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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XY1C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00380

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245574**

2. STATE VENDOR OR MEDICAID NO. (L2) **151743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **SHOLOM HOME WEST**
(L4) **3620 PHILLIPS PARKWAY SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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 **9/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

12.Total Facility Beds **179** (L18)

13.Total Certified Beds **179** (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
	179			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 10/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/19/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/24/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245574

October 17, 2016

Mr. Ronald Donacik, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

Dear Mr. Donacik:

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 28, 2016 the above facility is certified for:

179 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 179 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Revised Letter

Electronically delivered
October 19, 2016

Mr. Ronald Donacik, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

RE: Project Number S5574025, and Complaint Numbers H5574083 and H5574085

Dear Mr. Donacik:

Please note that the exit date for this facility has been changed. This letter has been revised to include this change.

On August 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 12, 2016 that included an investigation of complaint number H5574083 and H5574085. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On September 28, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on September 20, 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 a standard survey, completed on August 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 21, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 12, 2016, effective September 28, 2016 and therefore remedies outlined in our letter to you dated August 26, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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
245574 Y1	A. Building B. Wing Y2	9/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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 F0157	Correction	ID Prefix F0225	Correction	ID Prefix F0226	Correction
Reg. # 483.10(b)(11)	Completed	Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016
ID Prefix F0241	Correction	ID Prefix F0280	Correction	ID Prefix F0282	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016
ID Prefix F0309	Correction	ID Prefix F0312	Correction	ID Prefix F0314	Correction
Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016
ID Prefix F0323	Correction	ID Prefix F0334	Correction	ID Prefix F0353	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.25(n)	Completed	Reg. # 483.30(a)	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016
ID Prefix F0364	Correction	ID Prefix F0428	Correction	ID Prefix F0441	Correction
Reg. # 483.35(d)(1)-(2)	Completed	Reg. # 483.60(c)	Completed	Reg. # 483.65	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	10/19/2016	32982	9/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/12/2016

☐ 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
245574 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/20/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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 K0050	09/08/2016	LSC K0052	09/08/2016	LSC K0054	09/08/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0056	09/08/2016	LSC K0069	09/08/2016	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	
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/kfd	10/14/2016	37009	9/20/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/9/2016

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Revised Letter

Electronically delivered

October 19, 2016

Mr. Ronald Donacik, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

Re: Reinspection Results - Project Number S5574025, and Complaint Numbers H5574083 and H5574085

Dear Mr. Donacik:

Please note that the exit date for this facility has been changed. This letter has been revised to include this change.

On September 28, 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 September 29, 2016, that included an investigation of complaint number H5574083 and H5574085. 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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00380 Y1	A. Building B. Wing Y2	9/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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 20265	Correction	ID Prefix 20565	Correction	ID Prefix 20570	Correction
Reg. # MN Rule 4658.0085	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed	Reg. # MN Rule 4658.0405 Subp. 4	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016
ID Prefix 20800	Correction	ID Prefix 20830	Correction	ID Prefix 20850	Correction
Reg. # MN Rule 4658.0510 Subp. 1	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0520 Subp. 2 D	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016
ID Prefix 20900	Correction	ID Prefix 20960	Correction	ID Prefix 21375	Correction
Reg. # MN Rule 4658.0525 Subp. 3	Completed	Reg. # MN Rule 4658.0600 Subp. 1	Completed	Reg. # MN Rule 4658.0800 Subp. 1	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016
ID Prefix 21390	Correction	ID Prefix 21426	Correction	ID Prefix 21530	Correction
Reg. # MN Rule 4658.0800 Subp. 4 A-I	Completed	Reg. # MN St. Statute 144A.04 Subd. 3	Completed	Reg. # MN Rule 4658.1310 A.B.C	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016
ID Prefix 21665	Correction	ID Prefix 21805	Correction	ID Prefix 22000	Correction
Reg. # MN Rule 4658.1400	Completed	Reg. # MN St. Statute 144.651 Subd. 5	Completed	Reg. # MN St. Statute 626.557 Subd. 14 (a)-(c)	Completed
LSC	09/28/2016	LSC	09/28/2016	LSC	09/28/2016

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	10/19/2016	32982	9/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/12/2016

☐ 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**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XY1C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00380

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245574**

2. STATE VENDOR OR MEDICAID NO. (L2) **151743100**

3. NAME AND ADDRESS OF FACILITY
(L3) **SHOLOM HOME WEST**
(L4) **3620 PHILLIPS PARKWAY SOUTH**
(L5) **SAINT LOUIS PARK, MN** (L6) **55426**

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 **08/12/2016** (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 **179** (L18)

13.Total Certified Beds **179** (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
	179			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 09/11/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/20/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/24/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 26, 2016

Mr. Steve Fritzke, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

RE: Project Number S5574025 and Complaint Numbers H5574081 and H5574082, H5574083, H5574084 and H5574085

Dear Mr. Fritzke:

On August 12, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, investigation of complaint number H5574083 was completed. The complaint was substantiated and deficiencies were cited at F241, F312, F314, F353. An investigation of complaint number H5574085 was completed. The complaint was substantiated and deficiencies were cited at F280, F282 , F312, F314 and F353. Investigation of complaint numbers H5574081, H5574082 and H5574084 were completed. These complaints were unsubstantiated.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

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

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

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

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 21, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 21, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by November 12, 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 February 12, 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,

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

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An investigation of complaint number H5574083 was completed. The complaint was substantiated and deficiencies were cited at F241, F312, F314, F353 An investigation of complaint number H5574085 was completed. The complaint was substantiated and deficiencies were cited at F280, F282 , F312, F314 and F353. Investigation of complaint numbers H5574081, H5574082 and H5574084 were completed. These complaints were unsubstantiated.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial	F 157		9/21/16

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

Electronically Signed | 09/07/2016

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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F 157	Continued From page 1 status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the nurse practitioner (NP) of a medication error for 1 of 1 resident (R12). Findings include: R12's admission Minimal Data Set (MDS) dated 5/17/16, indicated R12 had mild cognitive impairment, experienced shortness of breath when walking, and received diuretics daily. R12's MDS indicated R12's diagnoses included congestive heart failure, hypertension, and dementia.	F 157	F000 This plan and response to these survey findings is written solely to maintain certification in the Medicare and Medical Assistance programs. These written responses do constitute an admission of noncompliance with any neither requirement nor an agreement with any finding. We wish to preserve our right to dispute these findings in their entirety at any time and in any legal action. We may submit a separate request for Informal Dispute Resolution for certain findings and determinations.	

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F 157	Continued From page 2 Review of Medication Administration Record (MAR) for 6/1/16 through 6/30/16, indicated R12 had a Lasix (a diuretic) order dated 5/22/16, for Lasix 20 milligrams (mg) twice a day. R1's Lasix order was changed on 6/2/16, to give Lasix 20 mg now and increase Lasix to 40 mg twice a day. On 6/13/16, the Lasix order was changed to Lasix 30 mg every morning and 20 mg every evening. A new Lasix order was written on 6/16/16, to give Lasix 40 mg twice a day. The order was transcribed on the MAR to give Lasix 40 mg twice a day at 8:00 a.m., 2:00 p.m. and 4:00 p.m. During interview on 8/10/16, at 4:33 p.m. registered nurse (RN)-D verified for the period from 6/17/16 through 6/27/16, three doses of Lasix 40 mg a day were signed as having been given, except for 6/19/16 and 6/21/16. On those days only two doses were signed for. On 6/19/16, the square for the 2:00 p.m. dose had a dot in it. On 6/28/16, two doses were signed as given. On 6/29/16, two doses were signed as given and a dot was placed in the 4:00 p.m. square. On 6/30/16, two doses were signed as given. RN-D stated a dot was sometimes placed in a square when the medication was prepared and then initials are placed over the dot when the medication has been given. RN-D was unable to say if the medications that were marked with a dot had been given. During interview on 8/11/16, at 12:41 p.m. NP-A said, "I was not told about the Lasix being given three times a day. R12 should not have been given Lasix three times a day. I saw [R12] on 6/13/16, 6/16/16 and 6/21/16. On 6/16/16, I started R12 on doxycycline (an antibiotic), continued Duo Nebs (inhaled medication to ease breathing) and the Lasix was increased to 40 mg	F 157	F157 The facility will continue to notify the resident, physician and legal representative of an medication error involving the resident. R12□s NP has been notified of the medication error of 6/17-6/27. Medication errors for past 3 months have been reviewed and provider notified if not already completed. Policy and procedure for notification of provider of changes in condition including medication errors has been reviewed and is current. Nursing staff have been educated on the policy and procedure. Nurse Managers are responsible for auditing of all medication errors ongoing. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for certification will be September 21, 2016	

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F 157	Continued From page 3 twice a day." NP-A said, "To my knowledge, I was not informed of him being given Lasix three times a day." NP-A said, "I don't think it negatively impacted [R12]. It did not impact his potassium level. NP-A said, "I am not happy. I would have expected to be told about a medication error before nine days." RN-B also present during interview with NP-A. RN-B stated he would get the passport (medication dispensing machine) dispense reports because he did not think that the staff had given three doses of Lasix a day. RN-B said he did not know why they (nurses or trained medication aides) would sign for giving three doses when two doses were given. The Passport dispense reports and the Medication error reports were requested but not provided. During interview on 8/12/16, at 11:06 a.m. the director on nurses (DON) said, "If they signed it, it means they gave the medication. They should have done a medication error report. I would expect them to notify the doctor or nurse practitioner." The Medication error report was requested and the DON said she did not believe there was a medication error report. The medication error policy requested but not received.	F 157		
F 225 SS=E	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 of residents or misappropriation of their property; and report any knowledge it has of actions by a	F 225		9/21/16

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F 225	Continued From page 4 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 report allegations of abuse in a timely manner for 2 of 4 residents (R55, R108), who were reviewed for vulnerable adult (VA) reporting, Abuse Prohibition and sufficient staffing. In addition, the facility failed to protect R55 during the investigation of an allegation of verbal abuse and protect R108 from an alleged	F 225	F225 The facility will ensure that there is an abuse prevention plan in place and that all alleged violations are fully investigated and prevent the potential for further abuse. Concern voiced by R108 was reported and investigated. No mistreatment	

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F 225	Continued From page 5 retailation. This had the potential to affect 91 residents in the facility as both aides could have been floated to other units in the facility. Findings include: R55 was admitted 11/27/15, with admission diagnoses of dementia without behavioral disturbance, major depressive disorder, hypertension, lung disease, weakness and spinal stenosis (internal narrowing of spinal column which may cause radiating pain, weakness, and/or numbness) per R55's admission Face Sheet. The annual Minimum Data Set (MDS) dated 5/12/16, noted R55 had severe cognitive impairment, moderate depression. R55 was dependent on staff, required extensive assist of two staff for transfers and toilet use, extensive assist of one staff for all other cares and mobility. The care plan dated 5/13/16, identified R55 as a vulnerable to abuse and neglect due to cognitive deficits, reduced mobility, language barriers, and increased reliance on staff to complete daily cares. R55 had impaired communication, sometimes understands and can be understood when speaking Russian. R55 was non-ambulatory, and was adult failure to thrive. The 2 North-group 9 Plan of care sheet for R55 directed staff, to assist every two hours by toileting at wake, HS (bedtime) and PRN (as needed). Staff were to toilet at 11:00 a.m. and 4:00 p.m. and apply barrier cream to buttocks after toileting. R55 was to attempt assist of 1 with transfer, if weak immediately use assist of two or EZ stand (a mechanical stand device).	F 225	suspected. File has been reviewed and is complete. Vulnerable Adult policy and procedure has been reviewed and updated. All staff will be educated on the facility Vulnerable Adult policy and procedure. The Campus Administrator has implemented a review procedure to ensure the procedure is being followed. The facility Social Worker or designee will periodically interview residents if they have concerns and ensure follow-up is completed and also monitor that the procedure is being followed. Review findings will be reported to the QA committee and action plans developed as needed. Correction date for certification is September 21, 2016	

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F 225	Continued From page 6 On 2/28/16, a visitor reported she had overheard a nursing assistant (NA)-F state to R55, "Now I've got you here, you are going to sit for 30 minutes [on the toilet]." The visitor further reported that NA-F then turned saw a nurse staff member and allegedly said, "You didn't hear that." The incident was reported to the SA on 2/28/16. During the investigation NA-F was not suspended to protect R55, as directed by the policy. NA-F during an interview at the time of the incident denied the allegation stating, "I didn't say that." The allegation of abuse occurred on a Sunday 2/28/16, the investigative report was due on Friday 3/4/16, and was not submitted until 3/7/16 (three days late). The Progress Notes of the time of the event were requested, but not provided. An Incident tracking log dated February 26th was provided, the incident was not listed, although a VA report was made to the SA. On 8/12/16, AT 8:33 a.m. the director of social work services (DSW)-A, social worker (SW)-B, administrator, and registered nurse (RN)-B regarding abuse and timely reporting. DSW-A stated she was the person who completed the initial report for R55 on 2/28/16, and when asked why the alleged perpetrator had not been suspended, stated "good question." The director of nursing (DON) who was no longer with the company was the person who submitted the report to the SA late, and DSW-A was not aware it had been submitted late. DSW-A verified the facility policy for Abuse Prohibition was not followed, R55 should have been protected by suspending NA-F (the alleged perpetrator), during the investigation. In addition, the five day investigative report should have been submitted in a timely fashion.	F 225		

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F 225	Continued From page 7 R108 was observed on first floor of facility by the courtyard on 8/10/16, at 1:33 p.m. R108 asked if he could speak with writer. R108 stated that there was a dietary aide (DA)-A who he had a verbal altercation with a couple months ago and now DA-A would not serve him." The only way I get to eat is to get one of the other aides to help bring me my food in the 2 north dining room." R108 stated he had told the kitchen manager and nurse manager three months ago and wrote a letter to the facility's executive committee director and was told by all three they would take care of it but no one had followed up yet. R108 stated he met with Ombudsman and other staff after the incident and was told they would look into the issue but the staff member still was not bringing food to him. R108 stated he did not appreciate being ignored and felt singled out. R108 was admitted 2/23/15, with admission diagnoses of end stage renal disease, diabetes mellitus, major depressive disorder, muscle weakness (generalized), history of falling, per the admission Face Sheet. R108's annual MDS dated 6/10/16, indicated R108 had no cognitive impairment, minimal signs and symptoms of depression. R108 needed occasional reminders and needed escort when in manual wheelchair to and from destinations. The Care Plan dated 6/28/16, identified R108 as vulnerable to abuse and neglect by others due to mobility impairments, increased reliance on others to assist with (ADLs), and verbally aggressive behaviors. Resident had a history of arguing with staff, resisting cares, and becoming verbally aggressive towards others.	F 225		

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F 225	Continued From page 8 Progress notes created by RD dated 12/30/15, indicated they were late entry notes from care conference held on 12/23/15. R108's nutritional status was stable and discussed concern that nutrition staff was not serving him-which appeared to have been related to a miscommunication between nursing and the dietary aid and would now be resolved. The administrator was informed of R108's concerns on 8/10/16, at 2:32 p.m. and a request of the reporting documentation, incident tracking log and operational policy regarding abuse prohibition regarding incident was made. The administrator stated he had not been employed at facility at the time when the incident occurred but he would expect staff to follow up with resident and follow format, report incident to supervisor and from there it moved up to administration. On 8/11/16, at 8:45 a.m. R108 was observed in dining room eating breakfast. R108 stated NA-G brought him his breakfast tray and identified DA-A as the staff member he had words with and who would not bring him his meals. Also stated DA-A had not brought him any meals since having words with him and he continued to serve the other residents. On 8/11/16, at 9:02 a.m. NA-G stated she did not know about any issues between DA-A and R108. On 8/11/16, at 9:03 a.m. DA-A stated the facility had rules that dietary aides are not supposed to serve residents and the food can only be served when NAs or nurses are present. The incident occurred when R108 came in to dining room and wanted DA-A to serve him and DA-A told him he	F 225		

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F 225	Continued From page 9	F 225		

could not serve him. DA-A stated R108 called him a "jerk" and "a*****e." DA-A stated R108 stated nobody would serve him and everyone else had their food which was not true as there was not a NA, licensed practical nurse or RN in the dining room at that time. Only one resident had food because her NA had brought her to the dining room and gave her cereal. Stated he explained to R108 the rule was a nurse or NA needs to be present in the dining room before food can be delivered to residents because that is the facility rule. DA-A stated his duties are to stand by the steam table, read meal tickets and put food on plates and then the NAs or nursing staff served it to the residents. DA-A stated he told his supervisor right away about R108 being upset, which was the facility policy.

On 8/11/16, at 9:20 a.m. SW-B stated that the registered dietician (RD) at the time of the incident was no longer employed at the facility but had met with R108 on 12/10/15, regarding his concern with DA-A who would not serve him. The RD at the time of the incident sent an email to the nutrition director and food service supervisors regarding R108's concern. At the 12/23/15, care conference RD documented resident's concern which was related to miscommunication and would be resolved.

On 8/11/16, at 11:27 a.m. SS-B stated that during the care conference on 12/22/15, she was unaware of a verbal altercation but just that an aide did not serve R108 so she did not report it. The facility would have suspended staff person, investigated the incident, reported, interviewed and provided re-education. The procedure was there but staff was unaware of altercation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 10 On 8/11/16, at 4:23 p.m. administrator stated when he was told yesterday about R108's concerns (which was 8/10/16) he did not think it was a reportable incident. He would have liked to talk with the resident himself and he was intending to talk with him. The administrator went to his staff and thought their research and reports were credible. He was uncertain of the timeframe but the documentation did not substantiate the complaint but he would have liked to have met with the resident for a preliminary investigation. The next step was to talk with resident and determine if he should report it. On 8/11/16, at 4:34 p.m. the administrator stated he was going to complete the investigation then. On 8/12/16, at 8:33 a.m. the administrator, SS-A, and SS-B. SS-A stated they met with R108 on 8/11/16, in the afternoon. It was determined that DA-A did serve food to residents and R108 felt that he was not being served by DA-A. DA-A was suspended pending investigation. The administrator stated he made the call to DA-A and he responded with some choice words. The administrator further stated an incident report had been filed with the Minnesota Department of Health. SS-A stated the facility was supposed to report immediately with immediate facts. In that incident, they wanted to speak with R108 first to know what happened. "We should have gathered the preliminary information sooner and then reported it." The facility did not prevent potential further alleged retaliation from DA-A to R108, as DA-A continued to serve other residents in the dining room and did not serve R108 their meals from the date of the incident according to the care conference note which was dated 12/23/15, to current. In addition, the facility did not report the continued non-serving of meals to R108 by DA-A	F 225		

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	245574	A. BUILDING _____ B. WING _____	08/12/2016

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F 225	Continued From page 11 to the SA in a timely manner once the facility was made aware of it on 8/10/16. Sholom Policy and Procedure Abuse Prohibition-Vulnerable Adult Protection/Abuse Prevention Plan revised 6/1/16, noted: Policy: 2. Residents will receive competent and compassionate care and treatment at all times. There is zero tolerance for maltreatment of residents, section VI. Reporting and Investigating/Responding section E. Notification: 1. Any known or suspected -abuse must be reported to the administrator immediately (Immediately means "as soon as possible") then contact the Director of Nursing. 2. The Administrator and/or designee will review events with the reporter and determine the need for immediate reporting to external agencies. b: The regulations require that facilities report incidents to the Minnesota Department of Health immediately (immediately means "as soon as possible)."	F 225		
F 226 SS=E	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 operationalization their Abuse Prohibition policy for 2 of 4 residents (R55,	F 226	F226 Sholom West has updated and operationalized the policy and procedures	9/21/16

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F 226	Continued From page 12 R108), who were reviewed for vulnerable adult (VA) reporting, and abuse Prohibition. This had the potential to affect 91 residents in the facility as both aides could have been floated to other units in the facility. Findings include: Sholom Policy and Procedure Abuse Prohibition-Vulnerable Adult Protection/Abuse Prevention Plan revised 6/1/16, noted: Policy: 2. Residents will receive competent and compassionate care and treatment at all times. There is zero tolerance for maltreatment of residents section VI. Reporting and Investigating/Responding section E. Notification: 1. Any known or suspected -abuse must be reported to the administrator immediately (Immediately means "as soon as possible") then contact the Director of Nursing. 2. The Administrator and/or designee will review events with the reporter and determine the need for immediate reporting to external agencies. b: The regulations require that facilities report incidents to the Minnesota Department of Health immediately (immediately means "as soon as possible"). R55 was admitted 11/27/15, with admission diagnoses of dementia without behavioral disturbance, major depressive disorder, hypertension, lung disease, weakness and spinal stenosis (internal narrowing of spinal column which may cause radiating pain, weakness, and/or numbness) per R55's admission Face Sheet.	F 226	that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property. Concern voiced by R108 was reported and investigated. File has been reviewed and is complete. Staff has been trained on the policy and procedure including reporting, investigating and notification requirements. Campus Administrator is responsible for auditing of concerns and VA reporting system per policy. All files will be audited for one month and then randomly for 6 months. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for compliance will be September 21, 2016	

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F 226	Continued From page 13	F 226		

On 2/28/16, a visitor reported she had overheard a nursing assistant (NA)-F state to R55, "Now I've got you here, you are going to sit for 30 minutes [on the toilet]." The visitor further reported that NA-F then turned saw a nurse staff member and allegedly said, " You didn't hear that. " The incident was reported to the State agency (SA) on 2/28/16. NA-F during an interview on 2/29/16, denied the allegation stating, "I didn't say that." During the investigation NA-F was not suspended to protect R55, as directed by the policy.

