resident MDS 3.0 Assessment and Plan of Care revised 03/12, indicated the care plan was to provide continuity of care from admission to discharge. The facility's Care Plan Policy dated September 2010, indicated the care plan would be used to enhance the optimal functioning of the resident, and/or aid in preventing or reducing decline in resident's functional status and/or functional levels. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		8/12/16

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2 830	Continued From page 11 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, ensure adequate supervision and implement interventions, to decrease the risk of further falls for 1 of 3 residents (R87) reviewed who sustained multiple falls. R87 experienced an injury while utilizing a Merry walker (a walker/chair combination type device), resulting in an immediate jeopardy (IJ) situation. The facility failed to investigate and comprehensively assess the resident's falls while utilizing the Merry walker to determine whether new interventions should have been implemented, and the facility failed to ensure interventions currently in place were adequate and consistently implemented to minimize the risk for further falls. The immediate jeopardy (IJ) began on 10/24/15, when R87 sustained a fall with injury while walking in the Merry walker. The facility's administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) situation on 7/19/16, at 7:05 p.m. The IJ was removed on 7/20/16, however, noncompliance remained at a	2 830	Corrected 8/12/2016 per Director of Nursing	

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2 830	Continued From page 12 lower level of G, isolated scope, with severity of actual harm that is not immediate jeopardy. Findings include: R87 was observed on 7/18/16, at 5:31 p.m. with a gait belt fastened around her waist, standing in a Merry walker made of PVC pipe. Cloth weights had been fastened with zip ties to the bottom of the walker on three sides and a cloth type strap was attached to the seat of the walker. The strap attached to the front of the walker and was located between R87's legs. R87 independently wandered about the Darling Springs unit utilizing the Merry walker. R87 was observed to walk with a shuffling gait and was noted to have an abrasion near her right eye. When she got to the doorway to the dining room, R87 couldn't move the Merry walker forward. R87 remained stationery in the doorway to the dining room until nursing assistant (NA)-D assisted R87 to turn around in the Merry walker so R87 could ambulate in the opposite direction. R87 continued to move around the area of the Darling Springs nurses' desk, bumping into walls and doorways. R87 was again observed on 7/18/16, at 6:48 p.m. walking in the Merry walker in the Darling Springs hallway with a shuffled gait. R87 was observed bumping into walls, doorways and residents in wheelchairs while walking down the hallway in the Merry walker device. The administrator was observed at that time to grasp a corner of the Merry walker to straighten R87's navigation. A few minutes later, R87 was observed to walk/bump into the right front corner of the Merry walker, bounced backward and came to rest on the seat of the Merry walker with half of her buttock positioned on the seat of the walker. R87 then stood and continued to wander throughout	2 830		

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2 830	Continued From page 13 the hallway while attempting to navigate the Merry walker. On 7/19/16, at 10:42 a.m. NA-E was observed to guide R87, who was in the Merry walker, out of her room to the hallway. NA-E then left R87 to independently walk in the Merry walker. R87 was observed to walk with a shuffled gait. She was located in the short hall outside of her room, but not within staff view. While in the Merry walker in the corner of the short hall, R87 was able to grasp the door handle to the bathroom door labeled B-13 and jiggle the handle. R87 then turned her body to the right side of the Merry walker, moved the walker in a sideways direction out from the corner and moved toward the nurses' desk located on the opposite side from the dining room. At 10:46 a.m. R87 continued to move about in the Merry walker with a shuffled gait. She navigated to and from the short hallway located near her room which was located on the side of the nurses' station desk without staff in the area. At 10:47 a.m. a lab (laboratory) tech (technician) and two facility staff walked near the side of the nurses' station facing the dining room. None of these three staff looked in the direction of R87 as they walked past this area. At 10:47 a.m. licensed practical nurse (LPN)-C returned to the nurses' station area and approached the medication cart which faced the opposite direction from R87. LPN-C did not move to an area where R87 could be supervised. During this time, R87 was observed to have turned herself within the Merry walker to face backwards, and was observed to have lifted her right knee onto the Merry walker seat. On 7/19/16, at 10:50 a.m. two NAs were observed in the hallway to propel a cart while water mugs were removed from resident rooms.	2 830		

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2 830	Continued From page 14 Neither NA looked in the direction of R87 as she once again maneuvered the Merry walker into the corner of the hall and was unable to propel it forward. At 10:51 a.m. R87 stood backwards in the Merry walker. The front and one side of the Merry walker were located against the corner walls in the short hallway. No staff were in the vicinity nor in view of R87 to provide supervision. At 10:55 a.m. R87 remained unable to move from the corner with the Merry walker. R87 raised her feet, one at a time, placing them onto the bottom bar of the Merry walker. She then placed her right knee onto the seat of the walker. At 10:57 a.m. R87 shuffled the Merry walker towards the location of the nurses' desk, leaned over the Merry walker bar, spit on the floor and continued forward with little shuffled steps in the direction of the corner located near the bathroom. NA-E was observed in the hall to be delivering water mugs to resident rooms but did not walk in R87's direction. At 11:00 a.m. R87 continued to ambulate with small steps, navigating the Merry walker toward the nurses' station. R87 stopped the movement of the walker when it butted up against the nurses' station desk. At 11:08 a.m. R87 stood up in the Merry walker while it was caught against the nurses' station. Staff were noted on the dining room side of the desk. At 11:11 a.m. on 7/19/16, R87 and another female resident seated in a wheelchair were in the vicinity of the nurses' desk. At 11:14 a.m. R87 pushed her Merry walker into the other female resident's wheel chair. When R87 could not propel forward, she grasped the top bar of the walker and shook it back and forth. At 11:17 a.m., while R87 continued to shake the Merry walker, the resident located in the wheel chair grasped R87's left wrist and stated "go tell your mother". R87 made no response but continued to shake	2 830		

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2 830	Continued From page 15 the walker. At 11:18 a.m. facility staff walked through the area pushing a housekeeping cart onto the elevator, without looking in the direction of R87. At 11:19 a.m. R87 finally seated herself in the Merry walker with only the right side of her buttock seated on the Merry walker seat. The Merry walker remained in contact with the other resident's wheel chair. At 11:19 a.m. R87 stood from the seat, and again began shaking the walker. The resident in the wheelchair stated, "do you want me to spank you?" and grasped R87's wrist. At that time, the surveyor summoned staff. At 11:22 a.m. registered nurse (RN)-A separated the two residents. R87's annual Minimum Data Set (MDS) dated 5/11/16, identified R87 had long and short term memory problems with no recall ability, was rarely to never understood, and required extensive assistance for all activities of daily living (ADL). A facility form, Order Summary Report signed by the physician 6/27/16, indicated R87's medical diagnoses included: dementia with Lewy Bodies, Parkinson's disease and anxiety disorders. R87's Care Area Assessment (CAA) dated 5/11/16, included: "Cognitive loss /Dementia: severe impairment w(with)/cognition triggered CAA r/t [related to] dx [diagnosis] of dementia with Lewy bodies, Parkinson's and depression.. ADL functional /Rehabilitation Potential: Requires assist with ADL's and mobilities r/t Parkinson's Disease, Dementia with Lewy Bodies, HTN [hypertension], osteoarthritis and Hx [history of falls]. See CP [care plan] for details. Safety interventions are in place to prevent falls/injuries. Noted to have 2 falls since previous MDS. Will monitor and implement safety interventions PRN [as needed]. Resident does wander about unit. At times will wander into other resident's rooms. Wander guard is in place to alert staff if resident	2 830		

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2 830	Continued From page 16 attempts to wander outside. Velcro sashes are put across other residents' doorways to detour resident of entering room. Does help detour at times. Is at risk for impaired communication r/t [related to] Dementia and Parkinson's Disease. Speech is mumbled and has difficulty finding the right words. Response does not always make sense. Is sometimes understood and sometimes understands communication. No referral needed at this time." Behavioral Symptoms: "Observed to have behaviors of physical abuse towards others and wandering. Staff will provide [R87] with PRN pain meds [medications] when is showing aggression in her face. [R87] will also ram into things with her Merry walker repetitively. PRN pain meds have shown to redirect this behaviors." R87's care plan reviewed 7/13/16, indicated the resident was "at risk for falls due to dementia with Lewy Bodies, and Parkinson's disease." Interventions included: "Ensure [R87] is wearing appropriate footwear when ambulating or mobilizing in wheel chair. Follow facility fall protocol. Physical therapy eval [evaluation] and treat as ordered or as needed. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident/family/caregivers/ IDT [interdisciplinary team] as to causes. Safety interventions: (1) Low bed and safety mats when in bed. (2) Shoes or gripper slippers to be worn when in Merry walker. (3) Close dining room and activity doors in the evening when [R87] is in Merry walker. Bathroom door to be closed when resident is not using the bathroom. (4) Weights on base of Merry walker to increase stability. (5) Keep an extra set up [SIK] slippers in Merry walker in case one falls off. (6) 1:1 staff assist/ supervision when in the dining room. (7) Clip call light to resident at NOC [night] to alert staff when	2 830		

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2 830	Continued From page 17	2 830		

she moves or gets up (has soft touch call light). (8) Staff will monitor whereabouts every 30 minutes and PRN. (9) Bring to bathroom before sitting in recliner."

R87's NA care sheet (a reference NAs used regarding specific care for residents) undated, identified safety interventions for R87 to include: (1) to ensure to take R87 to the bathroom before assisting to the recliner, (2) keep bathroom door closed, (3) clip call light on R87 at bed time, (4) low bed and safety mat (put mat against wall when not in bed), (5) keep gait belt on walker (close to resident), (6) Follow with wheel chair when ambulating, one to one assist when in dining room, use body pillow to position in bed, wanderguard worn. The NA care sheet also indicated in the comment section: "Merry Walker [see purple sheet in NA book]." The purple sheet directed staff to "observe frequently." Although the NA care sheet directed staff to observe R87 in the Merry walker, no specific time frame was given even though the care plan indicated staff to monitor R87's whereabouts every 30 minutes and PRN.
When interviewed on 7/19/16, at 11:22 a.m. RN-A stated R87 was safe to be unsupervised in the Merry walker and stated, "we check on her every half hour".

On 7/19/16, at 1:35 p.m. NA-E indicated it was usual practice to allow R87 to walk around while in the Merry walker unsupervised. NA-E stated, "We try to keep her safe, the nurses do a good job of keeping her close." NA-E verified that although she had not witnessed R87's falls involving the Merry walker, she'd heard that R87 had stepped on the bottom of the walker causing it to fall over and causing a cut to R87's face. NA-E pointed to the temple area.

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2 830	Continued From page 18 A review of R87's clinical record identified the following 20 documented fall incidents which involved the use of the Merry walker since R87 was admitted on March 2015: (1) 5/10/15- found on floor underneath Merry walker; No apparent injuries Care plan and multiple safety interventions were being followed at time of fall. Spoke with family member (F)-A. Discussed the risk vs. benefits of the Merry walker, F-A feels at this time, the merry walker continues to benefit greatly and feels is at a greater risk of injury if she was not using the Merry walker and self transferring without it. Staff will continue with 30 minute checks and follow Merry Walker guidelines as listed in CP (care plan). (2) 5/17/15- found on floor, had tipped over Merry walker; head up against the wall on right side; bruising on RUE (right upper extremity) from previous fall; No other noted injuries. Resident was crying but able to voice if she was hurt. Unwitnessed. Will place safety mat against wall when not in bed to prevent resident from tripping on mat or wheeling over it with Merry walker. Will also continue Q (every) 30 minute checks. (3) 5/20/15- found by a staff member laying on the floor with one leg still around the strap of Merry walker around 4:00 p.m. Resident assisted back into Merry walker with 2 staff and EZ (mechanical device) lift. No further documentation of IDT (interdisciplinary team) review of fall. (4) 6/20/15- found sitting opposite direction in Merry walker. Sitting on floor. No apparent injuries.	2 830		

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2 830	Continued From page 19 (4) 6/23/15- found on floor in Merry walker. When staff removed Merry walker to assist off the floor, resident began scooting on her butt on the floor. No injuries noted. CP being followed. (6) 6/28/15- in Merry walker, stumbled to the left and right leg crossed over left leg and resident grabbed for medication cart to catch herself and this caused [R87] and Merry walker to fall to the left. Right hip pain and right foot rotated inward. Lump on left side of head and above left eye. Pupils sluggish. Guarded movement to the right leg. Ice applied to head abrasion and lump. Sent to the emergency department (ED). (7) 8/1/15- found on floor in Merry walker in room. Got up with assist of 2 staff. Resident was uninjured (8) 8/4/15- found on floor at 11:30 a.m. in another resident's room with no injuries or hitting head. Was wearing slippers and in Merry walker at time of occurrence. Action: Up off floor and back in Merry walker. (9) 8/4/15- found on floor in front of nurses' station in Merry walker and slipper on. No injuries noted. Continue current CP. (10) 9/15/15- found sitting on floor backwards in Merry walker in her room, leg strap still attached between legs; shirt off at this time, gripper socks in place; R87 agitated at the time. Staff last checked in on R87 shortly before, less than hour prior to fall. (11) 9/19/15- observed on floor next to bed in room, was lying under the Merry walker. The Merry walker was intact, was assisted to the toilet and into the Merry walker at 2:20 p.m. No lumps	2 830		

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2 830	Continued From page 20 bumps or bruising noted to her head. (12) 9/22/15- found in room on the floor underneath Merry walker at 7:00 p.m. The strap was hooked around R87's foot and was lying on her back. A small quarter sized bruise was found on right buttock. Brought to the bathroom and returned to bed. (13) 10/24/15- Resident tipped merry walker over sideways and was found face down on floor, unable to move. [R87] hit head/mouth on floor; mouth bleeding from losing a tooth. No one seen [sik] the incident so don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift. A follow up nursing note dated 10/26/15 at 11:41 a.m. included, IDT reviewed fall from 10/24/15. Resident tipped over merry walker and landed on her face. Received a small abrasion under nose and lost a tooth as a result of the fall. Seroquel (antipsychotic medication) was recently decreased last Wednesday, [R87] more active since then. Per daughter's request, she would like Seroquel increased to the previous dose, she states she has seen her mom have more added behaviors and would like her mom to be more tired than anxious and falling. Referral filled out for MD (medical doctor). Also, weights added to the back of the merry walker to balance it. (The intervention of added weights to the base of the merry walker was initiated after R87 had sustained a fall on 6/28/15). A nurses' note dated 10/26/15, at 13:39 (1:39 p.m.) included:..."Res. face continues to be swelled and abrasion is scabbed. Call placed to [MD] to inquire about xray to face. RN UC [registered nurse unit coordinator] aware. [MD's] nurse will call back after talking to CNP [certified nurse practitioner]. Subsequent nursing notes indicated the physician	2 830		

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2 830	Continued From page 21 had ordered a head CT scan [computed tomography X-ray] for that date. Documentation from 16:53 (4:53 p.m.) 10/26/15 indicated CT scan results from that date, indicated the resident had presented with facial pain and more confusion than usual. The report further included: Conclusion: 1. Nondisplaced fracture through the anterior superior most maxilla (upper jaw) at the base of the nose. Additionally, a nurse's note from 10:49 a.m. on 10/27/15 indicated the resident required an oral surgery consult. Despite the number of falls and fracture while utilizing the Merry walker, the facility failed to reassess R87's fall risk and interventions. (14) 1/6/16- found on the floor in the bathroom still in Merry-walker, under the bar with leg strap intact. Resident was found leaning against the wall in the bathroom. No other injuries present. Resident was assisted with 3 and ez-lift (mechanical full body lift) off of the floor and into bed. Then placed in merry walker for meals. No further review of the fall by the IDT. (15) 1/8/16- found on the bathroom floor, still in Merry walker; Merry walker did not tip over. No injuries from fall. CP was being followed. Was assisted to the bathroom less than 2 hours prior to the fall, not attempting to go to the bathroom at the time of the fall. Action: intervention to keep the bathroom door closed when not using it, [R87] wanders into her room through out the day. No further IDT review of the fall documented. (16) 2/2/16- on floor in front of nurses' station at 7:30 a.m. in Merry walker. No injuries noted. Had foot wear on at time of occurrence. Continue CP. (17) 4/16/16- found sitting on the floor in the	2 830		

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	00108	A. BUILDING: _____ B. WING _____	07/22/2016

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2 830	Continued From page 22 activity room close to Turtle Beach (resident unit) still in the Merry walker; walker was still upright; assisted back into the Merry walker with the EZ lift and 3 staff assist. Continue with CP; Family continue to feel the Merry walker is safest option and continues to be appropriate. A physician visit form dated 4/18/16, identified R87 was seen for a "regularly scheduled visit." "Nursing has no concerns with [R87], she has been stable." (18) 5/13/16- found on right side, Merry walker was tipped over on the floor, laying on gray mat next to bed, feet still inside tipped Merry walker. Was trying to get to Herbergers, climbed on Merry walker and flipped Merry walker onto side. Aide found resident on floor. No injuries from fall. Staff educated to make sure the mat is not on the floor when [R87] not in bed. Sign placed on wall to remind staff to pick up the mat when not in bed. (19) 6/26/16- found on floor of other resident's room in Merry Walker on floor with feet on the seat. No injuries noted. Merry walker discussed with family at all care conferences and they feel this is her safest option to avoid injury and also gives her the freedom to ambulate and be more independent. Will continue with current interventions. CP followed. (20) 6/27/16- found lying on floor underneath Merry walker outside of room in hallway, lying on back and holding head up, appeared to be sleeping. No injuries. CP being followed;Will continue with these interventions. When interviewed on 7/19/16, at 2:55 p.m. the director of nursing (DON) identified an IDT	2 830		

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2 830	Continued From page 23 reviewed resident falls to identify the cause of the fall, current interventions in place, previous interventions and possible new interventions. This IDT review is added to the nurse's progress notes in the electronic record and documented onto a Falls log. Review of the facility form titled Resident Incidents, printed for the dates of January 2016 to July 2016 included the following falls involving the Merry walker for R87: -2/2/16- witness-none, interventions-Continue current interventions-no injury. -4/16/16- witness-none, interventions-Continue current interventions. -5/13/16- witness- none, interventions-Continue current interventions. -6/26/16-witness-none, interventions-Will continue with current interventions. -6/27/16-witness-none, interventions-No maltreatment, care plan was being followed. Resident has numerous fall interventions in place. Will continue with theses interventions. The Incident Log did not include all the documented falls that occurred during the selected time frame. The log also lacked documentation of a comprehensive re-assessment of R87 and lacked documentation of any additional interventions implemented to prevent re-occurrence of falls. R87's electronic and written records lacked any evidence of physical (PT) or occupational therapy (OT) evaluations and/or treatment. In addition, Morse Fall Scale documents completed on 8/28/15, 10/26/15, 11/20/15, 11/22/15 and 5/9/16, each identified R87's risk for falling, the use of a walker, and identified the resident as having a weak gait, stooped posture and described gait	2 830		

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2 830	Continued From page 24 with, "steps are short, resident may shuffle." Each of these Morse Fall Scale documents indicated the resident had a score of 80 with anything above 45 indicating a high risk for falls. None of the documents identified any other specific assessment information. On 7/19/16, at 4:19 p.m. registered nurse (RN)-A reviewed the progress notes and verified R87's falls involved the Merry walker and that assessments and new interventions were not consistently completed and/or implemented. RN-A identified the usual process after a fall as follows: (1) review the nurse's progress notes, (2) interview staff to see what [R87] was trying to do, (3) if interviewable, ask the resident, (4) reassess fall risk and whether planned interventions are effective. RN-A indicated these assessment findings would have been documented as a follow-up note after each fall. RN-A verified that R87 was cognitively impaired and that it was difficult to identify a cause for each fall because R87 could not express her needs or actions. RN-A further identified there were so many planned interventions it was difficult to identify any new ones, and RN-A also stated fall assessments were completed quarterly, not after each fall. A facility document was provided titled Restraint/ Physical (Quarterly/Annual Evaluation) dated 2/17/16. RN-A verified this was the most current assessment form and verified there were no other assessment forms related to a fall risk assessment for R87. RN-A stated therapy had been involved with the assessment for the use of a Merry walker and had been assessed when admitted. RN-A also stated the current CP included all of the current interventions and confirmed it was an expectation that staff follow the care plan. RN-A also stated the nurse was responsible to check on R87 every 30 minutes	2 830		

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2 830	Continued From page 25 and to document such. RN-A explained the Merry walker currently utilized by R87 had been obtained from storage in the basement of the facility, and stated she did not believe they had a written copy of the manufacturer's instructions/recommendations. RN-A indicated she may have to complete a "Google" search to obtain the instructions. On 7/19/16, at 4:57 p.m. the DON identified the nurse manager was responsible to complete an assessment for resident use of a Merry walker and explained the assessment involved standing the resident in the Merry walker to see whether it was safe. The DON further explained this was not an actual written assessment, but included more of an observation to see whether the Merry walker was appropriate. The DON verified this was the only Merry walker assessment completed. The DON further explained the staff and family were aware that R87 was not safe and remained at risk for falls while in the Merry walker. The DON confirmed they were honoring the family wishes since R87 was not utilizing a Merry walker, she would have to be placed into a Geri Chair (a reclining wheel chair). The DON also indicated implementation of interventions after a fall would be completed if staff identified problems with the Merry walker, identifying examples such as not walking with it, or not using it properly. The DON further indicated the expectation for care of a resident utilizing a Merry walker included frequent observations by all staff when walking by. The DON said if a resident were trying to crawl out of the Merry walker, staff may lay the resident in bed with a safety mat placed next to the bed. The DON reiterated staff were expected to follow the CP. The DON indicated they had tried numerous interventions but would follow family wishes related to the continued use	2 830		

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2 830	Continued From page 26 of the Merry walker. The DON stated the manufacturer's recommendations for use of the Merry walker was located in the storage area. On 7/19/16 at 5:50 p.m. RN-A provided manufacturer's recommendations for use of a Merry Walker print out from the Internet. These printed out recommendations included: "The walker is constructed of metal and weighted at the bottom and each one should be individually fitted to the resident. The height of the top frame should be at the height of the pelvis to promote good posture." However, the Merry walker R87 currently utilized was constructed of PVC pipe to which three fabric type weights with zip ties were secured to the bottom bar of the walker. In addition, it was noted the height of the top frame of the Merry walker R87 utilized was not at the height of the pelvis but above the pelvis. On 7/20/2016, at 9:33 a.m. physical therapist (PT)-A was interviewed. PT-A confirmed therapy duties included screening and treatment of residents related to transfers, balance,walking and determination of the most appropriate lifts for individual residents. PT-A stated, "[Merry walker] is not something we recommend, we want it to be functional walking with a walker or cane." PT-A identified resident considerations for use of a Merry walker would include: look safe, maintain balance and strength, have a good gait pattern and ability to propel forward without tripping. PT-A also verified that Merry walkers were able to tip over. PT-A indicated that when R87 was admitted to the facility, a quick screen to evaluate if therapy services were required was conducted. PT-A indicated that at that time services had not been determined to be needed so no physician order for treatment had been requested. PT-A confirmed R87 had not been provided therapy	2 830		

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2 830	Continued From page 27 services any time since admission (March 2015) and confirmed R87 had not been evaluated by PT for the use of the Merry walker. The facility policy titled, Falls- Clinical Protocol revised September 2012, Assessment and Recognition identified the following: #5 The staff will evaluate and document falls that occur while the individual is in the facility: for example, when and where they happen, and observations of the events, ect. Treatment/Management: #1- Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The immediate jeopardy that began on 10/24/15, and identified on 7/19/16, at 7:05 p.m, was removed on 7/20/16, at 3:30 p.m. when it could be verified by observation, record review and staff interviews, the the facility had implemented interventions including: -discontinuing the use of the Merry walker for R87 - 1:1 staffing implemented for R87 until appropriate assessments could be completed and a new safety plan initiated - the consultant pharmacist reviewed R87's medications - a PT assessment was conducted and a combination wheelchair/walker with 18" wheels for stability was ordered - PT also planned re-assessment of the new device upon arrival to determine appropriateness for R87 - a physician review was conducted - a comprehensive fall assessment was developed and staff were educated to implement appropriately; a post fall assessment, including required progress note, was created in the electronic chart to trigger a review of the care	2 830		

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2 830	Continued From page 28 plan to include modifications and review of interventions; all staff were educated either verbally, via e-mail and/or by written postings at nurses' stations; NAs, RNs, case managers, LPNs, activity staff, and PT staff were interviewed to confirm implementation of the plan. Although numerous interventions were initiated, noncompliance remained at the lower scope and severity of a G, isolated scope with severity of actual harm that is not immediate jeopardy, because the facility had failed to ensure ongoing assessment and staff compliance with identified interventions to maintain resident safety. SUGGESTED METHOD OF CORRECTION: The director of nurses' could inservice staff to ensure that assessments are conducted after each fall. A plan of care could be implemented to reduce the fall incidents. Audits could be conducted to ensure that equipment is used after assessed for safety and that falls are assessed. The results of the audits could be reported to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which	2 895		8/12/16

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2 895	Continued From page 29 provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions for identified contractures for 1 of 1 resident (R65) reviewed for range of motion (ROM.) Findings include: Review of R65's quarterly Minimum Data Set (MDS) dated 4/27/16, identified R65 had severe cognitive impairment and had diagnoses which included Parkinson's disease, Alzheimer's disease and cerebrovascular disease with hemiplegia . The MDS further identified R65 was totally dependent on staff for activities of daily living (ADL's) and had bilateral upper extremity contractures. Review of R65's annual Care Area Assessment (CAA) dated 8/19/15, identified R65 had severe cognitive impairment due to Alzheimer's disease, was totally dependent on staff for ADL's and had contractures. Review of R65's care plan print dated 2/25/16, identified R65 had bilateral contractures of the upper and lower extremities, was totally dependent on staff for all ADL's, required gentle range of motion with daily care, required gauze rolls in both hands 23/hrs/day: to be removed for	2 895	Corrected 8/12/2016 per Director of Nursing	

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2 895	Continued From page 30 30 minutes twice daily for hygiene for bilateral hand contractures. Review of R65's current physician orders signed 7/19/16, revealed an order with a start date of 10/21/2015, directed nursing staff to check R65's kerlix roll in bilateral hands for placement every shift, should have kerlix in hands at all times and additional gauze between thumb, change kerlix and gauze when soiled and as needed every shift for contractures. The orders also directed nursing staff to wash R65's hands twice daily per instruction sheet. Review of R65's provider progress note dated 5/27/16, revealed R65 had been seen for a routine visit in which R65 was assessed to have contractures which were most notably in her arms and hands. Review of R65's most recent occupational therapy (OT) assessment dated 11/17/12, revealed R65 had bilateral hand contractures which were in a fixed flexed position. The evaluation directed staff to implement ROM exercises and in hand splints for bilateral hand contractures. - R65's medical record lacked any further OT evaluations for hand contractures. Review of R65's July 2016, treatment administration record (TAR) revealed a check mark for R65's treatment of kerlix rolls in both hands three times a day. The TAR revealed a chart code legend which a check mark indicated the treatment was in place on all days. Review of R65's care conference note dated 5/17/16, revealed R65 continued to have	2 895		

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2 895	Continued From page 31	2 895		

contractures of her hands and extremities. The note further revealed staff were to continue to apply gauze to R65's hands daily. The note indicated that was to continue.

Review of R65's progress notes from 1/23/16, to 7/13/16, revealed the following:

-1/24/16, revealed R65 had contractures to bilateral hands and required vigilant monitoring and gauze rolls placed in both hands, extra care to keep R65's hands clean.

-2/5/16, revealed R65 received passive range of motion (PROM) to both upper and lower extremities due to contractures, staff continued to apply gauze rolls in both contracted hands daily.

-3/5/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's.

-4/6/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's.

-4/23/16, revealed a ADL note which identified R65 required total assistance with all ADL's due to contractures and blindness.

-4/27/16, revealed a restorative program note which identified R65 had bilateral hand contractures and staff was to put gauze rolls in both hands to help her contractures and maintain skin integrity.