The allegation of abuse occurred on a Sunday 2/28/16, the investigative report was due on Friday 3/4/16, and was not submitted until 3/7/16.

Progress notes of the time of the event were requested, but not provided. An Incident tracking log dated February 26th was provided, the incident was not listed, although a VA report was made to the SA on 2/28/16.

On 8/12/16, AT 8:33 a.m. an interview with the director of social work services (DSW)-A, social worker (SW)-B, administrator, and registered nurse (RN)-B regarding abuse and timely reporting. DSW-A stated she was the person who completed the initial report for R55 on 2/28/16, and when asked why the alleged perpetrator had not been suspended, stated "good question." The director of nursing (DON) who was no longer with the company was the person who submitted the report to the AS late, and DSW-A was not aware it had been submitted late. DSW-A verified the facility policy for Abuse Prohibition was not followed, R55 should have been protected by suspending NA-F (the alleged perpetrator), during the investigation. In addition, the five day investigative report should have been submitted

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F 226	Continued From page 14 in a timely fashion. R108 was observed on first floor of facility by the courtyard on 8/10/16, at 1:33 p.m. R108 asked if he could speak with writer. R108 stated that there was a dietary aide (DA)-A who he had a verbal altercation with a couple months ago and now DA-A would not serve him." The only way I get to eat is to get one of the other aides to help bring me my food in the 2 north dining room." R108 stated he had told the kitchen manager and nurse manager three months ago and wrote a letter to the facility's executive committee director and was told by all three they would take care of it but no one had followed up yet. R108 stated he met with Ombudsman and other staff after the incident and was told they would look into the issue but the staff member still was not bringing food to him. R108 stated he did not appreciate being ignored and felt singled out. Progress notes created by RD dated 12/30/15, indicated they were late entry notes from care conference held on 12/23/15. R108's nutritional status was stable and discussed concern that nutrition staff was not serving him-which appeared to have been related to a miscommunication between nursing and the dietary aid and would now be resolved. The administrator was informed of R108's concerns on 8/10/16, at 2:32 p.m. and a request of the reporting documentation, incident tracking log and operational policy regarding abuse prohibition regarding incident was made. The administrator stated he had not been employed at facility at the time when the incident occurred but he would expect staff to follow up with resident and follow format, report incident to supervisor	F 226		

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F 226	Continued From page 15 and from there it moved up to administration. On 8/11/16, at 8:45 a.m. R108 was observed in dining room eating breakfast. R108 stated NA-G brought him his breakfast tray and identified DA-A as the staff member he had words with and who would not bring him his meals. Also stated DA-A had not brought him any meals since having words with him and he continued to serve the other residents. On 8/11/16, at 9:03 a.m. DA-A stated the facility had rules that dietary aides are not supposed to serve residents and the food can only be served when NAs or nurses are present. The incident occurred when R108 came in to dining room and wanted DA-A to serve him and DA-A told him he could not serve him. DA-A sated R108 called him a "jerk" and "a*****e." DA-A stated R108 stated nobody would serve him and everyone else had their food which was not true as there was not a NA, licensed practical nurse or RN in the dining room at that time. Only one resident had food because her NA had brought her to the dining room and gave her cereal. Stated he explained to R108 the rule was a nurse or NA needs to be present in the dining room before food can be delivered to residents because that is the facility rule. DA-A stated his duties are to stand by the steam table, read meal tickets and put food on plates and then the NA's or nursing staff served it to the residents. DA-A stated he told his supervisor right away about R108 being upset, which was the facility policy. On 8/11/16, at 9:20 a.m. SW-B stated that the registered dietician (RD) at the time of the incident was no longer employed at the facility but had met with R108 on 12/10/15, regarding his	F 226		

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F 226	Continued From page 16	F 226		

concern with DA-A who would not serve him. The RD at the time of the incident sent an email to the nutrition director and food service supervisors regarding R108's concern. At the 12/23/15, care conference RD documented resident's concern which was related to miscommunication and would be resolved.

On 8/11/16, at 11:27 a.m. SS-B stated that during the care conference on 12/22/15, she was unaware of a verbal altercation but just that an aide did not serve R108 so she did not report it. The facility would have suspended staff person, investigated the incident, reported, interviewed and provided re-education. The procedure was there but staff was unaware of altercation.

On 8/11/16, at 4:23 p.m. administrator stated when he was told yesterday about R108's concerns (which was 8/10/16) that he did not think it was a reportable incident. He would have liked to talk with the resident himself and he was intending to talk with him. The administrator went to his staff and thought their research and reports were credible. He was uncertain of the timeframe but the documentation did not substantiate the complaint but he would have liked to have met with the resident for a preliminary investigation. The next step was to talk with resident and determine if he should report it. On 8/11/16, at 4:34 p.m. the administrator said he was going to complete the investigation now.

On 8/12/16, at 8:33 a.m. interview with administrator, SS-A, and SS-B. SS-A stated they met with R108 on 8/11/16, in the afternoon. It was determined that DA-A did serve food to residents and R108 felt that he was not being served by DA-A. DA-A was suspended pending

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F 226	Continued From page 17 investigation. The administrator stated that he made the call to DA-A and that he responded with some choice words. The administrator further stated that an incident report had been filed with the Minnesota Department of Health. SS-A stated the facility was supposed to report immediately with immediate facts. In that incident, they wanted to speak with R108 first to know what happened. "We should have gathered the preliminary information sooner and then reported it." The facility did not prevent potential further alleged retaliation from DA-A to R108, as DA-A continued to serve other residents in the dining room and did not serve R108 their meals from the date of the incident according to the care conference note which was dated 12/23/15, to current. In addition, the facility did not report the continued non-serving of meals to R108 by DA-A to the SA in a timely manner once the facility was made aware of it on 8/10/16.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified dining experience for 5 of 24 residents (R59, R152, R162, R167, R176) who required assistance to eat. Findings include:	F 241	F241 The facility does promote care for the residents in a manner and in an environment that maintains or enhances the dignity and respect of each resident. Residents R59, R152, R162, R167, and R176 have had their care plan reviewed	9/21/16

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F 241	Continued From page 18 During an observation on 8/8/16, at 5:46 p.m., nusring assistant (NA)-K was heard calling out "she is a feeder" three separate times and stated "both of these are feeders." NA-K was referring to R59 and R162. During an observation on 8/10/16, at 12:32 p.m., licensed practical nurse (LPN)-F was passing out clothing protectors and was referring to them as "bibs." At 12:40 p.m., while staff was passing out soup a dietary staff member called out, "make sure you give the whole table except (patients name), his soup is different. R59's quarterly Mminimum Data Set (MDS) dated 5/17/16, indicated she was severely cognitively impaired and required extensive assistance to eat. The MDS further indicated R59 was only able to communicate her needs "sometimes." During an observation on 8/9/16, at 8:55 a.m., an unidentified nursing assistant (NA) place a bowl of hot cereal in front of R59 but left it out of R59's reach. During an observation on 8/10/16, at 1:00 p.m., R59's table mates sat eating their soup while R59 was left with no food in front of her. R152's annual MDS dated 5/21/16, indicated she was severely cognitively impaired, rarely understood others, but could ususally be understood, but was able to eat independently after set-up. However, a Physicians Order Report dated 8/2/16, instructed staff to assist R152 with eating. The MDS further identified an impairment to R152's bilateral upper extremeties.	F 241	and updated as needed in the area of eating assistance. All other dependent residents that are unable to communicate needs will have their care plans reviewed and updated as needed. Policy and procedure for feeding assistance per the plan of care in a dignified manner has been reviewed and updated. All staff has been educated on the policy and procedure. licensed staff is responsible for auditing of the dining experience at least daily on each household at various mealtimes for one month then once weekly for 3 months. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for compliance will be September 21, 2016	

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F 241	Continued From page 19 During an observation on 8/10/16, at 12:41 p.m., a staff member placed a bowl of soup on the upper right hand corner of the table, out of R152's reach. At 12:51 p.m., R152's soup remained out of her reach. She sat at the table with her head down. At 12:55 p.m. staff served the main course to R152's table. At 12:58, 17 minutes after being served her soup, staff sat down and assisted R152 to eat her meal. On 8/10/16, at 5:55 p.m., R152 sat at the table in the dining room with no food in front of her. Her tablemates were eating their soup. On 8/11/16, at 8:55 a.m., R152 sat at the dining table from 8:55 a.m. to 9:08 a.m. waiting for staff to asisst her to eat. R162's quartely MDS dated 6/8/16, indicated she was severely cognitvely impaired, was rarely able to communicate her needs and required extensive assistance to eat. During an observation on 8/9/16, at 8:55 a.m., a staff member placed a bowl of hot cereal on the table, out of R162's reach and walked away. At 9:10 a.m., a staff member placed a plate containing scrambled eggs and pureed bread in front of R162. The staff member opened a jelly packet, placed it on R162's scrambled eggs and mixed it with the pureed bread and left the table. The bowl of cereal remined out of reach. R162 tasted the egg and bread mixture and attempted to reach for the creal. She looked at her tablemates and then closed her eyes. At 9:21 a.m, 26 minutes after receiving her food, NA-E sat with R162 and fed her. She ate 100% of her cereal but did not eat the mixture of eggs and bread.	F 241		

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F 241	Continued From page 20 During an observation on 8/10/16, at 12:38 p.m., a staff member placed a bowl of soup in front of R162. At 12:44 p.m., LPN-F stood behind and to the right of R162 and fed her five spoonfuls of soup and left. At 12:55 p.m., the main course was placed on the table out of R162's reach. At 1:00 p.m., NA-H lifted a chair over R162's head and sat down to feed another resident at the table. NA-H awoke R162 by speaking with her and moved the food within her reach. R162 ate 50% of her meal after it was placed within her reach. R176's quarterly MDS dated 5/28/16, indicated he was severely cognitively impiared and required extensive assistance to eat. During an observation on 8/11/16, at 8:55 a.m., R176 was seated at the dining room table with food in front of him. No staff members were assisting him to eat. R176's tablemates had food and were eating their meal. At 9:12 a.m., LPN-F sat down and assisted R176 to eat, 17 minutes after his table mates. On 8/10/16, at 1:12 p.m., NA-I stated the resident's food should not be place in front of them unitl staff is ready to assist them to eat. On 8/10/16, at 1:22 p.m., NA-H stated food should not be left in front of a resident who needs help for more than "five minutes tops" or the food will get cold. On 8/10/16, at 1:58 p.m., LPN-G stated R162 did not like to be fed. She stated R162 likes to have her food separated and will eat one thing at a time. LPN-G stated if R162's food is placed in front of her she will eat most of it by herself.	F 241		

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F 241	Continued From page 21 LPN-G further stated staff need to sit and assist the residents as needed after trays are passed. On 8/11/16, at 3:05 p.m., LPN-F stated she had fed R176. She stated she did no how long was too long for a resident to sit with food in front of them wihout being assisted. LPN-F referred to the resident's who need assistance as "Feeders" and stated "we have a lot of feeders." She stated 15 to 20 minutes would be a long time to sit with your food in front of you. On 8/12/16, at 11:06 a.m., the director of nursing (DON) stated "I don't know if we have enough staff in the dining room at this time." She further stated she expected the food to be served within 15 minutes of the scheduled meal time and all residents at the same table should be served within 30 seconds to a minute of each other. She stated staff should sit down and assist the residents right away so their food does not get cold. An undated facility policy titled Feeding A Resident instructed staff on how to feed a resident but did not address how long a residents meal should sit in front of them before assistance was provided.	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed	F 280		9/21/16

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F 280	Continued From page 22 within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess skin condition for 1 of 5 residents (R3) who developed a pressure ulcer in the facility. Findings include: During an observation on 8/11/16, at 7:23 a.m., licensed practical nurse (LPN)-A and RN-A completed a dressing change to R3's buttocks. R3's right and left ischial tuberosity ' s were red and excoriated with three separate open areas. RN-B described the area as having "lots of redness and three stage II pressure ulcers." LPN-A stated the wound had gotten bigger and now required a larger dressing than it had previously. The annual MDS dated 6/30/16, indicated he was cognitively intact, required extensive assistance for bed mobility, transfers and toileting and was frequently incontinent of bowel and bladder. A	F 280	F280 All residents have the opportunity to participate in development in their plan of care including changes to their plan of care. Resident R3 care plan has been reviewed and updated to reflect current status related to wound assessment and treatment. All other residents that have wounds will have their care plans reviewed and updated as needed. All changes to the plan of care will be communicated to the resident and this will be documented in the medical record. The policy and procedure for updating the plan of care has been reviewed and is current. The policy and procedure for Prevention and Treatment of Pressure Injury has been updated. Nursing staff have been educated on the policies and procedures for updating the	

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	245574	A. BUILDING _____ B. WING _____	08/12/2016

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F 280	Continued From page 23 care area assessment dated 6/30/16, identified a "high risk for pressure ulcer due to a history of pressure ulcers." R3's care plan dated 8/5/16, identified impaired mobility and directed staff to assist with bed mobility, transfers and toileting. A review of R3's Sholom Home West Physician Order Report dated 7/22/16 through 8/22/16, indicated on 7/14/16, the nurse practitioner wrote the following order: Left buttock ulcer- cleanse with normal saline, apply skin prep to surrounding skin, cover with Allevyn border (Allevyn Border is a wound covering dressing), change every other day. A Facility document titled weekly skin checklist dated 7/27/16, identified an open area on R3's left buttock. During an interview on 8/10/16, at 1:01 p.m., LPN-A stated she was aware of the open area to R3's buttocks. She stated the nurse practitioner saw him in July and found the area. During an interview on 8/11/16, at 7:02 a.m., two days after RN-A was made aware of the pressure ulcer on R3's buttock, RN-A stated she had not assessed the wound yet. She stated, "I think the nurses do the assessments daily" and stated she was responsible for the measuring of the wound. During an interview on 8/11/16, at 12:19 p.m., the DON stated when a skin concern was identified an incident report should be filled out and the care plan should be updated. She stated RN-A was responsible for implementing that process and stated she would have expected weekly skin assessments to be completed since the initial area was discovered by the nurse practitioner on	F 280	plan of care and Prevention and Treatment of Pressure Injury. Nurse Managers are responsible for auditing of 3 records of residents with wounds weekly for one month and then 3 records monthly for 3 months. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for compliance will be September 21, 2016.	

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F 280	Continued From page 24 7/14/16. A facility policy titled Prevention and Treatment of Wounds, undated, directed staff to monitor pressure ulcers daily including the status of the surrounding skin, signs of infection and whether pain is present. The policy further directed staff to initiate weekly wound monitoring to include onset of skin condition, location of wound, stage of wound, length, width, depth and wound characteristics. While the Physician Orders and Weekly Skin Checklist identified an open area to R3's buttock beginning on 7/14/16 and while nursing staff were completing a dressing change to R3's pressure ulcer every other day, there was no evidence an assessment of the wound was completed at any time between 7/14/16 and 8/11/16, to stage, describe, measure or track progress toward healing.	F 280		
F 282 SS=E	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 follow the plan of care for 4 of 5 residents (R180, R116, R28, R109, R24) reviewed for dialysis, activities of daily living (ADLs), repositioning, pressure ulcers, and dining observation.	F 282	F 282 The services provided by the facility are provided by qualified persons in accordance with the resident plan of care. Residents R180 has had care plan and assignment sheet reviewed and updated	9/21/16

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F 282	Continued From page 25 Findings include: Dialysis: R180's diagnoses included heart failure, hypertension and end stage renal disease (ESRD) obtained from the 14 day Minimum Data Set (MDS) dated 6/6/16. In addition the MDS indicated R180 received dialysis. On 8/9/16, at 12:30 p.m. when approached and asked how dialysis was going R180 stated everything was going well. R180 stated he had increased weight which was good as he was not eating well at the time he had been admitted to the facility. When asked about the diet and fluid restriction resident stated he was on a regular diet and did not have a fluid restrictions as surveyor noted two glasses of water on top of the night stand next to bed. On 8/11/16, at 9:10 a.m. went to resident room observed resident seated at edge of bed. R180 stated he had eaten breakfast in his room. R180 was observed to have slight edema on the face and lower extremities and appeared tired. When asked how he had slept resident stated well "I know am a little puffy." R180's Hospital Discharge Summaries dated 5/18/16, directed "Daily weights: Call provider for weight gain of more than 2 pounds per day or 5 pounds per week." In addition, the Physician Orders dated 6/30/16, directed the same. During review of the vital signs weight section the following weights were noted missing according to months: -May 5/19/16, 5/27/16, 5/28/16.	F 282	to reflect current status including daily weights per MD orders. R116 has had care plan and assignment sheet reviewed to include grooming needs use of adaptive equipment and care and treatment of wounds. R109 has been reassessed for appropriate texture of food and fluids. Plan of care, meal ticket and assignment sheet have been updated to reflect current status. R24 has had care plan and NAR assignment sheets reviewed and revised as needed in the areas of incontinence care, and alterations of skin integrity and treatment of wounds. All other care plans will be reviewed and revised per the RAI process. Nursing staff will be inserviced on the individualized plan of care and following the plan of care. Nurse Manager or designee will complete 3 audits weekly on each floor to ensure the plan of care is being followed for one month and then 3 audits monthly for 3 months to ensure follow through on the plan of care Audit results will be reported to the QA committee and action plans developed as needed. Correction date for certification is September 21, 2016	

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F 282	Continued From page 26 -June 6/1/16, 6/11/16, 6/14/16, 6/16/16, 6/17/16, 6/21/16, 6/30/16 -July 7/1/16, 7/2/16, 7/3/16, 7/4/16, 7/5/16, 7/7/16, 7/8/16, 7/9/16, 7/12/16, 7/15/16, 7/16/16, 7/11/16 -August 8/2/16, 8/3/16, 8/4/16, 8/5/16, 8/6/16, 8/7/16, 8/8/16, 8/9/16, 8/10/16. During review of the Medication and Treatment Administration Records for May 2016, through August 2016, it was revealed weights had not been documented in the record. In addition review of the interdisciplinary team notes (IDT) it was revealed the weights had not been documented there either. R180's undated care plan indicated resident was on dialysis and identified resident was at risk for shortness of breath (SOB), chest pain, edema and elevated blood pressure. The care plan directed staff to monitor and follow the Physician Orders. The 2 North Group 8 Plan of Care updated 8/11/16, directed staff to do a daily weight. On 8/11/16, at 3:31 p.m. registered nurse (RN)-B verified resident had an order for daily weights in the physician orders. RN-B then reviewed the vital signs tab and verified there were a lot of missing weights in the computer. RN-B stated he was going to check in the both the medication and treatment administration records on the nurses carts to see if the staff was recording the weights in there. -At 3:33 p.m. RN-B approached stated he had checked and found "they are not recording them." RN-B stated he would expect the nursing assistant to get the weights daily in the morning and record the weight to Point of Care which	F 282		

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F 282	Continued From page 27 would populate to Matrix. RN-B further stated he would expect the nurses to check daily to make sure the weights were done. On 8/12/16, at 7:45 a.m. the director of nursing (DON) stated she would expect the staff to follow the physician orders and resident plan of cares. On 8/12/16, at 10:1 a.m. via telephone the registered nurse to the primary doctor's clinic stated she would expect the care center to follow the physician orders but thought the resident sometimes may have not been weighed due to other medical appointments or dialysis days which was not documented why the weights had not been obtained in the resident medical record. R180 was not weighed according to the plan of care. Grooming removal of facial hairs R116's diagnoses included dementia, contracture, muscle weakness, anxiety, failure to thrive and osteoporosis obtained from the annual MDS dated 5/31/16. The MDS indicated resident had severely impaired cognition and required extensive to total dependence of one to two staff on all ADLs which included bed mobility, toilet use and transfers. On 8/8/16, at 6:00 p.m. resident was observed seated on the Broda wheelchair in the DR. Observed resident with multiple white facial hairs approximately half inch long on the lower chin area. On 8/9/16, at 10:30 a.m. during another random visit to the unit resident was observed on her wheelchair outside the dining room across from	F 282		

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the nursing station with eyes closed and still noted to have the facial hairs.