-5/20/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and

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2 895	Continued From page 32 required total assistance from staff for all ADL's. -5/28/16, revealed a order administration note which revealed staff was unable to place kerlix in R65's hands due to resident not able to open her hands. R65's progress notes lacked any follow up regarding inability to place gauze in R65's hands. -5/29/16, revealed a order administration note which revealed staff was unable to place kerlix in R65's hands due to resident not able to open her hands. R65's progress notes lacked any follow up regarding inability to place gauze in R65's hands. -6/20/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. -6/27/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. -7/13/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. On 7/18/16, at 5:38 p.m. R65 was seated in a tilt in space wheelchair across from the nurses station prior to the evening meal. Both of R65's hands were held in a fisted position, elbows were bent and hands rested on her chest, right hand rested near her heart and her left hand rested on her left upper chest. R65 did not have kerlix placed in her hands. At 6:55 p.m. R65 was seated in a tilt in space wheelchair near the nurses station following the evening meal. R65 remained without kerlix/gauze in both hands. On 7/19/16, from 8:45 a.m. to 10:55 a.m. R65 was lying in bed tilted to her right side with pillows against her back, blankets were observed to	2 895		

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2 895	Continued From page 33	2 895		

cover R65 to mid torso. R65's hands were in a fisted position , arms were bent at the elbow, fisted hands rested against her chest. R65 did not have kerlix in her hands.

On 7/21/16, at 4:57 p.m. R65 was seated in a tilt in space wheelchair with both arms bent at the elbows, hands were resting on her chest and were clenched fisted position. R65's right clenched hand was resting over her heart and her left clenched hand was resting on her upper left chest, no kerlix was observed in R65's hands.

When interviewed on 7/21/16, at 5:09 p.m. registered nurse manager (RN)-A confirmed R65 did not have kerlix in her contracted hands as care planned and was unsure why the kerlix was not in use. RN-A stated the medication nurses were responsible for checking to make sure R65's kerlix were in both hands for bilateral hand contractures. RN-A stated she felt R65 hands were too contracted for the kerlix to have fallen out, nor could R65 remove the kerlix independently. RN stated R65's hands were fully contracted and had been for years. RN-A directed a licensed practical nurse (LPN)-D to apply kerlix.

On 7/21/16, at 5:13 p.m. LPN-D attempted to open R65's right hand fingers from the contracted, fisted position and apply approximately an inch in diameter cotton kerlix roll into R65's hand. R65 stated it hurt and she was hurting her fingers, LPN-D immediately stopped opening R65's hand. At that time, LPN-D stated there were times when R65's hands needed to be soaked in warm water to help open the hands up. RN-A and NA-B then wheeled R65's to her room and NA-B wheeled R65 into her bathroom, while RN-A started to run the water out of the faucet. NA-B took R65's right hand,

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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) COMPLETE DATE
2 895	Continued From page 34 held it under the warm water while RN-A slowly opened R65's hand, washed, dried and applied the kerlix. NA-B then took R65's left hand, held it under the water while RN-A opened R65's hand, washed, dried and applied another roll of kerlix. NA-B assisted R65 back out of the bathroom in her wheelchair and wheeled R65 back to nursing station. On 7/21/16, at 5:12 p.m. NA-B stated R65 was supposed to have the kerlix in both of her hands at all times. NA-B stated the nurses usually put them in after R65's hands were washed. NA-B stated she felt about 3-4 times a week R65's kerlix were not in her hands and she would then place the kerlix into R65's hands and often had a hard time doing so. NA-B further stated she felt R65's hands were fisted very tightly so the kerlix could not fall out and she felt R65 would be unable to remove the kerlix herself. NA-B stated she felt R65's hands had not worsened over the last few years. On 7/22/16, at 10:23 a.m. NA-C stated R65 required total assistance with all ADL's, NA-C stated on average a few days a week R65 would not have the cloth rolls, (kerlix) in her hands and NA-C would then place the kerlix in R65's contracted hands. On 7/22/16, at 10:37 a.m. RN-A stated R65 had not had a recent occupational therapy evaluation, though had one a few years ago which identified R65 had complete contractures of both hands. RN-A confirmed R65's current physician orders directed nursing staff to ensure R65 had kerlix placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document	2 895		

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2 895	Continued From page 35 the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated R65 had fully contracted hands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing (DON) stated she expected physician orders and resident care plans to be implemented. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. Review of a facility policy titled, Restorative Nursing Program reviewed 5/2011, revealed a facility procedure to promote each residents highest practicable well being. A policy was requested regarding following physician orders, treatments and contractures; none were provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding implementation of the care plan to include completing range of motion as directed, and then audit to ensure compliance. The results could be reviewed as part of the overall quality assurance committee plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the	2 920		8/9/16

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2 920	Continued From page 36 comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral care and removal of facial hair for 2 of 3 residents (R78, R28) reviewed who were dependent upon staff for grooming and personal cares. Findings include: R78's admission Minimum Data Set (MDS) dated 7/1/16, identified R78 was moderately cognitively impaired, required extensive assistance for all areas of daily living (ADL)with exception of limited assistance to walk in corridor and diagnoses which included Parkinson's disease, dementia, arthritis and vision impairment. R78's undated care plan, identified R78 had a self care deficit related to Parkinson's Disease, hypertension, diabetes, and dementia as evidenced by requiring assist with ADL's -The resident requires extensive assist of 1 staff with personal hygiene. The undated resident care sheet, indicated R78 required assist of one staff with dressing and grooming. On 7/19/16, at 9:28 a.m. R78 stated, " I can't shave because of my Parkinson, that is one thing they are a little lax on." At this time R78 has	2 920	Corrected 8/9/2016 per Director of Nursing	

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2 920	Continued From page 37 stubble on chin and upper lip. On 7/20/16, at 7:57 a.m. R78 was propelled from his room to the dining room by nursing assistant (NA)-H. R78 had facial hair stubble on the upper lip and chin area. On 7/20/16, at 1:00 p.m. R78 was seated in his room in a stationary chair in front of the television. R87 remained unshaven. On 7/21/16, at 9:26 a.m. R78 was seated in room dressed, has not had face shaved, mustache and beard heavy stubble. On 7/20/16, at 8:51 a.m. NA-H indicated R78 tries to shave independently and will ask staff when he needs help. NA-H indicated R78 was new to the facility and NA-H was unsure of whether R78 had behaviors or refused cares. When interviewed on 7/20/16, at 1:00 p.m. R78 verified if he was able to shave himself he would do it every day. R78 stated staff will shave his face each morning when they get him up with an electric razor but some times they forget. R78 verified his facial hair had not been shaved off today and was unable to recall when staff last shaved him. On 7/20/16, at 1:17 p.m. NA-I identified R78 had no behaviors and did occasionally refuse to go for a walk, however, it was usually for a reason, for example if his wife was here or if he was having pain in his hip. On 7/21/16, at 9:54 a.m. NA-E indicated R78 was unable to shave independently due to shaky hands. NA-E verified he/she had not shaved R78 this a.m. NA-E indicated R78 refused the offer to	2 920		

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2 920	Continued From page 38 shave this a.m. and had a routine of shaving only "every so often." On 7/21/16, at 11:00 a.m. NA-F verified R78 had a good memory and what he says is accurate. NA-F indicated he/she did not provide cares for R78 often, however, did believe R78 was usually clean shaven. NA-F indicated staff usually assisted R78 with oral care and shaving. NA-F sated, " We would normally shave a person if they can't themselves." On 7/21/16, at 11:04 a.m. R78 verified he was not shaved this morning. R78 stated, " it (facial hair) isn't so hard to get off" if he is shaved every day. R78 further identified with a clean shaven face it was easier to keep clean as things get caught, stating "I drool." On 7/21/16, at 11:13 a.m. licensed practical nurse (LPN)-E verified R78 had facial stubble and had not been shaved. On 7/21/2016, at 11:14 a.m. registered nurse (RN)-A verified R78 required assistance with ADL's due to has Parkinson's Disease and although his abilities change from day to day, R78 was not able to shave independently with an electric razor. RN-A identified staff were expected to shave male residents daily and would not expect residents to have to ask for the assistance. When interviewed on 7/22/16, at 11:25 a.m. the director of nursing (DON) verified the expectation that staff follow the care plan and residents who require assistance with ADL's be provided the care and not expected to ask for assistance. The requested facility personal hygiene policy	2 920		

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2 920	Continued From page 39 was not provided. R28's quarterly Minimum Data Set (MDS) dated 6/15/16, identified R28 was moderately cognitively impaired and diagnoses which included: Alzheimer's, psychotic disorder and arthritis. The MDS indicated R28 required extensive assistance for completion of personal hygiene tasks. R28's care plan dated 7/15/16, identified R28 required extensive assistance to total assistance with personal hygiene and oral cares. The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 mouth swab and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed. The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28. The nursing oral assessment dated 6/13/16, indicated R28 had no natural teeth or tooth fragments, and indicated R28 chose not to wear dentures. The assessment identified R28 had a chewing and swallowing problem and received a pureed diet. During observation of morning cares on 7/20/16, from 8:23 a.m. to 8:54 a.m. NA-A and NA-G assisted R28 with personal cares which included washing her face, perineal cares and dressing. During the observation, R28 was not assisted nor offered the opportunity for completion of oral cares. R28's oral cavity and lips appeared very dry.	2 920		

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2 920	Continued From page 40 -At 8:57 a.m. NA-A assisted R28 with breakfast while R28 was positioned in bed. R28 was not wearing any dentures, and R28 refused the breakfast food items and juice offered. R28 did consume the strawberry supplement. -At 9:01 a.m. NA-A gathered the breakfast tray, shut off the bedroom lights and stated some days are good with feeding, and some days are not, just like today. NA-A then delivered the breakfast tray to the kitchen, R28 was not assisted nor offered the opportunity for completion of oral cares. During interview on 7/20/16, at 8:45 a.m. NA-A reported R28 no longer wears dentures, and stated she was going to wait until after R28 ate breakfast to provide oral cares which included swabbing out the mouth with a toothette. At 9:07 a.m. NA-A confirmed R28 had finished with the breakfast meal and confirmed she had completed morning cares for R28. NA-A verified she did not complete nor offer oral cares which included swabbing the mouth with a toothette or mouthwash. Further, NA-A confirmed she did not inspect her mouth with cares. During interview on 7/21/16, at 10:35 a.m. RN-B confirmed R28 no longer wore dentures. RN-B verified staff are expected to swab R28's mouth with morning cares, or at least attempting as R28 will at times refuse. RN-B confirmed R28 has a dry mouth and sleeps with the oral cavity open, therefore, oral care must be attempted. During interview on 7/22/16, at 10:08 a.m. the DON confirmed staff are expected to provide or offer oral cares to all resident twice per day as indicated on the care plan.	2 920		

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2 920	Continued From page 41 The facility's Mouth Care Policy dated October 2010, directed staff to review the resident's care plan for any special needs of the resident. and assemble the equipment and supplies as needed. The purpose is to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the implementation of the care plan related to the provision of oral hygiene and shaving of facial hair. The DON or designee, could provide training for all nursing staff related to providing the services. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the cleanliness of the walk-in cooler to promote sanitation and food safety in the main kitchen. This practice had the potential to affect all 80 who	21015	Corrected 8/11/2016 per Certified Dietary Manager	8/11/16

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21015	Continued From page 42 received food from the kitchen. Findings include: During the initial kitchen tour with cook (C)-A on 7/18/16, at 1:14 p.m. it was noted the outside of the walk-in refrigerator was wet. The frame of the door to the refrigerator had a thick layer of white frost and the stainless steel door frame had a dark brown substance evident when opened. A strong sour odor and garbage smell was evident inside the unit. Along the south wall of the cooler there was a significant number of irregular shaped areas of black colored substance located between the second and third shelves. Fresh vegetables (leaf lettuce, cabbage, spinach and tomatoes) were stored on these shelves. The tomatoes and leaf lettuce were open to air, without any covering of these food items. Throughout the entire unit large areas of missing and chipped paint were noted. It appeared the interior walls of the walk-in cooler had been silver but the walls had been painted a white color. This was evident as the paint was peeling from the interior walls. Located adjacent to the shelves of stored vegetables were stored fresh oranges and apples. These fruit items were next to the areas of the dark colored substance. On 7/21/16, at 1:55 p.m. dining director (DD) stated she had a designated staff person, dietary aid (DA)-A who cleaned the walk-in cooler on Monday which included the walls but if not completed, the cooks clean the walls of this refrigerator. DD stated DA-A worked this past Monday and should have cleaned the walls as she saw DA-A in the unit. DD stated if any kitchen equipment required any repairs, a work order would be entered into the computer. The DD confirmed the most recent work order entered had been related to a storage pallet sent last	21015		

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21015	Continued From page 43 week. It was observed on 7/21/16, at 2:05 p.m. that C-A was placing groceries onto the shelves located in the walk-in cooler/refrigerator when the DD and the surveyor re-entered the unit to confirm the presence of the mold identified on 7/18/16. C-A and DD indicated the humidity level was so high in the walk-in cooler that the refrigerator unit could not keep up with the excessive humidity. C-A stated it had been discussed with the maintenance manager (MM) approximately a week ago, indicating the door seal was not working properly. The MM had confirmed the broken gray seal had separated from the door, thus not working properly to maintain the conditions inside the cooler. The MM stated he was responsible for cleaning the door seals and confirmed that mold was evident along the door frame. He stated they just had to be careful to make sure the door was shut tight but verified the door was sweating and consequently, moisture was evident due to the broken seal and the humidity level. When C-A removed the shelving away from the wall, both C-A and DD confirmed there was black colored mold extending across the length of the shelving and down the entire length of the wall. It extended from above the level of the second shelf down to the floor. There were several irregular shaped black colored mold patches and streaks on the wall with several, up to 1-1/2 inches around or long. DD wiped a large black patch of the black substance with her fingers. A dark residue remained on her fingers. Both C-A and DD confirmed a strong odor was evident while in the cooler. C-A stated they did not have baking soda in the cooler anymore, but used to use it to control the odor. C-A also confirmed there was standing liquid in front of the shelf where a pork roast was thawing in a	21015		

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21015	Continued From page 44	21015		

cardboard box. He confirmed the frozen roast had leaked liquid onto the floor during thawing. C-A indicated both the pork and fish tend to leak onto the floor. C-A stated they have a galvanized floor in the walk-in cooler, which was damaged and had rusted. He confirmed the floor had significant rust located in front of the meat thawing rack which extended approximately 6 in. from the rack.

On 7/21/16, at 2:10 p.m. C-A removed the vegetables from the shelving and placed them on top of a stainless steel cart located in the cooler. It was observed that C-A was inside the walk-in cooler on his knees and had a small white plastic bucket containing bleach solution and a cleaning rag. C-A indicated he had never washed the walls inside the cooler, and was unsure of the last time it had been washed. He stated the black substance was present due to the high humidity level in the cooler. C-A indicated he had never noticed the black substance substance until the surveyor made them aware. As C-A wiped the black substance off the wall of the cooler with the bleach solution, gray colored water ran down the wall as it was washed.

On 7/21/16, at 3:45 p.m. DA-A stated she was scheduled to clean on Mondays from 9-11:30 a.m. but confirmed she had not washed the walls inside the walk-in cooler this past Monday during her scheduled hours. DA-A verified she doesn't wash the wall and was unsure how long it's been since they had been washed. She was unsure who was assigned this cleaning task and indicated only recently started sanitizing the shelf racks. DA-A explained she only conducted random checks of the cooler cleanliness as she had too many other tasks. DA-A stated she had noticed the black substance on the racks in the

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21015	Continued From page 45 past but was unsure how the mold returned as bleach kills it. When interviewed on 7/21/16, at 5:30 p.m. the MM and the administrator (A) confirmed they were unaware of the black substance in the walk-in cooler and agreed they needed to develop a system, procedure and cleaning schedule for the walk-in cooler. The administrator stated staff need to remove all of the food items and wash/clean the unit, including the shelves prior to returning the stored food items. Review of the undated facility policy, Sanitation of the Food Service Department identified the food service staff shall maintain the sanitation of the food service department through compliance with the cleaning schedule. Review of the dietary cleaning schedule , dated 4/08 identified refrigerators would be cleaned weekly. SUGGESTED METHOD OF CORRECTION: The dietary manager (DM) could develop policies and procedures regarding safe storage of foods. This could include a system for notification and repair of equipment in a timely manner. The DM could educate all appropriate staff on these policies. The DM could develop monitoring systems to ensure ongoing compliance and report to the quality assurance committee the audits conducted to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance	21685		8/11/16

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21685	Continued From page 46 Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: On 7/18/216, at 1:14 p.m. during the initial kitchen tour with cook (C)-A it was noted that the floor covering underneath and surrounding the affixed steamer and oven located in the food preparation area had an area of missing maroon floor tile, which measured approximately 18 inches (in) by 18 in. The area was filled with dark and light gray dust and dirt particles. In addition, there was another irregular shaped area directly under the steamer and next to the missing tile area that was a dark brown, sticky, sludge material which measured approximately 6 in by 4 in. The entire floor in the food preparation area was soiled with food particles and dirty. On 7/21/16, at 1:55 p.m. the dining director (DD) confirmed the damage and dirty kitchen floor. She indicated the floor had steadily gotten worse	21685	Corrected 8/11/2016 per Certified Dietary Manager	

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21685	Continued From page 47 this past year. DD also stated the floor is old and needed to be replaced. DD indicated they had purchased another oven, moved equipment around and had problems with water leaking from the steamer which caused the floor damage. DD stated the brown sticky substance was not grease but was compacted food material, dirt and grime. She confirmed the floor was no longer a cleanable surface, thus dirty. She stated housekeeping staff scrubbed the floor every other week, otherwise dietary was responsible for washing the floor. On 7/21/16, at 5:30 the maintenance manager (MM) and the administrator (A) confirmed the condition of the damaged floor tile and the dirty floor. MM knelt to the floor, wiped his hand across the area and visible gray dust was evident on his hand. MM and A confirmed the floor surface need to be repaired and/or replaced and agreed the damaged tile surface was unclean. MM and A confirmed a dark brown sticky material was evident on the floor behind steamer and stated it would be cleaned. Review of the undated facility policy, Sanitation of the Food Service Department identified the food service staff shall maintain the sanitation of the food service department through compliance with the cleaning schedule. SUGGESTED METHOD FOR CORRECTION: The administrator or designee could ensure all identified kitchen environmental concerns are corrected and monitored on an ongoing basis for good repair and resident satisfaction. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21)	21685		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00108	A. BUILDING: _____ B. WING _____	07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21685	Continued From page 48 days.	21685		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this	21980		8/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00108	A. BUILDING: _____ B. WING _____	07/22/2016

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21980	Continued From page 49 subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure injuries of unknown origin were reported to the State agency (SA) for 1 of 3 residents (R87) reviewed. Findings include: R87's annual Minimum Data Set (MDS) dated 5/11/16, identified long and short term memory problems with no recall ability, was rarely to never understood and required extensive assistance for all areas of daily living (ADL). The facility form titled Order Summary Report signed by the physician dated 6/27/16, identified R87's medical diagnoses to include dementia with Lewy Bodies, Parkinson's disease, and anxiety disorders. R87's care plan reviewed 7/13/16, indicated,"The resident is dependent upon staff etc. for emotional, intellectual, physical and social needs r/t [related to] Lewy Bodies, Physical Limitations" The care plan further indicated "The resident has physically abusive behaviors r/t dementia with	21980	Corrected per Director of Nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00108	A. BUILDING: _____ B. WING _____	07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21980	Continued From page 50 Lewy Bodies, unspecified psychosis". A review of R87's nursing progress notes identified the following : -10/24/15-"Data: resident tipped merry walker over sideways and was found face down on floor, unable to move. Resident hit head/mouth on floor. residents mouth was bleeding from loosing a tooth. no one seen [sik] the incident so we don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift." -10/26/15," IDT (interdisciplinary team) review of fall from 10/24/15, Resident tipped over merry walker and landed on her face. Received a small abrasion under [R87's] nose and lost a tooth as a result of the fall." Study results of an x-ray (CT) of R87's brain dated 10/26/15, identified the following Clinical information: [R87] presents with a fall, initial encounter. Nurse states -facial pain with more confusion than usual. Conclusion: Nondisplaced fracture thorough the anterior superior most maxilla (upper jaw) at the base of the nose. Review of the facility form titled 2015 Vulnerable Adult Incident Log, which logged the facility reports to the SA, indicated a report had not been submitted related to R87's fractured jaw from an unwitnessed fall on 10/24/15. On 7/22/16, at 11:28 a.m. the director of nursing (DON) verified a report had not been submitted to the SA when R87 had an unwitnessed fall on 10/24/15. The DON indicated she had not considered it a major injury at the time because it was unknown that R87 had a fractured jaw until a day or two after the fall occurred. The DON verified she had not considered to report to the state agency when it became known that R87	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21980	Continued From page 51 had a fractured jaw from the fall; however, would typically report an injury related to an unwitnessed fall when the resident is not cognitively intact. When interviewed on 7/22/16, at 1:10 p.m. the social services director (SSD) verified the responsibility of oversight for abuse prevention and reporting to the SA. SSD indicated training had been completed for many staff to submit VA reports to OHFC (Office of Health Facility Complaints)/MAARC (Minnesota Adult Abuse Reporting Center) including nurse managers, social services and nurses who worked the floor. SSD indicated the initial report was to be made immediately for alleged or suspected abuse, neglect, exploitation, and all things that fall under the facility vulnerable adult (VA) policy. When given the scenario of an unwitnessed fall of a cognitively impaired resident resulting in a fracture, SSD stated "I would have to look at the guidelines." When reviewed on SSD's lap top computer and the incident included no observation, resident unable to explain and the resulting injury; SSD responded, "I would think so" regarding R87's fractured jaw due to an unwitnessed fall. SSD indicated the facility staff had discussed the incident and had not found it to be a reportable incident. SSD verified the usual procedure for reporting an injury of unknown origin by reading aloud the facility policy: An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury. SSD request more time to review the electronic record before answering any more questions.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21980	Continued From page 52 On 7/22/16, at 1:56 p.m. SSD identified R87's fall had been reviewed with the interdisciplinary team (IDT) and stated,"we didn't think it was a serious injury." SSD further explained the fractured jaw did not result in a hospitalization or affect R87's quality of life; therefore it was not a serious injury. When interviewed on 7/22/16, at 1:56 p.m. the administrator indicated the report would be brought to the Quality Assurance meeting to review procedures for reporting. The facility policy titled Ecumen's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities updated 7/2015, identified " An injury is considered an injury of unknown source and must be reported when both of the following conditions are present (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure injuries of unknown origin are reported to the state agency (SA) immediately. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance.	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21980	Continued From page 53 TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21980		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement abuse policies and procedures to include consistent, immediate reporting of injuries of unknown origin to the State Agency (SA) for 1 of 3 residents (R87) reviewed. Findings include: The facility policy titled Ecumen's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities updated 7/2015, identified " An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the	21995	Corrected per Director of Nursing	8/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21995	Continued From page 54	21995		

injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time."

R87's annual Minimum Data Set (MDS) dated 5/11/16, identified long and short term memory problems with no recall ability, was rarely to never understood and required extensive assistance for all areas of daily living (ADL). The facility form titled Order Summary Report signed by the physician dated 6/27/16, identified R87's medical diagnoses to include dementia with Lewy Bodies, Parkinson's disease, and anxiety disorders.

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A review of R87's nursing progress notes identified the following :
-10/24/15-"Data: resident tipped merry walker over sideways and was found face down on floor, unable to move. Resident hit head/mouth on floor. residents mouth was bleeding from loosing a tooth. no one seen [sik] the incident so we don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift."
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21995	Continued From page 55	21995		

a fall, initial encounter. Nurse states -facial pain with more confusion than usual. Conclusion: Nondisplaced fracture thorough the anterior superior most maxilla (upper jaw) at the base of the nose.

Review of the facility form titled 2015 Vulnerable Adult Incident Log, which logged the facility reports to the SA, indicated a report had not been submitted related to R87's fractured jaw from an unwitnessed fall on 10/24/15.

On 7/22/16, at 11:28 a.m. the director of nursing (DON) verified a report had not been submitted to the SA when R87 had an unwitnessed fall on 10/24/15. The DON indicated she had not considered it a major injury at the time because it was unknown that R87 had a fractured jaw until a day or two after the fall occurred. The DON verified she had not considered to report to the state agency when it became known that R87 had a fractured jaw from the fall; however, would typically report an injury related to an unwitnessed fall when the resident is not cognitively intact.

When interviewed on 7/22/16, at 1:10 p.m. the social services director (SSD) verified the responsibility of oversight for abuse prevention and reporting to the SA. SSD indicated training had been completed for many staff to submit VA reports to OHFC (Office of Health Facility Complaints)/MAARC (Minnesota Adult Abuse Reporting Center) including nurse managers, social services and nurses who worked the floor. SSD indicated the initial report was to be made immediately for alleged or suspected abuse, neglect, exploitation, and all things that fall under the facility vulnerable adult (VA) policy. When given the scenario of an unwitnessed fall of a cognitively impaired resident resulting in a

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21995	Continued From page 56	21995		

fracture, SSD stated "I would have to look at the guidelines." When reviewed on SSD's lap top computer and the incident included no observation, resident unable to explain and the resulting injury; SSD responded, "I would think so" regarding R87's fractured jaw due to an unwitnessed fall. SSD indicated the facility staff had discussed the incident and had not found it to be a reportable incident. SSD verified the usual procedure for reporting an injury of unknown origin by reading aloud the facility policy: An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury. SSD request more time to review the electronic record before answering any more questions.

On 7/22/16, at 1:56 p.m. SSD identified R87's fall had been reviewed with the interdisciplinary team (IDT) and stated,"we didn't think it was a serious injury." SSD further explained the fractured jaw did not result in a hospitalization or affect R87's quality of life; therefore it was not a serious injury.

When interviewed on 7/22/16, at 1:56 p.m. the administrator indicated the report would be brought to the Quality Assurance meeting to review procedures for reporting.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure injuries of unknown origin are reported to the state agency (SA) immediately. The director of nursing (DON) or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

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21995	Continued From page 57 designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21995		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WIMT

Facility ID: 00108

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245434**
2.STATE VENDOR OR MEDICAID NO.
(L2) **568340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY HOME**
(L4) **1020 LARK STREET**
(L5) **ALEXANDRIA, MN** (L6) **56308**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **09/13/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **83** (L18)
13.Total Certified Beds **83** (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
	83			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Denise Erickson, HFE NEII 09/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 10/27/2016 (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
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/01/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5434

On September 13, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 9, 2016, the Department of Public Safety completed a PCR to verify the facility had achieved and maintained substantial compliance with deficiencies issued pursuant to the July 22, 2016 extended survey. We presumbed based on the facility's plan of correction that the facility had corrected these deficiencies as of September 1, 2016. We have determined based on our visit that the facility has corrected the deficiencies pursuant to the extended survey completed July 22, 2016, as of September 1, 2016.

As a result of the revisit findings, this Department is discontinuing the Category 1 remedy of State monitoring as of Septemer 1, 2016.

In addition, this Department recommended the following action to the CMS Region V Office as it relates to the remedy imposition in our letter of September 26, 2016:

Civil money penalty for the deficiency cited at F323 (S/S=J), remain in effect. (42 CFR 488.430 through 488.444)

Futher, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bethany Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 22, 2016.

Refer to the CMS 2567b forms for both health and life safety code.

Effective September 1, 2016, the facility is certified for 83 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245434

October 27, 2016

Mr. Matthew Fischer, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

Dear Mr. Fischer:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective September 1, 2016 the above facility is certified for:

83 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 83 skilled nursing facility beds.

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

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 26, 2016

Mr. Matthew Fischer, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

RE: Project Number S5434025

Dear Mr. Fischer:

On August 5, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective August 10, 2016. (42 CFR 488.422)

On August 5, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F323 (S/S=J). (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on July 22, 2016. Conditions in the facility at the time of the extended survey constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health or safety. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On September 13, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 6, 2016 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 an extended survey, completed on July 22, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 1, 2016. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on July 22, 2016, as of September 1, 2016.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective September 1, 2016.

However, as we notified you in our letter of August 5, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from July 22, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedy in our letter of August 5, 2016:

- Civil money penalty for deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)

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

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245434 Y1	A. Building B. Wing Y2	9/13/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0282	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	08/09/2016	LSC	08/09/2016	LSC	08/09/2016
ID Prefix F0312	Correction	ID Prefix F0318	Correction	ID Prefix F0323	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(e)(2)	Completed	Reg. # 483.25(h)	Completed
LSC	08/12/2016	LSC	08/12/2016	LSC	08/12/2016
ID Prefix F0334	Correction	ID Prefix F0371	Correction	ID Prefix F0456	Correction
Reg. # 483.25(n)	Completed	Reg. # 483.35(i)	Completed	Reg. # 483.70(c)(2)	Completed
LSC	08/30/2016	LSC	08/11/2016	LSC	08/11/2016
ID Prefix F0465	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(h)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/11/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	GA/mm	09/26/2016	31256	09/13/2016
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/22/2016

[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245434 Y1	A. Building 01 - NURSING HOME B. Wing Y2	9/6/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0018	08/02/2016	LSC	K0025	08/10/2016	LSC	K0027	08/10/2016
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0062	08/30/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	09/26/2016	36536	09/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/21/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245434	A. Building 02 - SUB ACUTE B. Wing	9/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 09/01/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [x]	REVIEWED BY (INITIALS) TL/mm	DATE 09/26/2016	SIGNATURE OF SURVEYOR 36536	DATE 09/26/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/21/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245434	A. Building 03 - CHAPEL AREA B. Wing	9/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 09/01/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY [X]	REVIEWED BY (INITIALS) TL/mm	DATE 09/26/2016	SIGNATURE OF SURVEYOR 36536	DATE 09/26/2016
REVIEWED BY CMS RO [ ]	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/21/2016	[ ] CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? [ ] YES [ ] NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245434	A. Building 04 - 2012 RENOVATED AREA B. Wing	9/6/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0051	Correction Completed 08/10/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 09/01/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TL/mm	09/26/2016	36536	09/26/2016~
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/21/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 26, 2016

Mr. Matthew Fischer, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

Re: Reinspection Results - Project Number S5434025

Dear Mr. Fischer:

On September 13, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on July 22, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00108 Y1	A. Building B. Wing Y2	9/13/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565	Correction	ID Prefix 20830	Correction	ID Prefix 20895	Correction
Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0525 Subp. 2.B	Completed
LSC	08/09/2016	LSC	08/12/2016	LSC	08/12/2016
ID Prefix 20920	Correction	ID Prefix 21015	Correction	ID Prefix 21685	Correction
Reg. # MN Rule 4658.0525 Subp. 6 B	Completed	Reg. # MN Rule 4658.0610 Subp. 7	Completed	Reg. # MN Rule 4658.1415 Subp. 2	Completed
LSC	08/12/2016	LSC	08/11/2016	LSC	08/11/2016
ID Prefix 21980	Correction	ID Prefix 21995	Correction	ID Prefix	Correction
Reg. # MN St. Statute 626.557 Subd. 3	Completed	Reg. # MN St. Statute 626.557 Subd. 4a	Completed	Reg. #	Completed
LSC	08/09/2016	LSC	08/09/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	GA/mm	09/26/2016	31256	09/13/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 7/22/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245434	BETHANY HOME

Type of Survey (select all that apply):

D	K				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 31223	09-12-2016	09-13-2016	1.00	0.00	15.25	0.00	9.50	0.00
2. Team Leader 31256	09-12-2016	09-13-2016	0.75	1.00	13.75	0.00	3.25	0.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

	1.50
Total Supervisory Review Hours	0.00
Total Clerical/Data Entry Hours.....	3.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	N

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245434	BETHANY HOME

Type of Survey (select all that apply):

D	H				

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 36536	09-06-2016	09-06-2016	0.25	0.00	0.50	0.00	0.75	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25 0.00

Total Clerical/Data Entry Hours..... 0.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: WIMT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00108

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245434**
2.STATE VENDOR OR MEDICAID NO.
(L2) **568340800**

3. NAME AND ADDRESS OF FACILITY
(L3) **BETHANY HOME**
(L4) **1020 LARK STREET**
(L5) **ALEXANDRIA, MN** (L6) **56308**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/22/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **83** (L18)
13.Total Certified Beds **83** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	83			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Beth Nowling, HFE NEII 08/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 09/01/2016 (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
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/01/2016
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5434

On July 22, 2016, an extended survey was completed at this facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. The facility was not in substantial compliance and the conditions in the facility constituted both substandard quality of care (SQC) and immediate jeopardy (IJ) to resident health or safety. The Department verified the condition resulting in our notification of immediate jeopardy has been removed.

As a result of the survey findings, this Department is the facility has not been given an opportunity to correct and the following Category 1 remedy was imposed:

State Monitoring effective August 10, 2016. (42 CFR 488.422)

In addition, this Department recommended the following enforcement remedy to the CMS Region V office for imposition:

Civil money penalty for the deficiency cited at F323 (S/S=J). (42 CFR 488.430 through 488.444)

Futher, Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bethany Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 22, 2016. Refer to the CMS 2567 forms for both health and life safety code, along with the facility's plan of correction. Post Certification Revisit (PCR) to follow.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 5, 2016

Mr. Matthew Fischer, Administrator
Bethany Home
1020 Lark Street
Alexandria, Minnesota 56308

RE: Project Number S5434025

Dear Mr.. Fischer:

On July 22, 2016, an extended survey was completed at your facility by the Minnesota Department of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. I

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

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

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

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate

jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on July 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Pam Kerssen, RN, APM
Minnesota Department of Health
1505 Pebble Lake Road #300
Fergus Falls, Minnesota 56537
Phone: (218) 308-2127
email: pam.kerssen@state.mn.us

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective August 10, 2016. (42 CFR 488.422)

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

• Civil money penalty for the deficiency cited at F323 (S/S=J). (42 CFR 488.430 through 488.444)

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Bethany Home is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective July 22, 2016. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

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

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

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

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated

in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by October 22, 2016 (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 January 22, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Mark Meath, Enforcement Specialist
Proggram Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: (651) 201-4118 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
	245434	A. BUILDING _____ B. WING _____	07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	1020 LARK STREET ALEXANDRIA, MN 56308

(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 A survey was conducted by the Minnesota Department of Health on July 18,2016 through July 22, 2016. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to comprehensively assess and effectively implement fall interventions for a Merry walker which resulted in the high potential for harm or death. The IJ began October 24, 2015 and was removed on July 20, 2016 at 3:30 p.m. As a result of identification of the IJ at F323, an extended survey was conducted by the Minnesota Department of Health on July 21 and 22, 2016. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment	F 225		8/9/16

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

Electronically Signed | 08/12/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1 of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure injuries of unknown origin were reported to the State agency (SA) for 1 of 3 residents (R87) reviewed. Findings include:	F 225	This plan of correction is submitted solely to comply with all applicable state and Federal regulatory requirements. These written responses do not constitute an Admission of non-compliance with any requirements nor an agreement with any	

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F 225	Continued From page 2 R87's annual Minimum Data Set (MDS) dated 5/11/16, identified long and short term memory problems with no recall ability, was rarely to never understood and required extensive assistance for all areas of daily living (ADL). The facility form titled Order Summary Report signed by the physician dated 6/27/16, identified R87's medical diagnoses to include dementia with Lewy Bodies, Parkinson's disease, and anxiety disorders. R87's care plan reviewed 7/13/16, indicated,"The resident is dependent upon staff etc. for emotional, intellectual, physical and social needs r/t [related to] Lewy Bodies, Physical Limitations" The care plan further indicated "The resident has physically abusive behaviors r/t dementia with Lewy Bodies, unspecified psychosis". A review of R87's nursing progress notes identified the following : -10/24/15-"Data: resident tipped merry walker over sideways and was found face down on floor, unable to move. Resident hit head/mouth on floor. residents mouth was bleeding from loosing a tooth. no one seen [sik] the incident so we don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift." -10/26/15," IDT (interdisciplinary team) review of fall from 10/24/15, Resident tipped over merry walker and landed on her face. Received a small abrasion under [R87's] nose and lost a tooth as a result of the fall." Study results of an x-ray (CT) of R87's brain dated 10/26/15, identified the following Clinical information: [R87] presents with a fall, initial encounter. Nurse states -facial pain with more confusion than usual. Conclusion: Nondisplaced fracture thorough the anterior	F 225	Findings. It is the policy of Ecumen Bethany Home that each resident receives and the facility provides the necessary care and services to attain or maintain the highest practicable physical mental and psychosocial wellbeing in accordance with the comprehensive assessment and plan of care. To assure continued compliance the following plan has been implemented. • Regarding cited residents: F225 Investigate Report allegations/individuals Per Abuse Prevention policy: An injury is considered an injury of unknown source and must be reported when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident. A. For R87 any further falls that result in a serious injury of unknown source that is unwitnessed and the resident is not able to explain, shall be reported to OHFC immediately per the abuse policy. B. All residents that are identified at risk for falls could be affected by not reporting immediately. For all incidents that result in a serious injury that are unwitnessed and the resident is not able to explain shall be reported to OHFC immediately per the abuse policy. C. Education to all licensed staff and individuals responsible for reporting provided on 8-9-16 via email. The education includes the Abuse and	

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F 225	Continued From page 3 superior most maxilla (upper jaw) at the base of the nose. Review of the facility form titled 2015 Vulnerable Adult Incident Log, which logged the facility reports to the SA, indicated a report had not been submitted related to R87's fractured jaw from an unwitnessed fall on 10/24/15. On 7/22/16, at 11:28 a.m. the director of nursing (DON) verified a report had not been submitted to the SA when R87 had an unwitnessed fall on 10/24/15. The DON indicated she had not considered it a major injury at the time because it was unknown that R87 had a fractured jaw until a day or two after the fall occurred. The DON verified she had not considered to report to the state agency when it became known that R87 had a fractured jaw from the fall; however, would typically report an injury related to an unwitnessed fall when the resident is not cognitively intact. When interviewed on 7/22/16, at 1:10 p.m. the social services director (SSD) verified the responsibility of oversight for abuse prevention and reporting to the SA. SSD indicated training had been completed for many staff to submit VA reports to OHFC (Office of Health Facility Complaints)/MAARC (Minnesota Adult Abuse Reporting Center) including nurse managers, social services and nurses who worked the floor. SSD indicated the initial report was to be made immediately for alleged or suspected abuse, neglect, exploitation, and all things that fall under the facility vulnerable adult (VA) policy. When given the scenario of an unwitnessed fall of a cognitively impaired resident resulting in a fracture, SSD stated "I would have to look at the guidelines." When reviewed on SSD's lap top	F 225	Prevention policy specifically in regards to reporting serious injuries of unknown origin due to unwitnessed falls and the resident not able to explain what happened. Nursing incident check list that now includes reporting serious injuries of unknown origin to OHFC, and education on the use of the Federal Long Term Care Report ability Under F225 injuries of unknown source. Face to face meetings were also held the week of 8-8-16 to provide education on reporting injuries of unknown origin. The policy, checklist and algorithm will be review at an all staff meeting on 8-23-16 as an additional education opportunity. D. Audits will be completed on all falls beginning 8-9-16 to assure any serious injury of unknown origin is reported to OHFC per policy. Audits will be completed after each reported fall for 4 weeks to assure compliance with the Abuse Prevention policy. E. Completion date 8-9-20-16. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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F 225	Continued From page 4	F 225		

computer and the incident included no observation, resident unable to explain and the resulting injury; SSD responded, "I would think so" regarding R87's fractured jaw due to an unwitnessed fall. SSD indicated the facility staff had discussed the incident and had not found it to be a reportable incident. SSD verified the usual procedure for reporting an injury of unknown origin by reading aloud the facility policy: An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury. SSD request more time to review the electronic record before answering any more questions.

On 7/22/16, at 1:56 p.m. SSD identified R87's fall had been reviewed with the interdisciplinary team (IDT) and stated,"we didn't think it was a serious injury." SSD further explained the fractured jaw did not result in a hospitalization or affect R87's quality of life; therefore it was not a serious injury.

When interviewed on 7/22/16, at 1:56 p.m. the administrator indicated the report would be brought to the Quality Assurance meeting to review procedures for reporting.

The facility policy titled Ecumen's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities updated 7/2015, identified " An injury is considered an injury of unknown source and must be reported when both of the following conditions are present
(1) The source of the injury was not observed by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 5 any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time."	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement abuse policies and procedures to include consistent, immediate reporting of injuries of unknown origin to the State Agency (SA) for 1 of 3 residents (R87) reviewed. Findings include: The facility policy titled Ecumen's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities updated 7/2015, identified " An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the	F 226	F226 Develop/Implement abuse/neglect etc. policies The facility does have a policy for reporting injury of unknown origin. Per Abuse Prevention policy: An injury is considered an injury of unknown source and must be reported when the source of the injury was not observed by any person or the source of the injury could not be explained by the resident. A. For R87 any further injury of unknown origin per policy will be reported and reviewed by the IDT. All major injuries that are unwitnessed and the resident is not able to explain shall be reported to OHFC immediately per the abuse prevention	8/9/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING _____ B. WING _____	07/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

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F 226	Continued From page 6 injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." R87's annual Minimum Data Set (MDS) dated 5/11/16, identified long and short term memory problems with no recall ability, was rarely to never understood and required extensive assistance for all areas of daily living (ADL). The facility form titled Order Summary Report signed by the physician dated 6/27/16, identified R87's medical diagnoses to include dementia with Lewy Bodies, Parkinson's disease, and anxiety disorders. R87's care plan reviewed 7/13/16, indicated,"The resident is dependent upon staff etc. for emotional, intellectual, physical and social needs r/t [related to] Lewy Bodies, Physical Limitations" The care plan further indicated "The resident has physically abusive behaviors r/t dementia with Lewy Bodies, unspecified psychosis". A review of R87's nursing progress notes identified the following : -10/24/15-"Data: resident tipped merry walker over sideways and was found face down on floor, unable to move. Resident hit head/mouth on floor. residents mouth was bleeding from loosing a tooth. no one seen [sik] the incident so we don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift." -10/26/15," IDT (interdisciplinary team) review of fall from 10/24/15, Resident tipped over merry walker and landed on her face. Received a small abrasion under [R87's] nose and lost a tooth as a result of the fall." Study results of an x-ray (CT) of R87's brain dated 10/26/15, identified the	F 226	policy. B. All residents that are identified at risk for falls could be affected by not reporting immediately. For all falls that result in a serious injury, that are unwitnessed and the resident is not able to explain shall be reported to OHFC immediately per the abuse policy. C. Education to all licensed staff and individuals responsible for reporting provided on 8-9-16 via email. The education includes the Abuse and Prevention policy specifically in regards to reporting injuries of unknown origin due to unwitnessed falls and the resident not able to explain what happened. Nursing incident check list that now includes reporting serious injuries of unknown origin to OHFC, and education on the use of the Federal Long Term Care Report ability Under F225 injuries of unknown source. Face to face meetings were also held the week of 8-8-16 to provide education on reporting injuries of unknown origin. The policy, checklist and algorithm will be review at an all staff meeting on 8-23-16 as an additional education opportunity. D. Audits will be completed on all falls beginning 8-9-16 to assure any serious injury of unknown origin is reported to OHFC per policy. Audits will be completed after each reported fall for 4 weeks to assure compliance with the Abuse Prevention policy. E. Completion date 8-9-2016. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional	

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F 226	Continued From page 7 following Clinical information: [R87] presents with a fall, initial encounter. Nurse states -facial pain with more confusion than usual. Conclusion: Nondisplaced fracture thorough the anterior superior most maxilla (upper jaw) at the base of the nose. Review of the facility form titled 2015 Vulnerable Adult Incident Log, which logged the facility reports to the SA, indicated a report had not been submitted related to R87's fractured jaw from an unwitnessed fall on 10/24/15. On 7/22/16, at 11:28 a.m. the director of nursing (DON) verified a report had not been submitted to the SA when R87 had an unwitnessed fall on 10/24/15. The DON indicated she had not considered it a major injury at the time because it was unknown that R87 had a fractured jaw until a day or two after the fall occurred. The DON verified she had not considered to report to the state agency when it became known that R87 had a fractured jaw from the fall; however, would typically report an injury related to an unwitnessed fall when the resident is not cognitively intact. When interviewed on 7/22/16, at 1:10 p.m. the social services director (SSD) verified the responsibility of oversight for abuse prevention and reporting to the SA. SSD indicated training had been completed for many staff to submit VA reports to OHFC (Office of Health Facility Complaints)/MAARC (Minnesota Adult Abuse Reporting Center) including nurse managers, social services and nurses who worked the floor. SSD indicated the initial report was to be made immediately for alleged or suspected abuse, neglect, exploitation, and all things that fall under the facility vulnerable adult (VA) policy. When	F 226	education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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given the scenario of an unwitnessed fall of a cognitively impaired resident resulting in a fracture, SSD stated "I would have to look at the guidelines." When reviewed on SSD's lap top computer and the incident included no observation, resident unable to explain and the resulting injury; SSD responded, "I would think so" regarding R87's fractured jaw due to an unwitnessed fall. SSD indicated the facility staff had discussed the incident and had not found it to be a reportable incident. SSD verified the usual procedure for reporting an injury of unknown origin by reading aloud the facility policy: An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury. SSD request more time to review the electronic record before answering any more questions.

On 7/22/16, at 1:56 p.m. SSD identified R87's fall had been reviewed with the interdisciplinary team (IDT) and stated,"we didn't think it was a serious injury." SSD further explained the fractured jaw did not result in a hospitalization or affect R87's quality of life; therefore it was not a serious injury.

When interviewed on 7/22/16, at 1:56 p.m. the administrator indicated the report would be brought to the Quality Assurance meeting to review procedures for reporting.

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F 282 SS=D	. 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the plan of care for 2 of 3 residents (R78, R28) reviewed who were dependent upon staff for shaving and oral cares and for 1 of 1 resident (R65) reviewed with bilateral hand contractures and required range of motion (ROM). Findings include: R78's admission Minimum Data Set (MDS) dated 7/1/16, identified R78 was moderately cognitively impaired, required extensive assistance for all areas of daily living (ADL)with exception of limited assistance to walk in corridor and diagnoses which included Parkinson's disease, dementia, arthritis and vision impairment. R78's undated care plan, identified R78 had a self	F 282	F282 Services by Qualified Persons/per care plan Policy: Nursing care standards: to ensure that every resident receives care to reach their highest practicable level of functioning. This includes: Assistance with or supervision of shaving residents as necessary to keep them clean and well groomed. Assistance as needed with oral hygiene to keep the mouth, teeth or dentures clean. Assistance with ROM or placement of a device. Residents do have the right to refuse care/assistance all refusals will be charted in the resident's record. A. For R78 shaving will be offered and provided by staff daily. Care plan for R78	8/9/16

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F 282	Continued From page 10 care deficit related to Parkinson's Disease, hypertension, diabetes, and dementia as evidenced by requiring assist with ADL's -The resident requires extensive assist of 1 staff with personal hygiene. The undated resident care sheet, indicated R78 required assist of one staff with dressing and grooming. On 7/19/16, at 9:28 a.m. R78 stated, " I can't shave because of my Parkinson, that is one thing they are a little lax on." At this time R78 has stubble on chin and upper lip. On 7/20/16, at 7:57 a.m. R78 was propelled from his room to the dining room by nursing assistant (NA)-H. R78 had facial hair stubble on the upper lip and chin area. On 7/20/16, at 1:00 p.m. R78 was seated in his room in a stationary chair in front of the television. R87 remained unshaven. On 7/21/16, at 9:26 a.m. R78 was seated in room dressed, has not had face shaved, mustache and beard heavy stubble. On 7/20/16, at 8:51 a.m. NA-H indicated R78 tries to shave independently and will ask staff when he needs help. NA-H indicated R78 was new to the facility and NA-H was unsure of whether R78 had behaviors or refused cares. When interviewed on 7/20/16, at 1:00 p.m. R78 verified if he was able to shave himself he would do it every day. R78 stated staff will shave his face each morning when they get him up with an electric razor but some times they forget. R78	F 282	has been reviewed with staff providing cares for R78 in regards to offering and providing shaving. For resident R28 oral cares will be offered and provided by staff at least 2 times per day. Care plan R28 has been updated to include resident does not wear dentures. The care plan has been reviewed with staff providing care for R28 in regards to providing oral cares at least 2 times per day. For R65 has had fixed contractures (irreversible) for years per OT evaluation 11-17-12. The kerlix rolls in hands are to prevent moisture related issues and not to prevent contractures. MD orders clarified and plan of care has been revised. All staff working with R56 will be provided education on placement of kerlix in hands. It will be the responsibility of all nursing staff to assure kerlix is in place. The care plan has been updated will be reviewed with staff providing care for R65 in regards to placement of gauze rolls in hands. B. All residents requiring assistance with cares have to potential to be affected by this same practice. C. Written Education was provided to all staff via email and on Point of Care messaging on 8-9-16 in regards to care expectations related to shaving, oral cares, placement of devices related to contractures and providing assistance to all resident per their plan of care. Face to face education was provided to staff the week of 8-8-16. Will also provide additional training opportunity at the 8-23-16 all staff meeting.	

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F 282	Continued From page 11 verified his facial hair had not been shaved off today and was unable to recall when staff last shaved him. On 7/20/16, at 1:17 p.m. NA-I identified R78 had no behaviors and did occasionally refuse to go for a walk, however, it was usually for a reason, for example if his wife was here or if he was having pain in his hip. On 7/21/16, at 9:54 a.m. NA-E indicated R78 was unable to shave independently due to shaky hands. NA-E verified he/she had not shaved R78 this a.m. NA-E indicated R78 refused the offer to shave this a.m. and had a routine of shaving only "every so often." On 7/21/16, at 11:00 a.m. NA-F verified R78 had a good memory and what he says is accurate. NA-F indicated he/she did not provide cares for R78 often, however, did believe R78 was usually clean shaven. NA-F indicated staff usually assisted R78 with oral care and shaving. NA-F sated, " We would normally shave a person if they can't themselves." On 7/21/16, at 11:04 a.m. R78 verified he was not shaved this morning. R78 stated, " it (facial hair) isn't so hard to get off" if he is shaved every day. R78 further identified with a clean shaven face it was easier to keep clean as things get caught, stating "I drool." On 7/21/16, at 11:13 a.m. licensed practical nurse (LPN)-E verified R78 had facial stubble and had not been shaved. On 7/21/2016, at 11:14 a.m. registered nurse (RN)-A verified R78 required assistance with	F 282	D. Audits implemented beginning 8-9-16 on 4 residents per week x 4 weeks to assure shaving, oral cares, and application of kerlix/devices are provided per policy. Further education and audits will be provided/conducted if compliance is not met. E. Completion date 8-9-2016. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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F 282	Continued From page 12 ADL's due to has Parkinson's Disease and although his abilities change from day to day, R78 was not able to shave independently with an electric razor. RN-A identified staff were expected to shave male residents daily and would not expect residents to have to ask for the assistance. When interviewed on 7/22/16, at 11:25 a.m. the director of nursing (DON) verified the expectation that staff follow the care plan and residents who require assistance with ADL's be provided the care and not expected to ask for assistance. R28's care plan dated 7/15/16, identified R28 required extensive assistance to total assistance with personal hygiene and oral cares. The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 mouth swab and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed. The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28. During observation of morning cares on 7/20/16, from 8:23 a.m. to 8:54 a.m. NA-A and NA-G assisted R28 with personal cares which included washing her face, perineal cares and dressing. During the observation, R28 was not assisted nor offered the opportunity for completion of oral cares. R28's oral cavity and lips appeared very dry. -At 8:57 a.m. NA-A assisted R28 with breakfast while R28 was positioned in bed. R28 was not	F 282		

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wearing any dentures, and R28 refused the breakfast food items and juice offered. R28 did consume the strawberry supplement.
-At 9:01 a.m. NA-A gathered the breakfast tray, shut off the bedroom lights and stated some days are good with feeding, and some days are not, just like today. NA-A then delivered the breakfast tray to the kitchen, R28 was not assisted nor offered the opportunity for completion of oral cares.

During interview on 7/20/16, at 8:45 a.m. NA-A reported R28 no longer wears dentures, and stated she was going to wait until after R28 ate breakfast to provide oral cares which included swabbing out the mouth with a toothette.

At 9:07 a.m. NA-A confirmed R28 had finished with the breakfast meal and confirmed she had completed morning cares for R28. NA-A verified she did not complete nor offer oral cares which included swabbing the mouth with a toothette or mouthwash. Further, NA-A confirmed she did not inspect her mouth with cares.

During interview on 7/21/16, at 10:35 a.m. RN-B confirmed R28 no longer wore dentures. RN-B verified staff are expected to swab R28's mouth with morning cares, or at least attempting as R28 will at times refuse. RN-B confirmed R28 has a dry mouth and sleeps with the oral cavity open, therefore, oral care must be attempted.

During interview on 7/22/16, at 10:08 a.m. the DON confirmed staff are expected to provide or offer oral cares to all resident twice per day as indicated on the care plan.

The facility's Mouth Care Policy dated October

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2010, directed staff to review the resident's care plan for any special needs of the resident. and assemble the equipment and supplies as needed.

Review of R65's quarterly Minimum Data Set (MDS) dated 4/27/16, identified R65 had severe cognitive impairment and had diagnoses which included Parkinson's disease, Alzheimer's disease and cerebravascular disease with hemiplegia . The MDS further identified R65 was totally dependent on staff for activities of daily living (ADL's) and had bilateral upper extremity contractures. Review of R65's annual Care Area Assessment (CAA) dated 8/19/15, identified R65 had severe cognitive impairment due to Alzheimer's disease, was totally dependent on staff for ADL's and had contractures.

Review of R65's care plan print dated 2/25/16, identified R65 had bilateral contractures of the upper and lower extremities, was totally dependent on staff for all ADL's, required gentle range of motion with daily care, required gauze rolls in both hands 23/hrs/day: to be removed for 30 minutes twice daily for hygiene for bilateral hand contractures.

On 7/18/16, at 5:38 p.m. R65 was seated in a tilt in space wheelchair across from the nurses station prior to the evening meal. Both of R65's hands were held in a fisted position, elbows were bent and hands rested on her chest, right hand rested near her heart and her left hand rested on her left upper chest. R65 did not have kerlix placed in her hands. At 6:55 p.m. R65 was seated in a tilt in space wheelchair near the nurses station following the evening meal. R65 remained without kerlix/gauze in both hands. On 7/19/16, from 8:45 a.m. to 10:55 a.m. R65

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was lying in bed tilted to her right side with pillows against her back, blankets were observed to cover R65 to mid torso. R65's hands were in a fisted position , arms were bent at the elbow, fisted hands rested against her chest. R65 did not have kerlix in her hands.

On 7/21/16, at 4:57 p.m. R65 was seated in a tilt in space wheelchair with both arms bent at the elbows, hands were resting on her chest and were clenched fisted position. R65's right clenched hand was resting over her heart and her left clenched hand was resting on her upper left chest, no kerlix was observed in R65's hands.

When interviewed on 7/21/16, at 5:09 p.m. registered nurse manager (RN)-A confirmed R65 did not have kerlix in her contracted hands as care planned and was unsure why the kerlix was not in use. RN-A stated the medication nurses were responsible for checking to make sure R65's kerlix were in both hands for bilateral hand contractures. RN-A stated she felt R65 hands were too contracted for the kerlix to have fallen out, nor could R65 remove the kerlix independently. RN stated R65's hands were fully contracted and had been for years. RN-A directed a licensed practical nurse (LPN)-D to apply kerlix.