On 8/10/16, at 6:53 a.m. resident was observed a sleep eyes closed lying on her right side pillow behind back. Resident remained to have the facial hairs.
-At 8:36 a.m. nursing assistant (NA)-A was observed reposition resident stated she was going to get another resident up and would come back in later to get resident ready for the day.
-At 8:52 a.m. to 9:29 a.m. both NA-A and NA-U were observed provide morning care, which included oral cares and washing resident up however never acknowledged or offered to remove the visible long white facial hairs.
-At 10:32 a.m. licensed practical nurse (LPN)-B was observed wheel resident to room, tilted Broda chair to the back then turned resident to the right side and tucked a pillow under. During the observation, LPN-B looked at resident face but never acknowledged to remove the facial hairs.

On 8/10/16, at 10:51 a.m. the RN-E stated resident had late on set progression of Alzheimer's disease, was dependent on staff for all cares and was non-verbal.

On 8/11/16, at 7:30 a.m. was observed on the Broda chair at the dining table dressed for the day. When approached the white facial hairs were still not remove and visible from standing 20 feet away. At 9:16 a.m. resident still in the dining room facial hair visible from standing 20 feet several staff by the steam table close to the table resident was seated none offered to remove the facial hairs.
-At 10:27 a.m. NA-U stated she had completed

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providing resident cares for that morning.
-At 10:30 a.m. LPN-A stated "[R116] was scheduled to get a shower today." LPN-A indicated because the unit had been working short resident had not received her shower yet. LPN-A further stated due to insufficient staff, many residents did not get there scheduled showers/baths however thought it was getting better now as the unit had been added a sixth aide to assist with cares.

On 8/11/16, at 3:09 p.m. LPN-A verified the long white facial hair on resident lower chin area. LPN-A actually touched resident chin and stated the staff was supposed to have removed it for resident with cares. LPN-A stated she was going to have one of the staff remove it and thought there were two residents in the unit who needed assistance to remove the facial hairs. LPN-A further stated resident had received shower after lunch as evening staff had come in early to assist since the unit was short of one NA.

R116's ADL care plan dated 6/11/16, indicated resident had potential alteration in self-care ability,needed assist with dressing/grooming/bathing and oral care related to advanced dementia with behavioral disturbance. The care plan directed staff for grooming to provide assist of one with combing hair, oral care, nail care and shaving.

The 3 South Weekly Bath List dated 8/8/16, indicated resident was scheduled to get a bath on Thursdays AM.

On 8/11/16, at 3:16 p.m. RN-A unit manager stated staff should have automatically removed the facial hairs "You think. Am totally with you."

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F 282	Continued From page 30 RN further stated staff was supposed to follow the plan of care. R116 was not groomed according to the plan of care. Repositioning/adaptive euipment: R116 was observed on 8/10/16, at 6:53 a.m. R116 was lying in bed with their eyes closed and lying on her right side pillow behind back. On top of the night stand were two Posey sleeves (provide comfortable protection for fragile or sensitive skin that may bruise or tear easily). -At 6:56 a.m. observed NA-U go to room stated she was going to get resident dressed but was going to leave R116 and would be back in 45 minutes. -At 7:14 a.m. observed NA-U reviewing the assignment sheet with NA-A outside resident room never heard discuss the last time R116 had been repositioned. When approached and asked about resident NA-A stated she was not a regular staff in the unit however was going to get resident up shortly. NA-A further stated because she did not know residents in the unit she would follow the care plan. -At 7:19 a.m. NA-A was observed go to room with linen stated she was not getting resident up but was just getting what she would need ready. NA-A never repositioned resident and left the room shortly. -At 7:27 a.m. resident asleep still observed wearing the arm sleeves on both arms still lying on her back to the right side. No activity to room until 8:28 a.m. -At 8:29 a.m. LPN-A stated she had informed NA-A that R116 was supposed to be repositioned every hour. When asked when resident had been last repositioned LPN-A stated she had got to the unit since 6:30 a.m. and did not know when	F 282		

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resident had last been repositioned. LPN-A stated resident had an open area which was improving however, the area was a recurring one in the same area.
-At 8:32 a.m. both NA-A and LPN-A were observed provide pericare and repositioned R116. During the observation R116's bottom appeared red and non-blanchable. The area on the tail of the coccyx was observed covered with a thick layer of cream. LPN-A wiped the area and a scabbed area was observed. LPN-A stated the bottom was red and non-blanchable because resident skin was so fragile. LPN-A verified the left heel boot was not on. At 8:36 a.m. NA-A stated LPN-A had informed her resident was supposed to be repositioned hourly however when she looked at the NA assignment sheet it directed resident to be repositioned one to two hours and because she had been pulled from another unit later into the shift she had not been told when resident had been repositioned last. R116 went one hour and 39 minutes without being repositioned.
-At 8:45 a.m. LPN-A verified resident Derma-savers (protect fragile skin from sustaining damage caused by friction, rubbing, abrasion and pressure that could lead to skin breakdowns, tears and splits) and Posey sleeves were supposed to be on at all times. LPN-A stated it was not on in the treatment sheet and was going to add it "I didn't know. I thought they were supposed to be off at night when staff put lotion."
-At 8:50 a.m. RN-A nurse manager reviewed the care plan in the computer and verified R116's skin care plan directed staff to turn resident side to side hourly when in bed and also verified the care plan was contradicting as it directed staff to reposition resident one to two hours and then

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hourly. RN-A verified the Derma and Posey sleeves were supposed to be on at all times. RN-A stated she would expect the staff to follow any resident plan of care and she was going to have a word with the staff as that was important.

On 8/10/16, at 8:52 a.m. to 9:18 a.m. R116's cares were observed provided by NA-A and NA-U who during the observed turned resident to the left and right never placed a pillow, three times never put a pillow to protect the boney prominences when repositioning.

On 8/10/16, at 10:36 a.m. LPN-A approached stated she had reviewed the NA group Plan of Care sheet and had noticed both the one to two hours and every hour for repositioning. LPN-A stated she was going to make sure it was update to reflect the hourly repositioning schedule only as this was confusing and misleading for the staff. At 10:42 a.m. LPN-A stated R116 had an open area that was pressure related as it was the same area where it had healed before. LPN-A further stated she thought it was healing well and was a stage II (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater).

On 8/10/16, at 10:51 a.m. the RN-E stated resident had late on set progression of Alzheimer's disease, was dependent on staff for all cares and was non-verbal.

On 8/12/16, at 7:20 a.m. observed resident seated on Broda chair in front of the dining room door noted to have blue boots to both feet however did not have the pillow placed on foot rest when in Broda to protect skin as directed by

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the care plan.
-At 7:30 a.m. RN-A verified the pillow was not on the foot rest as directed by the care plan to protect skin breakdown.

R116's diagnoses included dementia, contracture, muscle weakness, anxiety, failure to thrive and osteoporosis obtained from the annual MDS dated 5/31/16. The MDS indicated resident had severe impaired cognition and required extensive to total dependence of one to two staff on all activities of daily living which included bed mobility, toilet use and transfers. In addition the MDS indicated R116 was at risk for pressure ulcers and did not have unhealed pressure area at the time of the assessment.

R116's care plan dated 7/8/16, indicated resident was at risk for alteration in skin integrity related to dementia, incontinence of bowel and bladder, dependency with ADLs, poor nutritional intake, and had a chair fast status. R116 had a history of bruising easy and had fragile skin. The care plan directed staff "Place pillow on foot rest when resident is in BRODA chair, elevate lower extremities when in bed above level of heart. Turn side to side hourly while in bed, use pillows to protect bony prominences when repositioning, Repositioning hourly while in BRODA chair (specialized wheelchair), Posey sleeves upper extremities (Full arm) and derma-savers to lower extremities at all times, remove at bedtime [HS] to apply lotion, then reapply. Heel blue boots on to both feet when lying in bed and sitting up daily on all three shifts..."

On 8/12/16, at 7:36 a.m. DON stated she would expect staff to have repositioned resident timely, removed the facial hairs and followed the plan of

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 34 care. R116 was not repositioned according to the plan of care minimize and/or prevent further skin break down. A facility policy titled Prevention and Treatment of Wounds, undated, directed staff to monitor pressure ulcers daily including the status of the surrounding skin, signs of infection and whether pain is present. The policy further directed staff to initiate weekly wound monitoring to include onset of skin condition, location of wound, stage of wound, length, width, depth and wound characteristics. Meal consistency R109 on 8/8/16, at 6:13 p.m. was heard coughing continuously when standing at the desk. At 6:14 p.m. the resident was observed coughing continuously, as another resident in the same table stated repeatedly "[R109] cover your mouth." At 6:15 p.m. NA-P and NA-K in the dining room stated R109 coughed like that everyday. At 6:17 p.m. when asked if the food had been thickened as noted in the meal ticket, NA-P stated the food had already been pre-thickened and added at times for example the soup staff would have to add the thickener however not for that particular meal. The pureed food on the plate was noted to be runny and thin. At 6:18 p.m. R109 continued to cough with each bite. At 6:22 p.m. NA-P stood up and asked R109 if he was going to eat all his food. At 6:23 p.m. R109 coughed again. Staff still standing over resident. At 6:24 p.m. resident coughed again after a bite of the runny pureed food on the plate and was observed hold his head and NA-P asked R109 if he was having a headache and resident would nod. At 6:25 p.m. NA- asked NA-P "do you think I should give him juice." At 6:26 p.m. another NA	F 282		

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came into the dinning room and NA-P requested her to wheel resident out of the dining room.
-At 6:29 p.m. resident observed at the nursing station still coughing loud and holding his head. At 6:32 p.m. observed R109 had been moved into his room and was still cough.

On 8/8/16, at 6:39 p.m. the nutritional service manager (NSM) stated the cook who had cooked that evening had left for the night and asked surveyor to come back and talk to cook the next day. When asked if she was familiar with what had been added to the pureed food for R109, NSM stated she would not exactly know what had been added to the food before it was brought to the floor for the pureed food. Surveyor requested if NSM would contact the cook and at this time NSM called the cook who indicated to all the pureed food cook stated he would add one to two scoops of thickener.
-At 6:59 p.m. RN-B approached stated the nurse practitioner was working on resident diet order to determine if it was appropriate and at that time the food was pureed and liquids were supposed to be honey consistency. RN-B stated R109 had a history of aspiration pneumonia, and currently was on a patch to decrease secretions and was on Mucinex (used to relieve the symptoms of cough and loosen mucus in the chest). At 7:06 p.m. RN-B verified the 7/29/16, which directed staff to add two teaspoons of thickener stated the nurse had signed off on it. RN-B stated on the meal ticket the three packets of thickener were for the coffee, juice and soup if he needed them and this was to alert staff of what the resident needed.
-At 7:18 p.m. approached NA-P who had been assisting R109 with eating and she stated she had watched the tray from when it had been

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served and when she started to assist resident and she had not seen the LPN-C add thickener to the food as LPN-C had indicated.

On 8/9/16, at 9:16 a.m. observed R109's food served into a divided plate covered and sat on top of the steam table. No thickener was added to plate at this time. At 9:18 a.m. the plate of food remained in the same spot. At 9:33 a.m. NA-F take the sippy cups of cranberry juice and water which were already honey thickened consistency and added a packet of thickener to each of the four ounce cups, then brought them back and set them on the tray on top of the steam table. As NA-F was mixing the thickener LPN-C came into the nourishment center and left never said a word. No thickener was added to the pureed food at this time.
-At 9:39 a.m. when approached and asked about the thickened liquids dietary aide (DA)-A stated the liquids came already pre-thickened and showed surveyor bottles of honey and water and juice in the refrigerator that were opened. He indicated he poured the beverages and nursing took care of the rest if they needed to add more thickener to the beverages.
-At 10:04 a.m. NA-F went to the dining room grabbed the tray surveyor went into the nourishment center NA-F stated she was going to assist resident and was warming the food.
-At 10:07 a.m. NA-F went to R109's room door at the door went in with the tray, applied the clothing protector, pulled a chair next to R109 and mixed the food. When approached and asked if she had added thickener to the food NA-F stated she had not. NA-F was then observed give resident one quick bite when surveyor intervened and stopped her before the second bite at 10:10 a.m. NA-F then came with surveyor out of the room stated

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she was not aware resident food was supposed to be added more thickener and thought was only the fluids which she had. As surveyor and NA walked out of the room resident was heard coughing.
-At 10:13 a.m. NA-F went to room with the RN-B who looked at the meal ticket and looked at the food and stated the food consistency was good left the room. NA-F indicated to RN-B she had not seen the nurse add thickener to the food.
-At 10:15 a.m. came back to room found LPN-C and NA-F in room. LPN-C verified she had not added the thickener to the food and was in another room doing a dressing change. LPN-C directed NA-F to add two teaspoons to the pureed food.
-At 10:17 a.m. when asked if the NA-F had been informed about adding the thickener to the food LPN-C stated this had not been communicated to the NA-F. LPN verified the order was dated 7/29/16, and NA-F was a regular staff was not aware she was supposed to add the thickener to the food.
-At 10:19 a.m. RN-B verified the team assignment sheet updated 8/8/16, did not have the two teaspoons order for thickener to be added to the food. RN-B stated he expected the nurses to implement the doctors orders and to make sure the orders were communicated to the nursing assistants.

R109's nurse practitioner (NP) progress note dated 7/12/16, indicated resident was at high risk aspiration and respiratory infectious due to the coughing.

Resident physician order dated 7/22/16, indicated resident diet was pureed and honey thick liquids In addition another physician order dated 7/29/16,

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F 282	Continued From page 38 directed staff to "add 2 teaspoons of thickener to pureed diet three times a day [TID] during meals for coughing. Resident should be up in chair for meals at all times." The 2 North Group 9 Plan of Care dated 8/8/16, for nursing assistants indicated R109 was on a mechanical soft diet with nectar thick liquids. The plan of care did not indicated two teaspoons of thickener were supposed to be added to the food three times daily. R109's care plan dated 8/9/16, indicated resident had potential for nutrition related concerns diagnoses of intellectual disability, impulse control, and dysphagia. The care plan indicated resident continued to have coughing episodes with and without intake and was on pureed diet and honey thickened liquids. The care plan directed staff to "Add 2 teaspoons of thicken powder to puree diet TID during meals per orders..." On 8/11/16, at 3:23 p.m. registered dietician (RD) stated she had worked the kitchen the Friday when the order had been obtained 7/29/16, and had not been able to update the care plan and update the meal ticket. RD stated physician orders were part of the resident plan of care and acknowledged the order should have been implemented since nursing was aware of the order. RD further stated the new order was a trial to help with the coughing resident had with eating. On 8/12/16, at 7:34 a.m. DON stated she would expect communication to the staff on the orders and staff was to follow all physician orders. R24's care plan dated 7/26/16, identified	F 282		

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incontinence and directed staff to apply barrier cream to perineal area after each incontinence episode and observe condition of skin. The care plan further identified risk for alteration in skin integrity and directed staff to observe for changes in skin and report to licensed staff and a weekly skin assessment done by licensed staff.

A facility document titled 2 North Plan of Care, undated indicated R24 had a history of skin breakdown in the sacral area and directed staff to lay R24 down in bed or reposition in wheel chair.

During an initial interview on 8/8/16, at 3:50 p.m., RN-B stated R24 did not have a pressure ulcer.

During an interview on 8/9/16, at 7:44 a.m., R24 stated he had pain. He stated the pain was in his Buttocks and stated it was because he had a sore on it.

During an observation on 8/11/16, at 8:41 a.m. R24's right and left ischial tuberosity were noted to be reddened, excoriated and had five open areas approximately one centimeter x one centimeter each. The red areas were approximately four inches x two inches on the left side and approximately two inches x one inch on the right.

A review of facility documents titled Weekly Skin Checklist indicated R24 had an open area on his right shin on 8/6/16, but did not identify an alteration to his buttocks. The Weekly Skin Checklist for July 2016 was not filled out for the entire month. The facility's failure to complete the weekly skin checks for R24 resulted in five new open areas to R24's buttocks.

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F 282	Continued From page 40 A review of R24's Treatment Flowsheet dated 8/1/16 through 8/12/16, indicated the following: - Reposition patient every two hours in order to displace weight on sacral/coccyx area. The area of the flowsheet designated for a nurses signature was left blank the entire months of July and August 2016. - Skin assessment weekly on bath day. The area of the flowsheet designated for a nurses signature was left blank the entire months of July and August 2016. - Apply barrier ointment to sacral coccyx area twice daily with cares. The facility did not follow the care plan forn monitoring the skin integrity. During an interview on 8/11/16, at 8:18 a.m., NA-Q stated she updated the nurses when R24's bottom had sores and stated RN-B should have been aware of it. During an interview on 8/11/16, at 2:42 p.m., R24 stated he had the sores on his bottom on and off for a year. During an interview on 8/11/16, at 8:54 a.m., RN-B stated he was not aware R24 had an alteration to the skin on his bottom. He stated the nurses should be performing skin checks weekly for R24. He stated the nurses should be reporting anything that was not noted on a previous assessment. However, there was no evidence of skin assessments performed during the month of July even though R24 stated he has had the sore on his bottom for a year. During a subsequent interview on 8/11/16, at 2:57 p.m., RN-B described R24's bottom as "breakdown of left buttock, moving to the right." He stated it looked like it started as "chafing" and stated the skin had been "sheared" off.	F 282		

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F 282	Continued From page 41 During an interview on 8/11/16, at 12:29 p.m. the DON stated weekly skin checks should have been completed for R24. The facility Care Plan policy reviewed 10/15, directed "6. The Resident Care Plan is constantly changing. It is to be updated routinely with changes in doctor's orders and resident condition change. The Resident Care Plan is reviewed for accuracy, updated with annual MDS..."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow physician orders for daily weights, for 1 of 1 resident (R180) reviewed for dialysis. Findings include: R180's diagnoses included heart failure, hypertension and end stage renal disease (ESRD) obtained from the 14 day Minimum Data Set (MDS) dated 6/6/16. In addition the MDS indicated R180 received dialysis.	F 309	F309 Each resident will continue to receive the necessary care and services to attain and maintain the highest practicable level of physical, mental, and psychosocial well-being in accordance with the plan of care. Resident R180 has been reassessed for MD orders for daily weights. Treatment records are updated to reflect current orders. All residents with orders for weights outside of facility policy for monthly	9/21/16

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F 309	Continued From page 42 On 8/9/16, at 12:30 p.m. when approached and asked how dialysis was going R180 stated everything was going well. R180 stated he had increased weight which was good as he was not eating well at the time he had been admitted to the facility. When asked about the diet and fluid restriction resident stated he was on a regular diet and did not have a fluid restrictions as surveyor noted two glasses of water on top of the night stand next to bed. On 8/11/16, at 9:10 a.m. went to resident room observed resident seated at edge of bed. R180 stated he had eaten breakfast in his room. R180 was observed to have slight edema on the face and lower extremities and appeared tired. When asked how he had slept resident stated well "I know am a little puffy." R180's Hospital Discharge Summaries dated 5/18/16, directed "Daily weights: Call provider for weight gain of more than 2 pounds per day or 5 pounds per week." In addition Physician Orders dated 6/30/16, directed the same. During review of the vital signs weight section the following weights were noted missing according to months: -May 5/19/16, 5/27/16, 5/28/16. -June 6/1/16, 6/11/16, 6/14/16, 6/16/16, 6/17/16, 6/21/16, 6/30/16 -July 7/1/16, 7/2/16, 7/3/16, 7/4/16, 7/5/16, 7/7/16, 7/8/16, 7/9/16, 7/12/16, 7/15/16, 7/16/16, 7/11/16 -August 8/2/16, 8/3/16, 8/4/16, 8/5/16, 8/6/16, 8/7/16, 8/8/16, 8/9/16, 8/10/16. During review of the Medication and Treatment Administration Records for May 2016, through August 2016, it was revealed weights had not	F 309	weights have had treatment records reviewed to ensure orders are current and are being followed per orders. Policy and procedure on follow-through on physician orders has been reviewed and is current. All nursing staff has been educated on following of MD orders and documentation of such. Nurse Managers or designee will be responsible for auditing treatment records of 3 residents per unit for follow through of MD orders for daily weights for one month and then monthly for 3 months. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for certification is September 21, 2016	

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been documented in the record. In addition review of the interdisciplinary team notes (IDT) it was revealed the weights had not been documented there either.