On 7/21/16, at 5:13 p.m. LPN-D attempted to open R65's right hand fingers from the contracted, fisted position and apply approximately an inch in diameter cotton kerlix roll into R65's hand. R65 stated it hurt and she was hurting her fingers, LPN-D immediately stopped opening R65's hand. At that time, LPN-D stated there were times when R65's hands needed to be soaked in warm water to help open the hands up. RN-A and NA-B then wheeled

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R65's to her room and NA-B wheeled R65 into her bathroom, while RN-A started to run the water out of the faucet. NA-B took R65's right hand, held it under the warm water while RN-A slowly opened R65's hand, washed, dried and applied the kerlix. NA-B then took R65's left hand, held it under the water while RN-A opened R65's hand, washed, dried and applied another roll of kerlix. NA-B assisted R65 back out of the bathroom in her wheelchair and wheeled R65 back to nursing station.

On 7/21/16, at 5:12 p.m. NA-B stated R65 was supposed to have the kerlix in both of her hands at all times. NA-B stated the nurses usually put them in after R65's hands were washed. NA-B stated she felt about 3-4 times a week R65's kerlix were not in her hands and she would then place the kerlix into R65's hands and often had a hard time doing so. NA-B further stated she felt R65's hands were fisted very tightly so the kerlix could not fall out and she felt R65 would be unable to remove the kerlix herself. NA-B stated she felt R65's hands had not worsened over the last few years.

On 7/22/16, at 10:23 a.m. NA-C stated R65 required total assistance with all ADL's, NA-C stated on average a few days a week R65 would not have the cloth rolls, (kerlix) in her hands and NA-C would then place the kerlix in R65's contracted hands.

On 7/22/16, at 10:37 a.m. RN-A stated R65 had not had a recent occupational therapy evaluation, though had one a few years ago which identified R65 had complete contractures of both hands. RN-A confirmed R65's current physician orders directed nursing staff to ensure R65 had kerlix

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F 282	Continued From page 17 placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated R65 had fully contracted hands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing (DON) stated she expected resident care plans to be implemented as directed. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. The facility policy titled Resident MDS 3.0 Assessment and Plan of Care revised 03/12, indicated the care plan was to provide continuity of care from admission to discharge. The facility's Care Plan Policy dated September 2010, indicated the care plan would be used to enhance the optimal functioning of the resident, and/or aid in preventing or reducing decline in resident's functional status and/or functional levels.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		8/12/16

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F 312	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral care and removal of facial hair for 2 of 3 residents (R78, R28) reviewed who were dependent upon staff for grooming and personal cares. Findings include: R78's admission Minimum Data Set (MDS) dated 7/1/16, identified R78 was moderately cognitively impaired, required extensive assistance for all areas of daily living (ADL)with exception of limited assistance to walk in corridor and diagnoses which included Parkinson's disease, dementia, arthritis and vision impairment. R78's undated care plan, identified R78 had a self care deficit related to Parkinson's Disease, hypertension, diabetes, and dementia as evidenced by requiring assist with ADL's -The resident requires extensive assist of 1 staff with personal hygiene. The undated resident care sheet, indicated R78 required assist of one staff with dressing and grooming. On 7/19/16, at 9:28 a.m. R78 stated, " I can't shave because of my Parkinson, that is one thing they are a little lax on." At this time R78 has stubble on chin and upper lip. On 7/20/16, at 7:57 a.m. R78 was propelled from his room to the dining room by nursing assistant (NA)-H. R78 had facial hair stubble on the upper	F 312	F312 ADL care provided for dependent residents Policy: Nursing care standards: to ensure that every resident receives care to reach their highest practicable level of functioning. This includes: Assistance with or supervision of shaving residents as necessary to keep them clean and well groomed. Assistance as needed with oral hygiene to keep the mouth, teeth or dentures clean. Assistance with ROM or placement of a device. Residents do have the right to refuse care/assistance all refusals will be charted in the resident's record. A. For R78 shaving has been offered and provided by staff daily. Care plan for R78 has been reviewed with staff providing cares for R78 in regards to offering and providing shaving. a. For R28 oral cares will be offered and provided by staff at least 2 times per day. Care plan R28 has been updated to include resident does not wear dentures. The care plan has been reviewed with staff providing care for R28 in regards to providing oral cares at least 2 times per day. b. R65 has had fixed contractures (irreversible) for years per OT evaluation 11-17-12. The kerlix rolls in hands are to prevent moisture related issues and not to prevent contractures. MD orders clarified	

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F 312	Continued From page 19 lip and chin area. On 7/20/16, at 1:00 p.m. R78 was seated in his room in a stationary chair in front of the television. R87 remained unshaven. On 7/21/16, at 9:26 a.m. R78 was seated in room dressed, has not had face shaved, mustache and beard heavy stubble. On 7/20/16, at 8:51 a.m. NA-H indicated R78 tries to shave independently and will ask staff when he needs help. NA-H indicated R78 was new to the facility and NA-H was unsure of whether R78 had behaviors or refused cares. When interviewed on 7/20/16, at 1:00 p.m. R78 verified if he was able to shave himself he would do it every day. R78 stated staff will shave his face each morning when they get him up with an electric razor but some times they forget. R78 verified his facial hair had not been shaved off today and was unable to recall when staff last shaved him. On 7/20/16, at 1:17 p.m. NA-I identified R78 had no behaviors and did occasionally refuse to go for a walk, however, it was usually for a reason, for example if his wife was here or if he was having pain in his hip. On 7/21/16, at 9:54 a.m. NA-E indicated R78 was unable to shave independently due to shaky hands. NA-E verified he/she had not shaved R78 this a.m. NA-E indicated R78 refused the offer to shave this a.m. and had a routine of shaving only "every so often." On 7/21/16, at 11:00 a.m. NA-F verified R78 had	F 312	and plan of care has been revised. All staff working with R56 have been provided education on placement of kerlix in hands. It will be the responsibility of all nursing staff to assure kerlix is in place. The care plan has been updated will be reviewed with staff providing care for R65 in regards to placement of kerlix rolls in hands. B. All residents requiring assistance with care have been reviewed to determine if they have been affected by the same practice. C. Written education has been provided to all staff via email and on Point of Care messaging on 8-9-16 in regards to care expectations related to shaving, oral cares, placement of devices related to contractures and providing assistance to all resident per their plan of care. Face to face education was also provided to staff the week of 8-8-16. Will also provide additional training opportunity at the 8-23-16 all staff meeting. D. Audits will be implemented beginning 8-9-16 on 4 residents per week x 4 weeks to assure shaving, oral cares, and application of kerlix/devices are provided per policy. E. Completion date 8-12-2016. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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a good memory and what he says is accurate. NA-F indicated he/she did not provide cares for R78 often, however, did believe R78 was usually clean shaven. NA-F indicated staff usually assisted R78 with oral care and shaving. NA-F sated, " We would normally shave a person if they can't themselves."

On 7/21/16, at 11:04 a.m. R78 verified he was not shaved this morning. R78 stated, " it (facial hair) isn't so hard to get off" if he is shaved every day. R78 further identified with a clean shaven face it was easier to keep clean as things get caught, stating "I drool."

On 7/21/16, at 11:13 a.m. licensed practical nurse (LPN)-E verified R78 had facial stubble and had not been shaved.

On 7/21/2016, at 11:14 a.m. registered nurse (RN)-A verified R78 required assistance with ADL's due to has Parkinson's Disease and although his abilities change from day to day, R78 was not able to shave independently with an electric razor. RN-A identified staff were expected to shave male residents daily and would not expect residents to have to ask for the assistance.

When interviewed on 7/22/16, at 11:25 a.m. the director of nursing (DON) verified the expectation that staff follow the care plan and residents who require assistance with ADL's be provided the care and not expected to ask for assistance.

The requested facility personal hygiene policy was not provided.

R28's quarterly Minimum Data Set (MDS) dated

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6/15/16, identified R28 was moderately cognitively impaired and diagnoses which included: Alzheimer's, psychotic disorder and arthritis. The MDS indicated R28 required extensive assistance for completion of personal hygiene tasks.

R28's care plan dated 7/15/16, identified R28 required extensive assistance to total assistance with personal hygiene and oral cares. The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 mouth swab and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed.

The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28.

The nursing oral assessment dated 6/13/16, indicated R28 had no natural teeth or tooth fragments, and indicated R28 chose not to wear dentures. The assessment identified R28 had a chewing and swallowing problem and received a pureed diet.

During observation of morning cares on 7/20/16, from 8:23 a.m. to 8:54 a.m. NA-A and NA-G assisted R28 with personal cares which included washing her face, perineal cares and dressing. During the observation, R28 was not assisted nor offered the opportunity for completion of oral cares. R28's oral cavity and lips appeared very dry.
-At 8:57 a.m. NA-A assisted R28 with breakfast while R28 was positioned in bed. R28 was not

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wearing any dentures, and R28 refused the breakfast food items and juice offered. R28 did consume the strawberry supplement.
-At 9:01 a.m. NA-A gathered the breakfast tray, shut off the bedroom lights and stated some days are good with feeding, and some days are not, just like today. NA-A then delivered the breakfast tray to the kitchen, R28 was not assisted nor offered the opportunity for completion of oral cares.

During interview on 7/20/16, at 8:45 a.m. NA-A reported R28 no longer wears dentures, and stated she was going to wait until after R28 ate breakfast to provide oral cares which included swabbing out the mouth with a toothette.

At 9:07 a.m. NA-A confirmed R28 had finished with the breakfast meal and confirmed she had completed morning cares for R28. NA-A verified she did not complete nor offer oral cares which included swabbing the mouth with a toothette or mouthwash. Further, NA-A confirmed she did not inspect her mouth with cares.

During interview on 7/21/16, at 10:35 a.m. RN-B confirmed R28 no longer wore dentures. RN-B verified staff are expected to swab R28's mouth with morning cares, or at least attempting as R28 will at times refuse. RN-B confirmed R28 has a dry mouth and sleeps with the oral cavity open, therefore, oral care must be attempted.

During interview on 7/22/16, at 10:08 a.m. the DON confirmed staff are expected to provide or offer oral cares to all resident twice per day as indicated on the care plan.

The facility's Mouth Care Policy dated October

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F 312	Continued From page 23 2010, directed staff to review the resident's care plan for any special needs of the resident. and assemble the equipment and supplies as needed. The purpose is to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth.	F 312		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions for identified contractures for 1 of 1 resident (R65) reviewed for range of motion (ROM.) Findings include: Review of R65's quarterly Minimum Data Set (MDS) dated 4/27/16, identified R65 had severe cognitive impairment and had diagnoses which included Parkinson's disease, Alzheimer's disease and cerebrovascular disease with hemiplegia . The MDS further identified R65 was totally dependent on staff for activities of daily living (ADL's) and had bilateral upper extremity contractures.	F 318	F318 Increase/Prevent decrease in Range of Motion Per Policy: to promote each resident's ability to adapt to attain his or her maximum functional potential. To promote each resident's highest practicable level of physical, mental and psychosocial functioning. A. R65 admitted to Bethany with contractures. Per OT assessment 11-17-12 contractures in hands are in a fixed position. Kerlix placed in hands daily is to prevent moisture associated damage and/or skin breakdown. MD order has been clarified to state such and R65 plan of care has been updated.	8/12/16

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F 318	Continued From page 24 Review of R65's annual Care Area Assessment (CAA) dated 8/19/15, identified R65 had severe cognitive impairment due to Alzheimer's disease, was totally dependent on staff for ADL's and had contractures. Review of R65's care plan print dated 2/25/16, identified R65 had bilateral contractures of the upper and lower extremities, was totally dependent on staff for all ADL's, required gentle range of motion with daily care, required gauze rolls in both hands 23/hrs/day: to be removed for 30 minutes twice daily for hygiene for bilateral hand contractures. Review of R65's current physician orders signed 7/19/16, revealed an order with a start date of 10/21/2015, directed nursing staff to check R65's kerlix roll in bilateral hands for placement every shift, should have kerlix in hands at all times and additional gauze between thumb, change kerlix and gauze when soiled and as needed every shift for contractures. The orders also directed nursing staff to wash R65's hands twice daily per instruction sheet. Review of R65's provider progress note dated 5/27/16, revealed R65 had been seen for a routine visit in which R65 was assessed to have contractures which were most notably in her arms and hands. Review of R65's most recent occupational therapy (OT) assessment dated 11/17/12, revealed R65 had bilateral hand contractures which were in a fixed flexed position. The evaluation directed staff to implement ROM exercises and in hand splints for bilateral hand	F 318	B. All resident's with devices for ROM and or contractures has the potential to be affected by the same practice. C. All resident's that have devices for ROM and/or contractures will be reviewed to assure the device is being used for the appropriate reasons and that the devices are being placed per MD orders, and that the care plan and care sheets are current. D. Audits for devices to assure MD order is correct, care plan is correct, devices are being applied and care sheets are current will be done on each resident with a device until all residents with a device have been reviewed. E. Completion date 8-12-16. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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contractures.

- R65's medical record lacked any further OT evaluations for hand contractures.

Review of R65's July 2016, treatment administration record (TAR) revealed a check mark for R65's treatment of kerlix rolls in both hands three times a day. The TAR revealed a chart code legend which a check mark indicated the treatment was in place on all days.

Review of R65's care conference note dated 5/17/16, revealed R65 continued to have contractures of her hands and extremities. The note further revealed staff were to continue to apply gauze to R65's hands daily. The note indicated that was to continue.

Review of R65's progress notes from 1/23/16, to 7/13/16, revealed the following:

-1/24/16, revealed R65 had contractures to bilateral hands and required vigilant monitoring and gauze rolls placed in both hands, extra care to keep R65's hands clean.

-2/5/16, revealed R65 received passive range of motion (PROM) to both upper and lower extremities due to contractures, staff continued to apply gauze rolls in both contracted hands daily.

-3/5/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's.

-4/6/16, revealed a monthly charting note which identified R65 had bilateral hand contractures

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and required total assistance from staff for all ADL's.

-4/23/16, revealed a ADL note which identified R65 required total assistance with all ADL's due to contractures and blindness.

-4/27/16, revealed a restorative program note which identified R65 had bilateral hand contractures and staff was to put gauze rolls in both hands to help her contractures and maintain skin integrity.

-5/20/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's.

-5/28/16, revealed a order administration note which revealed staff was unable to place kerlix in R65's hands due to resident not able to open her hands. R65's progress notes lacked any follow up regarding inability to place gauze in R65's hands.

-5/29/16, revealed a order administration note which revealed staff was unable to place kerlix in R65's hands due to resident not able to open her hands. R65's progress notes lacked any follow up regarding inability to place gauze in R65's hands.

-6/20/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's.

-6/27/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's.

-7/13/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and

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F 318	Continued From page 27 required total assistance from staff for all ADL's. On 7/18/16, at 5:38 p.m. R65 was seated in a tilt in space wheelchair across from the nurses station prior to the evening meal. Both of R65's hands were held in a fisted position, elbows were bent and hands rested on her chest, right hand rested near her heart and her left hand rested on her left upper chest. R65 did not have kerlix placed in her hands. At 6:55 p.m. R65 was seated in a tilt in space wheelchair near the nurses station following the evening meal. R65 remained without kerlix/gauze in both hands. On 7/19/16, from 8:45 a.m. to 10:55 a.m. R65 was lying in bed tilted to her right side with pillows against her back, blankets were observed to cover R65 to mid torso. R65's hands were in a fisted position , arms were bent at the elbow, fisted hands rested against her chest. R65 did not have kerlix in her hands. On 7/21/16, at 4:57 p.m. R65 was seated in a tilt in space wheelchair with both arms bent at the elbows, hands were resting on her chest and were clenched fisted position. R65's right clenched hand was resting over her heart and her left clenched hand was resting on her upper left chest, no kerlix was observed in R65's hands. When interviewed on 7/21/16, at 5:09 p.m. registered nurse manager (RN)-A confirmed R65 did not have kerlix in her contracted hands as care planned and was unsure why the kerlix was not in use. RN-A stated the medication nurses were responsible for checking to make sure R65's kerlix were in both hands for bilateral hand contractures. RN-A stated she felt R65 hands were too contracted for the kerlix to have fallen out, nor could R65 remove the kerlix	F 318		

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independently. RN stated R65's hands were fully contracted and had been for years. RN-A directed a licensed practical nurse (LPN)-D to apply kerlix.

On 7/21/16, at 5:13 p.m. LPN-D attempted to open R65's right hand fingers from the contracted, fisted position and apply approximately an inch in diameter cotton kerlix roll into R65's hand. R65 stated it hurt and she was hurting her fingers, LPN-D immediately stopped opening R65's hand. At that time, LPN-D stated there were times when R65's hands needed to be soaked in warm water to help open the hands up. RN-A and NA-B then wheeled R65's to her room and NA-B wheeled R65 into her bathroom, while RN-A started to run the water out of the faucet. NA-B took R65's right hand, held it under the warm water while RN-A slowly opened R65's hand, washed, dried and applied the kerlix. NA-B then took R65's left hand, held it under the water while RN-A opened R65's hand, washed, dried and applied another roll of kerlix. NA-B assisted R65 back out of the bathroom in her wheelchair and wheeled R65 back to nursing station.

On 7/21/16, at 5:12 p.m. NA-B stated R65 was supposed to have the kerlix in both of her hands at all times. NA-B stated the nurses usually put them in after R65's hands were washed. NA-B stated she felt about 3-4 times a week R65's kerlix were not in her hands and she would then place the kerlix into R65's hands and often had a hard time doing so. NA-B further stated she felt R65's hands were fisted very tightly so the kerlix could not fall out and she felt R65 would be unable to remove the kerlix herself. NA-B stated she felt R65's hands had not worsened over the last few years.

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F 318	Continued From page 29 On 7/22/16, at 10:23 a.m. NA-C stated R65 required total assistance with all ADL's, NA-C stated on average a few days a week R65 would not have the cloth rolls, (kerlix) in her hands and NA-C would then place the kerlix in R65's contracted hands. On 7/22/16, at 10:37 a.m. RN-A stated R65 had not had a recent occupational therapy evaluation, though had one a few years ago which identified R65 had complete contractures of both hands. RN-A confirmed R65's current physician orders directed nursing staff to ensure R65 had kerlix placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated R65 had fully contracted hands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing (DON) stated she expected physician orders and resident care plans to be implemented. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. Review of a facility policy titled, Restorative Nursing Program reviewed 5/2011, revealed a facility procedure to promote each residents highest practicable well being. A policy was requested regarding following	F 318		

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F 318	Continued From page 30 physician orders, treatments and contractures; none were provided.	F 318		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, ensure adequate supervision and implement interventions, to decrease the risk of further falls for 1 of 3 residents (R87) reviewed who sustained multiple falls. R87 experienced an injury while utilizing a Merry walker (a walker/chair combination type device), resulting in an immediate jeopardy (IJ) situation. The facility failed to investigate and comprehensively assess the resident's falls while utilizing the Merry walker to determine whether new interventions should have been implemented, and the facility failed to ensure interventions currently in place were adequate and consistently implemented to minimize the risk for further falls. The immediate jeopardy (IJ) began on 10/24/15, when R87 sustained a fall with injury while walking in the Merry walker. The facility's administrator and director of nursing (DON) were	F 323	F323 Free of accident hazards/supervision/devices A. On 7-20-2016 the following was implemented immediately for R87. 1. Current Merry Walker was discontinued; 1-1 staff implemented and was in place until all assessments were completed and new plan for safety was initiated. 2. We immediately implemented a new written assessment for all falls. The Post-Fall assessment includes root cause analysis and intervention options to prevent further falls. A new Progress note type was created in the electronic chart and titled fall which triggers the user to review the care plan and make modifications and revise interventions as needed.	8/12/16

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F 323	Continued From page 31 notified of the immediate jeopardy (IJ) situation on 7/19/16, at 7:05 p.m. The IJ was removed on 7/20/16, however, noncompliance remained at a lower level of G, isolated scope, with severity of actual harm that is not immediate jeopardy. Findings include: R87 was observed on 7/18/16, at 5:31 p.m. with a gait belt fastened around her waist, standing in a Merry walker made of PVC pipe. Cloth weights had been fastened with zip ties to the bottom of the walker on three sides and a cloth type strap was attached to the seat of the walker. The strap attached to the front of the walker and was located between R87's legs. R87 independently wandered about the Darling Springs unit utilizing the Merry walker. R87 was observed to walk with a shuffling gait and was noted to have an abrasion near her right eye. When she got to the doorway to the dining room, R87 couldn't move the Merry walker forward. R87 remained stationery in the doorway to the dining room until nursing assistant (NA)-D assisted R87 to turn around in the Merry walker so R87 could ambulate in the opposite direction. R87 continued to move around the area of the Darling Springs nurses' desk, bumping into walls and doorways. R87 was again observed on 7/18/16, at 6:48 p.m. walking in the Merry walker in the Darling Springs hallway with a shuffled gait. R87 was observed bumping into walls, doorways and residents in wheelchairs while walking down the hallway in the Merry walker device. The administrator was observed at that time to grasp a corner of the Merry walker to straighten R87's navigation. A few minutes later, R87 was observed to walk/bump into the right front corner of the Merry	F 323	3. Physician reviewed the current status and provided directives for care. Consulting pharmacy reviewed medication regime. Physical Therapy reviewed and assessed for recommendations. 4. Interventions for all falls that occur in the facility will be reviewed each time for appropriateness at IDT meeting. 5. Education was provided to all licensed staff on new written assessment and progress note types on 7-20-16, verbally, via email and postings at nurse's stations. Alert messages with new plan of care was sent to direct care givers via PCC. 6. R87 will be audited for any falls that occur in the next 6 week to assure that written assessments and interventions have been implemented. Will report to QAPI monthly. Will continue to audit as needed. B. All resident who are at risk for falls have the potential to be affected. C. The new fall note and post fall assessment was put in place on 7-20-16 for all residents in the facility that sustain a fall. Education was provided on 7-20-16. Face to face education provided the week of 8-8-16. Additional educational opportunity will be provide at the 8-23-16 all staff meeting. Will also have Ecumen QI nurse provide education on this topic on 8-25-16. Ecumen QI nurse will also Audit notes and assessments 1 x per	

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F 323	Continued From page 32 walker, bounced backward and came to rest on the seat of the Merry walker with half of her buttock positioned on the seat of the walker. R87 then stood and continued to wander throughout the hallway while attempting to navigate the Merry walker. On 7/19/16, at 10:42 a.m. NA-E was observed to guide R87, who was in the Merry walker, out of her room to the hallway. NA-E then left R87 to independently walk in the Merry walker. R87 was observed to walk with a shuffled gait. She was located in the short hall outside of her room, but not within staff view. While in the Merry walker in the corner of the short hall, R87 was able to grasp the door handle to the bathroom door labeled B-13 and jiggle the handle. R87 then turned her body to the right side of the Merry walker, moved the walker in a sideways direction out from the corner and moved toward the nurses' desk located on the opposite side from the dining room. At 10:46 a.m. R87 continued to move about in the Merry walker with a shuffled gait. She navigated to and from the short hallway located near her room which was located on the side of the nurses' station desk without staff in the area. At 10:47 a.m. a lab (laboratory) tech (technician) and two facility staff walked near the side of the nurses' station facing the dining room. None of these three staff looked in the direction of R87 as they walked past this area. At 10:47 a.m. licensed practical nurse (LPN)-C returned to the nurses' station area and approached the medication cart which faced the opposite direction from R87. LPN-C did not move to an area where R87 could be supervised. During this time, R87 was observed to have turned herself within the Merry walker to face backwards, and was observed to have lifted her right knee onto	F 323	month x 3 months. D. 8-9-16 we will begin auditing fall note and post fall assessment to assure staff are appropriately completing the note/assessment and adding new interventions as needed. Audits will be done on all falls x4 weeks to assure compliance. E. Completion date for 8-12-16. Audit results will be reviewed at the September 21, 2016 QAPI meeting where the team will determine what, in any additional education is required, and determine the future frequency of audits. Director of Nursing or designee will be responsible.	

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the Merry walker seat.

On 7/19/16, at 10:50 a.m. two NAs were observed in the hallway to propel a cart while water mugs were removed from resident rooms. Neither NA looked in the direction of R87 as she once again maneuvered the Merry walker into the corner of the hall and was unable to propel it forward. At 10:51 a.m. R87 stood backwards in the Merry walker. The front and one side of the Merry walker were located against the corner walls in the short hallway. No staff were in the vicinity nor in view of R87 to provide supervision. At 10:55 a.m. R87 remained unable to move from the corner with the Merry walker. R87 raised her feet, one at a time, placing them onto the bottom bar of the Merry walker. She then placed her right knee onto the seat of the walker. At 10:57 a.m. R87 shuffled the Merry walker towards the location of the nurses' desk, leaned over the Merry walker bar, spit on the floor and continued forward with little shuffled steps in the direction of the corner located near the bathroom. NA-E was observed in the hall to be delivering water mugs to resident rooms but did not walk in R87's direction. At 11:00 a.m. R87 continued to ambulate with small steps, navigating the Merry walker toward the nurses' station. R87 stopped the movement of the walker when it butted up against the nurses' station desk. At 11:08 a.m. R87 stood up in the Merry walker while it was caught against the nurses' station. Staff were noted on the dining room side of the desk.

At 11:11 a.m. on 7/19/16, R87 and another female resident seated in a wheelchair were in the vicinity of the nurses' desk. At 11:14 a.m. R87 pushed her Merry walker into the other female resident's wheel chair. When R87 could not

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propel forward, she grasped the top bar of the walker and shook it back and forth. At 11:17 a.m., while R87 continued to shake the Merry walker, the resident located in the wheel chair grasped R87's left wrist and stated "go tell your mother". R87 made no response but continued to shake the walker. At 11:18 a.m. facility staff walked through the area pushing a housekeeping cart onto the elevator, without looking in the direction of R87. At 11:19 a.m. R87 finally seated herself in the Merry walker with only the right side of her buttock seated on the Merry walker seat. The Merry walker remained in contact with the other resident's wheel chair. At 11:19 a.m. R87 stood from the seat, and again began shaking the walker. The resident in the wheelchair stated, "do you want me to spank you?" and grasped R87's wrist. At that time, the surveyor summoned staff. At 11:22 a.m. registered nurse (RN)-A separated the two residents.

R87's annual Minimum Data Set (MDS) dated 5/11/16, identified R87 had long and short term memory problems with no recall ability, was rarely to never understood, and required extensive assistance for all activities of daily living (ADL). A facility form, Order Summary Report signed by the physician 6/27/16, indicated R87's medical diagnoses included: dementia with Lewy Bodies, Parkinson's disease and anxiety disorders. R87's Care Area Assessment (CAA) dated 5/11/16, included: "Cognitive loss /Dementia: severe impairment w(with)/cognition triggered CAA r/t [related to] dx [diagnosis] of dementia with Lewy bodies, Parkinson's and depression.. ADL functional /Rehabilitation Potential: Requires assist with ADL's and mobilities r/t Parkinson's Disease, Dementia with Lewy Bodies, HTN [hypertension], osteoarthritis and Hx [history of

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F 323	Continued From page 35 falls]. See CP [care plan] for details. Safety interventions are in place to prevent falls/injuries. Noted to have 2 falls since previous MDS. Will monitor and implement safety interventions PRN [as needed]. Resident does wander about unit. At times will wander into other resident's rooms. Wander guard is in place to alert staff if resident attempts to wander outside. Velcro sashes are put across other residents' doorways to detour resident of entering room. Does help detour at times. Is at risk for impaired communication r/t [related to] Dementia and Parkinson's Disease. Speech is mumbled and has difficulty finding the right words. Response does not always make sense. Is sometimes understood and sometimes understands communication. No referral needed at this time." Behavioral Symptoms: "Observed to have behaviors of physical abuse towards others and wandering. Staff will provide [R87] with PRN pain meds [medications] when is showing aggression in her face. [R87] will also ram into things with her Merry walker repetitively. PRN pain meds have shown to redirect this behaviors." R87's care plan reviewed 7/13/16, indicated the resident was "at risk for falls due to dementia with Lewy Bodies, and Parkinson's disease." Interventions included: "Ensure [R87] is wearing appropriate footwear when ambulating or mobilizing in wheel chair. Follow facility fall protocol. Physical therapy eval [evaluation] and treat as ordered or as needed. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident/family/caregivers/ IDT [interdisciplinary team] as to causes. Safety interventions: (1) Low bed and safety mats when in bed. (2) Shoes or gripper slippers to be worn when in Merry walker. (3) Close dining room and	F 323		

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activity doors in the evening when [R87] is in Merry walker. Bathroom door to be closed when resident is not using the bathroom. (4) Weights on base of Merry walker to increase stability. (5) Keep an extra set up [SIK] slippers in Merry walker in case one falls off. (6) 1:1 staff assist/ supervision when in the dining room. (7) Clip call light to resident at NOC [night] to alert staff when she moves or gets up (has soft touch call light). (8) Staff will monitor whereabouts every 30 minutes and PRN. (9) Bring to bathroom before sitting in recliner."

R87's NA care sheet (a reference NAs used regarding specific care for residents) undated, identified safety interventions for R87 to include: (1) to ensure to take R87 to the bathroom before assisting to the recliner, (2) keep bathroom door closed, (3) clip call light on R87 at bed time, (4) low bed and safety mat (put mat against wall when not in bed), (5) keep gait belt on walker (close to resident), (6) Follow with wheel chair when ambulating, one to one assist when in dining room, use body pillow to position in bed, wanderguard worn. The NA care sheet also indicated in the comment section: "Merry Walker [see purple sheet in NA book]." The purple sheet directed staff to "observe frequently." Although the NA care sheet directed staff to observe R87 in the Merry walker, no specific time frame was given even though the care plan indicated staff to monitor R87's whereabouts every 30 minutes and PRN.
When interviewed on 7/19/16, at 11:22 a.m. RN-A stated R87 was safe to be unsupervised in the Merry walker and stated, "we check on her every half hour".

On 7/19/16, at 1:35 p.m. NA-E indicated it was

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usual practice to allow R87 to walk around while in the Merry walker unsupervised. NA-E stated, "We try to keep her safe, the nurses do a good job of keeping her close." NA-E verified that although she had not witnessed R87's falls involving the Merry walker, she'd heard that R87 had stepped on the bottom of the walker causing it to fall over and causing a cut to R87's face. NA-E pointed to the temple area.

A review of R87's clinical record identified the following 27 documented fall incidents which involved the use of the Merry walker since R87 was admitted on March 2015:

(1) 5/10/15- found on floor underneath Merry walker; No apparent injuries
Care plan and multiple safety interventions were being followed at time of fall. Spoke with family member (F)-A. Discussed the risk vs. benefits of the Merry walker, F-A feels at this time, the merry walker continues to benefit greatly and feels is at a greater risk of injury if she was not using the Merry walker and self transferring without it. Staff will continue with 30 minute checks and follow Merry Walker guidelines as listed in CP (care plan).

(2) 5/17/15- found on floor, had tipped over Merry walker; head up against the wall on right side; bruising on RUE (right upper extremity) from previous fall; No other noted injuries. Resident was crying but able to voice if she was hurt. Unwitnessed. Will place safety mat against wall when not in bed to prevent resident from tripping on mat or wheeling over it with Merry walker. Will also continue Q (every) 30 minute checks.

(3) 5/20/15- found by a staff member laying on

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the floor with one leg still around the strap of Merry walker around 4:00 p.m. Resident assisted back into Merry walker with 2 staff and EZ (mechanical device) lift. No further documentation of IDT (interdisciplinary team) review of fall.

(4) 5/30/15- found on the floor in her Merry walker with one leg around Merry walker strap. No injuries noted. Will continue current interventions.

(5) 6/20/15- found sitting opposite direction in Merry walker. Sitting on floor. No apparent injuries.

(6) 6/23/15- found on floor in Merry walker. When staff removed Merry walker to assist off the floor, resident began scooting on her butt on the floor. No injuries noted. CP being followed.

(7) 6/28/15- in Merry walker, stumbled to the left and right leg crossed over left leg and resident grabbed for medication cart to catch herself and this caused [R87] and Merry walker to fall to the left. Right hip pain and right foot rotated inward. Lump on left side of head and above left eye. Pupils sluggish. Guarded movement to the right leg. Ice applied to head abrasion and lump. Sent to the emergency department (ED).

(8) 6/30/15- in Merry walker when lost her balance and fell to the floor, tipping Merry walker over. Was sent to ER (emergency room) and returned with no fractures or injuries. CP being followed. Action: Weights added to base of merry walker to add stability.

(9) 8/1/15- found on floor in Merry walker in room. Got up with assist of 2 staff. Resident was uninjured.

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F 323	Continued From page 39 (10) 8/3/15- found on the floor of bedroom in Merry walker. No injuries noted from fall. CP was being followed. Will continue current interventions. (11) 8/4/15- found on floor at 11:30 a.m. in another resident's room with no injuries or hitting head. Was wearing slippers and in Merry walker at time of occurrence. Action: Up off floor and back in Merry walker. (12) 8/4/15- found on floor in front of nurses' station in Merry walker and slipper on. No injuries noted. Continue current CP. (13) 8/5/15- had 2 falls in one day. Resident appears to be more restless and has facial grimacing. Is not always able to communicate pain with staff. No injuries from either fall. CP was being followed. Action: Physician referral out to schedule pain meds to see if this helps with restlessness. (14) 9/15/15- found sitting on floor backwards in Merry walker in her room, leg strap still attached between legs; shirt off at this time, gripper socks in place; R87 agitated at the time. Staff last checked in on R87 shortly before, less than hour prior to fall. (15) 9/16/15- found on the floor, in Merry walker, Merry walker did not tip over. No injuries noted from fall. CP being followed. (16) 9/19/15- observed on floor next to bed in room, was lying under the Merry walker. The Merry walker was intact, was assisted to the toilet and into the Merry walker at 2:20 p.m. No lumps	F 323		

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bumps or bruising noted to her head.

(17) 9/21/15- found on floor, in Merry walker at the time of fall. No injuries noted. CP being followed. Resident has been showing increased signs of pain and has been more anxious, likely related to pain. Fentanyl patch was increased today; Will also continue with current interventions.

(18) 9/22/15- found in room on the floor underneath Merry walker at 7:00 p.m. The strap was hooked around R87's foot and was lying on her back. A small quarter sized bruise was found on right buttock. Brought to the bathroom and returned to bed.

(19) 9/23/15- found on the floor in room per staff interview, [R87\ assisted just prior to fall. Received a small bruise to buttocks as a result of the fall. Action: Fentanyl patch (pain medication) was recently increased on 9/21. Will continue to monitor pain and effects of Fentanyl patch as pain causes [R87] to be more anxious and increased her risk for falls.

(20) 10/24/15- Resident tipped merry walker over sideways and was found face down on floor, unable to move. [R87] hit head/mouth on floor; mouth bleeding from losing a tooth. No one seen [sik] the incident so don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift. A follow up nursing note dated 10/26/15 at 11:41 a.m. included, IDT reviewed fall from 10/24/15. Resident tipped over merry walker and landed on her face. Received a small abrasion under nose and lost a tooth as a result of the fall. Seroquel (antipsychotic medication) was recently

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decreased last Wednesday, [R87] more active since then. Per daughter's request, she would like Seroquel increased to the previous dose, she states she has seen her mom have more added behaviors and would like her mom to be more tired than anxious and falling. Referral filled out for MD (medical doctor). Also, weights added to the back of the merry walker to balance it. (The intervention of added weights to the base of the merry walker was initiated after R87 had sustained a fall on 6/28/15). A nurses' note dated 10/26/15, at 13:39 (1:39 p.m.) included:..."Res. face continues to be swelled and abrasion is scabbed. Call placed to [MD] to inquire about xray to face. RN UC [registered nurse unit coordinator] aware. [MD's] nurse will call back after talking to CNP [certified nurse practitioner]. Subsequent nursing notes indicated the physician had ordered a head CT scan [computed tomography X-ray] for that date. Documentation from 16:53 (4:53 p.m.) 10/26/15 indicated CT scan results from that date, indicated the resident had presented with facial pain and more confusion than usual. The report further included: Conclusion: 1. Nondisplaced fracture through the anterior superior most maxilla (upper jaw) at the base of the nose. Additionally, a nurse's note from 10:49 a.m. on 10/27/15 indicated the resident required an oral surgery consult.

Despite the number of falls and fracture while utilizing the Merry walker, the facility failed to reassess R87's fall risk and interventions.

(21) 1/6/16- found on the floor in the bathroom still in Merry-walker, under the bar with leg strap intact. Resident was found leaning against the wall in the bathroom. No other injuries present. Resident was assisted with 3 and ez-lift

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(mechanical full body lift) off of the floor and into bed. Then placed in merry walker for meals. No further review of the fall by the IDT.

(22) 1/8/16- found on the bathroom floor, still in Merry walker; Merry walker did not tip over. No injuries from fall. CP was being followed. Was assisted to the bathroom less than 2 hours prior to the fall, not attempting to go to the bathroom at the time of the fall. Action: intervention to keep the bathroom door closed when not using it, [R87] wanders into her room through out the day. No further IDT review of the fall documented.

(23) 2/2/16- on floor in front of nurses' station at 7:30 a.m. in Merry walker. No injuries noted. Had foot wear on at time of occurrence. Continue CP.

(24) 4/16/16- found sitting on the floor in the activity room close to Turtle Beach (resident unit) still in the Merry walker; walker was still upright; assisted back into the Merry walker with the EZ lift and 3 staff assist. Continue with CP; Family continue to feel the Merry walker is safest option and continues to be appropriate.

A physician visit form dated 4/18/16, identified R87 was seen for a "regularly scheduled visit." "Nursing has no concerns with [R87], she has been stable."

(25) 5/13/16- found on right side, Merry walker was tipped over on the floor, laying on gray mat next to bed, feet still inside tipped Merry walker. Was trying to get to Herbergers, climbed on Merry walker and flipped Merry walker onto side. Aide found resident on floor. No injuries from fall. Staff educated to make sure the mat is not on the floor when [R87] not in bed. Sign placed on wall

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F 323	Continued From page 43 to remind staff to pick up the mat when not in bed. (26) 6/26/16- found on floor of other resident's room in Merry Walker on floor with feet on the seat. No injuries noted. Merry walker discussed with family at all care conferences and they feel this is her safest option to avoid injury and also gives her the freedom to ambulate and be more independent. Will continue with current interventions. CP followed. (27) 6/27/16- found lying on floor underneath Merry walker outside of room in hallway, lying on back and holding head up, appeared to be sleeping. No injuries. CP being followed;Will continue with these interventions. When interviewed on 7/19/16, at 2:55 p.m. the director of nursing (DON) identified an IDT reviewed resident falls to identify the cause of the fall, current interventions in place, previous interventions and possible new interventions. This IDT review is added to the nurse's progress notes in the electronic record and documented onto a Falls log. Review of the facility form titled Resident Incidents, printed for the dates of January 2016 to July 2016 included the following falls involving the Merry walker for R87: -2/2/16- witness-none, interventions-Continue current interventions-no injury. -4/16/16- witness-none, interventions-Continue current interventions. -5/13/16- witness- none, interventions-Continue current interventions. -6/26/16-witness-none, interventions-Will continue with current interventions.	F 323		

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-6/27/16-witness-none, interventions-No maltreatment, care plan was being followed. Resident has numerous fall interventions in place. Will continue with theses interventions.

The Incident Log did not include all the documented falls that occurred during the selected time frame. The log also lacked documentation of a comprehensive re-assessment of R87 and lacked documentation of any additional interventions implemented to prevent re-occurrence of falls.

R87's electronic and written records lacked any evidence of physical (PT) or occupational therapy (OT) evaluations and/or treatment. In addition, Morse Fall Scale documents completed on 8/28/15, 10/26/15, 11/20/15, 11/22/15 and 5/9/16, each identified R87's risk for falling, the use of a walker, and identified the resident as having a weak gait, stooped posture and described gait with, "steps are short, resident may shuffle." Each of these Morse Fall Scale documents indicated the resident had a score of 80 with anything above 45 indicating a high risk for falls. None of the documents identified any other specific assessment information.

On 7/19/16, at 4:19 p.m. registered nurse (RN)-A reviewed the progress notes and verified R87's falls involved the Merry walker and that assessments and new interventions were not consistently completed and/or implemented. RN-A identified the usual process after a fall as follows: (1) review the nurse's progress notes, (2) interview staff to see what [R87] was trying to do, (3) if interviewable, ask the resident, (4) reassess fall risk and whether planned interventions are effective. RN-A indicated these

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assessment findings would have been documented as a follow-up note after each fall. RN-A verified that R87 was cognitively impaired and that it was difficult to identify a cause for each fall because R87 could not express her needs or actions. RN-A further identified there were so many planned interventions it was difficult to identify any new ones, and RN-A also stated fall assessments were completed quarterly, not after each fall. A facility document was provided titled Restraint/ Physical (Quarterly/Annual Evaluation) dated 2/17/16. RN-A verified this was the most current assessment form and verified there were no other assessment forms related to a fall risk assessment for R87. RN-A stated therapy had been involved with the assessment for the use of a Merry walker and had been assessed when admitted. RN-A also stated the current CP included all of the current interventions and confirmed it was an expectation that staff follow the care plan. RN-A also stated the nurse was responsible to check on R87 every 30 minutes and to document such. RN-A explained the Merry walker currently utilized by R87 had been obtained from storage in the basement of the facility, and stated she did not believe they had a written copy of the manufacturer's instructions/recommendations. RN-A indicated she may have to complete a "Google" search to obtain the instructions.

On 7/19/16, at 4:57 p.m. the DON identified the nurse manager was responsible to complete an assessment for resident use of a Merry walker and explained the assessment involved standing the resident in the Merry walker to see whether it was safe. The DON further explained this was not an actual written assessment, but included more of an observation to see whether the Merry

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walker was appropriate. The DON verified this was the only Merry walker assessment completed. The DON further explained the staff and family were aware that R87 was not safe and remained at risk for falls while in the Merry walker. The DON confirmed they were honoring the family wishes since R87 was not utilizing a Merry walker, she would have to be placed into a Geri Chair (a reclining wheel chair). The DON also indicated implementation of interventions after a fall would be completed if staff identified problems with the Merry walker, identifying examples such as not walking with it, or not using it properly. The DON further indicated the expectation for care of a resident utilizing a Merry walker included frequent observations by all staff when walking by. The DON said if a resident were trying to crawl out of the Merry walker, staff may lay the resident in bed with a safety mat placed next to the bed. The DON reiterated staff were expected to follow the CP. The DON indicated they had tried numerous interventions but would follow family wishes related to the continued use of the Merry walker. The DON stated the manufacturer's recommendations for use of the Merry walker was located in the storage area.

On 7/19/16 at 5:50 p.m. RN-A provided manufacturer's recommendations for use of a Merry Walker print out from the Internet. These printed out recommendations included: "The walker is constructed of metal and weighted at the bottom and each one should be individually fitted to the resident. The height of the top frame should be at the height of the pelvis to promote good posture." However, the Merry walker R87 currently utilized was constructed of PVC pipe to which three fabric type weights with zip ties were secured to the bottom bar of the walker. In

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addition, it was noted the height of the top frame of the Merry walker R87 utilized was not at the height of the pelvis but above the pelvis.

On 7/20/2016, at 9:33 a.m. physical therapist (PT)-A was interviewed. PT-A confirmed therapy duties included screening and treatment of residents related to transfers, balance,walking and determination of the most appropriate lifts for individual residents. PT-A stated, "[Merry walker] is not something we recommend, we want it to be functional walking with a walker or cane." PT-A identified resident considerations for use of a Merry walker would include: look safe, maintain balance and strength, have a good gait pattern and ability to propel forward without tripping. PT-A also verified that Merry walkers were able to tip over. PT-A indicated that when R87 was admitted to the facility, a quick screen to evaluate if therapy services were required was conducted. PT-A indicated that at that time services had not been determined to be needed so no physician order for treatment had been requested. PT-A confirmed R87 had not been provided therapy services any time since admission (March 2015) and confirmed R87 had not been evaluated by PT for the use of the Merry walker.

The facility policy titled, Falls- Clinical Protocol revised September 2012, Assessment and Recognition identified the following: #5 The staff will evaluate and document falls that occur while the individual is in the facility: for example, when and where they happen, and observations of the events, ect. Treatment/Management: #1- Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling.

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F 323	Continued From page 48 The immediate jeopardy that began on 10/24/15, and identified on 7/19/16, at 7:05 p.m, was removed on 7/20/16, at 3:30 p.m. when it could be verified by observation, record review and staff interviews, the the facility had implemented interventions including: -discontinuing the use of the Merry walker for R87 - 1:1 staffing implemented for R87 until appropriate assessments could be completed and a new safety plan initiated - the consultant pharmacist reviewed R87's medications - a PT assessment was conducted and a combination wheelchair/walker with 18" wheels for stability was ordered - PT also planned re-assessment of the new device upon arrival to determine appropriateness for R87 - a physician review was conducted - a comprehensive fall assessment was developed and staff were educated to implement appropriately; a post fall assessment, including required progress note, was created in the electronic chart to trigger a review of the care plan to include modifications and review of interventions; all staff were educated either verbally, via e-mail and/or by written postings at nurses' stations; NAs, RNs, case managers, LPNs, activity staff, and PT staff were interviewed to confirm implementation of the plan. Although numerous interventions were initiated, noncompliance remained at the lower scope and severity of a G, isolated scope with severity of actual harm that is not immediate jeopardy, because the facility had failed to ensure ongoing assessment and staff compliance with identified interventions to maintain resident safety.	F 323		

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F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has	F 334		8/30/16

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F 334	Continued From page 50 already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Pneumococcal Conjugate Vaccine-13 (PCV13) vaccines were offered to 4 of 5 residents (R20, R71, R91, R94) as recommended by the Centers for Disease Control (CDC) whose vaccination histories were reviewed and failed to develop guidelines for PCV13 as recommended by the CDC. Findings include:	F 334	F334 Influenza and Pneumococcal immunization Guidelines for administration of the use of PCV13 have been obtained. Medical Director's order obtained, and staff education on new guidelines completed on 8-4-16. A. R20, R71, R91, R94 will be offered PVC13 according to the CDC guidelines.	

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F 334	Continued From page 51 R20's Immunization Audit Report dated 7/22/16, indicated the 91 year old had received Pneumovax dose 1 on 1/1/07; however, the medical record lacked evidence R20 was also offered the PCV-13 vaccination as recommended by the CDC. R71's Immunization Audit Report dated 7/22/16, indicated the 95 year old had received Pneumovax dose 1 on 6/22/11; however, the medical record lacked evidence R71 was also offered the PCV-13 vaccination as recommended by the CDC. R91's Immunization Audit Report dated 7/22/16, indicated the 102 year old had received Pneumovax dose 1 on 10/1/90; however, the medical record lacked evidence R 91 was also offered the PCV-13 vaccination as recommended by the CDC. R94's Immunization Audit Report dated 7/22/16, indicated the 96 year old had received Pneumovax dose 1 on 9/17/09; however, the medical record lacked evidence R94 was also offered the PCV-13 vaccination as recommended by the CDC. When interviewed on 7/22/16, at 1:42 p.m. registered nurse (RN)-D who was responsible for the facility's infection control program confirmed the facility was aware of the CDC recommendation related to PCV13 and stated it was not a standard of practice to offer/administer the vaccination to the residents, only if the physician specifically ordered it. Further, RN-D verified the CDC's recommendations were not reflected in the facility's pneumococcal policy.	F 334	B. All resident have the potential to be affected by this practice. Upon admission residents will be assessed for the need of the pneumococcal vaccination (PCV13) as per the CDC guidelines. PCV13 will be offered first per the CDC guidelines and administrated if the resident so desires. Education will be given at the time of the offer of the vaccination explaining the risk VS benefits of the vaccination. Will follow up with the PPSV23 vaccination per guidelines. All residents currently residing in the building and that have previously had the PPSV23 vaccination, will be offered PCV13 according to the guidelines. All residents who qualify for the PCV 13 vaccination will be offered and vaccination will be administered if the resident so desires. C. Audits on all new residents for the administration of the PCV13 will be completed on the next 20 admissions, to assure guidelines are being followed. D. Audits on all current LTC residents to assure the PVC13 was given/offered if they qualify according to the CDC guidelines. E. Completion for the administration of the PVC 13 8-30-16. Results will be reported to monthly QAPI meeting. DON or designee responsible.	

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F 334	Continued From page 52 The facility's Pneumococcal Vaccine Policy dated December 2012, indicated all resident would be offered the Pneumovax (pneumococcal vaccine) to aid in preventing pneumococcal infections. The policy, however, did not incorporate the new CDC guidelines to ensure residents were offered timely immunizations.	F 334		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the cleanliness of the walk-in cooler to promote sanitation and food safety in the main kitchen. This practice had the potential to affect all 80 who received food from the kitchen. Findings include: During the initial kitchen tour with cook (C)-A on 7/18/16, at 1:14 p.m. it was noted the outside of the walk-in refrigerator was wet. The frame of the door to the refrigerator had a thick layer of white frost and the stainless steel door frame had a dark brown substance evident when opened. A strong sour odor and garbage smell was evident	F 371	F371 Food Procure, Store/Prepare/Serve-Sanitary • The Walk in cooler has been fully cleaned and sanitized by dietary staff in order to store, prepare and distribute food under sanitary conditions per regulation. • Current walk in cooler will be fully replaced with an entirely brand new unit as of 10/1/2016 by Alexandria Refrigeration. • A full cleaning schedule to include the entire current walk in cooler has been put into place to allow for and promote sanitation and food safety. • All dietary staff have been educated	8/11/16

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BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(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 371	Continued From page 53 inside the unit. Along the south wall of the cooler there was a significant number of irregular shaped areas of black colored substance located between the second and third shelves. Fresh vegetables (leaf lettuce, cabbage, spinach and tomatoes) were stored on these shelves. The tomatoes and leaf lettuce were open to air, without any covering of these food items. Throughout the entire unit large areas of missing and chipped paint were noted. It appeared the interior walls of the walk-in cooler had been silver but the walls had been painted a white color. This was evident as the paint was peeling from the interior walls. Located adjacent to the shelves of stored vegetables were stored fresh oranges and apples. These fruit items were next to the areas of the dark colored substance. On 7/21/16, at 1:55 p.m. dining director (DD) stated she had a designated staff person, dietary aid (DA)-A who cleaned the walk-in cooler on Monday which included the walls but if not completed, the cooks clean the walls of this refrigerator. DD stated DA-A worked this past Monday and should have cleaned the walls as she saw DA-A in the unit. DD stated if any kitchen equipment required any repairs, a work order would be entered into the computer. The DD confirmed the most recent work order entered had been related to a storage pallet sent last week. It was observed on 7/21/16, at 2:05 p.m. that C-A was placing groceries onto the shelves located in the walk-in cooler/refrigerator when the DD and the surveyor re-entered the unit to confirm the presence of the mold identified on 7/18/16. C-A and DD indicated the humidity level was so high in the walk-in cooler that the refrigerator unit	F 371	as of 8/11/2016 on the proper cleaning schedule and process per Ecumen Bethany cleaning policy. • Audits of Cleaning schedule completeness and cleanliness of walk in cooler will be completed by Certified Dietary Manger or designee for 4 weeks, results will be provided to QAPI team for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 371	Continued From page 54	F 371		

could not keep up with the excessive humidity. C-A stated it had been discussed with the maintenance manager (MM) approximately a week ago, indicating the door seal was not working properly. The MM had confirmed the broken gray seal had separated from the door, thus not working properly to maintain the conditions inside the cooler. The MM stated he was responsible for cleaning the door seals and confirmed that mold was evident along the door frame. He stated they just had to be careful to make sure the door was shut tight but verified the door was sweating and consequently, moisture was evident due to the broken seal and the humidity level. When C-A removed the shelving away from the wall, both C-A and DD confirmed there was black colored mold extending across the length of the shelving and down the entire length of the wall. It extended from above the level of the second shelf down to the floor. There were several irregular shaped black colored mold patches and streaks on the wall with several, up to 1-1/2 inches around or long. DD wiped a large black patch of the black substance (mold) with her fingers. A dark residue remained on her fingers. Both C-A and DD confirmed a strong odor was evident while in the cooler. C-A stated they did not have baking soda in the cooler anymore, but used to use it to control the odor. C-A also confirmed there was standing liquid in front of the shelf where a pork roast was thawing in a cardboard box. He confirmed the frozen roast had leaked liquid onto the floor during thawing. C-A indicated both the pork and fish tend to leak onto the floor. C-A stated they have a galvanized floor in the walk-in cooler, which was damaged and had rusted. He confirmed the floor had significant rust located in front of the meat thawing rack which extended approximately 6 in.

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F 371	Continued From page 55 from the rack. On 7/21/16, at 2:10 p.m. C-A removed the vegetables from the shelving and placed them on top of a stainless steel cart located in the cooler. It was observed that C-A was inside the walk-in cooler on his knees and had a small white plastic bucket containing bleach solution and a cleaning rag. C-A indicated he had never washed the walls inside the cooler, and was unsure of the last time it had been washed. He stated the black substance was present due to the high humidity level in the cooler. C-A indicated he had never noticed the black mold substance until the surveyor made them aware. As C-A wiped the black substance off the wall of the cooler with the bleach solution, gray colored water ran down the wall as it was washed. On 7/21/16, at 3:45 p.m. DA-A stated she was scheduled to clean on Mondays from 9-11:30 a.m. but confirmed she had not washed the walls inside the walk-in cooler this past Monday during her scheduled hours. DA-A verified she doesn't wash the wall and was unsure how long it's been since they had been washed. She was unsure who was assigned this cleaning task and indicated only recently started sanitizing the shelf racks. DA-A explained she only conducted random checks of the cooler cleanliness as she had too many other tasks. DA-A stated she had noticed the black substance on the racks in the past but was unsure how the mold returned as bleach kills it. When interviewed on 7/21/16, at 5:30 p.m. the MM and the administrator (A) confirmed they were unaware of the mold (black substance) in the walk-in cooler and agreed they needed to	F 371		

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F 371	Continued From page 56 develop a system, procedure and cleaning schedule for the walk-in cooler. The administrator stated staff need to remove all of the food items and wash/clean the unit, including the shelves prior to returning the stored food items. Review of the undated facility policy, Sanitation of the Food Service Department identified the food service staff shall maintain the sanitation of the food service department through compliance with the cleaning schedule. Review of the dietary cleaning schedule , dated 4/08 identified refrigerators would be cleaned weekly.	F 371		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the condition of the walk-in cooler located in the dietary kitchen was properly maintained to control the humidity level and ensure the proper storage of perishable food. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: During the initial kitchen tour with cook (C)-A on 7/18/16, at 1:14 p.m. it was noted the outside of the walk-in refrigerator was wet. The frame of the	F 456	F456 Essential Equipment, Safe Operating Condition • The Walk in cooler has been fully cleaned, sanitized and maintained by dietary staff in order to store, prepare and distribute food under sanitary conditions and safe operation condition per regulation. • Current walk in cooler will be fully replaced with an entirely brand new unit as of 10/1/2016 by Alexandria Refrigeration. • A full cleaning schedule to include the	8/11/16

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F 456	Continued From page 57 door to the refrigerator had a thick layer of white frost and the stainless steel door frame had a dark brown substance evident when opened. A strong sour odor and garbage smell was evident inside the unit. Along the south wall of the cooler there was a significant number of irregular shaped areas of black colored substance located between the second and third shelves. Fresh vegetables (leaf lettuce, cabbage, spinach and tomatoes) were stored on these shelves. The tomatoes and leaf lettuce were open to air, without any covering of these food items. Located adjacent to the shelves of stored vegetables were stored fresh oranges and apples. These fruit items were next to the areas of the dark colored substance. On 7/21/16, at 1:55 p.m. dining director (DD) stated if any kitchen equipment required any repairs, a work order would be entered into the computer. The DD confirmed the most recent work order entered had been related to a storage pallet sent the previous week. It was observed on 7/21/16, at 2:05 p.m. that C-A was placing groceries onto the shelves located in the walk-in cooler/refrigerator when the DD and the surveyor re-entered the unit to confirm the presence of the mold identified on 7/18/16. C-A and DD indicated the humidity level was so high in the walk-in cooler that the refrigerator unit could not keep up with the excessive humidity. C-A stated it had been discussed with the maintenance manager (MM) approximately a week ago, indicating the door seal was not working properly. The MM had confirmed at that time that the broken gray door seal had separated from the door, thus not working properly to maintain the conditions inside the	F 456	entire current walk in cooler has been put into place to allow for and promote sanitation and food safety. • All dietary staff have been educated as of 8/11/2016 on the proper cleaning schedule and process per Ecumen Bethany Community cleaning policy. • Audits of Cleaning schedule completeness and cleanliness of walk in cooler will be completed by Certified Dietary Manger or designee for 4 weeks, results will be provided to QAPI team for review.	