R180's nutrition Care Area Assessment (CAA) dated 5/26/16, indicated resident had a significant weight loss over the past 180 day period and the weight loss was attributed to fluid status changes that were planned with dialysis, however also with decreased intake prior to and during the hospitalization, which resulted in weight loss below dry weight. CAA indicated the possible complications of significant weight loss of both fluid and actual mass loss include skin breakdown, higher risk for infection, depression, edema, cardiac/kidney strain, altered labs and death.

R180's undated care plan indicated resident was on dialysis and identified resident was at risk for shortness of breath (SOB), chest pain, edema and elevated blood pressure. The care plan directed staff to monitor and follow the physician orders.

The 2 North Group 8 Plan of Care updated 8/11/16, directed staff to do a daily weight.

On 8/11/16, at 3:31 p.m. registered nurse (RN)-B verified resident had an order for daily weights in the physician orders. RN-B then reviewed the vital signs tab and verified there were a lot of missing weights in the computer. RN-B stated he was going to check in the both the medication and treatment administration records on the nurses carts to see if the staff was recording the weights in there.
-At 3:33 p.m. RN-B approached stated he had

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F 309	Continued From page 44 checked and found "they are not recording them." RN-B stated he would expect the nursing assistant to get the weights daily in the morning and record the weight to Point of Care which would populate to Matrix. RN-B further stated he would expect the nurses to check daily to make sure the weights were done. On 8/12/16, at 7:45 a.m. the director of nursing stated she would expect the staff to follow the physician orders. On 8/12/16, at 10:11 a.m. via telephone the registered nurse to the primary doctor's clinic stated she would expect the care center to follow the physician orders but thought the resident sometimes may have not been weighed due to other medical appointments or dialysis days which was not documented why the weights had not been obtained in the resident medical record.	F 309		
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. This REQUIREMENT is not met as evidenced by: Based on observations, interview and document review, the facility failed to provide grooming for 1 of 3 residents (R116) who was dependent for activities of daily living (ADL) reviewed for ADL. Findings include:	F 312	F312 The residents that are unable to carry out activities of daily living will continue to receive the necessary services to maintain good nutrition, grooming and personal hygiene.	9/21/16

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F 312	Continued From page 45 On 8/8/16, at 6:00 p.m. resident was observed seated on the Broda wheelchair in the DR. Observed resident with multiple white facial hairs approximately half inch long on the lower chin area. On 8/9/16, at 10:30 a.m. during another random visit to the unit resident was observed on her wheelchair outside the dining room across from the nursing station with eyes closed and still noted to have the facial hairs. On 8/10/16, at 6:53 a.m. resident was observed a sleep eyes closed lying on her right side pillow behind back. Resident remained to have the facial hairs. -At 8:36 a.m. nursing assistant (NA)- A was observed reposition resident stated she was going to get another resident up and would come back in later to get resident ready for the day. -At 8:52 a.m. to 9:29 a.m. both NA-A and NA-U were observed provide morning care, which included oral cares and washing resident up however never acknowledged or offered to remove the visible long white facial hairs. -At 10:32 a.m. licensed practical nurse (LPN)-B was observed wheel resident to room, tilted Broda chair to the back then turned resident to the right side and tucked a pillow under. During the observation, LPN-B looked at resident face but never acknowledged to remove the facial hairs. On 8/10/16, at 10:51 a.m. the RN-E stated resident had late on set progression of Alzheimer's disease, was dependent on staff for all cares and was non-verbal.	F 312	Resident R116 has had the plan of care and NAR assignment sheet reviewed and updated for ADL needs. NAR assignment sheets for those residents that are dependent in ADLs have been reviewed and updated as needed. Nurse Managers or designee will audit 3 dependent residents per unit weekly for one month and then 3 residents monthly for 3 months to ensure assignment sheets are being followed. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for certification is September 21, 2016	

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F 312	Continued From page 46 On 8/11/16, at 7:30 a.m. was observed on the Broda chair at the dining table dressed for the day. When approached the white facial hairs were still not remove and visible from standing 20 feet away. At 9:16 a.m. resident still in the dining room facial hair visible from standing 20 feet several staff by the steam table close to the table resident was seated none offered to remove the facial hairs. -At 10:27 a.m. NA-U stated she had completed providing resident cares for that morning. -At 10:30 a.m. LPN-A stated "[R116] was scheduled to get a shower today." LPN-A indicated because the unit had been working short resident had not received her shower yet. LPN-A further stated due to insufficient staff, many residents did not get there scheduled showers/baths however thought it was getting better now as the unit had been added a sixth aide to assist with cares. On 8/11/16, at 3:09 p.m. LPN-A verified the long white facial hair on resident lower chin area. LPN-A actually touched resident chin and stated the staff was supposed to have removed it for resident with cares. LPN-A stated she was going to have one of the staff remove it and thought there were two residents in the unit who needed assistance to remove the facial hairs. LPN-A further stated resident had received shower after lunch as evening staff had come in early to assist since the unit was short of one NA. R116's diagnoses included dementia, contracture, muscle weakness, anxiety, failure to thrive and osteoporosis obtained from the annual Minimum Data Set dated 5/31/16. The MDS indicated resident had severely impaired cognition and required extensive to total	F 312		

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F 312	Continued From page 47 dependence of one to two staff on all activities of daily living which included bed mobility, toilet use and transfers. R116's pressure ulcer Care Area Assessment dated 5/31/16, indicated resident was at risk for pressure ulcer related to impaired mobility, dementia and bowel incontinence. CAA directed staff to assist with cares. R116's activities of daily living care plan dated 6/11/16, indicated resident had potential alteration in self-care ability, needed assist with dressing/grooming/bathing and oral care related to advanced dementia with behavioral disturbance. The care plan directed staff for grooming to provide assist of one with combing hair, oral care, nail care and shaving. The 3 South Weekly Bath List dated 8/8/16, indicated resident was scheduled to get a bath on Thursdays AM. On 8/11/16, at 3:16 p.m. registered nurse (RN)-A unit manager stated staff should have automatically removed the facial hairs "You think. Am totally with you." RN further stated staff was supposed to follow the plan of care. On 8/12/16, at 7:36 a.m. the director of nursing stated she would expect staff to follow the plan of care, to reposition timely and assist a resident to remove the facial hairs with cares "it's a dignity thing."	F 312		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a	F 314		9/21/16

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F 314	Continued From page 48 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively re-assess residents' skin integrity to ensure residents received the necessary treatment and services to promote healing and/or prevent new sores from developing for 4 of 5 residents (R24, R3, R28, R116) reviewed for pressure ulcers. This resulted in actual harm for R24 and R3 who developed multiple stage II pressure ulcers (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Findings include: During interview on 8/8/16 at 3:50 p.m., registered nurse (RN)-B stated R24 did not have a pressure ulcer. On 8/9/16, at 7:44 a.m., R24 was interviewed and stated he had pain. He stated the pain he had a sore on his buttocks which caused him pain. During an observation on 8/11/16, at 8:41 a.m. nursing assistant (NA)-Q toileted R24. R24's right and left ischial tuberosities were noted to be	F 314	F 314 The Facility will continue to ensure that residents admitted to the facility will not develop pressure sores unless the individual□s clinical condition demonstrate that they were unavoidable and residents having pressure sores receive the necessary treatments to promote healing, prevent infection and prevent new ones from developing. Residents R 3 and R24 have been reassessed for pressure sore risk and care plans and NAR assignment sheets have been updated to reflect current status. All other residents that this may affect to include those with a Braden score of 15-19 will have assessments reviewed and care plans and NAR assignment sheets reviewed and updated as needed. Policy and Procedure for Prevention and treatment of Pressure Injuries has been updated. All nurses will be educated on updated policy and procedure. Nurse Managers or designee will audit 3 resident□s records to include	

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F 314	Continued From page 49 reddened and excoriated (an ischial tuberosity is a bony swelling on the buttocks that bears the weight of the body while sitting). There were five open areas observed which each measured approximately one centimeter (cm) x one cm. The areas of redness were noted to be approximately four inches x two inches on the left side and approximately two inches x one inch on the right. R24's Care Area Assessment (CAA) dated 4/6/16, indicated R24 was at risk for pressure ulcers due to the need for extensive assist with bed mobility and incontinence. A quarterly Minimum Data Set (MDS) dated 6/30/16, indicated R24 was cognitively intact, occasionally incontinent of bladder, frequently incontinent of bowel and required extensive assistance for bed mobility, toileting and transfers. R24's care plan dated 7/26/16, indicated the resident experienced incontinence and interventions directed staff to apply a barrier cream to the resident ' s perineal area after each incontinent episode, and to observe the condition of R24 ' s skin. The care plan further identified R24 had a risk for alteration in skin integrity and directed staff to observe for changes in skin, to report changes to the licensed staff, and for the licensed staff to conduct a weekly skin assessment. R24's Treatment Flowsheet from 8/1/16 through 8/12/16, indicated the following interventions were to be implemented: Reposition patient every two hours in order to displace weight on sacral/coccyx area; Skin assessment weekly on bath day; Apply barrier ointment to sacral coccyx area twice daily with cares.	F 314	assessment, care plan and NAR assignment sheets per unit weekly for one month and then 3 residents monthly for 3 months to ensure compliance with policy and procedure. Repositioning audits will be completed using the same schedule. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for certification is September 21, 2016	

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A review of a facility document titled Weekly Skin Checklist for August 2016, indicated R24 had an open area to his right shin on 8/6/16. The Weekly Skin Checklist did not identify any alteration to the skin on his buttocks. When reviewed, the Weekly Skin Checklist for July 2016 had void of any documentation for the entire month.

A review of the Nurse's Progress Note late entry dated 8/12/16, indicated R3 "has stage 2 ulcers (multiple open areas on right and left buttocks)." Family notified of pressure ulcers.
A facility document titled 2 North Plan of Care (NA worksheet) undated, indicated R24 had a history of skin breakdown in the sacral area and directed staff to lay R24 down in bed or reposition in wheel chair.

During an interview on 8/11/16 at 8:18 a.m., nursing assistant (NA)-Q stated R24 complained of pain in his bottom and stated he gets "rashes" on it. NA-Q stated the resident has stated it gets better, then worse. NA-Q stated she would update the nurse when R24's bottom was noted to have sores on it. NA-Q was asked if RN-B was aware of the open areas and NA-Q replied, "He should have been aware of it."

During an interview on 8/11/16 at 8:54 a.m., RN-B stated he was not aware R24 had an alteration to the skin on his bottom. He stated the nurses should be performing weekly skin checks for R24 and should be reporting anything that had not been noted on a previous assessment. However, there was no evidence the weekly skin assessments had been conducted during the month of July.

During an interview on 8/11/16, at 12:29 p.m. the

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director of nursing (DON) stated weekly skin checks should have been completed for R24 and stated RN-B should have been aware of the pressure ulcers to R24's bottom as RN-B was the nurse manager on the unit.

During a follow up interview with R24 on 8/11/16 at 2:42 p.m., R24 stated he'd had sores on his bottom on and off for a year.

During a subsequent interview with RN-B on 8/11/16 at 2:57 p.m., RN-B described R24's bottom as "breakdown of left buttock, moving to the right." RN-B stated the areas looked like they had started as "chafing" and then the skin had been "sheared" off.

RN-A stated during interview on 8/9/16 at 7:12 a.m., that she was unaware of any alterations to R3's skin but that she would look at it. At 7:28 a.m., RN-A reported to the surveyor that she had looked R3's skin, and had observed an open area on his right buttock. RN-A described the area as a stage I pressure ulcer (non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators).

During an observation on 8/11/16 at 7:23 a.m., licensed practical nurse (LPN)-A and RN-A completed a dressing change to R3's buttocks. R3's right and left ischial tuberosities were observed to be red and excoriated with three separate open areas. RN-A described the area as having "lots of redness and three stage II pressure ulcers." LPN-A stated the wound had gotten bigger since the last time she'd done the dressing change and now required a larger

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F 314	Continued From page 52 dressing than it had previously. A review of Nurses' Progress Notes from 2/12/16 through 8/11/16, identified R3 had a history of open areas to the buttocks. The notes indicated R3 had a stage II pressure ulcer on 2/23/16. R3's annual MDS dated 6/30/16, indicated he was cognitively intact, required extensive assistance for bed mobility, transfers and toileting and was frequently incontinent of bowel and bladder. A CAA dated 6/30/16, indicated R3 had a "high risk for pressure ulcer due to a history of pressure ulcers." R3's care plan dated 8/5/16, identified a problem area of impaired mobility, and interventions included for staff to assist with bed mobility, transfers and toileting. R3's care plan had been updated on 8/11/16, to include identification of an open area to his left buttock measuring 1.5 cm (centimeters) x 1.5 cm. Although the observation on 8/11/16 at 7:23 a.m. had identified three open areas, a Nurses' Progress Note dated 8/11/16, indicated a message had been left for the nurse practitioner regarding: "two open areas (1.2 cm x 1.2 cm) on resident's left buttock. " A review of R3's Physician Order Report dated 7/22/16 through 8/22/16, indicated on 7/14/16, the nurse practitioner had written the following order: Left buttock ulcer-cleanse with normal saline, apply skin prep to surrounding skin, cover with Allevyn border (Allevyn Border is a wound covering dressing), change every other day. A Weekly Skin Checklist dated 7/27/16, identified an open area on R3's left buttock.	F 314		

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While the Physician Orders and Weekly Skin Checklist identified an open area to R3's buttock beginning on 7/14/16, there was no evidence an assessment of the wound was completed at any time between 7/14/16 and 8/11/16 to stage, describe, measure or track progress toward healing.

During an interview on 8/10/16 at 1:01 p.m., LPN-A stated she was aware of the open area to R3's buttocks. She stated the nurse practitioner saw him in July and found the area. LPN-A further stated R3 had experienced problems with the skin on his bottom in the past.

During an interview on 8/11/16, at 7:02 a.m., two days after RN-A was made aware of the pressure ulcer on R3's buttock, RN-A stated she had not assessed the wound yet. She stated, "I think the nurses do the assessments daily." However, review of the record reflected there had been no assessment to measure and monitor R3's pressure ulcers.

During an interview on 8/11/16 at 12:19 p.m., the DON stated when a skin concern was identified an incident report should be filled out and the care plan should be updated. She stated RN-A was responsible for implementing the process and stated weekly skin assessments would have been expected to be completed since the initial area had been discovered by the nurse practitioner on 7/14/16.

R28's quarterly MDS dated 6/23/16, indicated she was moderately cognitively impaired, frequently incontinent of bowel and bladder and required extensive assistance of two staff for bed mobility, toileting and transfers. R28's care plan dated

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7/31/16, indicated she required assistance using a mechanical stand to transfer related to osteoarthritis and neuropathy. The care plan further identified a pressure ulcer to R28's right buttocks and directed staff to monitor weekly, reposition with pillows and provide a pressure relieving cushion in wheel chair. A facility document titled 2 North-Plan of Care undated, directed staff to "be diligent with turning and repositioning" but did not identify a frequency. Prior to inquiry by surveyor, the care plan reflected every hour repositioning based on tissue tolerance tests.

A Nursing Progress Noted dated 7/29/16, indicated R28 had a stage II pressure ulcer present on her right buttock.

During continuous observation on 8/10/16 from 8:06 a.m.-10:07 a.m., R28 remained seated in the wheelchair without repositioning. At 8:06 a.m. on 8/10/16, R28 was seated in a standard wheel chair with a cushion on the seat. At 8:58 a.m., R28 remained seated in the wheel chair in the dining room. At 9:26 a.m., staff escorted R28 to her room where she remained seated in her chair without repositioning. At 10:07 a.m. R28 remained in the wheelchair.

NA-Q was interviewed at 10:15 a.m. on 8/10/16. NA-Q stated she knew to reposition R28 every two hours and stated she thought the resident had last been repositioned about 8:30 a.m. However, R28 was seated in the dining room at 8:30 a.m. and had not been repositioned. At 10:24 a.m., NA-Q stated R28 had left for the beauty shop and had still not been repositioned. At that time, R28 had been in her wheel chair for two hours and 18 minutes without repositioning.

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At 11:05 a.m., NA-Q stated she had taken R28 to the bathroom after she returned from the beauty shop but did not specify an exact time.

During an interview on 8/10/16, at 10:11 a.m., registered nurse (RN)-B stated another staff completed the assessments and the care plans and he updated the care sheets (the 2 North -Plan of Care). RN-B stated if the care plan directed staff to reposition R28 every hour it should be reflected on the care sheet and staff should be repositioning her every hour.

During an interview on 8/11/16 at 12:26 p.m., the DON stated R28 should have been repositioned every hour as directed by the care plan. She further indicated the care sheets should indicate a frequency to guide the nursing assistants.