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F 456	Continued From page 58 cooler. MM had instructed they just had to be careful to make sure the door was shut tight but verified the door was sweating and consequently, moisture was evident due to the broken seal and the humidity level. C-A confirmed the mold was evident between the shelves and when he pulled the shelving away from the refrigerator wall, areas of dark colored substance extended down the wall from the area above the second shelf to the floor of the refrigerator. He stated they have a galvanized floor in the walk-in cooler, which damaged and had rusted. On 7/21/16, at 2:10 p.m. C-A removed the vegetables from the shelving and placed them on top of a stainless steel cart located in the cooler. He stated the black substance was present due to the high humidity level in the cooler. On 7/21/16, at 3:45 p.m. DA-A stated she had noticed the black substance on the racks in the past. When interviewed on 7/21/16, at 5:30 p.m. the MM stated he was unaware of the broken seal on the door to the walk-in cooler and confirmed the evidence of the humidity/moisture problem on the walk-in cooler door and walls inside the cooler door.	F 456		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		8/11/16

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F 465	Continued From page 59 This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: On 7/18/216, at 1:14 p.m. during the initial kitchen tour with cook (C)-A it was noted that the floor covering underneath and surrounding the affixed steamer and oven located in the food preparation area had an area of missing maroon floor tile, which measured approximately 18 inches (in) by 18 in. The area was filled with dark and light gray dust and dirt particles. In addition, there was another irregular shaped area directly under the steamer and next to the missing tile area that was a dark brown, sticky, sludge material which measured approximately 6 in by 4 in. The entire floor in the food preparation area was soiled with food particles and dirty. On 7/21/16, at 1:55 p.m. the dining director (DD) confirmed the damage and dirty kitchen floor. She indicated the floor had steadily gotten worse this past year. DD also stated the floor is old and needed to be replaced. DD indicated they had purchased another oven, moved equipment around and had problems with water leaking from the steamer which caused the floor damage. DD stated the brown sticky substance was not grease but was compacted food material, dirt and grime. She confirmed the floor was no longer a cleanable surface, thus dirty. She stated	F 465	F465 Safe/Functional/Sanitary/Comfortable Environment • Kitchen Floor Tile has been fully cleaned throughout entire Kitchen area to provide a safe, functional, sanitary and comfortable environment for residents and staff. • Damaged Tile in kitchen has been replaced and repaired as of 8/23/2016 • A full floor cleaning schedule to include the entire kitchen area floors has been put into place • All dietary staff have been educated as of 8/11/52016 on the proper cleaning schedule and process per Ecumen Bethany Community cleaning policy. • Audits of cleaning schedule completeness and cleanliness of kitchen floors with be completed by Certified Dietary Manger or designee for 4 weeks, results will be provided to QAPI team for review.	

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F 465	Continued From page 60 housekeeping staff scrubbed the floor every other week, otherwise dietary was responsible for washing the floor. On 7/21/16, at 5:30 the maintenance manager (MM) and the administrator (A) confirmed the condition of the damaged floor tile and the dirty floor. MM knelt to the floor, wiped his hand across the area and visible gray dust was evident on his hand. MM and A confirmed the floor surface need to be repaired and/or replaced and agreed the damaged tile surface was unclean. MM and A confirmed a dark brown sticky material was evident on the floor behind steamer and stated it would be cleaned. Review of the undated facility policy, Sanitation of the Food Service Department identified the food service staff shall maintain the sanitation of the food service department through compliance with the cleaning schedule.	F 465		

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	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**07/21/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Bethany Home Building 01 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/2016

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

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K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Bethany Home facility was surveyed as 4 buildings as follows: Building 01 - The Nursing Home, was constructed in 1962 and 1977, is 1-story, with full basement and was determined to be of Type II(000) construction. Building 02 - The Sub Acute building, was constructed in 2003, and is a 3-story structure with full basement that was determined to be of Type II (111) construction. The Sub Acute building 02 is connected to building 01 and is separated by a 2 hour fire barrier. the Sub Acute Building 02 is also connected to an assisted living occupancy that was not surveyed because the assisted living facility is separated from the the Sub Acute building 02 by a 2-hour fire barrier. Building 03 - The Chapel Addition, was	K 000		

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K 000	Continued From page 2 constructed in 2002, is a 1-story building with no basement that was determined to be of Type IV (Heavy Timber) Building 04 - The 2012 Renovation, is the 1st floor of the east side of the Nursing Home building 01 and two floors of the Main entrance and dining area adjacent to the Sub Acute Building 02. This was a full renovation. The facility is protected throughout be an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with smoke detectors in all common areas and spaces open to the corridor installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a licensed capacity of 83 beds and had a census of 78 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door	K 018		8/2/16

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K 018	Continued From page 3 and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke resistance of 1 resident room door according to NFPA 101 LSC (00) section 19.3.6.3.1. This deficient practice could affect the safety of 20 of the 78 residents and an undetermined amount of staff and visitors, if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On the facility tour between 8:00 am to 3:00 pm on 07/21/2016 observations and staff interview revealed resident room door 2124 did not fit tightly in the frame. This deficient condition was verified by the Executive Director and the Maintenance Manager.	K 018	Ecumen Bethany Home Matthew Fischer Executive Director 8/12/2016 Life Safety Code Survey Plan of Correction. Bethany Home Building 01 K018 Resident room 2124 has been corrected by facility maintenance to fit tightly to door frame to maintain the smoke resistance according to NFPA 101 LSC Date of completion is 8/2/2016 Weekly audits will be completed by facility Maintenance Staff to ensure continued compliance. Individuals responsible for correction and assurance of compliance are as follows; Facility Executive Director and Facility Maintenance Manger	
K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke	K 025		8/10/16

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K 025	Continued From page 4 barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper construction of 1 of several smoke barrier walls according to the requirements of NFPA 101 - 2000 edition, Sections 19-3.7.3 and 8.3. This deficient practice could affect 31 of the 78 residents and an undetermined amount of staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On the facility tour between 8:00 am to 3:00 pm on 07/21/2016 observations and staff interview revealed penetrations in two smoke barriers,one located at the North side of Latoka Landing and one located in the North side of the chapel lobby, above the corridor doors. This deficient condition was verified by the Executive Director and the Maintenance Manager.	K 025	K025 Smoke barriers located on the north side of Latoka Landing Hallway and the North side of the Chapel lobby above the corridor doors has been sealed by facility maintenance per NFPA 101 LSC to prevent smoke propagation between compartments. Date of completion is 8/10/2016 Weekly audits will be completed by facility Maintenance Staff to ensure continued compliance. Individuals responsible for correction and assurance of compliance are as follows; Facility Executive Director and Facility Maintenance Manger	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6,	K 027		8/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 027	Continued From page 5 19.3.7.7 This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility has failed to maintain 1 of several smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect 20 of the 78 residents, and an undtermined amount of staff and visitors by allowing smoke to propagate from one smoke compartment to another. Findings include: On the facility tour between 8:00 am to 3:00 pm on 07/21/2016 observations and staff interview revealed the smoke barrier doors on the second floor, south of the admin suite did not close properly due to a broken door coordinator. This deficient condition was verified by the Executive Director and the Maintenance Manager.	K 027	K027 Smoke barrier doors located outside of the admin suite have been fitted with a new door coordinator by facility maintenance to allow for proper closure and smoke/fire barrier. Date of completion is 8/10/2016 Weekly audits will be completed by facility Maintenance Staff to ensure continued compliance. Individuals responsible for correction and assurance of compliance are as follows; Facility Executive Director and Facility Maintenance Manger	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is	K 062	K062 Quarterly sprinkler system tests of the automatic sprinkler system in accordance with NFPA 101 LSC have been scheduled to be completed each quarter by Summit Companies. Electronic TELS system through Direct Supply has been set up for quarterly reminders. Date of completion is scheduled for 9/1/2016	8/30/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **01 - NURSING HOME** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 6 fully operational in the event of a fire and could negatively affect, all of the 78 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 3:00 pm on 07/21/2016 record review, observations and staff interview revealed the following. 1. Quarterly sprinkler system tests were not being conducted. 2. The fluid color of the sprinkler head in the kitchen freezer was not red. This deficient condition was verified by the Executive Director and the Maintenance Manager.	K 062	Weekly audits will be completed by facility Maintenance Staff to ensure continued compliance. The sprinkler head located in the kitchen freezer has been replaced with a new head by NOVA. Date of completion is scheduled for 8/30/2016. Weekly audits will be completed by facility Maintenance Staff to ensure continued compliance. Individuals responsible for correction and assurance of compliance are as follows; Facility Executive Director and Facility Maintenance Manger	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Bethany Home Building 02 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

By e-mail to:
Marian.Whitney@state.mn.us
and
Angela.Kappenman@state.mn.us

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

The Bethany Home facility was surveyed as 4 buildings as follows:

Building 01 - The Nursing Home, was constructed in 1962 and 1977, is 1-story, with full basement and was determined to be of Type II(000) construction.

Building 02 - The Sub Acute building, was constructed in 2003, and is a 3-story structure with full basement that was determined to be of Type II (111) construction. The Sub Acute building 02 is connected to building 01 and is separated by a 2 hour fire barrier. the Sub Acute Building 02 is also connected to an assisted living occupancy that was not surveyed because the assisted living facility is separated from the the Sub Acute building 02 by a 2-hour fire barrier.

Building 03 - The Chapel Addition, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 constructed in 2002, is a 1-story building with no basement that was determined to be of Type IV (Heavy Timber) Building 04 - The 2012 Renovation, is the 1st floor of the east side of the Nursing Home building 01 and two floors of the Main entrance and dining area adjacent to the Sub Acute Building 02. This was a full renovation. The facility is protected throughout be an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with smoke detectors in all common areas and spaces open to the corridor installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a licensed capacity of 83 beds and had a census of 78 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062		9/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **02 - SUB ACUTE** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3 Based on record review and staff interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 78 residents, and an undetermined amount of staff and visitors. Findings include On the facility tour between 8:00 am to 3:00 pm on 07/21/2016 record review, and staff interview revealed quarterly sprinkler system tests were not being conducted. This deficient condition was verified by the Executive Director and the Maintenance Manager.	K 062	Bethany Home Building 02 K062 Quarterly sprinkler system tests of the automatic sprinkler system in accordance with NFPA 101 LSC have been scheduled to be completed each quarter by Summit Companies. Electronic TELS system through Direct Supply has been set up for quarterly reminders. Date of completion is scheduled for 9/1/2016 Weekly audits will be completed by facility Maintenance Staff to ensure continued compliance. Individuals responsible for correction and assurance of compliance are as follows; Facility Executive Director and Facility Maintenance Manger	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **03 - CHAPEL AREA** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Bethany Home Building 03 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **03 - CHAPEL AREA** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Bethany Home facility was surveyed as 4 buildings as follows: Building 01 - The Nursing Home, was constructed in 1962 and 1977, is 1-story, with full basement and was determined to be of Type II(000) construction. Building 02 - The Sub Acute building, was constructed in 2003, and is a 3-story structure with full basement that was determined to be of Type II (111) construction. The Sub Acute building 02 is connected to building 01 and is separated by a 2 hour fire barrier. the Sub Acute Building 02 is also connected to an assisted living occupancy that was not surveyed because the assisted living facility is separated from the the Sub Acute building 02 by a 2-hour fire barrier. Building 03 - The Chapel Addition, was	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **03 - CHAPEL AREA** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 constructed in 2002, is a 1-story building with no basement that was determined to be of Type IV (Heavy Timber) Building 04 - The 2012 Renovation, is the 1st floor of the east side of the Nursing Home building 01 and two floors of the Main entrance and dining area adjacent to the Sub Acute Building 02. This was a full renovation. The facility is protected throughout be an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with smoke detectors in all common areas and spaces open to the corridor installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a licensed capacity of 83 beds and had a census of 78 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by:	K 062		9/1/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **03 - CHAPEL AREA** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3 Based on record review and staff interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 19.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 78 residents, and an undetermined amount of staff and visitors. Findings include On the facility tour between 8:00 am to 3:00 pm on 07/21/2016 record review, and staff interview revealed quarterly sprinkler system tests were not being conducted. This deficient condition was verified by the Executive Director and the Maintenance Manager.	K 062	Bethany Home Building 03 K062 Quarterly sprinkler system tests of the automatic sprinkler system in accordance with NFPA 101 LSC have been scheduled to be completed each quarter by Summit Companies. Electronic TELS system through Direct Supply has been set up for quarterly reminders. Date of completion is scheduled for 9/1/2016 Weekly audits will be completed by facility Maintenance Staff to ensure continued compliance. Individuals responsible for correction and assurance of compliance are as follows; Facility Executive Director and Facility Maintenance Manger	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **04 - 2012 RENOVATED AREA** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Bethany Home Building 04 was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

HEALTH CARE FIRE INSPECTIONS
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145, or

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/12/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **04 - 2012 RENOVATED AREA** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. The Bethany Home facility was surveyed as 4 buildings as follows: Building 01 - The Nursing Home, was constructed in 1962 and 1977, is 1-story, with full basement and was determined to be of Type II(000) construction. Building 02 - The Sub Acute building, was constructed in 2003, and is a 3-story structure with full basement that was determined to be of Type II (111) construction. The Sub Acute building 02 is connected to building 01 and is separated by a 2 hour fire barrier. the Sub Acute Building 02 is also connected to an assisted living occupancy that was not surveyed because the assisted living facility is separated from the the Sub Acute building 02 by a 2-hour fire barrier. Building 03 - The Chapel Addition, was	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **04 - 2012 RENOVATED AREA** B. WING _____	**07/21/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HOME	**1020 LARK STREET ALEXANDRIA, MN 56308**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 constructed in 2002, is a 1-story building with no basement that was determined to be of Type IV (Heavy Timber) Building 04 - The 2012 Renovation, is the 1st floor of the east side of the Nursing Home building 01 and two floors of the Main entrance and dining area adjacent to the Sub Acute Building 02. This was a full renovation. The facility is protected throughout be an automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with corridor smoke detection with smoke detectors in all common areas and spaces open to the corridor installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for fire department notification. Hazardous areas have automatic fire detection that is on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a licensed capacity of 83 beds and had a census of 78 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 051 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other	K 051		8/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245434	A. BUILDING **04 - 2012 RENOVATED AREA** B. WING _____	**07/21/2016**

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K 051	Continued From page 3 transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code (00) section 18.3.4.2, 9.6.1.4 and NFPA 72 National Fire Alarm Code (99) section 2-3.6.6.2. This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 3:00 pm on 07/21/2016 observations and staff interview revealed a smoke detector within 36 inches of an HVAC diffuser on the second floor east of the Pelican Bay entrance. This deficient condition was verified by the Executive Director and the Maintenance Manager.	K 051	Bethany Home Building 04 K051 The smoke detector located on the second floor of the east Pelican Bay entrance has been relocated to be outside of the 36 inch window by facility maintenance and in accordance with NFPA 101 LSC. Date of completion is 8/10/2016 Weekly audits will be completed by facility Maintenance Staff to ensure continued compliance. Individuals responsible for correction and assurance of compliance are as follows; Facility Executive Director and Facility Maintenance Manger	
K 062	NFPA 101 LIFE SAFETY CODE STANDARD	K 062		9/1/16

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K 062 SS=F	Continued From page 4 Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 Life Safety Code (00), Section 18.7.6, and 4.6.12, NFPA 13 Installation of Sprinkler Systems (99), and NFPA 25 Standard for the Inspection, Testing and Maintenance of Water Based Fire Protection Systems, (98). This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect, all of the 78 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 8:00 am to 3:00 pm on 07/21/2016 record review, observations and staff interview revealed the following. 1. Quarterly sprinkler system tests were not being conducted. 2. An escutcheon was missing from a sprinkler head in the closet of resident room 123. This deficient condition was verified by the Executive Director and the Maintenance Manager.	K 062	K062 Quarterly sprinkler system tests of the automatic sprinkler system in accordance with NFPA 101 LSC have been scheduled to be completed each quarter by Summit Companies. Electronic TELS system through Direct Supply has been set up for quarterly reminders. Date of completion is scheduled for 9/1/2016 Weekly audits will be completed by facility Maintenance Staff to ensure continued compliance. An Escutcheon was installed on the sprinkler head in the closet of room 123 by facility maintenance. Date of completion is 8/2/2016 Weekly audits will be completed by facility Maintenance Staff to ensure continued compliance. Individuals responsible for correction and assurance of compliance are as follows; Facility Executive Director and Maintenance Manger	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
September 7, 2016

Mr. Matthew Fischer, Administrator
Bethany Home
1020 Lark Street
Alexandria, MN 56308

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5434025

Dear Mr. Fischer:

The above facility was surveyed on July 18, 2016 through July 22, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Pam Kerssen at (218) 308-2129 or email: pam.kerssen@state.mn.us.**

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00108	A. BUILDING: _____ B. WING _____	07/22/2016

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 7/18/2016, through 7/22/2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement the plan of care for 2 of 3 residents (R78, R28) reviewed who were dependent upon staff for shaving and oral cares and for 1 of 1 resident (R65) reviewed with bilateral hand contractures and required range of motion (ROM). Findings include: R78's admission Minimum Data Set (MDS) dated 7/1/16, identified R78 was moderately cognitively impaired, required extensive assistance for all areas of daily living (ADL)with exception of limited assistance to walk in corridor and diagnoses which included Parkinson's disease, dementia, arthritis and vision impairment. R78's undated care plan, identified R78 had a self care deficit related to Parkinson's Disease, hypertension, diabetes, and dementia as evidenced by requiring assist with ADL's -The	2 565	Corrected 8/9/2016 per Director of Nursing	8/9/16

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2 565	Continued From page 3 resident requires extensive assist of 1 staff with personal hygiene. The undated resident care sheet, indicated R78 required assist of one staff with dressing and grooming. On 7/19/16, at 9:28 a.m. R78 stated, " I can't shave because of my Parkinson, that is one thing they are a little lax on." At this time R78 has stubble on chin and upper lip. On 7/20/16, at 7:57 a.m. R78 was propelled from his room to the dining room by nursing assistant (NA)-H. R78 had facial hair stubble on the upper lip and chin area. On 7/20/16, at 1:00 p.m. R78 was seated in his room in a stationary chair in front of the television. R87 remained unshaven. On 7/21/16, at 9:26 a.m. R78 was seated in room dressed, has not had face shaved, mustache and beard heavy stubble. On 7/20/16, at 8:51 a.m. NA-H indicated R78 tries to shave independently and will ask staff when he needs help. NA-H indicated R78 was new to the facility and NA-H was unsure of whether R78 had behaviors or refused cares. When interviewed on 7/20/16, at 1:00 p.m. R78 verified if he was able to shave himself he would do it every day. R78 stated staff will shave his face each morning when they get him up with an electric razor but some times they forget. R78 verified his facial hair had not been shaved off today and was unable to recall when staff last shaved him.	2 565		

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2 565	Continued From page 4 On 7/20/16, at 1:17 p.m. NA-I identified R78 had no behaviors and did occasionally refuse to go for a walk, however, it was usually for a reason, for example if his wife was here or if he was having pain in his hip. On 7/21/16, at 9:54 a.m. NA-E indicated R78 was unable to shave independently due to shaky hands. NA-E verified he/she had not shaved R78 this a.m. NA-E indicated R78 refused the offer to shave this a.m. and had a routine of shaving only "every so often." On 7/21/16, at 11:00 a.m. NA-F verified R78 had a good memory and what he says is accurate. NA-F indicated he/she did not provide cares for R78 often, however, did believe R78 was usually clean shaven. NA-F indicated staff usually assisted R78 with oral care and shaving. NA-F sated, " We would normally shave a person if they can't themselves." On 7/21/16, at 11:04 a.m. R78 verified he was not shaved this morning. R78 stated, " it (facial hair) isn't so hard to get off" if he is shaved every day. R78 further identified with a clean shaven face it was easier to keep clean as things get caught, stating "I drool." On 7/21/16, at 11:13 a.m. licensed practical nurse (LPN)-E verified R78 had facial stubble and had not been shaved. On 7/21/2016, at 11:14 a.m. registered nurse (RN)-A verified R78 required assistance with ADL's due to has Parkinson's Disease and although his abilities change from day to day, R78 was not able to shave independently with an electric razor. RN-A identified staff were expected to shave male residents daily and would	2 565		

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2 565	Continued From page 5 not expect residents to have to ask for the assistance. When interviewed on 7/22/16, at 11:25 a.m. the director of nursing (DON) verified the expectation that staff follow the care plan and residents who require assistance with ADL's be provided the care and not expected to ask for assistance. R28's care plan dated 7/15/16, identified R28 required extensive assistance to total assistance with personal hygiene and oral cares. The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 mouth swab and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed. The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28. During observation of morning cares on 7/20/16, from 8:23 a.m. to 8:54 a.m. NA-A and NA-G assisted R28 with personal cares which included washing her face, perineal cares and dressing. During the observation, R28 was not assisted nor offered the opportunity for completion of oral cares. R28's oral cavity and lips appeared very dry. -At 8:57 a.m. NA-A assisted R28 with breakfast while R28 was positioned in bed. R28 was not wearing any dentures, and R28 refused the breakfast food items and juice offered. R28 did consume the strawberry supplement. -At 9:01 a.m. NA-A gathered the breakfast tray, shut off the bedroom lights and stated some days are good with feeding, and some days are not,	2 565		

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2 565	Continued From page 6	2 565		

just like today. NA-A then delivered the breakfast tray to the kitchen, R28 was not assisted nor offered the opportunity for completion of oral cares.

During interview on 7/20/16, at 8:45 a.m. NA-A reported R28 no longer wears dentures, and stated she was going to wait until after R28 ate breakfast to provide oral cares which included swabbing out the mouth with a toothette.

At 9:07 a.m. NA-A confirmed R28 had finished with the breakfast meal and confirmed she had completed morning cares for R28. NA-A verified she did not complete nor offer oral cares which included swabbing the mouth with a toothette or mouthwash. Further, NA-A confirmed she did not inspect her mouth with cares.

During interview on 7/21/16, at 10:35 a.m. RN-B confirmed R28 no longer wore dentures. RN-B verified staff are expected to swab R28's mouth with morning cares, or at least attempting as R28 will at times refuse. RN-B confirmed R28 has a dry mouth and sleeps with the oral cavity open, therefore, oral care must be attempted.

During interview on 7/22/16, at 10:08 a.m. the DON confirmed staff are expected to provide or offer oral cares to all resident twice per day as indicated on the care plan.

The facility's Mouth Care Policy dated October 2010, directed staff to review the resident's care plan for any special needs of the resident. and assemble the equipment and supplies as needed.

Review of R65's quarterly Minimum Data Set (MDS) dated 4/27/16, identified R65 had severe cognitive impairment and had diagnoses which

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2 565	Continued From page 7	2 565		

included Parkinson's disease, Alzheimer's disease and cerebravascular disease with hemiplegia . The MDS further identified R65 was totally dependent on staff for activities of daily living (ADL's) and had bilateral upper extremity contractures. Review of R65's annual Care Area Assessment (CAA) dated 8/19/15, identified R65 had severe cognitive impairment due to Alzheimer's disease, was totally dependent on staff for ADL's and had contractures.

Review of R65's care plan print dated 2/25/16, identified R65 had bilateral contractures of the upper and lower extremities, was totally dependent on staff for all ADL's, required gentle range of motion with daily care, required gauze rolls in both hands 23/hrs/day: to be removed for 30 minutes twice daily for hygiene for bilateral hand contractures.

On 7/18/16, at 5:38 p.m. R65 was seated in a tilt in space wheelchair across from the nurses station prior to the evening meal. Both of R65's hands were held in a fisted position, elbows were bent and hands rested on her chest, right hand rested near her heart and her left hand rested on her left upper chest. R65 did not have kerlix placed in her hands. At 6:55 p.m. R65 was seated in a tilt in space wheelchair near the nurses station following the evening meal. R65 remained without kerlix/gauze in both hands.
On 7/19/16, from 8:45 a.m. to 10:55 a.m. R65 was lying in bed tilted to her right side with pillows against her back, blankets were observed to cover R65 to mid torso. R65's hands were in a fisted position , arms were bent at the elbow, fisted hands rested against her chest. R65 did not have kerlix in her hands.

On 7/21/16, at 4:57 p.m. R65 was seated in a tilt

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2 565	Continued From page 8	2 565		

in space wheelchair with both arms bent at the elbows, hands were resting on her chest and were clenched fisted position. R65's right clenched hand was resting over her heart and her left clenched hand was resting on her upper left chest, no kerlix was observed in R65's hands.

When interviewed on 7/21/16, at 5:09 p.m. registered nurse manager (RN)-A confirmed R65 did not have kerlix in her contracted hands as care planned and was unsure why the kerlix was not in use. RN-A stated the medication nurses were responsible for checking to make sure R65's kerlix were in both hands for bilateral hand contractures. RN-A stated she felt R65 hands were too contracted for the kerlix to have fallen out, nor could R65 remove the kerlix independently. RN stated R65's hands were fully contracted and had been for years. RN-A directed a licensed practical nurse (LPN)-D to apply kerlix.

On 7/21/16, at 5:13 p.m. LPN-D attempted to open R65's right hand fingers from the contracted, fisted position and apply approximately an inch in diameter cotton kerlix roll into R65's hand. R65 stated it hurt and she was hurting her fingers, LPN-D immediately stopped opening R65's hand. At that time, LPN-D stated there were times when R65's hands needed to be soaked in warm water to help open the hands up. RN-A and NA-B then wheeled R65's to her room and NA-B wheeled R65 into her bathroom, while RN-A started to run the water out of the faucet. NA-B took R65's right hand, held it under the warm water while RN-A slowly opened R65's hand, washed, dried and applied the kerlix. NA-B then took R65's left hand, held it under the water while RN-A opened R65's hand, washed, dried and applied another roll of kerlix. NA-B assisted R65 back out of the bathroom in

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2 565	Continued From page 9 her wheelchair and wheeled R65 back to nursing station. On 7/21/16, at 5:12 p.m. NA-B stated R65 was supposed to have the kerlix in both of her hands at all times. NA-B stated the nurses usually put them in after R65's hands were washed. NA-B stated she felt about 3-4 times a week R65's kerlix were not in her hands and she would then place the kerlix into R65's hands and often had a hard time doing so. NA-B further stated she felt R65's hands were fisted very tightly so the kerlix could not fall out and she felt R65 would be unable to remove the kerlix herself. NA-B stated she felt R65's hands had not worsened over the last few years. On 7/22/16, at 10:23 a.m. NA-C stated R65 required total assistance with all ADL's, NA-C stated on average a few days a week R65 would not have the cloth rolls, (kerlix) in her hands and NA-C would then place the kerlix in R65's contracted hands. On 7/22/16, at 10:37 a.m. RN-A stated R65 had not had a recent occupational therapy evaluation, though had one a few years ago which identified R65 had complete contractures of both hands. RN-A confirmed R65's current physician orders directed nursing staff to ensure R65 had kerlix placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated R65 had fully contracted hands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing	2 565		

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2 565	Continued From page 10 (DON) stated she expected resident care plans to be implemented as directed. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. The facility policy titled Resident MDS 3.0 Assessment and Plan of Care revised 03/12, indicated the care plan was to provide continuity of care from admission to discharge. The facility's Care Plan Policy dated September 2010, indicated the care plan would be used to enhance the optimal functioning of the resident, and/or aid in preventing or reducing decline in resident's functional status and/or functional levels. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and	2 830		8/12/16

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2 830	Continued From page 11 custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, ensure adequate supervision and implement interventions, to decrease the risk of further falls for 1 of 3 residents (R87) reviewed who sustained multiple falls. R87 experienced an injury while utilizing a Merry walker (a walker/chair combination type device), resulting in an immediate jeopardy (IJ) situation. The facility failed to investigate and comprehensively assess the resident's falls while utilizing the Merry walker to determine whether new interventions should have been implemented, and the facility failed to ensure interventions currently in place were adequate and consistently implemented to minimize the risk for further falls. The immediate jeopardy (IJ) began on 10/24/15, when R87 sustained a fall with injury while walking in the Merry walker. The facility's administrator and director of nursing (DON) were notified of the immediate jeopardy (IJ) situation on 7/19/16, at 7:05 p.m. The IJ was removed on 7/20/16, however, noncompliance remained at a	2 830	Corrected 8/12/2016 per Director of Nursing	

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2 830	Continued From page 12 lower level of G, isolated scope, with severity of actual harm that is not immediate jeopardy. Findings include: R87 was observed on 7/18/16, at 5:31 p.m. with a gait belt fastened around her waist, standing in a Merry walker made of PVC pipe. Cloth weights had been fastened with zip ties to the bottom of the walker on three sides and a cloth type strap was attached to the seat of the walker. The strap attached to the front of the walker and was located between R87's legs. R87 independently wandered about the Darling Springs unit utilizing the Merry walker. R87 was observed to walk with a shuffling gait and was noted to have an abrasion near her right eye. When she got to the doorway to the dining room, R87 couldn't move the Merry walker forward. R87 remained stationery in the doorway to the dining room until nursing assistant (NA)-D assisted R87 to turn around in the Merry walker so R87 could ambulate in the opposite direction. R87 continued to move around the area of the Darling Springs nurses' desk, bumping into walls and doorways. R87 was again observed on 7/18/16, at 6:48 p.m. walking in the Merry walker in the Darling Springs hallway with a shuffled gait. R87 was observed bumping into walls, doorways and residents in wheelchairs while walking down the hallway in the Merry walker device. The administrator was observed at that time to grasp a corner of the Merry walker to straighten R87's navigation. A few minutes later, R87 was observed to walk/bump into the right front corner of the Merry walker, bounced backward and came to rest on the seat of the Merry walker with half of her buttock positioned on the seat of the walker. R87 then stood and continued to wander throughout	2 830		

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2 830	Continued From page 13 the hallway while attempting to navigate the Merry walker. On 7/19/16, at 10:42 a.m. NA-E was observed to guide R87, who was in the Merry walker, out of her room to the hallway. NA-E then left R87 to independently walk in the Merry walker. R87 was observed to walk with a shuffled gait. She was located in the short hall outside of her room, but not within staff view. While in the Merry walker in the corner of the short hall, R87 was able to grasp the door handle to the bathroom door labeled B-13 and jiggle the handle. R87 then turned her body to the right side of the Merry walker, moved the walker in a sideways direction out from the corner and moved toward the nurses' desk located on the opposite side from the dining room. At 10:46 a.m. R87 continued to move about in the Merry walker with a shuffled gait. She navigated to and from the short hallway located near her room which was located on the side of the nurses' station desk without staff in the area. At 10:47 a.m. a lab (laboratory) tech (technician) and two facility staff walked near the side of the nurses' station facing the dining room. None of these three staff looked in the direction of R87 as they walked past this area. At 10:47 a.m. licensed practical nurse (LPN)-C returned to the nurses' station area and approached the medication cart which faced the opposite direction from R87. LPN-C did not move to an area where R87 could be supervised. During this time, R87 was observed to have turned herself within the Merry walker to face backwards, and was observed to have lifted her right knee onto the Merry walker seat. On 7/19/16, at 10:50 a.m. two NAs were observed in the hallway to propel a cart while water mugs were removed from resident rooms.	2 830		

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2 830	Continued From page 14	2 830		

Neither NA looked in the direction of R87 as she once again maneuvered the Merry walker into the corner of the hall and was unable to propel it forward. At 10:51 a.m. R87 stood backwards in the Merry walker. The front and one side of the Merry walker were located against the corner walls in the short hallway. No staff were in the vicinity nor in view of R87 to provide supervision. At 10:55 a.m. R87 remained unable to move from the corner with the Merry walker. R87 raised her feet, one at a time, placing them onto the bottom bar of the Merry walker. She then placed her right knee onto the seat of the walker. At 10:57 a.m. R87 shuffled the Merry walker towards the location of the nurses' desk, leaned over the Merry walker bar, spit on the floor and continued forward with little shuffled steps in the direction of the corner located near the bathroom. NA-E was observed in the hall to be delivering water mugs to resident rooms but did not walk in R87's direction. At 11:00 a.m. R87 continued to ambulate with small steps, navigating the Merry walker toward the nurses' station. R87 stopped the movement of the walker when it butted up against the nurses' station desk. At 11:08 a.m. R87 stood up in the Merry walker while it was caught against the nurses' station. Staff were noted on the dining room side of the desk.

At 11:11 a.m. on 7/19/16, R87 and another female resident seated in a wheelchair were in the vicinity of the nurses' desk. At 11:14 a.m. R87 pushed her Merry walker into the other female resident's wheel chair. When R87 could not propel forward, she grasped the top bar of the walker and shook it back and forth. At 11:17 a.m., while R87 continued to shake the Merry walker, the resident located in the wheel chair grasped R87's left wrist and stated "go tell your mother". R87 made no response but continued to shake

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2 830	Continued From page 15 the walker. At 11:18 a.m. facility staff walked through the area pushing a housekeeping cart onto the elevator, without looking in the direction of R87. At 11:19 a.m. R87 finally seated herself in the Merry walker with only the right side of her buttock seated on the Merry walker seat. The Merry walker remained in contact with the other resident's wheel chair. At 11:19 a.m. R87 stood from the seat, and again began shaking the walker. The resident in the wheelchair stated, "do you want me to spank you?" and grasped R87's wrist. At that time, the surveyor summoned staff. At 11:22 a.m. registered nurse (RN)-A separated the two residents. R87's annual Minimum Data Set (MDS) dated 5/11/16, identified R87 had long and short term memory problems with no recall ability, was rarely to never understood, and required extensive assistance for all activities of daily living (ADL). A facility form, Order Summary Report signed by the physician 6/27/16, indicated R87's medical diagnoses included: dementia with Lewy Bodies, Parkinson's disease and anxiety disorders. R87's Care Area Assessment (CAA) dated 5/11/16, included: "Cognitive loss /Dementia: severe impairment w(with)/cognition triggered CAA r/t [related to] dx [diagnosis] of dementia with Lewy bodies, Parkinson's and depression.. ADL functional /Rehabilitation Potential: Requires assist with ADL's and mobilities r/t Parkinson's Disease, Dementia with Lewy Bodies, HTN [hypertension], osteoarthritis and Hx [history of falls]. See CP [care plan] for details. Safety interventions are in place to prevent falls/injuries. Noted to have 2 falls since previous MDS. Will monitor and implement safety interventions PRN [as needed]. Resident does wander about unit. At times will wander into other resident's rooms. Wander guard is in place to alert staff if resident	2 830		

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2 830	Continued From page 16	2 830		

attempts to wander outside. Velcro sashes are put across other residents' doorways to detour resident of entering room. Does help detour at times. Is at risk for impaired communication r/t [related to] Dementia and Parkinson's Disease. Speech is mumbled and has difficulty finding the right words. Response does not always make sense. Is sometimes understood and sometimes understands communication. No referral needed at this time." Behavioral Symptoms: "Observed to have behaviors of physical abuse towards others and wandering. Staff will provide [R87] with PRN pain meds [medications] when is showing aggression in her face. [R87] will also ram into things with her Merry walker repetitively. PRN pain meds have shown to redirect this behaviors."

R87's care plan reviewed 7/13/16, indicated the resident was "at risk for falls due to dementia with Lewy Bodies, and Parkinson's disease." Interventions included: "Ensure [R87] is wearing appropriate footwear when ambulating or mobilizing in wheel chair. Follow facility fall protocol. Physical therapy eval [evaluation] and treat as ordered or as needed. Review information on past falls and attempt to determine cause of falls. Record possible root causes. Educate resident/family/caregivers/ IDT [interdisciplinary team] as to causes. Safety interventions: (1) Low bed and safety mats when in bed. (2) Shoes or gripper slippers to be worn when in Merry walker. (3) Close dining room and activity doors in the evening when [R87] is in Merry walker. Bathroom door to be closed when resident is not using the bathroom. (4) Weights on base of Merry walker to increase stability. (5) Keep an extra set up [SIK] slippers in Merry walker in case one falls off. (6) 1:1 staff assist/ supervision when in the dining room. (7) Clip call light to resident at NOC [night] to alert staff when

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2 830	Continued From page 17 she moves or gets up (has soft touch call light). (8) Staff will monitor whereabouts every 30 minutes and PRN. (9) Bring to bathroom before sitting in recliner." R87's NA care sheet (a reference NAs used regarding specific care for residents) undated, identified safety interventions for R87 to include: (1) to ensure to take R87 to the bathroom before assisting to the recliner, (2) keep bathroom door closed, (3) clip call light on R87 at bed time, (4) low bed and safety mat (put mat against wall when not in bed), (5) keep gait belt on walker (close to resident), (6) Follow with wheel chair when ambulating, one to one assist when in dining room, use body pillow to position in bed, wanderguard worn. The NA care sheet also indicated in the comment section: "Merry Walker [see purple sheet in NA book]." The purple sheet directed staff to "observe frequently." Although the NA care sheet directed staff to observe R87 in the Merry walker, no specific time frame was given even though the care plan indicated staff to monitor R87's whereabouts every 30 minutes and PRN. When interviewed on 7/19/16, at 11:22 a.m. RN-A stated R87 was safe to be unsupervised in the Merry walker and stated, "we check on her every half hour". On 7/19/16, at 1:35 p.m. NA-E indicated it was usual practice to allow R87 to walk around while in the Merry walker unsupervised. NA-E stated, "We try to keep her safe, the nurses do a good job of keeping her close." NA-E verified that although she had not witnessed R87's falls involving the Merry walker, she'd heard that R87 had stepped on the bottom of the walker causing it to fall over and causing a cut to R87's face. NA-E pointed to the temple area.	2 830		

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2 830	Continued From page 18 A review of R87's clinical record identified the following 27 documented fall incidents which involved the use of the Merry walker since R87 was admitted on March 2015: (1) 5/10/15- found on floor underneath Merry walker; No apparent injuries Care plan and multiple safety interventions were being followed at time of fall. Spoke with family member (F)-A. Discussed the risk vs. benefits of the Merry walker, F-A feels at this time, the merry walker continues to benefit greatly and feels is at a greater risk of injury if she was not using the Merry walker and self transferring without it. Staff will continue with 30 minute checks and follow Merry Walker guidelines as listed in CP (care plan). (2) 5/17/15- found on floor, had tipped over Merry walker; head up against the wall on right side; bruising on RUE (right upper extremity) from previous fall; No other noted injuries. Resident was crying but able to voice if she was hurt. Unwitnessed. Will place safety mat against wall when not in bed to prevent resident from tripping on mat or wheeling over it with Merry walker. Will also continue Q (every) 30 minute checks. (3) 5/20/15- found by a staff member laying on the floor with one leg still around the strap of Merry walker around 4:00 p.m. Resident assisted back into Merry walker with 2 staff and EZ (mechanical device) lift. No further documentation of IDT (interdisciplinary team) review of fall. (4) 5/30/15- found on the floor in her Merry walker with one leg around Merry walker strap. No injuries noted. Will continue current interventions.	2 830		

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2 830	Continued From page 19 (5) 6/20/15- found sitting opposite direction in Merry walker. Sitting on floor. No apparent injuries. (6) 6/23/15- found on floor in Merry walker. When staff removed Merry walker to assist off the floor, resident began scooting on her butt on the floor. No injuries noted. CP being followed. (7) 6/28/15- in Merry walker, stumbled to the left and right leg crossed over left leg and resident grabbed for medication cart to catch herself and this caused [R87] and Merry walker to fall to the left. Right hip pain and right foot rotated inward. Lump on left side of head and above left eye. Pupils sluggish. Guarded movement to the right leg. Ice applied to head abrasion and lump. Sent to the emergency department (ED). (8) 6/30/15- in Merry walker when lost her balance and fell to the floor, tipping Merry walker over. Was sent to ER (emergency room) and returned with no fractures or injuries. CP being followed. Action: Weights added to base of merry walker to add stability. (9) 8/1/15- found on floor in Merry walker in room. Got up with assist of 2 staff. Resident was uninjured. (10) 8/3/15- found on the floor of bedroom in Merry walker. No injuries noted from fall. CP was being followed. Will continue current interventions. (11) 8/4/15- found on floor at 11:30 a.m. in another resident's room with no injuries or hitting head. Was wearing slippers and in Merry walker at time of occurrence. Action: Up off floor and back in Merry walker.	2 830		

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2 830	Continued From page 20 (12) 8/4/15- found on floor in front of nurses' station in Merry walker and slipper on. No injuries noted. Continue current CP. (13) 8/5/15- had 2 falls in one day. Resident appears to be more restless and has facial grimacing. Is not always able to communicate pain with staff. No injuries from either fall. CP was being followed. Action: Physician referral out to schedule pain meds to see if this helps with restlessness. (14) 9/15/15- found sitting on floor backwards in Merry walker in her room, leg strap still attached between legs; shirt off at this time, gripper socks in place; R87 agitated at the time. Staff last checked in on R87 shortly before, less than hour prior to fall. (15) 9/16/15- found on the floor, in Merry walker, Merry walker did not tip over. No injuries noted from fall. CP being followed. (16) 9/19/15- observed on floor next to bed in room, was lying under the Merry walker. The Merry walker was intact, was assisted to the toilet and into the Merry walker at 2:20 p.m. No lumps bumps or bruising noted to her head. (17) 9/21/15- found on floor, in Merry walker at the time of fall. No injuries noted. CP being followed. Resident has been showing increased signs of pain and has been more anxious, likely related to pain. Fentanyl patch was increased today; Will also continue with current interventions. (18) 9/22/15- found in room on the floor underneath Merry walker at 7:00 p.m. The strap	2 830		

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2 830	Continued From page 21 was hooked around R87's foot and was lying on her back. A small quarter sized bruise was found on right buttock. Brought to the bathroom and returned to bed. (19) 9/23/15- found on the floor in room per staff interview, [R87\ assisted just prior to fall. Received a small bruise to buttocks as a result of the fall. Action: Fentanyl patch (pain medication) was recently increased on 9/21. Will continue to monitor pain and effects of Fentanyl patch as pain causes [R87] to be more anxious and increased her risk for falls. (20) 10/24/15- Resident tipped merry walker over sideways and was found face down on floor, unable to move. [R87] hit head/mouth on floor; mouth bleeding from losing a tooth. No one seen [sik] the incident so don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift. A follow up nursing note dated 10/26/15 at 11:41 a.m. included, IDT reviewed fall from 10/24/15. Resident tipped over merry walker and landed on her face. Received a small abrasion under nose and lost a tooth as a result of the fall. Seroquel (antipsychotic medication) was recently decreased last Wednesday, [R87] more active since then. Per daughter's request, she would like Seroquel increased to the previous dose, she states she has seen her mom have more added behaviors and would like her mom to be more tired than anxious and falling. Referral filled out for MD (medical doctor). Also, weights added to the back of the merry walker to balance it. (The intervention of added weights to the base of the merry walker was initiated after R87 had sustained a fall on 6/28/15). A nurses' note dated 10/26/15, at 13:39 (1:39 p.m.) included:..."Res. face continues to be swelled and abrasion is	2 830		

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2 830	Continued From page 22 scabbed. Call placed to [MD] to inquire about xray to face. RN UC [registered nurse unit coordinator] aware. [MD's] nurse will call back after talking to CNP [certified nurse practitioner]. Subsequent nursing notes indicated the physician had ordered a head CT scan [computed tomography X-ray] for that date. Documentation from 16:53 (4:53 p.m.) 10/26/15 indicated CT scan results from that date, indicated the resident had presented with facial pain and more confusion than usual. The report further included: Conclusion: 1. Nondisplaced fracture through the anterior superior most maxilla (upper jaw) at the base of the nose. Additionally, a nurse's note from 10:49 a.m. on 10/27/15 indicated the resident required an oral surgery consult. Despite the number of falls and fracture while utilizing the Merry walker, the facility failed to reassess R87's fall risk and interventions. (21) 1/6/16- found on the floor in the bathroom still in Merry-walker, under the bar with leg strap intact. Resident was found leaning against the wall in the bathroom. No other injuries present. Resident was assisted with 3 and ez-lift (mechanical full body lift) off of the floor and into bed. Then placed in merry walker for meals. No further review of the fall by the IDT. (22) 1/8/16- found on the bathroom floor, still in Merry walker; Merry walker did not tip over. No injuries from fall. CP was being followed. Was assisted to the bathroom less than 2 hours prior to the fall, not attempting to go to the bathroom at the time of the fall. Action: intervention to keep the bathroom door closed when not using it, [R87] wanders into her room through out the day. No further IDT review of the fall documented.	2 830		

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2 830	Continued From page 23 (23) 2/2/16- on floor in front of nurses' station at 7:30 a.m. in Merry walker. No injuries noted. Had foot wear on at time of occurrence. Continue CP. (24) 4/16/16- found sitting on the floor in the activity room close to Turtle Beach (resident unit) still in the Merry walker; walker was still upright; assisted back into the Merry walker with the EZ lift and 3 staff assist. Continue with CP; Family continue to feel the Merry walker is safest option and continues to be appropriate. A physician visit form dated 4/18/16, identified R87 was seen for a "regularly scheduled visit." "Nursing has no concerns with [R87], she has been stable." (25) 5/13/16- found on right side, Merry walker was tipped over on the floor, laying on gray mat next to bed, feet still inside tipped Merry walker. Was trying to get to Herbergers, climbed on Merry walker and flipped Merry walker onto side. Aide found resident on floor. No injuries from fall. Staff educated to make sure the mat is not on the floor when [R87] not in bed. Sign placed on wall to remind staff to pick up the mat when not in bed. (26) 6/26/16- found on floor of other resident's room in Merry Walker on floor with feet on the seat. No injuries noted. Merry walker discussed with family at all care conferences and they feel this is her safest option to avoid injury and also gives her the freedom to ambulate and be more independent. Will continue with current interventions. CP followed. (27) 6/27/16- found lying on floor underneath Merry walker outside of room in hallway, lying on back and holding head up, appeared to be	2 830		

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2 830	Continued From page 24 sleeping. No injuries. CP being followed;Will continue with these interventions. When interviewed on 7/19/16, at 2:55 p.m. the director of nursing (DON) identified an IDT reviewed resident falls to identify the cause of the fall, current interventions in place, previous interventions and possible new interventions. This IDT review is added to the nurse's progress notes in the electronic record and documented onto a Falls log. Review of the facility form titled Resident Incidents, printed for the dates of January 2016 to July 2016 included the following falls involving the Merry walker for R87: -2/2/16- witness-none, interventions-Continue current interventions-no injury. -4/16/16- witness-none, interventions-Continue current interventions. -5/13/16- witness- none, interventions-Continue current interventions. -6/26/16-witness-none, interventions-Will continue with current interventions. -6/27/16-witness-none, interventions-No maltreatment, care plan was being followed. Resident has numerous fall interventions in place. Will continue with theses interventions. The Incident Log did not include all the documented falls that occurred during the selected time frame. The log also lacked documentation of a comprehensive re-assessment of R87 and lacked documentation of any additional interventions implemented to prevent re-occurrence of falls. R87's electronic and written records lacked any evidence of physical (PT) or occupational therapy (OT) evaluations and/or treatment. In addition,	2 830		

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2 830	Continued From page 25 Morse Fall Scale documents completed on 8/28/15, 10/26/15, 11/20/15, 11/22/15 and 5/9/16, each identified R87's risk for falling, the use of a walker, and identified the resident as having a weak gait, stooped posture and described gait with, "steps are short, resident may shuffle." Each of these Morse Fall Scale documents indicated the resident had a score of 80 with anything above 45 indicating a high risk for falls. None of the documents identified any other specific assessment information. On 7/19/16, at 4:19 p.m. registered nurse (RN)-A reviewed the progress notes and verified R87's falls involved the Merry walker and that assessments and new interventions were not consistently completed and/or implemented. RN-A identified the usual process after a fall as follows: (1) review the nurse's progress notes, (2) interview staff to see what [R87] was trying to do, (3) if interviewable, ask the resident, (4) reassess fall risk and whether planned interventions are effective. RN-A indicated these assessment findings would have been documented as a follow-up note after each fall. RN-A verified that R87 was cognitively impaired and that it was difficult to identify a cause for each fall because R87 could not express her needs or actions. RN-A further identified there were so many planned interventions it was difficult to identify any new ones, and RN-A also stated fall assessments were completed quarterly, not after each fall. A facility document was provided titled Restraint/ Physical (Quarterly/Annual Evaluation) dated 2/17/16. RN-A verified this was the most current assessment form and verified there were no other assessment forms related to a fall risk assessment for R87. RN-A stated therapy had been involved with the assessment for the use of a Merry walker and had been assessed when	2 830		

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2 830	Continued From page 26 admitted. RN-A also stated the current CP included all of the current interventions and confirmed it was an expectation that staff follow the care plan. RN-A also stated the nurse was responsible to check on R87 every 30 minutes and to document such. RN-A explained the Merry walker currently utilized by R87 had been obtained from storage in the basement of the facility, and stated she did not believe they had a written copy of the manufacturer's instructions/recommendations. RN-A indicated she may have to complete a "Google" search to obtain the instructions. On 7/19/16, at 4:57 p.m. the DON identified the nurse manager was responsible to complete an assessment for resident use of a Merry walker and explained the assessment involved standing the resident in the Merry walker to see whether it was safe. The DON further explained this was not an actual written assessment, but included more of an observation to see whether the Merry walker was appropriate. The DON verified this was the only Merry walker assessment completed. The DON further explained the staff and family were aware that R87 was not safe and remained at risk for falls while in the Merry walker. The DON confirmed they were honoring the family wishes since R87 was not utilizing a Merry walker, she would have to be placed into a Geri Chair (a reclining wheel chair). The DON also indicated implementation of interventions after a fall would be completed if staff identified problems with the Merry walker, identifying examples such as not walking with it, or not using it properly. The DON further indicated the expectation for care of a resident utilizing a Merry walker included frequent observations by all staff when walking by. The DON said if a resident were trying to crawl out of the Merry walker, staff may	2 830		

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2 830	Continued From page 27	2 830		

lay the resident in bed with a safety mat placed next to the bed. The DON reiterated staff were expected to follow the CP. The DON indicated they had tried numerous interventions but would follow family wishes related to the continued use of the Merry walker. The DON stated the manufacturer's recommendations for use of the Merry walker was located in the storage area.

On 7/19/16 at 5:50 p.m. RN-A provided manufacturer's recommendations for use of a Merry Walker print out from the Internet. These printed out recommendations included: "The walker is constructed of metal and weighted at the bottom and each one should be individually fitted to the resident. The height of the top frame should be at the height of the pelvis to promote good posture." However, the Merry walker R87 currently utilized was constructed of PVC pipe to which three fabric type weights with zip ties were secured to the bottom bar of the walker. In addition, it was noted the height of the top frame of the Merry walker R87 utilized was not at the height of the pelvis but above the pelvis.

On 7/20/2016, at 9:33 a.m. physical therapist (PT)-A was interviewed. PT-A confirmed therapy duties included screening and treatment of residents related to transfers, balance,walking and determination of the most appropriate lifts for individual residents. PT-A stated, "[Merry walker] is not something we recommend, we want it to be functional walking with a walker or cane." PT-A identified resident considerations for use of a Merry walker would include: look safe, maintain balance and strength, have a good gait pattern and ability to propel forward without tripping. PT-A also verified that Merry walkers were able to tip over. PT-A indicated that when R87 was admitted to the facility, a quick screen to evaluate if

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2 830	Continued From page 28 therapy services were required was conducted. PT-A indicated that at that time services had not been determined to be needed so no physician order for treatment had been requested. PT-A confirmed R87 had not been provided therapy services any time since admission (March 2015) and confirmed R87 had not been evaluated by PT for the use of the Merry walker. The facility policy titled, Falls- Clinical Protocol revised September 2012, Assessment and Recognition identified the following: #5 The staff will evaluate and document falls that occur while the individual is in the facility: for example, when and where they happen, and observations of the events, ect. Treatment/Management: #1- Based on the preceding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The immediate jeopardy that began on 10/24/15, and identified on 7/19/16, at 7:05 p.m, was removed on 7/20/16, at 3:30 p.m. when it could be verified by observation, record review and staff interviews, the the facility had implemented interventions including: -discontinuing the use of the Merry walker for R87 - 1:1 staffing implemented for R87 until appropriate assessments could be completed and a new safety plan initiated - the consultant pharmacist reviewed R87's medications - a PT assessment was conducted and a combination wheelchair/walker with 18" wheels for stability was ordered - PT also planned re-assessment of the new device upon arrival to determine appropriateness for R87 - a physician review was conducted	2 830		

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2 830	Continued From page 29 - a comprehensive fall assessment was developed and staff were educated to implement appropriately; a post fall assessment, including required progress note, was created in the electronic chart to trigger a review of the care plan to include modifications and review of interventions; all staff were educated either verbally, via e-mail and/or by written postings at nurses' stations; NAs, RNs, case managers, LPNs, activity staff, and PT staff were interviewed to confirm implementation of the plan. Although numerous interventions were initiated, noncompliance remained at the lower scope and severity of a G, isolated scope with severity of actual harm that is not immediate jeopardy, because the facility had failed to ensure ongoing assessment and staff compliance with identified interventions to maintain resident safety. SUGGESTED METHOD OF CORRECTION: The director of nurses' could inservice staff to ensure that assessments are conducted after each fall. A plan of care could be implemented to reduce the fall incidents. Audits could be conducted to ensure that equipment is used after assessed for safety and that falls are assessed. The results of the audits could be reported to quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities	2 895		8/12/16

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2 895	Continued From page 30 through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions for identified contractures for 1 of 1 resident (R65) reviewed for range of motion (ROM.) Findings include: Review of R65's quarterly Minimum Data Set (MDS) dated 4/27/16, identified R65 had severe cognitive impairment and had diagnoses which included Parkinson's disease, Alzheimer's disease and cerebrovascular disease with hemiplegia . The MDS further identified R65 was totally dependent on staff for activities of daily living (ADL's) and had bilateral upper extremity contractures. Review of R65's annual Care Area Assessment (CAA) dated 8/19/15, identified R65 had severe cognitive impairment due to Alzheimer's disease, was totally dependent on staff for ADL's and had contractures. Review of R65's care plan print dated 2/25/16,	2 895	Corrected 8/12/2016 per Director of Nursing	

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2 895	Continued From page 31	2 895		

identified R65 had bilateral contractures of the upper and lower extremities, was totally dependent on staff for all ADL's, required gentle range of motion with daily care, required gauze rolls in both hands 23/hrs/day: to be removed for 30 minutes twice daily for hygiene for bilateral hand contractures.

Review of R65's current physician orders signed 7/19/16, revealed an order with a start date of 10/21/2015, directed nursing staff to check R65's kerlix roll in bilateral hands for placement every shift, should have kerlix in hands at all times and additional gauze between thumb, change kerlix and gauze when soiled and as needed every shift for contractures. The orders also directed nursing staff to wash R65's hands twice daily per instruction sheet.