R116 was observed on 8/10/16, at 6:53 a.m. lying in bed on her right side, eyes closed and a pillow behind her back. Two Posey sleeves (provide comfortable protection for fragile or sensitive skin that may bruise or tear easily) were observed on top of the night stand.
At 6:56 a.m. NA-U was observed to enter R116's room. NA-U stated she was going to get R116 dressed but then said she would leave R116 and would be back in 45 minutes. At 7:14 a.m. NA-U was overheard reviewing the assignment sheet with NA-A outside R116's room. When interviewed at that time, and asked about when R116 had last received care, NA-A stated she was not a regular staff on the unit but would be getting R116 up shortly. NA-A stated because she did not know residents in the unit she would follow their care plans.
At 7:19 a.m. NA-A was observed go to R116's room with linens. She stated she was not getting

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F 314	Continued From page 56 R116 up yet, but was just getting what she would need ready. At that time, NA-A did not reposition the resident. At 7:27 a.m. R116 was observed to be asleep on the bed wearing the arm sleeves on both arms still lying on her back, positioned to her right side. At 8:29 a.m. LPN-A stated she had informed NA-A that R116 was supposed to be repositioned every hour. When asked when the resident had been last repositioned, LPN-A stated she had gotten to the unit at 6:30 a.m. but did not know when R116 had last been repositioned. LPN-A stated R116 had an open area which was improving however, the area was a recurring one in the same area. At 8:32 a.m. both NA-A and LPN-A were observed to provide pericare and repositioning for R116. During the observation R116's bottom appeared red and non-blanchable. The area on the tail of the coccyx was observed covered with a thick layer of cream. LPN-A wiped the area and a scab was observed. LPN-A stated the bottom was red and non-blanchable because R116's skin was so fragile. LPN-A also verified R116 was supposed to be wearing a left heel boot which was not on. At 8:36 a.m., NA-A stated LPN-A had informed her R116 was supposed to be repositioned hourly however when she'd looked at the NA assignment sheet, it indicated R116 was to be repositioned every one to two hours, and because she had been pulled from another unit later into the shift she had not been told when R116 had been repositioned last. R116 went one hour and 39 minutes without being repositioned. At 8:45 a.m. on 8/10/16, LPN-A verified the resident was supposed to wear the Posey sleeves at all times. LPN-A stated it was not on the treatment sheet but that she was going to add it.	F 314		

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F 314	Continued From page 57 On 8/10/16 at 8:50 a.m., RN-A reviewed R116's care plan and verified R116's care plan indicated staff were to reposition her side to side hourly when in bed. However, the care plan was contradictory as it also directed staff to reposition the resident every one to two hours. RN-A verified the Posey sleeves were supposed to be on at all times. RN-A stated she would expect staff to follow the resident's plan of care. On 8/10/16, R116 was observed from 8:52 a.m. to 9:18 a.m. R116's cares were observed provided by NA-A and NA-U who turned R116 from the left to the right but never placed a pillow behind the resident. On 8/10/16 at 10:36 a.m., LPN-A stated she had reviewed the NA group Plan of Care sheet and had noticed both the one to two hours and every hour for repositioning. LPN-A stated she was going to make sure it was updated to reflect the hourly repositioning schedule as this was confusing and misleading for staff. At 10:42 a.m. LPN-A stated R116 had an open area that was pressure related as it was the same area where it had healed before. LPN-A stated the area was a stage II which was healing well. On 8/12/16 at 7:20 a.m., R116 was observed seated in a Broda chair in front of the dining room door. R116 was noted to have blue boots on both feet however, did not have a pillow placed on the foot rest. At 7:30 a.m. RN-A verified their was no pillow in place on the foot rest. R116's annual MDS dated 5/31/16, identified the resident's diagnoses as: dementia, contracture, muscle weakness, anxiety, failure to thrive and	F 314		

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osteoporosis. The MDS also indicated R116 had severely impaired cognition and required extensive to total dependence of one to two staff for all activities of daily living which included bed mobility, toilet use and transfers. In addition the MDS indicated R116 was at risk for pressure ulcers, but had no unhealed pressure areas at the time of the assessment.

R116's pressure ulcer CAA dated 5/31/16, indicated the resident was at risk for pressure ulcers related to impaired mobility, dementia and bowel incontinence. The CAA directed staff to assist R116 with turning and repositioning and to observe skin daily during cares.

R116's care plan dated 7/8/16, indicated she was at risk for alteration in skin integrity related to dementia, incontinence of bowel and bladder, dependency with ADLs, poor nutritional intake, and being chair fast. The care plan further indicated R116 had a history of bruising easily and had fragile skin. Care plan interventions included: "Place pillow on foot rest when resident is in BRODA chair, elevate lower extremities when in bed above level of heart. Turn side to side hourly while in bed, use pillows to protect bony prominences when repositioning, Repositioning hourly while in BRODA chair (specialized wheelchair), Posey sleeves upper extremities (Full arm) and derma-savers to lower extremities at all times, remove at bedtime to apply lotion, then reapply. Heel blue boots on both feet when lying in bed and sitting up daily on all three shifts..."

During review of the Event Reports assessments and the Interdisciplinary team notes (IDT) the following were revealed:

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	245574	A. BUILDING _____ B. WING _____	08/12/2016

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F 314	Continued From page 59 -A Weekly Summary dated 7/7/16, indicated resident required physical extensive assistance of staff with bed mobility and repositioning. -Skin Integrity Events -- Pressure Sore/Stasis Ulcer/Arterial dated 8/1/16, indicated R116 had a stage II- partial thickness loss of skin layers that presents clinically as an abrasion blister, or shallow crater. The open area was on the left buttocks and measured 1.5 centimeters (cm) by 1.0 cm. The assessment indicated resident had history of pressure ulcer and directed interventions included but not limited to turning and repositioning and use of pressure relieving devices in chair and bed. -Interdisciplinary note (IDT) note dated 8/4/16, indicated resident pressure open area on right bottom measured "1/4 cm x 1/8 cm, washed with normal saline [NS], patted dry, barrier cream applied to area." On 8/12/16, at 7:36 a.m. DON stated she would expect staff to have repositioned R116 timely in accordance with the care plan. A facility policy titled Prevention and Treatment of Wounds undated, directed staff to monitor pressure ulcers daily including the status of the surrounding skin, signs of infection and whether pain is present. The policy further directed staff to initiate weekly wound monitoring to include onset of skin condition, location of wound, stage of wound, length, width, depth and wound characteristics.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		9/21/16

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F 323	Continued From page 60 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 provide appropriate textured food/fluids in order to prevent choking/aspiration for 1 of 1 residents (R109) who had been identified as at risk reviewed during a dining observations. In addition, the facility failed to ensure grab bars on toilets were secured for 6 of 10 residents (R29, R58, R186, R101, R96, R176). This has the potential to affect 118 residents who have grab bars on their toilets. Findings include: R109's meal service was observed on 8/8/16, at 6:13 p.m. R109 was heard coughing continuously when standing at the desk. At 6:14 p.m. the resident was observed coughing continuously, as another resident in the same table stated repeatedly, "[R109] cover your mouth." At 6:15 p.m. nursing assistants (NA)-P and NA-K in the dining room stated to R109 coughed like that every day. At 6:17 p.m. when asked if the food had been thickened as noted in the meal ticket, NA-P stated the food had already been pre-thickened and added at times for example the soup staff would have to add the thickener however, not for that particular meal. The pureed food on the plate was noted to be runny and thin. At 6:18 p.m. R109 continued to cough with each bite. At 6:22 p.m. NA-P stood up and asked R109	F 323	F 323 The facility will continue to ensure that the resident□s environment remains as free of accident hazards as possible. Resident R109 has been reassessed for appropriate texture of food and fluids. Plan of care, meal ticket and assignment sheet have been updated to reflect current status. All other residents affected by this will be reviewed and care plans and NAR assignment sheets updated as needed. Education has been conducted with nursing staff on following the plan of care related to appropriate textures of food and fluids. Dietary servers have been educated on providing appropriate textures while serving meals. Nurse Manager or designee will complete 3 audits weekly on each floor to ensure the plan of care is being followed for one month and then 3 audits monthly for 3 months to ensure follow through on the plan of care. Director of Culinary services or designee is responsible to audit servers to ensure compliance 3 times weekly for one month and then 3 times monthly for 3 months. All grab bars on toilets have been audited	

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F 323	Continued From page 61 if he was going to eat all his food. At 6:23 p.m. R109 coughed again. Staff were still standing over the resident. At 6:24 p.m. the resident coughed again after a bite of the runny pureed food on the plate and was observed hold his head and NA-P asked R109 if he was having a headache and resident would nod. At 6:25 p.m. NA- asked NA-P "Do you think I should give him juice." At 6:26 p.m. another NA came into the dining room and NA-P requested her to wheel resident out of the dining room. -At 6:29 p.m. resident observed at the nursing station still coughing loud and holding his head. At 6:32 p.m. observed R109 had been moved into his room and was still cough. On 8/8/16, at 6:39 p.m. the nutritional service manager (NSM) stated the cook who had cooked that evening had left for the night. When asked if she was familiar with what had been added to the pureed food for R109, NSM stated she would not exactly know what had been added to the food before it was brought to the floor for the pureed food. A request of NSM to see if they would contact the cook at that time. NSM called the cook who indicated all the cook added one to two scoops of thickener to all pureed food. -At 6:59 p.m. registered nurse (RN)-B approached stated the nurse practitioner was working on resident diet order to determine if it was appropriate and at that time the food was pureed and liquids were supposed to be honey consistency. RN-B stated R109 had a history of aspiration pneumonia, and currently was on a patch to decrease secretions and was on Mucinex (used to relieve the symptoms of cough and loosen mucus in the chest). At 7:06 p.m. RN-B verified the 7/29/16, which directed staff to add two teaspoons of thickener stated the nurse	F 323	for safety. All are currently in working order. Maintenance Director or designee will be responsible for routine auditing of grab bars to ensure ongoing compliance. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for certification is September 21, 2016	

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had signed off on it. RN-B stated on the meal ticket the three packets of thickener were for the coffee, juice and soup if he needed them and that was to alert staff of what the resident needed.
-At 7:18 p.m. approached NA-P who had been assisting R109 with eating and she stated she had watched the tray from when it had been served and when she started to assist resident and she had not seen the licensed practical nurse (LPN)-C add thickener to the food as LPN-C had indicated.

On 8/9/16, at 9:16 a.m. observed R109's food served into a divided plate covered and sat on top of the steam table. No thickener was added to plate at that time. At 9:18 a.m. the plate of food remained in the same spot. At 9:33 a.m. NA-F took the sippy cups of cranberry juice and water (which were already honey thickened consistency) and added a packet of thickener to each of the 4 ounce cups, then brought them back and set them on the tray on top of the steam table. As NA-F was mixing the thickener LPN-C came into the nourishment center and left never said a word. No thickener was added to the pureed food at that time.
-At 9:39 a.m. when approached and asked about the thickened liquids dietary aide (DA)-A stated the liquids came already pre-thickened. He indicated he poured the beverages and nursing took care of the rest if they needed to add more thickener to the beverages.
-At 10:04 a.m. NA-F went to the dining room grabbed the tray and went into the nourishment center. NA-F stated she was going to assist resident and was warming the food.
-At 10:07 a.m. NA-F went to R109's room door at the door went in with the tray, applied the clothing protector, pulled a chair next to R109 and mixed

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the food. When approached and asked if she had added thickener to the food NA-F stated she had not. NA-F was then observed give resident one quick bite when surveyor intervened and stopped her before the second bite at 10:10 a.m. NA-F stated she was not aware resident food was supposed to be added more thickener and thought that was only the fluids which she had. As NA-F walked out of the room, the resident was heard coughing.
-At 10:13 a.m. NA-F went to room with the RN-B who looked at the meal ticket and looked at the food and stated the food consistency was good left the room. NA-F indicated to RN-B she had not seen the nurse add thickener to the food.
-At 10:15 a.m. came back to room found LPN-C and NA-F in room. LPN-C verified she had not added the thickener to the food and was in another room doing a dressing change. LPN-C directed NA-F to add two teaspoons to the pureed food.
-At 10:17 a.m. when asked if the NA-F had been informed about adding the thickener to the food LPN-C stated that had not been communicated to the NA-F. LPN verified the order was dated 7/29/16, and NA-F was a regular staff was not aware she was supposed to add the thickener to the food.
-At 10:19 a.m. RN-B verified the team assignment sheet updated 8/8/16, did not have the two teaspoons order for thickener to be added to the food. RN-B stated he expected the nurses to implement the doctors' orders and to make sure the orders were communicated to the nursing assistants.

R109's nutrition Care Area Assessment (CAA) dated 11/5/15, indicated the resident was on a mechanically altered diet, had dysphagia, was

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edentulous and did not have dentures. CAA indicated R109's diet had been downgraded to pureed and honey thickened liquids but continued to have as needed cough which may or may not be related to intake.

The resident quarterly Minimum Data Set (MDS) dated 5/3/16, indicated resident required extensive physical assistance of one staff with eating, had coughing or choking during meals or when swallowing medications and was on a mechanically altered diet. In addition the MDS indicated resident had a diagnoses of dysphagia.

R109's nurse practitioner (NP) progress note dated 7/12/16, indicated resident was at high risk aspiration and respiratory infectious due to the coughing.

Resident physician order dated 7/22/16, indicated resident diet was pureed and honey thick liquids. In addition, another physician order dated 7/29/16, directed staff to "add 2 teaspoons of thickener to pureed diet three times a day [TID] during meals for coughing. Resident should be up in chair for meals at all times."

The 2 North Group 9 Plan of Care dated 8/8/16, for nursing assistants indicated R109 was on a mechanical soft diet with nectar thick liquids. The plan of care did not indicated two teaspoons of thickener were supposed to be added to the food three times daily.

R109's care plan dated 8/9/16, indicated resident had potential for nutrition related concerns diagnoses of intellectual disability, impulse control, and dysphagia. The care plan indicated resident continued to have coughing episodes

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F 323	Continued From page 65 with and without intake and was on pureed diet and honey thickened liquids. The care plan directed staff to "Add 2 teaspoons of thicken powder to puree diet TID during meals per orders..." On 8/11/16, at 3:23 p.m. registered dietician (RD) stated she had worked the kitchen the Friday when the order had been obtained 7/29/16, and had not been able to update the care plan and update the meal ticket. RD stated physician orders were part of the resident plan of care and acknowledged the order should have been implemented since nursing was aware of the order. RD further stated the new order was a trial to help with the coughing resident had with eating. On 8/12/16, at 7:34 a.m. the director of nursing (DON) stated she would expect communication to the staff on the orders and staff was to follow all physician orders. Grab bars R29's left grab bars affixed to the bed was observed on 8/8/16, at 2:51 p.m. during resident room observations to be loose moved three inches back and forth when touched. Resident stated she used it and noted the grab bar had been loose for a while now. On 8/10/16, at 11:47 a.m. when asked about the grab bar resident again stated she had thought about letting the staff know to fix it but she always forgot something's. R29's activities of daily living (ADL)/Functional Status Care Area Assessment dated 4/16/16,	F 323		

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F 323	Continued From page 66 indicated resident required extensive assist with bed mobility, transfers, ambulation, locomotion, dressing, toilet use and personal hygiene. R29's quarterly MDS dated 7/9/16, indicated resident had intact cognition. Resident diagnoses included Parkinson's tremors, osteoporosis and osteoarthritis obtained from the face sheet dated 8/8/16. R29's care plan dated 8/8/16, indicated resident had an alteration in mobility related to weakness, depression, arthritis, history of falls and history of fractures. Care plan directed staff to provide extensive assist with bed mobility. Staff was to lift feet into/out of bed and extensive assistance with ambulation using a walker and transfer belt. The care plan did not indicated resident used grab bars in the bed for mobility. 2 North Group 8 assignment sheet updated 8/9/16, indicated resident had safety grab bars. The plan of care did not indicate who was responsible for checking the grab bars to ensure they were properly affixed to the bed frame. On 8/10/16, at 11:52 a.m. RN-B stated maintenance fixed the grab bars. RN- B stated he would expect the staff to put in a work order either in paper if they did not have access to the computer. At 11:53 a.m. RN-B went to room and verified the left grab bar was loose. He indicated he thought it was a loose from bolts not fitting properly. -At 12:10 p.m. NA-O stated she had not noticed the loose grab bar. When asked if resident used the grab bars to turn side to side when in bed or when she got in and out of the bed and during cares NA-O stated "yes she does."	F 323		

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F 323	Continued From page 67 -At 12:18 p.m. RN-B stated about two weeks ago the interim DON had requested the staff to do an assessment and check if residents needed to have the grab bars in the beds. At the time resident had indicated she wanted to keep the grab bars in her bed and had been given the risks and benefits of the grab bars. RN-B stated he had not at the time checked the grab bars to make sure they were properly affixed to the bed frame and had not since completed an assessment and was getting to it. RN-B further stated maintenance had also gone through the entire unit he thought and switched out the beds if a resident had asked to have only one grab bar and was not sure if maintenance had check the grab bars to make sure they were properly affixed to the bed and directed the surveyor to the maintenance staff. On 8/10/16, at 12:47 p.m. environmental supervisor (EVS) stated he had been in his position for the last one week. He indicated his department did not have grab bars on a routine preventative routine plan to be checked and his department depended on house-keeping and nursing to report any concerns for his staff to come and fix the grab bars. -At 12:51 maintenance staff verified the grab bar was loose. He indicated it was the bolts that needed to be tightened up. He further stated the grab bar on the left was supposed to be affixed firmly to the bed frame as the right side and that was caused due to the residents using the grab bars repeatedly. R58's grab bars on toilet seat were observed to move the toilet seat 15 degrees to the right and left during the initial tour on 8/9/16, at 10:17 a.m.	F 323		

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F 323	Continued From page 68 R58's admission MDS dated 5/31/16, indicated R58 was cognitively intact, walked in room using a walker with supervision and required assistance with toileting. R58's MDS indicated R58's diagnoses included congestive heart failure, hypertension, and Alzheimer's disease. R58's care plan revised 6/17/16, indicated R58 required assistance with toileting related to dementia and impaired mobility and was at risk for falls. The care plan instructed staff to anticipate needs for toileting, follow safety precautions, and assist of one to transfer on and off the toilet. The Nursing assistant assignment sheet dated 6/23/16, instructed staff that R58 required minimal assist with ambulation and toileting. The Progress Note dated 6/29/16, indicated R58 was independent with toileting. On 8/9/16, at 10:22 a.m. NA-L verified R58 used the toilet and the seat/grab bar combination are supposed to be tight and the seat should not wiggle. On 8/11/16, at 12:13 p.m. EVS said, "This [toilet grab bar] needs to be replaced. We need to develop a preventative program for checking this [toilet grab bar]." R186's room was observed on 8/8/16, at 2:41 p.m. The grab bars on toilet seat were observed to be loose, allowing the toilet seat to move side to side. On 8/9/16, at 10:50 a.m. toilet grab bars were still loose.	F 323		

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R186's quarterly MDS dated 6/23/16, indicated R186 was severely cognitively impaired, did not walk in room, required assistance with toileting. R186's MDS indicated R186's diagnoses included osteoarthritis, and Alzheimer's disease.

R186's care plan revised 8/3/16, indicated R186 required assistance to transfer on and off the toilet and was at risk for falls. The care plan instructed staff to anticipate needs for toileting, follow safety precautions, and provide assist of one to transfer on and off the toilet.

The Nursing Assistant Assignment Sheet dated 8/4/16, instructed staff that R186 required assist with transfers and toileting.

On 8/8/16, at 2:45 p.m. NA-K verified R186 used the toilet with staff assistance and that the toilet seat moving might cause a fall. NA-K was observed telling the health unit coordinator about the loose toilet grab bars.

On 8/11/16, at 12:17 p.m. the administrator verified the toilet grab bar was loose.

R101's room was observed on 8/8/16, at 5:19 p.m. and the grab bars on the toilet seat were observed to be loose, allowing the toilet seat to twist.

R101's MDS dated 6/1/16, indicated R101 was severely cognitively impaired, required assistance with toileting. R101's MDS indicated R101's diagnoses included hypertension, and dementia.

The Nursing Assistant Assignment Sheet dated 6/23/16, indicated R101 was a fall risk and

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instructed staff that R101 required assist with ambulation using a front wheel walker and with toileting.

R101's care plan revised 7/1/16, indicated R101 required assistance with toileting related to dementia and impaired mobility and was at risk for falls related to unsteady gait and history of falls. The care plan instructed staff to anticipate needs for toileting, follow safety precautions, and assist of one to transfer on and off the toilet.

On 8/8/16, at 5:25 p.m. NA-N verified R101 used the toilet and stated, "The seat should not wiggle this much."

On 8/11/16, at 12:13 p.m. EVS said all but one nut that secured the toilet grab bar were loose.

R96's room was observed on 8/8/16, at 6:13 p.m. The bilateral grab bars on the toilet when grabbed caused the toilet seat to twist.

R96's quarterly MDS dated 6/16/16, indicated R96 was moderately cognitively impaired, and required assistance with toileting. R96's MDS indicated R58's diagnoses included seizure disorder, and dementia.

The Nursing Assistant Assignment sheet dated 6/23/16, instructed staff that R96 required assist with of EZ Stand (a mechanical lift that assists a resident to come to a standing position) for transfers with toileting.

R96's care plan revised 7/1/16, indicated R96 had impaired range of motion due to contractures in both hips and knees. R96 required assistance

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F 323	Continued From page 71	F 323		

with toileting related to and cognitive changes, impaired sitting balance and was at risk for falls. The care plan instructed staff to provide assist of two staff member to transfer R96 on and off the toilet.

On 8/8/16, at 6:25 p.m. NA-N verified R96 used the bathroom and stated the seat should not wiggle this much.

On 8/11/16, at 12:07 p.m. EVS verified toilet grab bar and seat were loose. EVS stated he depended on nursing and housekeeping staff to notify maintenance that a repair is needed.

R176's room was observed on 8/8/16, at 3:31 p.m. The grab bars on toilet seat were observed to be loose, allowing the toilet seat to twist side to side.

R176's quarterly MDS dated 5/28/16, indicated R176 was severely cognitively impaired, walked in room using a walker with assistance and required assistance with toileting. R176's MDS indicated R176's diagnoses included Parkinson's (involuntary movement disorder), and Dementia.

R176's care plan revised 6/17/16, indicated R176 required assistance with toileting related to muscle weakness and Parkinson's and was at risk for falls. The care plan instructed staff to anticipate needs for safety, toilet safety frame (toilet grab bars), and assist of one staff for toilet use and incontinence care.

The Nursing Assistant Assignment sheet dated 6/23/16, instructed staff that R176 required assist of two staff to transfer and reposition. Staff were

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F 323	Continued From page 72 to assist R176 to the bathroom upon rising, after meals, at bed time, during rounds at night and as needed. On 8/8/16, at 3:35 p.m. NA-N verified R176 used the bathroom and stated the seat should not wiggle this much. On 8/11/16, at 12:09 p.m. EVS verified the toilet seat turned 15 to 20 degrees to the left and right. EVS said this was a fall risk. During interview at end of environmental tour on 8/11/16, at 12:21 p.m. the EVS said, "I would expect the nursing assistants and housekeeping to notify maintenance immediately if they saw a loose grab bar." EVS verified that the grab bars on the toilets were not to be loose and that all but one of the grab bars observed could be fixed with a wrench. EVS stated one grab bar on the toilet was broken and needed to be replaced. EVS stated, "If a resident grabbed the bar with one hand it could move, causing them to slip." The EVS stated they did not have a preventative maintenance program for checking the toilet grab bars. On 8/11/16, at 4:41 p.m. the administrator stated, "We do not have a policy for reporting issues to maintenance but we do have a process, both paper and computer for staff to report things that need to be fixed. All staff can use at least one of the systems." On 8/12/16, at 11:06 a.m. the DON said, "I would expect the nursing assistants and nurses to report loose grab bars to maintenance."	F 323		
F 334	483.25(n) INFLUENZA AND PNEUMOCOCCAL	F 334		9/21/16

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F 334 SS=E	Continued From page 73 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	F 334		

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F 334	Continued From page 74 medically contraindicated or the resident has 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 implement a policy and procedure related to pneumococcal conjugate vaccine (PCV13) for 4 of 5 residents (R50, R84, R153, R176) whose vaccination histories were reviewed. Findings include: The Center for Disease Control and Prevention	F 334	F 334 The facility policy and procedure for pneumococcal immunization has been updated to include the conjugated vaccine for PCV13. Nursing staff have been educated on policy and procedure. Nurse Manager or designee will audit all new admissions for one month and then 5 admissions per month to ensure	

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F 334	Continued From page 75 identified "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine 23) should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. R50's Immunization record, undated indicated the 102 year old resident received the Pneumovax PPSV23 on 1/1/05. There was no evidence she had been offered the PCV13 vaccine since her admission to the facility on 10/10/11. R94's immunization record, undated, indicated the 84 year old received the Pneumovax PPSV23 but did not specify a date. The undated record was signed by R94 on 2/3/2012. There was no evidence she had been offered the PCV13 vaccine since her re-admission to the facility on 2/1/16. R153's immunization record dated 7/5/2016 indicated the 82 year old resident received the Pneumovax PPSV23 6/26/2008. There was no evidence she had been offered the PCV13 vaccine since her admission to the facility on 7/11/16. R176's immunization record, undated, indicated the 70 year old resident received the Pneumovax PPSV23 on 8/4/2011. There was no evidence she had been offered the PCV13 vaccine since his admission to the facility on 3/12/14. On 8/12/16, at 10:57 a.m., the registered nurse clinical specialist (RNCS)-A stated the facility had not started implementing the pneumococcal PCV13 at this time.	F 334	compliance. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for certification is September 21, 2016	

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F 334	Continued From page 76 A policy for the pneumococcal PCV13 was requested but not received.	F 334		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate staffing for residents to receive the highest practicable well-being. This had the potential to affect all 145 residents in the facility. Findings include:	F 353	F353 Current staffing patterns for all units have been reviewed daily to ensure staffing is appropriate for current resident needs. Staffing levels will be reviewed daily and adjusted with changes in resident needs. Posting of hours will be updated daily to	9/21/16

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F 353	Continued From page 77 The task of sufficient staffing was triggered by an OHFC (Office of Health Facility Complaints) complaints to survey, H5574085 and H5574083, as well as family complaints of lack of staffing on site. In addition, three OHFC surveyors entered the facility with the survey team to investigate three additional complaints. See F282 failure to follow the care plan. See F309 failure to provide cares for highest practicable wellbeing. See F312 activities of daily living. See F314 pressure ulcer development. Complaint number H5574083 noted, "Facility has been short staff and as a result there have been 22 falls in a month, In addition, medications were given late, wound care treatments were not being completed and residents were waiting up to 90 minutes for call lights to be answered." Complaint number H5574085 noted, "Facility short of staff and resident, R116 was not getting personal cares completed, and not being repositioned." R116 had recurrent stage 2 pressure ulcers (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater), which had opened 8/1/16, aide sheet was not updated to say reposition hourly, bottom red and non-blanchable, according to the nurse manager. R116 was not repositioned from 9:18 to 10:32 she sat, after the initial hour 36. Resident is nonverbal, unable to move, totally dependent on staff)." R136 was a Russian Speaking resident with mild cognitive impairment, moderate depression, and required extensive assistance of one person for	F 353	include changes made throughout the day. Audits of daily posting will be completed daily for 2 weeks and weekly for 2 months to ensure compliance. All concerns/grievances related to staffing/call light response will be investigated per policy. Call light reports will be reviewed daily with nursing management for one month and then weekly for 3 months and actions taken as needed. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for certification is September 21, 2016	

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bed mobility, transfers, and toilet use. On 8/10/16, at 3:40 p.m. family member (F)-D (daughter of R136) Stated: "I know that people work hard, and weekends are short staffed. But there is also a lack of communication that impacts care. When I tell the staff I see a change in my father, or to watch for changes in his skin, (a bruise or scratch), I come back 3 days later and it's worse, and when I ask the nurse working, they know nothing about it, or they say it doesn't say where the scratch is; shouldn't they lift up his shirt and look? It seems like the staff are not even doing the skin checks. Changes don't get reported to the doctor when I point them out, and the next thing you know he is back on antibiotics, or back in the hospital. Just a lack of communication between staff and doctors, staff don't listen when given concerns. What about the people who don't have someone who can come every day." A review of the residents chart revealed wound sites that worsened and required antibiotics and additional treatments, and documentation that R136's daughter notified staff of changes 24 hours before he was transferred to the hospital on 8/9/16.

Grievances were reviewed and revealed:
On 7/27/16, 2 South, medical doctor (MD)-A and consultant pharmacist (CP) approached voicing the following concerns related to resident service in the dining room during lunch today. Reported two of MD-A's residents had concerns with not eating. Requested aide to get a resident juice twice and nothing happened. MD-A then offered her patients applesauce and yogurt, which MD-A then served to the patients, MD-A also physically fed a resident soup. Call light audits indicated one call light was on greater than 15 minutes, two call lights were on greater than 20 minutes, two call

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lights were on greater than 25 minutes, and one call light was on greater than 45 minutes. Staffing was not requested.

On 7/25/16, spouse of R21 stated resident was not getting walked three times per day as ordered, "only 1 staff member ever walks him." Call light audits indicated three call light was on greater than 15 minutes, one call light was on greater than 20 minutes, two call lights were on greater than 25 minutes, one call light was on greater than 30 minutes, one call light was on greater than 35 minutes. On 7/25/16, Day shift: 2 North had 2 LPN and 6 NA. 2 South had 1 manager working the unit, 1 LPN, 1 TMA and 3 NA. 3 North had 2 LPN and 6 NA. 3 South had 2 LPN and 6 NA. Evening shift: 2 North had 2 LPN and 6 NA, 2 South had 2 LPN (1 was agency), and 3 NA. 3 North 1 RN, 1 LPN, and 6 NA, 3 South had 1 LPN 2 TMP and 6 NA. Night shift: 2 North had 1 LPN, 2 NA. 2 South had 1 RN and 2 NA. 3 North had 1 LPN (agency nurse did double shift) and 2 NA. 3 South had 1 RN and 2 NA. The staff posting was incorrect for the number of LPN hours, as it was not updated with changes and the manger working the unit on day shift on 2 South was not counted in the direct staff hours.

On 7/20/16, daughter stated mother, admitted 7/10/16, had not yet been showered. Call light audits indicated two call lights were on greater than 15 minutes, two call lights were on greater than 20 minutes, one call light was on greater than 25 minutes, one call light was on greater than 30 minutes and one call light was on greater than 40 minutes. On 7/11/16, Day shift: 2 North had 1 RN, 2 TMA and 6 NA. 2 South had 2 LPN, and 3 NA. 3 North had 2 LPN and 6 NA. 3 South had 1 RN, 1 LPN and 5 NA. Evening shift: 2

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North had 2 LPN and 6 NA, 2 South had 2 LPN, and 4 NA. 3 North 1 RN, 1 LPN, and 6 NA, 3 South had 2 LPN and 6 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN and 2 NA. 3 North had 1 RN and 2 NA. 3 South had 1 RN and 2 NA. The staff posting was incorrect for the number of RN, LPN and NA hours, as it was not updated with changes.

On 7/11/16, spouse of R177 complained of staff not knowing how to properly read meal tickets, and residents were not getting their ordered diets. Call light audits indicated four call lights were on greater than 15 minutes, two call lights were on greater than 20 minutes. On 7/11/16, Day shift: 2 North had 2 LPN and 6 NA. 2 South had 1 LPN, 1 TMA and 2 NA. 3 North had 2 LPN and 6 NA. 3 South had 1 RN, 1 LPN and 6 NA. Evening shift: 2 North had 2 LPN and 6 NA, 2 South had 1 LPN, 1 TMA, and 2 NA. 3 North 1 RN, 2 TMA, and 5 NA, 3 South had 2 LPN and 6 NA. Night shift: 2 North 1 RN, 2 NA. 2 South had 1 RN and 2 NA. 3 North had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of RN, LPN and NA hours, as it was not updated with changes.

Multiple complaints of lack of food from multiple residents in July.
On 6/13/16, R126's, husband and daughter approached SW to request assistance to move to another facility due to NA's not following care plan, not meeting dietary needs, poor intake and gradual weight loss, an overall feeling that resident is not receiving quality of care she needs to be successful. Call light audits indicated four call lights were on greater than 15 minutes, three call lights were on greater than 20 minutes, two call light were on greater than 25 minutes and

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F 353	Continued From page 81 one call light was on greater than 45 minutes. On 6/13/16, Day shift: 2 North had 2 LPN and 4 NA. 2 South had 1 LPN, 1 TMA and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 4 NA. Evening shift: 2 North had 1 RN, 1 LPN and 4 NA, 2 South had 2 LPN, and 3 NA. 3 North 1 RN, 1 LPN and 5 NA, 3 South had 2 LPN and 4 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN and 1 NA. 3 North had 1 RN and 1 NA. 3 South had 1 RN and 2 NA. The staff posting was incorrect for the number of RN, LPN and NA hours, as it was not updated with changes. On 5/29/16, Call light audits indicated seven call lights were on greater than 15 minutes, five call lights were on greater than 20 minutes, and three call light were on greater than 25 minutes. On 5/29/16, Day shift: 2 North had 2 LPN and 4 NA. 2 South had 1 LPN, 1 TMA and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 4 NA. Evening shift: 2 North had 1 RN, 1 LPN and 4 NA, 2 South had 2 LPN, and 3 NA. 3 North 1 RN, 1 LPN and 5 NA, 3 South had 2 LPN and 4 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN and 1 NA. 3 North had 1 RN and 1 NA. 3 South had 1 RN and 2 NA. The staff posting was incorrect for the number of RN, LPN and NA hours, as it was not updated with changes. On 5/24/16, requested by surveyor investigating H H5574083, multiple falls in one day. Call light audits indicated six call lights were on greater than 15 minutes, two call lights were on greater than 20 minutes, two call lights were on greater than 25 minutes, one call light was on greater than 30 minutes and one call light was on greater than 35 minutes. On 5/24/16, Day shift: 2 North had 1 RN, 1 LPN and 6 NA. 2 South had 1 RN, 1	F 353		

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TMA and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. Evening shift: 2 North had 1 RN, 1 LPN (double from days) and 5 NA, 2 South had 1 RN, 1 TMA and 2 NA. 3 North 2 LPN and 5 NA, 3 South had 1 RN, 1 LPN and 3 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN and 1 NA. 3 North had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of RN, LPN and NA hours, as it was not updated with changes.

On 5/19/16, staff did not take resident R135 to dining room for 30 minutes, and did not return from dining room for 30 minutes, was told inadequate staff on the floor. Call light audits indicated one call light was on greater than 15 minutes, and two call lights were on greater than 20 minutes. On 5/19/16, Day shift: 2 North had 1 RN, 1 LPN and 6 NA. 2 South had 2 LPN and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. Evening shift: 2 North had 2 LPN and 6 NA, 2 South had 1 LPN, 1 TMA and 2 NA. 3 North 2 RNS and 3 (SHORT 3 NA ON THIS SHIFT) NA. 3 South had 2 LPN and 5 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN, 1 LPN and 1 NA. 3 North had 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was not provided for that day.

On 5/17/16, R140, letter from family verbal and physical threats against resident and visitor by resident adjacent, learned he was already hitting other people (no mention of OHFC report made). Unfounded allegation and response made, nurse manager meet with daughter that day. Call light audits indicated two call lights were on greater than 15 minutes, one call light was on greater than 20 minutes, one call light was on greater

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than 25 minutes, three call lights were on greater than 30 minutes and one call light was on greater than 65 minutes (1 hour 5 minutes). On 5/17/16, Day shift: 2 North had 1 RN, 1 LPN and 6 NA. 2 South had 1 RN, 1 TMA and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. Evening shift: 2 North had 1 RN, 1 LPN (double from days) and 5 NA, 2 South had 1 RN, 1 TMA and 2 NA. 3 North 2 LPN and 5 NA, 3 South had 1 RN, 1 LPN and 3 NA, and a note to take no admit. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN and 1 NA. 3 North had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of LPN and NA hours, as it was not updated with changes.

On 5/9/16, R500, complained nursing, was not bringing R500 to meals, he had untreated pain, not toileting/changing of incontinent pads (recorded weight loss in May and June). Call light audits indicated two call lights were on greater than 15 minutes, one call light was on greater than 30 minutes. On 5/9/16 staff was short 1 NA, Day shift: 2 North had 2 LPN and 5 NA. 2 South had 1 RN, 1 LPN and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. Evening shift: 2 North had 2 LPN and 6 NA, 2 South had 1 RN, 1 TMA and 2 NA. 3 North had 1 RN, 1 LPN and 5 NA, 3 South had 2 LPN (1 doubled from days) and 5 NA. Night shift: 2 North had1 LPN, 2 NA. 2 South had 1 RN and 1 NA. 3 North had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of LPN and NA hours, as it was not updated with changes.

On 5/7/16, R146, waited 1 ½ hours for pain medication, was not dressed, staff argued over who was helping, daughter helped. (No mention

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of investigation or report to State agency (SA). Call light audits indicated one call light was on greater than 15 minutes, three call lights were on greater than 20 minutes, one call light was on greater than 25 minutes, one call light was on greater than 30 minutes and one call light was on greater than 35 minutes. The staffing 5/7/16, on Day shift was short 1 NA for 2 North day shift, and had 2 LPN and 5 NA. 2 South had 1 LPN and 1 TMA and 2 NA. 3 N had 2 LPN and 5 NA. 3 South had 1 LPN, 2 TMA and 4 NA. Evening shift: 2 North had 2 LPN and 5 NA. 2 South had 1 LPN, 1 TMA, and 2 NA. 3 North had 1 RN, 1 LPN, and 5 NA. 3 South had 1 RN, 1 LPN, and 5 NA. Night shift: 1 LPN, 2 NA. 2 South had 1 LPN and 1 NA. 3 North had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of RN hours, as it was not updated with changes.

On 8/8/16, at 5:30 p.m. MD-A arrived on 2 South and asked staff working their names and their positions. At 5:40 p.m. MD-A stated there had been a huge turnover this summer, and assumed these were some of the new nurses. Stated staffing had been a challenge and that was why one wing had been shut down, they didn't have enough staff (see Grievance on 7/27/16).

On 8/11/16, 12:30 p.m. the director of nursing (DON) and the clinical services director for all of Sholom home (CSD) were interviewed for sufficient staffing. Stated basic staffing pattern is indicated on the staffing sheets. Day shift: 2 North had 1 RN, 1 LPN and 6 NA. 2 South had 1 RN, 1 TMA and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. Evening shift: 2 North had 1 RN, 1 LPN and 6 NA, 2 South had 1 RN, 1 TMA and 2 NA. 3 North 2 LPN and 5 NA,

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3 South had 1 RN, 1 LPN and 3 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 LPN and 1 NA. 3 North had 1 RN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of LPN and NA hours, as it was not updated with changes.

Supervisors did the staff changes and took call in's on the off shifts. Supplemental Nursing Service Agencies (SNSA) were currently in use, but expected the hiring and training to be completed and SNSA nurses to be phased out by September 1st. The last training class was starting on 8/15/16. Staffing was flexed for census, also look at acuity on transtitional care unit and have recently been increasing staffing for 2 North, because they had a couple of IV's (intravenous infusions). We expect the nurse manage (NM) to ask for more help, we look at behaviors, IV's, wounds, and admits to adjust staffing. Staffing was also flexed down when census decreased.

The DCS verified staff had brought forward concerns about the workload and how groups were divided, but not in the last couple of months. DCS stated there are days that we have three call in's and cannot replace them, but we shuffle around as much as we can too even the work load. New nurses get one year of training and then leave to go to hospital jobs.

The annual turnover rate which was reported at the Quality Assurance (QA) meeting, for the nursing (RN-LPN) was 82.52%, the monthly nursing department turnover rate ranged between 5.45% to 11.67%.

The annual turnover rate for NA was 65.14%. The

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monthly nursing department turnover rate ranged 1.92% to 10.71%.
A review of the Termination Reason report indicated: 18% SNSA staff use, 13% terminated for misconduct, 4% no call/no show, 3% Job Abandonment, 2% terminated for performance, 2% Excessive Tardiness.

When asked about the call light waits (recorded above) DCS stated the facility expectation for answering call lights was five minutes or less, "would really like less than 10, maybe not communicated here very well." The DCS stated tracking and trending of falls and incidents for patterns was probably not done as it should have been by the prior nursing leadership group, and would be a focus of the new nursing leadership.

The DCS stated there was no staffing policy, but provided the Call Light System policy, reviewed 10/15. Stated "Residents will have a means of contacting staff to obtain assistance at all times. Call lights will be answered promptly. Residents needs will be met in a timely manner.