Review of R65's provider progress note dated 5/27/16, revealed R65 had been seen for a routine visit in which R65 was assessed to have contractures which were most notably in her arms and hands.

Review of R65's most recent occupational therapy (OT) assessment dated 11/17/12, revealed R65 had bilateral hand contractures which were in a fixed flexed position. The evaluation directed staff to implement ROM exercises and in hand splints for bilateral hand contractures.

- R65's medical record lacked any further OT evaluations for hand contractures.

Review of R65's July 2016, treatment administration record (TAR) revealed a check mark for R65's treatment of kerlix rolls in both hands three times a day. The TAR revealed a

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2 895	Continued From page 32 chart code legend which a check mark indicated the treatment was in place on all days. Review of R65's care conference note dated 5/17/16, revealed R65 continued to have contractures of her hands and extremities. The note further revealed staff were to continue to apply gauze to R65's hands daily. The note indicated that was to continue. Review of R65's progress notes from 1/23/16, to 7/13/16, revealed the following: -1/24/16, revealed R65 had contractures to bilateral hands and required vigilant monitoring and gauze rolls placed in both hands, extra care to keep R65's hands clean. -2/5/16, revealed R65 received passive range of motion (PROM) to both upper and lower extremities due to contractures, staff continued to apply gauze rolls in both contracted hands daily. -3/5/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. -4/6/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. -4/23/16, revealed a ADL note which identified R65 required total assistance with all ADL's due to contractures and blindness. -4/27/16, revealed a restorative program note which identified R65 had bilateral hand contractures and staff was to put gauze rolls in	2 895		

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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) COMPLETE DATE
2 895	Continued From page 33 both hands to help her contractures and maintain skin integrity. -5/20/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. -5/28/16, revealed a order administration note which revealed staff was unable to place kerlix in R65's hands due to resident not able to open her hands. R65's progress notes lacked any follow up regarding inability to place gauze in R65's hands. -5/29/16, revealed a order administration note which revealed staff was unable to place kerlix in R65's hands due to resident not able to open her hands. R65's progress notes lacked any follow up regarding inability to place gauze in R65's hands. -6/20/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. -6/27/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. -7/13/16, revealed a monthly charting note which identified R65 had bilateral hand contractures and required total assistance from staff for all ADL's. On 7/18/16, at 5:38 p.m. R65 was seated in a tilt in space wheelchair across from the nurses station prior to the evening meal. Both of R65's hands were held in a fisted position, elbows were bent and hands rested on her chest, right hand rested near her heart and her left hand rested on her left upper chest. R65 did not have kerlix placed in her hands. At 6:55 p.m. R65 was seated in a tilt in space wheelchair near the	2 895		

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2 895	Continued From page 34	2 895		

nurses station following the evening meal. R65 remained without kerlix/gauze in both hands. On 7/19/16, from 8:45 a.m. to 10:55 a.m. R65 was lying in bed tilted to her right side with pillows against her back, blankets were observed to cover R65 to mid torso. R65's hands were in a fisted position , arms were bent at the elbow, fisted hands rested against her chest. R65 did not have kerlix in her hands.

On 7/21/16, at 4:57 p.m. R65 was seated in a tilt in space wheelchair with both arms bent at the elbows, hands were resting on her chest and were clenched fisted position. R65's right clenched hand was resting over her heart and her left clenched hand was resting on her upper left chest, no kerlix was observed in R65's hands.

When interviewed on 7/21/16, at 5:09 p.m. registered nurse manager (RN)-A confirmed R65 did not have kerlix in her contracted hands as care planned and was unsure why the kerlix was not in use. RN-A stated the medication nurses were responsible for checking to make sure R65's kerlix were in both hands for bilateral hand contractures. RN-A stated she felt R65 hands were too contracted for the kerlix to have fallen out, nor could R65 remove the kerlix independently. RN stated R65's hands were fully contracted and had been for years. RN-A directed a licensed practical nurse (LPN)-D to apply kerlix.

On 7/21/16, at 5:13 p.m. LPN-D attempted to open R65's right hand fingers from the contracted, fisted position and apply approximately an inch in diameter cotton kerlix roll into R65's hand. R65 stated it hurt and she was hurting her fingers, LPN-D immediately stopped opening R65's hand. At that time, LPN-D stated there were times when R65's hands

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2 895	Continued From page 35	2 895		

needed to be soaked in warm water to help open the hands up. RN-A and NA-B then wheeled R65's to her room and NA-B wheeled R65 into her bathroom, while RN-A started to run the water out of the faucet. NA-B took R65's right hand, held it under the warm water while RN-A slowly opened R65's hand, washed, dried and applied the kerlix. NA-B then took R65's left hand, held it under the water while RN-A opened R65's hand, washed, dried and applied another roll of kerlix. NA-B assisted R65 back out of the bathroom in her wheelchair and wheeled R65 back to nursing station.

On 7/21/16, at 5:12 p.m. NA-B stated R65 was supposed to have the kerlix in both of her hands at all times. NA-B stated the nurses usually put them in after R65's hands were washed. NA-B stated she felt about 3-4 times a week R65's kerlix were not in her hands and she would then place the kerlix into R65's hands and often had a hard time doing so. NA-B further stated she felt R65's hands were fisted very tightly so the kerlix could not fall out and she felt R65 would be unable to remove the kerlix herself. NA-B stated she felt R65's hands had not worsened over the last few years.

On 7/22/16, at 10:23 a.m. NA-C stated R65 required total assistance with all ADL's, NA-C stated on average a few days a week R65 would not have the cloth rolls, (kerlix) in her hands and NA-C would then place the kerlix in R65's contracted hands.

On 7/22/16, at 10:37 a.m. RN-A stated R65 had not had a recent occupational therapy evaluation, though had one a few years ago which identified R65 had complete contractures of both hands. RN-A confirmed R65's current physician orders

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2 895	Continued From page 36 directed nursing staff to ensure R65 had kerlix placed in both contracted hands and only to be removed when washed twice daily. RN-A stated the licensed nurses were responsible to ensure R65 had the kerlix in place and would document the kerlix on the (TAR.) RN-A stated she expected the kerlix to be in place as any care staff could apply the kerlix. RN-A stated R65 had fully contracted hands and fingers. On 07/22/16, at 11:13 a.m. the director of nursing (DON) stated she expected physician orders and resident care plans to be implemented. DON stated she did not feel that R65's kerlix treatment was for her hand contractures but were more for moisture control. The DON confirmed R65's current physician orders in point click care electronic medical record identified R65's kerlix treatment was ordered for hand contractures. Review of a facility policy titled, Restorative Nursing Program reviewed 5/2011, revealed a facility procedure to promote each residents highest practicable well being. A policy was requested regarding following physician orders, treatments and contractures; none were provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice nursing staff regarding implementation of the care plan to include completing range of motion as directed, and then audit to ensure compliance. The results could be reviewed as part of the overall quality assurance committee plan. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		

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2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. 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 MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide oral care and removal of facial hair for 2 of 3 residents (R78, R28) reviewed who were dependent upon staff for grooming and personal cares. Findings include: R78's admission Minimum Data Set (MDS) dated 7/1/16, identified R78 was moderately cognitively impaired, required extensive assistance for all areas of daily living (ADL)with exception of limited assistance to walk in corridor and diagnoses which included Parkinson's disease, dementia, arthritis and vision impairment. R78's undated care plan, identified R78 had a self care deficit related to Parkinson's Disease, hypertension, diabetes, and dementia as evidenced by requiring assist with ADL's -The resident requires extensive assist of 1 staff with personal hygiene. The undated resident care sheet, indicated R78 required assist of one staff with dressing and grooming.	2 920	Corrected 8/9/2016 per Director of Nursing	8/9/16

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2 920	Continued From page 38 On 7/19/16, at 9:28 a.m. R78 stated, " I can't shave because of my Parkinson, that is one thing they are a little lax on." At this time R78 has stubble on chin and upper lip. On 7/20/16, at 7:57 a.m. R78 was propelled from his room to the dining room by nursing assistant (NA)-H. R78 had facial hair stubble on the upper lip and chin area. On 7/20/16, at 1:00 p.m. R78 was seated in his room in a stationary chair in front of the television. R87 remained unshaven. On 7/21/16, at 9:26 a.m. R78 was seated in room dressed, has not had face shaved, mustache and beard heavy stubble. On 7/20/16, at 8:51 a.m. NA-H indicated R78 tries to shave independently and will ask staff when he needs help. NA-H indicated R78 was new to the facility and NA-H was unsure of whether R78 had behaviors or refused cares. When interviewed on 7/20/16, at 1:00 p.m. R78 verified if he was able to shave himself he would do it every day. R78 stated staff will shave his face each morning when they get him up with an electric razor but some times they forget. R78 verified his facial hair had not been shaved off today and was unable to recall when staff last shaved him. On 7/20/16, at 1:17 p.m. NA-I identified R78 had no behaviors and did occasionally refuse to go for a walk, however, it was usually for a reason, for example if his wife was here or if he was having pain in his hip. On 7/21/16, at 9:54 a.m. NA-E indicated R78 was	2 920		

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unable to shave independently due to shaky hands. NA-E verified he/she had not shaved R78 this a.m. NA-E indicated R78 refused the offer to shave this a.m. and had a routine of shaving only "every so often."

On 7/21/16, at 11:00 a.m. NA-F verified R78 had a good memory and what he says is accurate. NA-F indicated he/she did not provide cares for R78 often, however, did believe R78 was usually clean shaven. NA-F indicated staff usually assisted R78 with oral care and shaving. NA-F sated, " We would normally shave a person if they can't themselves."

On 7/21/16, at 11:04 a.m. R78 verified he was not shaved this morning. R78 stated, " it (facial hair) isn't so hard to get off" if he is shaved every day. R78 further identified with a clean shaven face it was easier to keep clean as things get caught, stating "I drool."

On 7/21/16, at 11:13 a.m. licensed practical nurse (LPN)-E verified R78 had facial stubble and had not been shaved.

On 7/21/2016, at 11:14 a.m. registered nurse (RN)-A verified R78 required assistance with ADL's due to has Parkinson's Disease and although his abilities change from day to day, R78 was not able to shave independently with an electric razor. RN-A identified staff were expected to shave male residents daily and would not expect residents to have to ask for the assistance.

When interviewed on 7/22/16, at 11:25 a.m. the director of nursing (DON) verified the expectation that staff follow the care plan and residents who require assistance with ADL's be provided the

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2 920	Continued From page 40 care and not expected to ask for assistance. The requested facility personal hygiene policy was not provided. R28's quarterly Minimum Data Set (MDS) dated 6/15/16, identified R28 was moderately cognitively impaired and diagnoses which included: Alzheimer's, psychotic disorder and arthritis. The MDS indicated R28 required extensive assistance for completion of personal hygiene tasks. R28's care plan dated 7/15/16, identified R28 required extensive assistance to total assistance with personal hygiene and oral cares. The care plan indicated R28 had upper and lower dentures. Staff were to assist with cleaning dentures and to offer R28 mouth swab and mouth was in the AM and while getting ready for bed, and staff were to complete an oral inspection with cares and as needed. The undated resident care sheet, indicated R28 did not wear the dentures. The resident care sheet lacked any direction regarding oral cares for R28. The nursing oral assessment dated 6/13/16, indicated R28 had no natural teeth or tooth fragments, and indicated R28 chose not to wear dentures. The assessment identified R28 had a chewing and swallowing problem and received a pureed diet. During observation of morning cares on 7/20/16, from 8:23 a.m. to 8:54 a.m. NA-A and NA-G assisted R28 with personal cares which included washing her face, perineal cares and dressing. During the observation, R28 was not assisted nor	2 920		

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2 920	Continued From page 41 offered the opportunity for completion of oral cares. R28's oral cavity and lips appeared very dry. -At 8:57 a.m. NA-A assisted R28 with breakfast while R28 was positioned in bed. R28 was not wearing any dentures, and R28 refused the breakfast food items and juice offered. R28 did consume the strawberry supplement. -At 9:01 a.m. NA-A gathered the breakfast tray, shut off the bedroom lights and stated some days are good with feeding, and some days are not, just like today. NA-A then delivered the breakfast tray to the kitchen, R28 was not assisted nor offered the opportunity for completion of oral cares. During interview on 7/20/16, at 8:45 a.m. NA-A reported R28 no longer wears dentures, and stated she was going to wait until after R28 ate breakfast to provide oral cares which included swabbing out the mouth with a toothette. At 9:07 a.m. NA-A confirmed R28 had finished with the breakfast meal and confirmed she had completed morning cares for R28. NA-A verified she did not complete nor offer oral cares which included swabbing the mouth with a toothette or mouthwash. Further, NA-A confirmed she did not inspect her mouth with cares. During interview on 7/21/16, at 10:35 a.m. RN-B confirmed R28 no longer wore dentures. RN-B verified staff are expected to swab R28's mouth with morning cares, or at least attempting as R28 will at times refuse. RN-B confirmed R28 has a dry mouth and sleeps with the oral cavity open, therefore, oral care must be attempted. During interview on 7/22/16, at 10:08 a.m. the DON confirmed staff are expected to provide or	2 920		

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2 920	Continued From page 42 offer oral cares to all resident twice per day as indicated on the care plan. The facility's Mouth Care Policy dated October 2010, directed staff to review the resident's care plan for any special needs of the resident. and assemble the equipment and supplies as needed. The purpose is to keep the resident's lips and oral tissues moist, to cleanse and freshen the resident's mouth, and to prevent infections of the mouth. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the implementation of the care plan related to the provision of oral hygiene and shaving of facial hair. The DON or designee, could provide training for all nursing staff related to providing the services. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain the	21015	Corrected 8/11/2016 per Certified Dietary Manager	8/11/16

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cleanliness of the walk-in cooler to promote sanitation and food safety in the main kitchen. This practice had the potential to affect all 80 who received food from the kitchen.
Findings include:

During the initial kitchen tour with cook (C)-A on 7/18/16, at 1:14 p.m. it was noted the outside of the walk-in refrigerator was wet. The frame of the door to the refrigerator had a thick layer of white frost and the stainless steel door frame had a dark brown substance evident when opened. A strong sour odor and garbage smell was evident inside the unit. Along the south wall of the cooler there was a significant number of irregular shaped areas of black colored substance located between the second and third shelves. Fresh vegetables (leaf lettuce, cabbage, spinach and tomatoes) were stored on these shelves. The tomatoes and leaf lettuce were open to air, without any covering of these food items. Throughout the entire unit large areas of missing and chipped paint were noted. It appeared the interior walls of the walk-in cooler had been silver but the walls had been painted a white color. This was evident as the paint was peeling from the interior walls. Located adjacent to the shelves of stored vegetables were stored fresh oranges and apples. These fruit items were next to the areas of the dark colored substance.

On 7/21/16, at 1:55 p.m. dining director (DD) stated she had a designated staff person, dietary aid (DA)-A who cleaned the walk-in cooler on Monday which included the walls but if not completed, the cooks clean the walls of this refrigerator. DD stated DA-A worked this past Monday and should have cleaned the walls as she saw DA-A in the unit. DD stated if any kitchen equipment required any repairs, a work order

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would be entered into the computer. The DD confirmed the most recent work order entered had been related to a storage pallet sent last week.

It was observed on 7/21/16, at 2:05 p.m. that C-A was placing groceries onto the shelves located in the walk-in cooler/refrigerator when the DD and the surveyor re-entered the unit to confirm the presence of the mold identified on 7/18/16. C-A and DD indicated the humidity level was so high in the walk-in cooler that the refrigerator unit could not keep up with the excessive humidity. C-A stated it had been discussed with the maintenance manager (MM) approximately a week ago, indicating the door seal was not working properly. The MM had confirmed the broken gray seal had separated from the door, thus not working properly to maintain the conditions inside the cooler. The MM stated he was responsible for cleaning the door seals and confirmed that mold was evident along the door frame. He stated they just had to be careful to make sure the door was shut tight but verified the door was sweating and consequently, moisture was evident due to the broken seal and the humidity level. When C-A removed the shelving away from the wall, both C-A and DD confirmed there was black colored mold extending across the length of the shelving and down the entire length of the wall. It extended from above the level of the second shelf down to the floor. There were several irregular shaped black colored mold patches and streaks on the wall with several, up to 1-1/2 inches around or long. DD wiped a large black patch of the black substance with her fingers. A dark residue remained on her fingers. Both C-A and DD confirmed a strong odor was evident while in the cooler. C-A stated they did not have baking soda in the cooler anymore, but

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used to use it to control the odor. C-A also confirmed there was standing liquid in front of the shelf where a pork roast was thawing in a cardboard box. He confirmed the frozen roast had leaked liquid onto the floor during thawing. C-A indicated both the pork and fish tend to leak onto the floor. C-A stated they have a galvanized floor in the walk-in cooler, which was damaged and had rusted. He confirmed the floor had significant rust located in front of the meat thawing rack which extended approximately 6 in. from the rack.

On 7/21/16, at 2:10 p.m. C-A removed the vegetables from the shelving and placed them on top of a stainless steel cart located in the cooler. It was observed that C-A was inside the walk-in cooler on his knees and had a small white plastic bucket containing bleach solution and a cleaning rag. C-A indicated he had never washed the walls inside the cooler, and was unsure of the last time it had been washed. He stated the black substance was present due to the high humidity level in the cooler. C-A indicated he had never noticed the black substance substance until the surveyor made them aware. As C-A wiped the black substance off the wall of the cooler with the bleach solution, gray colored water ran down the wall as it was washed.

On 7/21/16, at 3:45 p.m. DA-A stated she was scheduled to clean on Mondays from 9-11:30 a.m. but confirmed she had not washed the walls inside the walk-in cooler this past Monday during her scheduled hours. DA-A verified she doesn't wash the wall and was unsure how long it's been since they had been washed. She was unsure who was assigned this cleaning task and indicated only recently started sanitizing the shelf racks. DA-A explained she only conducted

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21015	Continued From page 46 random checks of the cooler cleanliness as she had too many other tasks. DA-A stated she had noticed the black substance on the racks in the past but was unsure how the mold returned as bleach kills it. When interviewed on 7/21/16, at 5:30 p.m. the MM and the administrator (A) confirmed they were unaware of the black substance in the walk-in cooler and agreed they needed to develop a system, procedure and cleaning schedule for the walk-in cooler. The administrator stated staff need to remove all of the food items and wash/clean the unit, including the shelves prior to returning the stored food items. Review of the undated facility policy, Sanitation of the Food Service Department identified the food service staff shall maintain the sanitation of the food service department through compliance with the cleaning schedule. Review of the dietary cleaning schedule , dated 4/08 identified refrigerators would be cleaned weekly. SUGGESTED METHOD OF CORRECTION: The dietary manager (DM) could develop policies and procedures regarding safe storage of foods. This could include a system for notification and repair of equipment in a timely manner. The DM could educate all appropriate staff on these policies. The DM could develop monitoring systems to ensure ongoing compliance and report to the quality assurance committee the audits conducted to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		

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21685	Continued From page 47	21685		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, document review and interview the facility failed to maintain the condition of the kitchen floor covering in a clean and functional manner to promote sanitation in the main kitchen. This practice had the potential to affect all 80 residents who received food from the kitchen. Findings include: On 7/18/216, at 1:14 p.m. during the initial kitchen tour with cook (C)-A it was noted that the floor covering underneath and surrounding the affixed steamer and oven located in the food preparation area had an area of missing maroon floor tile, which measured approximately 18 inches (in) by 18 in. The area was filled with dark and light gray dust and dirt particles. In addition, there was another irregular shaped area directly under the steamer and next to the missing tile area that was a dark brown, sticky, sludge material which measured approximately 6 in by 4 in. The entire floor in the food preparation area was soiled with food particles and dirty.	21685	Corrected 8/11/2016 per Certified Dietary Manager	8/11/16

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21685	Continued From page 48 On 7/21/16, at 1:55 p.m. the dining director (DD) confirmed the damage and dirty kitchen floor. She indicated the floor had steadily gotten worse this past year. DD also stated the floor is old and needed to be replaced. DD indicated they had purchased another oven, moved equipment around and had problems with water leaking from the steamer which caused the floor damage. DD stated the brown sticky substance was not grease but was compacted food material, dirt and grime. She confirmed the floor was no longer a cleanable surface, thus dirty. She stated housekeeping staff scrubbed the floor every other week, otherwise dietary was responsible for washing the floor. On 7/21/16, at 5:30 the maintenance manager (MM) and the administrator (A) confirmed the condition of the damaged floor tile and the dirty floor. MM knelt to the floor, wiped his hand across the area and visible gray dust was evident on his hand. MM and A confirmed the floor surface need to be repaired and/or replaced and agreed the damaged tile surface was unclean. MM and A confirmed a dark brown sticky material was evident on the floor behind steamer and stated it would be cleaned. Review of the undated facility policy, Sanitation of the Food Service Department identified the food service staff shall maintain the sanitation of the food service department through compliance with the cleaning schedule. SUGGESTED METHOD FOR CORRECTION: The administrator or designee could ensure all identified kitchen environmental concerns are corrected and monitored on an ongoing basis for good repair and resident satisfaction. The quality assessment and assurance committee could	21685		

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21685	Continued From page 49 perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21685		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has	21980		8/9/16

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21980	Continued From page 50 reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure injuries of unknown origin were reported to the State agency (SA) for 1 of 3 residents (R87) reviewed. Findings include: R87's annual Minimum Data Set (MDS) dated 5/11/16, identified long and short term memory problems with no recall ability, was rarely to never understood and required extensive assistance for all areas of daily living (ADL). The facility form titled Order Summary Report signed by the physician dated 6/27/16, identified R87's medical diagnoses to include dementia with Lewy Bodies, Parkinson's disease, and anxiety disorders. R87's care plan reviewed 7/13/16, indicated,"The resident is dependent upon staff etc. for emotional, intellectual, physical and social needs	21980	Corrected per Director of Nursing	

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21980	Continued From page 51	21980		

r/t [related to] Lewy Bodies, Physical Limitations" The care plan further indicated "The resident has physically abusive behaviors r/t dementia with Lewy Bodies, unspecified psychosis".

A review of R87's nursing progress notes identified the following :
-10/24/15-"Data: resident tipped merry walker over sideways and was found face down on floor, unable to move. Resident hit head/mouth on floor. residents mouth was bleeding from loosing a tooth. no one seen [sik] the incident so we don't know what resident was trying to do at the time. Action: resident was lifted up from the floor w/ assist of 3 and EZ lift."
-10/26/15," IDT (interdisciplinary team) review of fall from 10/24/15, Resident tipped over merry walker and landed on her face. Received a small abrasion under [R87's] nose and lost a tooth as a result of the fall." Study results of an x-ray (CT) of R87's brain dated 10/26/15, identified the following Clinical information: [R87] presents with a fall, initial encounter. Nurse states -facial pain with more confusion than usual. Conclusion: Nondisplaced fracture thorough the anterior superior most maxilla (upper jaw) at the base of the nose.

Review of the facility form titled 2015 Vulnerable Adult Incident Log, which logged the facility reports to the SA, indicated a report had not been submitted related to R87's fractured jaw from an unwitnessed fall on 10/24/15.

On 7/22/16, at 11:28 a.m. the director of nursing (DON) verified a report had not been submitted to the SA when R87 had an unwitnessed fall on 10/24/15. The DON indicated she had not considered it a major injury at the time because it was unknown that R87 had a fractured jaw until a

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21980	Continued From page 52	21980		

day or two after the fall occurred. The DON verified she had not considered to report to the state agency when it became known that R87 had a fractured jaw from the fall; however, would typically report an injury related to an unwitnessed fall when the resident is not cognitively intact.

When interviewed on 7/22/16, at 1:10 p.m. the social services director (SSD) verified the responsibility of oversight for abuse prevention and reporting to the SA. SSD indicated training had been completed for many staff to submit VA reports to OHFC (Office of Health Facility Complaints)/MAARC (Minnesota Adult Abuse Reporting Center) including nurse managers, social services and nurses who worked the floor. SSD indicated the initial report was to be made immediately for alleged or suspected abuse, neglect, exploitation, and all things that fall under the facility vulnerable adult (VA) policy. When given the scenario of an unwitnessed fall of a cognitively impaired resident resulting in a fracture, SSD stated "I would have to look at the guidelines." When reviewed on SSD's lap top computer and the incident included no observation, resident unable to explain and the resulting injury; SSD responded, "I would think so" regarding R87's fractured jaw due to an unwitnessed fall. SSD indicated the facility staff had discussed the incident and had not found it to be a reportable incident. SSD verified the usual procedure for reporting an injury of unknown origin by reading aloud the facility policy: An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the

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21980	Continued From page 53 injury. SSD request more time to review the electronic record before answering any more questions. On 7/22/16, at 1:56 p.m. SSD identified R87's fall had been reviewed with the interdisciplinary team (IDT) and stated,"we didn't think it was a serious injury." SSD further explained the fractured jaw did not result in a hospitalization or affect R87's quality of life; therefore it was not a serious injury. When interviewed on 7/22/16, at 1:56 p.m. the administrator indicated the report would be brought to the Quality Assurance meeting to review procedures for reporting. The facility policy titled Ecumen's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities updated 7/2015, identified " An injury is considered an injury of unknown source and must be reported when both of the following conditions are present (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure injuries of unknown origin are reported to the state agency (SA) immediately. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures.	21980		

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21980	Continued From page 54 The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21980		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to implement abuse policies and procedures to include consistent, immediate reporting of injuries of unknown origin to the State Agency (SA) for 1 of 3 residents (R87) reviewed. Findings include: The facility policy titled Ecumen's Abuse Prevention Plan For Minnesota Skilled Nursing Facilities updated 7/2015, identified " An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the	21995	Corrected per Director of Nursing	8/9/16

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21995	Continued From page 55	21995		

injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time."

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21995	Continued From page 56	21995		

result of the fall." Study results of an x-ray (CT) of R87's brain dated 10/26/15, identified the following Clinical information: [R87] presents with a fall, initial encounter. Nurse states -facial pain with more confusion than usual. Conclusion: Nondisplaced fracture thorough the anterior superior most maxilla (upper jaw) at the base of the nose.

Review of the facility form titled 2015 Vulnerable Adult Incident Log, which logged the facility reports to the SA, indicated a report had not been submitted related to R87's fractured jaw from an unwitnessed fall on 10/24/15.

On 7/22/16, at 11:28 a.m. the director of nursing (DON) verified a report had not been submitted to the SA when R87 had an unwitnessed fall on 10/24/15. The DON indicated she had not considered it a major injury at the time because it was unknown that R87 had a fractured jaw until a day or two after the fall occurred. The DON verified she had not considered to report to the state agency when it became known that R87 had a fractured jaw from the fall; however, would typically report an injury related to an unwitnessed fall when the resident is not cognitively intact.

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21995	Continued From page 57	21995		

the facility vulnerable adult (VA) policy. When given the scenario of an unwitnessed fall of a cognitively impaired resident resulting in a fracture, SSD stated "I would have to look at the guidelines." When reviewed on SSD's lap top computer and the incident included no observation, resident unable to explain and the resulting injury; SSD responded, "I would think so" regarding R87's fractured jaw due to an unwitnessed fall. SSD indicated the facility staff had discussed the incident and had not found it to be a reportable incident. SSD verified the usual procedure for reporting an injury of unknown origin by reading aloud the facility policy: An injury is considered an injury of unknown source and must be reported when both of the following conditions are present: (1) The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and (2) The injury is suspicious because of the extent of the injury or the location of the injury. SSD request more time to review the electronic record before answering any more questions.

On 7/22/16, at 1:56 p.m. SSD identified R87's fall had been reviewed with the interdisciplinary team (IDT) and stated,"we didn't think it was a serious injury." SSD further explained the fractured jaw did not result in a hospitalization or affect R87's quality of life; therefore it was not a serious injury.

When interviewed on 7/22/16, at 1:56 p.m. the administrator indicated the report would be brought to the Quality Assurance meeting to review procedures for reporting.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and/or revise policies and

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21995	Continued From page 58 procedures to ensure injuries of unknown origin are reported to the state agency (SA) immediately. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	21995		