Staffing interviews
On 8/8/16, at 11:55 a.m. when approached and asked about staffing nursing assistant (NA)-C stated "Woo you are asking me this has been a problem for a while here. We have 43 residents here and sometimes with being a long-term unit a lot of residents needed total help. We are just not able to get the work done like putting residents to the toilet and walking them sometimes the resident I have to walk I will tell them I just don't have time to do it because it's just too much. This new management has been doing something but it's still bad. I can go on and on about this and will not be done. The residents are not getting what

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F 353	Continued From page 87 they are supposed to get." On 8/8/16, at 12:04 p.m. NA-B stated staffing had gotten a lot better for the last two months but still was a problem. NA-B stated she had noticed a lot of new staff working in the facility as a lot of staff was coming and going right away. When asked about how she was able to provide cares NA-B stated she was able to do cares however felt she rushed the residents through to get all the stuff done. On 8/9/16, at 7:21 a.m. NA-E approached surveyor called surveyor into a resident room and shut the door staff then stated the facility was very short staffed and thought the residents were not getting their needs met. "We sometimes have 16 to 20 residents and are told someone is coming but never comes. Do you want to tell me the residents are getting total cares? They continue to give particular staff raises but not some of us. It is so bad and we are not able to ambulate, toilet and do all the cares to the residents. We have to get the residents up by routine." On 8/10/16, at 6:37 a.m. NA-T stated "I don't think I am allowed to say anything. We have two aides at night as the census is low and when the census goes up we will get more help." On 8/10/16, at 6:43 a.m. NA-C approached surveyor in the hallway of 3 South unit and stated "we are working short today again." When asked if the facility was working on replacing the staff NA-C who appeared upset stated "we are iron people" when asked how short the unit was NA-C stated one NA. -At 6:50 a.m. licensed practical nurse (LPN)-A	F 353		

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F 353	Continued From page 88 and NA-U were overheard in the hallway state they did not understand why they were always working short in the unit. When approached and asked about staffing NA-U stated "we are always working short staffed in this unit and this is almost daily thing." On 8/11/16, at 8:12 a.m. when approached and asked who was assigned to Group 1, 3 South LPN-B stated the group was split right now because there was not enough staff on the floor and current five staff had been assigned according to room numbers to ensure the resident got the care they required. LPN-B stated "there was a miscommunication and we had to split the groups. This is not how we like it to be but it is what it is." Family members On 8/10/16, at 4:06 p.m. family member (FM)-A when asked is there enough staff to help family member replied, "No, are you kidding, there are not enough and the ones they have are very inefficient." FM-A further stated "The care they provide is very poor, I am sorry to say. I am thinking of finding him a new place even though it would be more difficult for me to see them." On 8/12/16, at 12:00 pm family member (FM)-C stated, "I am concerned about the amount of staff at the nursing home, and their training. You know there is a problem with staffing when you see the activities people helping with the breakfast." FM-C said, "When a resident needs more help and does not speak up for themselves the care is not there." Staff interviews	F 353		

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F 353	Continued From page 89 On 8/08/16, at 2:45 p.m. NA-M raised eyebrows when asked do you have enough staff to get your work done and stated "it all depends, today since you are here, we have enough. We have six [aides] today. Normally it is a good day if we have five. NA-M said, "Is that enough, no. We have a lot of two people assists for turning and EZ stands [mechanical lift that helps a resident stand up]. We might have to break up a group and rearrange it. I do not normally work this floor, so I do not know the residents which makes it harder to plan my work. On 8/08/16, at 7:04 p.m. LPN-H stated, "No we do not have enough staff. We should have six aides but normally we have only five and have to split a team. Our patients have Alzheimer's and they sundown, so when the aide is busy the nurse has to stand with the resident to ensure they do not fall. The dining room can be crazy depending on the mood." On 8/09/16, at 8:15 a.m. anonymous licensed practical nurse (LPN) stated "the staffing here is so short. Administration has the right model but not enough staff to fill it. They did have a very big hiring fair recently but not everyone is staying. This morning 3 North had two people not show up so I had to rearrange staff. Most of the time we would have had to tell them to work short and only replace one staff member but not during survey. Sometimes the nurses cannot get everything done because they are trying to help the aides. The aides are rushing from one thing to the next which can cause problems. The aides care and try really hard. I observe staff as they are working to be sure they are following the care plan, I make sure to tell them if they are showing signs of burn out, to take a break. When we are	F 353		

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F 353	Continued From page 90 short staffed, that is hard and a lot of the aides are tired." On 8/11/16, at 2:34 p.m. NA's were heard arguing at the nursing desk about assignments NA-R stated "I have group 4 otherwise I am going home." NA-S stated, "Not if I am here it is my regular group if I cannot have my group I am going home."	F 353		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide food in an attractive and proper appearance for 1 of 1 resident (R162) observed for dining. Findings include: During dining room observation on 8/9/16, at 8:55 a.m. an unidentified nursing assistant (NA) placed hot cereal in front of R162 out of R162's reach. R162 was awake and stared at the cereal. -At 9:10 a.m. a nursing assistant woke R162 up when they placed a divided plate with scrambled eggs and pureed bread in front of R162. -At 9:12 a.m. nursing assistant (NA)-E was observed to sit down next to R162. NA-E put the contents of an individual jelly packet on R162	F 364	F 364 The process for meal delivery was reviewed and staff educated on providing dignity with dining. Resident R162 has been reassessed for appropriate interventions and care plan updated as appropriate. Referral to Occupational therapy will be made if indicated following reassessment. Nursing staff will be educated on providing a dignified dining experience. Nurse Managers or designee is responsible for auditing of the dining experience at least daily on each household at various mealtimes for one month then once weekly for 3 months. Audit results will be reported to the QA	9/21/16

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F 364	Continued From page 91 scrambled eggs. NA-E then mixed the scrambled eggs with jelly and pureed bread together. NA-E put the plate with eggs and bread in front of R162 and placed the cream of rice on the table on the opposite side of the placemat, out of R162's reach. NA-E then left the table. R162 tasted the mixture of scrambled eggs pureed bread and then attempted to reach the cereal. R162 sat in wheelchair looking at other residents and then closed her eyes. -At 9:21 a.m. NA-E sat down at the table and moved the plate with the mixture of scrambled eggs and pureed bread away from R162, and started feeding R162 cream of rice. R162 ate 100% (percent) of the cream of rice and 0% of the egg and bread mixture. R162's quarterly Minimum Data Set (MDS) dated 6/8/16, indicated R162 was severely cognitively impaired and was rarely able to communicate needs. R162's MDS indicated R162's diagnoses included Alzheimer's disease, and dysphagia (difficulty swallowing). R162's nutritional care plan dated 6/8/16, indicated R162 had dysphagia and had a weight decline from January 2016, to April 2016. The goal listed on the care plan was to maintain weight at 125 pounds or greater. The care plan instructed staff to "provide feeding assistance at meals if res [resident] accepts. May feed self some items w/[with] fingers (does not like to use utensils). Divided plate at meals for pureed diet." R162's vision care plan revised 7/1/16, indicated R162 had impaired vision and was unable to read or identify colors. The care plan instructed staff to observe for inability to find food on plate at meals and assist as needed.	F 364	committee and action plans developed as needed.	

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R162's nursing assistant assignment sheet dated 6/22/16, instructed staff that R162 required assist with feeding and was to be seated at a table with staff.

R162 ' s Physician Order Report signed 7/5/16, instructed staff R162 was to be given a pureed diet, ok for regular soft breads, gefilte fish, and scrambled eggs. It also instructed staff to offer pudding, ice cream or yogurt three times a day between meals because of weight loss. " Give R162 four ounces of Mighty shake (a high calorie, high protein liquid supplement) three times a day for weight loss. "

R162's weights reviewed from 2/19/16 through 8/5/16. Highest weight recorded was 130 pounds on 5/25/16. Current weight on 8/5/16, was 121.4 pounds.

On 8/10/16, at 1:12 p.m. NA-I stated, "You do not put the food in front of a resident who needs help before you are ready for them to eat. A resident's tray is served the way it is meant to be eaten. You can mix the gravy with the potatoes or meat but not mix them all together."

On 8/10/16, at 1:22 p.m. NA-H stated "you do not mix all of a resident's food together before feeding them. They will refuse to eat it."

On 8/10/16, at 1:24 p.m. NA-J stated "I would never mix a residents food together. We are taught that is a dignity issue and I want to treat all my residents with dignity."

On 8/10/16, at 1:58 p.m. LPN-G stated "[R162] does not like people to feed her. She will put her finger into the food and lick it off. She likes her

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F 364	Continued From page 93 tray to have each item separate and will eat all of one and then all of the next. If you leave her food within reach she can eat most of it by herself. If her food is at the far edge of the placemat she cannot reach it to feed herself. Sometimes we have to wake her up or sit with her and talk to her." On 8/11/16, at 3:05 p.m. LPN-F stated, "It is not okay to mix a resident's food together, even if they are on a puree diet. It would most likely not appeal to the resident and they would refuse to eat it. You can add appropriate seasoning, if it is ok with their diet." On 8/12/16 at 11:06 a.m. the director of nurses (DON) stated that she expected staff to ask the resident if they wanted salt or pepper or anything else when they brought the food to the table. DON said she would not expect staff to place jelly on scrambled eggs unless the resident requested it. DON said it would not be appropriate to mix scrambled eggs and pureed bread together unless the resident requests it.	F 364		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428		9/21/16

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F 428	Continued From page 94 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to act on recommendations made by the consultant pharmacist for 1 of 5 residents (R147) reviewed for unnecessary medications. Findings include: A review of a Physician Recommendation From Pharmacist for R147 dated 11/25/15, indicated R147 was currently taking Quetiapine (Quetiapine is an anti-psychotic medication used to treat certain mental/mood conditions associated with Bipolar Disorder) 100 milligrams (mg) at bed time and Divalproex (Divalproex is used to treat the manic phase of bipolar disorder) 2 tablets at bedtime for mixed Bipolar Disorder. The recommendation indicated progress notes and nursing notes have been reporting no changes in behavior, reports of hallucinations or delusions and recommended a tapering of R147's Seroquel to 75mg. There was no evidence the recommendation was followed up on by the facility. R147's significant change Minimum Data Set dated 5/25/16, indicated she was moderately cognitively impaired, displayed no behaviors and no symptoms of depression. R147's care plan dated 8/12/16, identified a potential for alteration in psychosocial well-being related to diagnosis of Parkinson's disease and bipolar disorder. The care plan further identified the use of psychotropic medications, potential for behavioral symptoms and identified a sleep pattern of "8 hour intervals."	F 428	F428 Pharmacist recommendation dated 11/25/15 and 8/11/16 for resident R147 has been communicated with the MD and follow-up has been documented. Policy and procedure for pharmacy recommendation follow up has been reviewed and is current. Nursing staff including Nurse Managers have been educated on the policy and procedure. Nurse Managers or designee will be responsible to audit all pharmacy recommendations for appropriate follow-up for 2 months and then 10% monthly for 3 months. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for certification is September 21, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING _____ B. WING _____	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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F 428	Continued From page 95 On 8/2/16, a Physician Recommendation from Pharmacist again recommended a taper of Quetiapine from 100mg to 75mg and indicated the progress and nursing noted reported no changes in behavior, no hallucinations and no delusion. On 8/11/16, at 12:51 p.m., social worker (SW)-B stated the pharmacist reviews medications monthly. She stated she documents on each resident every quarter and reviews why they are taking certain medications. SW-B stated R147 has not shown any signs of manic behaviors. On 8/11/16, at 3:11 p.m., registered nurse (RN)-B stated the pharmacy recommendations are given to the physician or the nurse practitioner for follow-up. He stated if there are new orders based on the recommendations they will show up in the medication administration record. RN-B stated there was no process in place for following up on the pharmacists recommendations.	F 428		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		9/21/16

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F 441	Continued From page 96 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review facility failed ensure sanitizing of the glucometer machine for 2 of 2 residents (R5, R253) during a random observation. In addition, the facility failed to perform tracking, trending and analysis of infections. This had the potential to affect all 145 residents residing in the facility. Findings include: R5's annual Minimum Data Set (MDS) dated 7/17/16, indicated R5 was severely cognitively	F 441	F441 The policy and procedure for cleaning of glucometers has been reviewed and revised. Nursing staff have been educated on the policy and procedure. Nurse Managers are responsible for auditing 2 nurses per week for one month and then one week for one month. Facility policy and procedure for Infection Control tracking has been reviewed and updated.	

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F 441	Continued From page 97 impaired and was rarely able to communicate. R5's MDS indicated R5's diagnoses included diabetes and dementia. Physicians Order Report signed by physician on 5/18/16, indicated R5 was to have blood sugar checks done three times a day before meals. During random observation on 8/09/16 at 7:20 a.m. R5's blood sugar (BS) was checked by licensed practical nurse (LPN)-F with a glucometer (a machine for checking blood sugars) while R5 was sitting in a wheelchair in the hallway across from the nurses desk. R5's BS was 86. LPN-F removed gloves and put the glucometer on top of the lancets (a small sharp pointed object for drawing blood) without cleaning the glucometer. R253 Resident Face Sheet printed 8/5/16, indicated R253's diagnoses included diabetes, dementia, and history of methicillin resistant staphylococcus aureus infection (a bacterial infection that is very resistive to antibiotic treatment.) Diabetic flow sheet dated 8/5/16, indicated R253 was to have BS checks done twice a day on Monday, Wednesday, and Friday. During a continuous observation on 8/09/16, at 7:26 a.m. R253was approached by LPN-F in the hallway in front of the nurses desk. LPN-F wiped R253's finger with an alcohol wipe and stuck it with a lancet and then checked R253's BS using the same glucometer that had been used to check R5's BS and had not been cleaned. R253's blood sugar was 117. LPN-F then removed gloves, threw the soiled lancet away and put the glucometer on top of loose lancets that were in a plastic caddy without cleaning the glucometer. Surveyor was unable to stop LPN-F before	F 441	Director of Nursing is responsible for auditing logs monthly and tracking and trending of infections to observe for patterns. Audit results will be reported to the QA committee and action plans developed as needed. Correction date for certification is September 21, 2016	

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F 441	Continued From page 98 checking R253's blood sugar. On 8/09/16, at 8:00 a.m. LPN-F said, "We clean the glucometer twice a shift. They are getting individual glucometers soon." LPN-F verified she should have offered to take both residents to their rooms but did not and she acknowledge she did not clean glucometer between residents. On 8/09/2016, at 8:01 a.m. LPN-E stated, "We clean the glucometers after each use with sanitizing wipes. We wipe the glucometers down well and wrap them in a clean wipe for at least two minutes and then let them air dry." On 8/09/16, at 8:15 a.m. LPN-D nurse manager stated "It was expected glucometers to be cleaned after every time they were used. A glucometer was to be cleaned in accordance with specific product used some have a two minute wet time and some products have a three minute wet time. Staff should do blood sugars in resident's rooms unless the resident refused." On 8/12/16, at 11:06 a.m. the director of nurses (DON) stated, "I expect them [staff] to do blood sugar checks privately not out in the main stream. I would expect to them [staff] to ask the resident to go to their room. They [staff] have become a task oriented group. We need to go back to the basics." DON further stated, "The staff are supposed to clean the glucometer between each resident. We have ordered glucometers for each resident. The staff were just all trained on when to clean the glucometers." Cleaning Glucose Machine policy revised 07/16, instructed staff, "To prevent the transmission of blood-borne pathogens glucometers will be	F 441		

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F 441	Continued From page 99 cleaned after each use." The Monthly Infection Control Logs for the 2N (2 north) unit were reviewed from December 2015 through June 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved but did not identify any organisms. No logs were available prior to December 2015 or for the months of July and August of 2016. Monthly Infection Control Logs for the 3N (3 North) unit were reviewed From July 2015 through April 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available for the months of June, July and August of 2016. Monthly Infection Control Logs were reviewed for the 2 south unit from July 2015 through March 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available from April 2016 through August 2016. Monthly Infection Control Logs were reviewed for the 3 South unit from July 2015 through June 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available for the months of July and August 2016. On 8/12/16, at 10:31 a.m., the DON stated there was a plan in place to keep infection control logs and review the logs ongoing to determine if patterns exist. She stated the facility is currently doing spot checks and observing staff's infection control practiced across different shifts.	F 441		

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F 441	Continued From page 100 While the facility had been keeping logs to identify resident infection and illness, there was no evidence of ongoing tracking and trending past June 2016. A policy for tracking and trending of resident infections was requested, but none was received.	F 441		

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	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2016**

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on August 09, 2016. At the time of this survey, Sholom Home West was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street., Suite 145 St. Paul, MN 55101-5101 FAX: 651-215-0525	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/02/2016

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

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K 000	Continued From page 1 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was determined to be of Type II(222) construction. It has a partial basement and is fully fire sprinklered. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridor that is monitored for automatic fire department notification. The facility has a capacity of 156 beds and had a census of 145 beds at the time of the survey.	K 000		
K 050 SS=C	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and	K 050		9/8/16

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K 050	Continued From page 2 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 145 residents. Findings include: On a facility tour between the hours of 09:00 AM and 01:00 PM on August 09, 2016, observation revealed that the facility did not have documentation for fire drills being conducted during the 1st quarter, 3rd shift of 2016 and the 2nd quarter, 2nd shift of 2016. This deficient practice was confirmed by the Director of Maintenance at the time of inspection.	K 050	K050 FIRE DRILLS The facility did not have documentation for fire drills being conducted during the 1st quarter, 3rd shift of 2016 and the 2nd quarter, 2nd shift of 2016. The fire drills will be conducted once per shift per quarter for all staff under varying times and conditions required by 2000 NFPA 101, section 19.7.1.2 This will be monitored by the Director of Maintenance or designee and completed by 9/8/2016. Attachment #1	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility's fire alarm system maintenance is not	K 052	K052 FIRE ALARM SYSTEM The facility's fire alarm system	9/8/16

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K 052	Continued From page 3 documented in accordance with NFPA 72, (99). This deficient practice could affect all 145 residents. Findings include: On a facility tour between the hours of 09:00 AM and 01:00 PM on August 09, 2016, observation revealed that the facility could not provide documentation of a current annual fire alarm inspection. This deficient practice was verified by the Director of Maintenance at the time of the inspection.	K 052	maintenance is not documented in accordance with NFPA 72 (99). The facility's fire alarm system maintenance report conducted by Integrated Fire and Security and completed on 9/21/2015 will be kept in the Director of maintenance's office. Attachment #2 The annual fire alarm system maintenance inspection will be completed by a licensed contractor and a copy of the report will be documented in accordance with NFPA72 (99). The Director of Maintenance or designee will monitor for proper compliance.	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has not been documenting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 145 residents. Findings include: On a facility tour between the hours of 09:00 AM and 01:00 PM on August 09, 2016, observation revealed that the facility could not provide documentation of a current smoke detector sensitivity test.	K 054	K054 SMOKE DETECTORS The facility has not been documenting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA72 (99), Sec. 7-3.2.1. The sensitivity test will be completed by a licensed contractor and a copy of the report will be kept in the Director of maintenances office. This will be monitored by the Director of maintenance or designee and completed by 9/8/2016.	9/8/16

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K 054	Continued From page 4 This deficient practice was verified by the Director of Maintenance at the time of inspection.	K 054		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observations and staff interview, the automatic sprinkler system is not installed and maintained in accordance with NAPA 13 the Standard for the Installation of Sprinkler Systems 1999 edition. The failure to maintain the sprinkler system in compliance with NAPA 13 (99) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect all 145 residents. Findings include: 1) On a facility tour between the hours of 09:00 AM and 01:00 PM on August 09, 2016, observation revealed that the facility could not provide documentation for an annual automatic sprinkler system inspection. 2) On a facility tour between the hours of 09:00 AM and 01:00 PM on August 09, 2016, observation revealed that the facility could not	K 056	K056 AUTOMATIC SPRINKLER SYSTEM 1. The facility could not provide documentation for an annual automatic sprinkler system inspection. In compliance with NFPA 13 (99). The facilities annual automatic sprinkler system inspection conducted by Olsen Fire Inspection and completed on 8/21/15 will be kept in the Director of Maintenance Office Attachment #4 The annual automatic sprinkler system inspection will be completed by a licensed contractor and a copy of the report will be kept in the Director of Maintenance office. This will be monitored by the Director of maintenance or designee and completed by 9/8/2016	9/8/16

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K 056	Continued From page 5 provide documentation of quarterly automatic sprinkler system flow tests for the 3rd and 4th quarters of 2015 and the 1st and 2nd quarter of 2016. This deficient practice was verified by Director of Maintenance at the time of inspection .	K 056	2. The facility could not provide documentation of quarterly automatic sprinkler system flow tests for the 3rd and 4th quarters of 2015 and the 1st and 2nd quarter of 2016. In compliance with NFPA 13 (99). The facility will contract with an outside licensed sprinkler service contractor to ensure that four quarterly water flow tests are conducted every 12 months. The director of maintenance will monitor the schedule for the quarterly inspection and will contact the contractor at the appropriate intervals and a copy of the report will be kept in the Director of maintenance office. This will be monitored by the Director of maintenance or designee and completed by 9/8/2016. Attachment #3	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide and maintain cooking facilities in accordance with the requirements of NFPA 101-2000 edition, Sections 19.3.2.6 and 9.2.3; NFPA 96-1998 edition. Findings include: On a facility tour between the hours of 09:00 AM and 01:00 PM on August 09, 2016, observation revealed that the facility could not provide documentation of the last two 6 month kitchen hood and duct system inspection.	K 069	KO69 I I KITCHEN HOOD AND DUCT SYSTEM. The facility could not provide documentation of the last two 6 month kitchen hood and duct system inspection in accordance with the requirements of NFPA 101-2000 edition, Sections 19.3.2.6 and 9.2.3; NFPA 96-1998 edition. The facility will contract with an outside licensed contractor to ensure that two 6 month kitchen hood and duct system inspections are conducted. The director of	9/8/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245574	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	**3620 PHILLIPS PARKWAY SOUTH** **SAINT LOUIS PARK, MN 55426**

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K 069	Continued From page 6 This deficient practice was verified by the Director of Maintenance at the time of inspection.	K 069	maintenance will monitor the schedule for the 2 every six month inspection and will contact the contractor at the appropriate intervals and a copy of the report will be kept in the Director of maintenance office. This will be monitored by the Director of maintenance or designee and completed by 9/8/2016.	

MDH
Minnesota
Department
of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
August 26, 2016

Mr. Steve Fritzke, Administrator
Sholom Home West
3620 Phillips Parkway South
Saint Louis Park, MN 55426

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5574025 and Complaint numbers H5574081, H5574082, H5574083, H5574084 and H5574085

Dear Mr. Fritzke:

The above facility was surveyed on August 8, 2016 through August 12, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number **H5574083 was completed. The complaint was substantiated at MN Rule 4658.0510 Subp. 1 (0800), MN Statute 144.651 Subd. 5 (1805), MN Rule 4658.0520 Subp. 2 D. (0850) and MN Rule 4658.0525 Supb. 3 A. and B. (0900). An investigation of complaint number H5574085 was completed. The complaint was substantiated at MN Rule 4658.0405 Subp. 4 (0570), MN Rule 4658.0405 Subp. 3 (0565), MN Rule 4658.0510 Subp. 1 (0800), MN Rule 4658.0520 Subp. 2 D. (0850) and MN Rule 4658.0525 Subp. 3 A. and B. (0900). An investigation of complaint numbers H5574081, H5574082, and H5574084 were conducted and found to be unsubstantiated.** 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 contact Gloria Derfus, Unit Supervisor at (651) 201-3792.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	08/12/2016

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SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

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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 August 8th through August 12, 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.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. An investigation of complaint number H5574083 was completed. The complaint was substantiated at MN Rule 4658.0510 Subp. 1 (0800), MN Statute 144.651 Subd. 5 (1805), MN Rule 4658.0520 Subp. 2 D. (0850) and MN Rule 4658.0525 Supb. 3 A. and B. (0900). An investigation of complaint number H5574085 was completed. The complaint was substantiated at MN Rule 4658.0405 Subp. 4 (0570), MN Rule 4658.0405 Subp. 3 (0565), MN Rule 4658.0510 Subp. 1 (0800), MN Rule 4658.0520 Subp. 2 D. (0850) and MN Rule 4658.0525 Subp. 3 A. and B. (0900). An investigation of complaint numbers H5574081, H5574082, and H5574084 were conducted and found to be unsubstantiated.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the	2 265		9/21/16

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2 265	Continued From page 3 appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the nurse practitioner (NP) of a medication error for 1 of 1 resident (R12). Findings include: R12's admission Minimal Data Set (MDS) dated 5/17/16, indicated R12 had mild cognitive impairment, experienced shortness of breath when walking, and received diuretics daily. R12's MDS indicated R12's diagnoses included congestive heart failure, hypertension, and dementia. Review of Medication Administration Record	2 265	See ePOC	

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2 265	Continued From page 4	2 265		

(MAR) for 6/1/16 through 6/30/16, indicated R12 had a Lasix (a diuretic) order dated 5/22/16, for Lasix 20 milligrams (mg) twice a day. R1's Lasix order was changed on 6/2/16, to give Lasix 20 mg now and increase Lasix to 40 mg twice a day. On 6/13/16, the Lasix order was changed to Lasix 30 mg every morning and 20 mg every evening. A new Lasix order was written on 6/16/16, to give Lasix 40 mg twice a day. The order was transcribed on the MAR to give Lasix 40 mg twice a day at 8:00 a.m., 2:00 p.m. and 4:00 p.m.

During interview on 8/10/16, at 4:33 p.m. registered nurse (RN)-D verified for the period from 6/17/16 through 6/27/16, three doses of Lasix 40 mg a day were signed as having been given, except for 6/19/16 and 6/21/16. On those days only two doses were signed for. On 6/19/16, the square for the 2:00 p.m. dose had a dot in it. On 6/28/16, two doses were signed as given. On 6/29/16, two doses were signed as given and a dot was placed in the 4:00 p.m. square. On 6/30/16, two doses were signed as given. RN-D stated a dot was sometimes placed in a square when the medication was prepared and then initials are placed over the dot when the medication has been given. RN-D was unable to say if the medications that were marked with a dot had been given.

During interview on 8/11/16, at 12:41 p.m. NP-A said, "I was not told about the Lasix being given three times a day. R12 should not have been given Lasix three times a day. I saw [R12] on 6/13/16, 6/16/16 and 6/21/16. On 6/16/16, I started R12 on doxycycline (an antibiotic), continued Duo Nebs (inhaled medication to ease breathing) and the Lasix was increased to 40 mg twice a day. " NP-A said, "To my knowledge, I was not informed of him being given Lasix three

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2 265	Continued From page 5 times a day." NP-A said, " I don't think it negatively impacted [R12]. It did not impact his potassium level. NP-A said, "I am not happy. I would have expected to be told about a medication error before nine days." RN-B also present during interview with NP-A. RN-B stated he would get the passport (medication dispensing machine) dispense reports because he did not think that the staff had given three doses of Lasix a day. RN-B said he did not know why they (nurses or trained medication aides) would sign for giving three doses when two doses were given. The Passport dispense reports and the Medication error report were requested but not provided. During interview on 8/12/16, at 11:06 a.m. the director on nurses (DON) said, "If they signed it, it means they gave the medication. They should have done a medication error report. I would expect them to notify the doctor or nurse practitioner." The Medication error report was requested and the DON said she did not believe there was a medication error report. The medication error policy requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revise policies and procedures, conduct audits related to Notification of Change in Resident Health to ensure proper notification is conducted to the appropriate party when there is a change in health status. The director of nursing or designee could develop ensure staff training is conducted on an ongoing basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 265		

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2 565	Continued From page 6	2 565		
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: Citation Text for Tag 0282, Regulation FF09 Based on observation, interview and document review the facility failed to follow the plan of care for 4 of 5 residents (R180, R116, R28, R109, R24) reviewed for dialysis, activities of daily living (ADLs), repositioning, pressure ulcers, and dining observation. Findings include: Dialysis: R180's diagnoses included heart failure, hypertension and end stage renal disease (ESRD) obtained from the 14 day Minimum Data Set (MDS) dated 6/6/16. In addition the MDS indicated R180 received dialysis. On 8/9/16, at 12:30 p.m. when approached and asked how dialysis was going R180 stated everything was going well. R180 stated he had increased weight which was good as he was not eating well at the time he had been admitted to the facility. When asked about the diet and fluid restriction resident stated he was on a regular diet and did not have a fluid restrictions as surveyor noted two glasses of water on top of the night stand next to bed.	2 565	See ePOC	9/21/16

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2 565	Continued From page 7 On 8/11/16, at 9:10 a.m. went to resident room observed resident seated at edge of bed. R180 stated he had eaten breakfast in his room. R180 was observed to have slight edema on the face and lower extremities and appeared tired. When asked how he had slept resident stated well "I know am a little puffy." R180's Hospital Discharge Summaries dated 5/18/16, directed "Daily weights: Call provider for weight gain of more than 2 pounds per day or 5 pounds per week." In addition, the Physician Orders dated 6/30/16, directed the same. During review of the vital signs weight section the following weights were noted missing according to months: -May 5/19/16, 5/27/16, 5/28/16. -June 6/1/16, 6/11/16, 6/14/16, 6/16/16, 6/17/16, 6/21/16, 6/30/16 -July 7/1/16, 7/2/16, 7/3/16, 7/4/16, 7/5/16, 7/7/16, 7/8/16, 7/9/16, 7/12/16, 7/15/16, 7/16/16, 7/11/16 -August 8/2/16, 8/3/16, 8/4/16, 8/5/16, 8/6/16, 8/7/16, 8/8/16, 8/9/16, 8/10/16. During review of the Medication and Treatment Administration Records for May 2016, through August 2016, it was revealed weights had not been documented in the record. In addition review of the interdisciplinary team notes (IDT) it was revealed the weights had not been documented there either. R180's undated care plan indicated resident was on dialysis and identified resident was at risk for shortness of breath (SOB), chest pain, edema and elevated blood pressure. The care plan directed staff to monitor and follow the Physician Orders.	2 565		

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2 565	Continued From page 8 The 2 North Group 8 Plan of Care updated 8/11/16, directed staff to do a daily weight. On 8/11/16, at 3:31 p.m. registered nurse (RN)-B verified resident had an order for daily weights in the physician orders. RN-B then reviewed the vital signs tab and verified there were a lot of missing weights in the computer. RN-B stated he was going to check in the both the medication and treatment administration records on the nurses carts to see if the staff was recording the weights in there. -At 3:33 p.m. RN-B approached stated he had checked and found "they are not recording them." RN-B stated he would expect the nursing assistant to get the weights daily in the morning and record the weight to Point of Care which would populate to Matrix. RN-B further stated he would expect the nurses to check daily to make sure the weights were done. On 8/12/16, at 7:45 a.m. the director of nursing (DON) stated she would expect the staff to follow the physician orders and resident plan of cares. On 8/12/16, at 10:1 a.m. via telephone the registered nurse to the primary doctor's clinic stated she would expect the care center to follow the physician orders but thought the resident sometimes may have not been weighed due to other medical appointments or dialysis days which was not documented why the weights had not been obtained in the resident medical record. R180 was not weighed according to the plan of care. Grooming removal of facial hairs R116's diagnoses included dementia,	2 565		

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2 565	Continued From page 9 contracture, muscle weakness, anxiety, failure to thrive and osteoporosis obtained from the annual MDS dated 5/31/16. The MDS indicated resident had severely impaired cognition and required extensive to total dependence of one to two staff on all ADLs which included bed mobility, toilet use and transfers. On 8/8/16, at 6:00 p.m. resident was observed seated on the Broda wheelchair in the DR. Observed resident with multiple white facial hairs approximately half inch long on the lower chin area. On 8/9/16, at 10:30 a.m. during another random visit to the unit resident was observed on her wheelchair outside the dining room across from the nursing station with eyes closed and still noted to have the facial hairs. On 8/10/16, at 6:53 a.m. resident was observed a sleep eyes closed lying on her right side pillow behind back. Resident remained to have the facial hairs. -At 8:36 a.m. nursing assistant (NA)-A was observed reposition resident stated she was going to get another resident up and would come back in later to get resident ready for the day. -At 8:52 a.m. to 9:29 a.m. both NA-A and NA-U were observed provide morning care, which included oral cares and washing resident up however never acknowledged or offered to remove the visible long white facial hairs. -At 10:32 a.m. licensed practical nurse (LPN)-B was observed wheel resident to room, tilted Broda chair to the back then turned resident to the right side and tucked a pillow under. During the observation, LPN-B looked at resident face but never acknowledged to remove the facial hairs.	2 565		

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	00380	A. BUILDING: _____ B. WING _____	08/12/2016

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2 565	Continued From page 10 On 8/10/16, at 10:51 a.m. the RN-E stated resident had late on set progression of Alzheimer's disease, was dependent on staff for all cares and was non-verbal. On 8/11/16, at 7:30 a.m. was observed on the Broda chair at the dining table dressed for the day. When approached the white facial hairs were still not remove and visible from standing 20 feet away. At 9:16 a.m. resident still in the dining room facial hair visible from standing 20 feet several staff by the steam table close to the table resident was seated none offered to remove the facial hairs. -At 10:27 a.m. NA-U stated she had completed providing resident cares for that morning. -At 10:30 a.m. LPN-A stated "[R116] was scheduled to get a shower today." LPN-A indicated because the unit had been working short resident had not received her shower yet. LPN-A further stated due to insufficient staff, many residents did not get there scheduled showers/baths however thought it was getting better now as the unit had been added a sixth aide to assist with cares. On 8/11/16, at 3:09 p.m. LPN-A verified the long white facial hair on resident lower chin area. LPN-A actually touched resident chin and stated the staff was supposed to have removed it for resident with cares. LPN-A stated she was going to have one of the staff remove it and thought there were two residents in the unit who needed assistance to remove the facial hairs. LPN-A further stated resident had received shower after lunch as evening staff had come in early to assist since the unit was short of one NA. R116's ADL care plan dated 6/11/16, indicated	2 565		

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2 565	Continued From page 11 resident had potential alteration in self-care ability,needed assist with dressing/grooming/bathing and oral care related to advanced dementia with behavioral disturbance. The care plan directed staff for grooming to provide assist of one with combing hair, oral care, nail care and shaving. The 3 South Weekly Bath List dated 8/8/16, indicated resident was scheduled to get a bath on Thursdays AM. On 8/11/16, at 3:16 p.m. RN-A unit manager stated staff should have automatically removed the facial hairs "You think. Am totally with you." RN further stated staff was supposed to follow the plan of care. R116 was not groomed according to the plan of care. Repositioning/adaptive euipment: R116 was observed on 8/10/16, at 6:53 a.m. R116 was lying in bed with their eyes closed and lying on her right side pillow behind back. On top of the night stand were two Posey sleeves (provide comfortable protection for fragile or sensitive skin that may bruise or tear easily). -At 6:56 a.m. observed NA-U go to room stated she was going to get resident dressed but was going to leave R116 and would be back in 45 minutes. -At 7:14 a.m. observed NA-U reviewing the assignment sheet with NA-A outside resident room never heard discuss the last time R116 had been repositioned. When approached and asked about resident NA-A stated she was not a regular staff in the unit however was going to get resident up shortly. NA-A further stated because she did not know residents in the unit she would follow the care plan.	2 565		

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2 565	Continued From page 12 -At 7:19 a.m. NA-A was observed go to room with linen stated she was not getting resident up but was just getting what she would need ready. NA-A never repositioned resident and left the room shortly. -At 7:27 a.m. resident asleep still observed wearing the arm sleeves on both arms still lying on her back to the right side. No activity to room until 8:28 a.m. -At 8:29 a.m. LPN-A stated she had informed NA-A that R116 was supposed to be repositioned every hour. When asked when resident had been last repositioned LPN-A stated she had got to the unit since 6:30 a.m. and did not know when resident had last been repositioned. LPN-A stated resident had an open area which was improving however, the area was a recurring one in the same area. -At 8:32 a.m. both NA-A and LPN-A were observed provide pericare and repositioned R116. During the observation R116's bottom appeared red and non-blanchable. The area on the tail of the coccyx was observed covered with a thick layer of cream. LPN-A wiped the area and a scabbed area was observed. LPN-A stated the bottom was red and non-blanchable because resident skin was so fragile. LPN-A verified the left heel boot was not on. At 8:36 a.m. NA-A stated LPN-A had informed her resident was supposed to be repositioned hourly however when she looked at the NA assignment sheet it directed resident to be repositioned one to two hours and because she had been pulled from another unit later into the shift she had not been told when resident had been repositioned last. R116 went one hour and 39 minutes without being repositioned. -At 8:45 a.m. LPN-A verified resident Derma-savers (protect fragile skin from sustaining damage caused by friction, rubbing,	2 565		

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2 565	Continued From page 13	2 565		

abrasion and pressure that could lead to skin breakdowns, tears and splits) and Posey sleeves were supposed to be on at all times. LPN-A stated it was not on in the treatment sheet and was going to add it "I didn't know. I thought they were supposed to be off at night when staff put lotion."
-At 8:50 a.m. RN-A nurse manager reviewed the care plan in the computer and verified R116's skin care plan directed staff to turn resident side to side hourly when in bed and also verified the care plan was contradicting as it directed staff to reposition resident one to two hours and then hourly. RN-A verified the Derma and Posey sleeves were supposed to be on at all times. RN-A stated she would expect the staff to follow any resident plan of care and she was going to have a word with the staff as that was important.

On 8/10/16, at 8:52 a.m. to 9:18 a.m. R116's cares were observed provided by NA-A and NA-U who during the observed turned resident to the left and right never placed a pillow, three times never put a pillow to protect the boney prominences when repositioning.

On 8/10/16, at 10:36 a.m. LPN-A approached stated she had reviewed the NA group Plan of Care sheet and had noticed both the one to two hours and every hour for repositioning. LPN-A stated she was going to make sure it was update to reflect the hourly repositioning schedule only as this was confusing and misleading for the staff. At 10:42 a.m. LPN-A stated R116 had an open area that was pressure related as it was the same area where it had healed before. LPN-A further stated she thought it was healing well and was a stage II (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion,

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2 565	Continued From page 14 blister, or shallow crater). On 8/10/16, at 10:51 a.m. the RN-E stated resident had late on set progression of Alzheimer's disease, was dependent on staff for all cares and was non-verbal. On 8/12/16, at 7:20 a.m. observed resident seated on Broda chair in front of the dining room door noted to have blue boots to both feet however did not have the pillow placed on foot rest when in Broda to protect skin as directed by the care plan. -At 7:30 a.m. RN-A verified the pillow was not on the foot rest as directed by the care plan to protect skin breakdown. R116's diagnoses included dementia, contracture, muscle weakness, anxiety, failure to thrive and osteoporosis obtained from the annual MDS dated 5/31/16. The MDS indicated resident had severe impaired cognition and required extensive to total dependence of one to two staff on all activities of daily living which included bed mobility, toilet use and transfers. In addition the MDS indicated R116 was at risk for pressure ulcers and did not have unhealed pressure area at the time of the assessment. R116's care plan dated 7/8/16, indicated resident was at risk for alteration in skin integrity related to dementia, incontinence of bowel and bladder, dependency with ADLs, poor nutritional intake, and had a chair fast status. R116 had a history of bruising easy and had fragile skin. The care plan directed staff "Place pillow on foot rest when resident is in BRODA chair, elevate lower extremities when in bed above level of heart. Turn side to side hourly while in bed, use pillows to protect bony prominences when repositioning,	2 565		

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2 565	Continued From page 15 Repositioning hourly while in BRODA chair (specialized wheelchair), Posey sleeves upper extremities (Full arm) and derma-savers to lower extremities at all times, remove at bedtime [HS] to apply lotion, then reapply. Heel blue boots on to both feet when lying in bed and sitting up daily on all three shifts..." On 8/12/16, at 7:36 a.m. DON stated she would expect staff to have repositioned resident timely, removed the facial hairs and followed the plan of care. R116 was not repositioned according to the plan of care minimize and/or prevent further skin break down. A facility policy titled Prevention and Treatment of Wounds, undated, directed staff to monitor pressure ulcers daily including the status of the surrounding skin, signs of infection and whether pain is present. The policy further directed staff to initiate weekly wound monitoring to include onset of skin condition, location of wound, stage of wound, length, width, depth and wound characteristics. Meal consistency R109 on 8/8/16, at 6:13 p.m. was heard coughing continuously when standing at the desk. At 6:14 p.m. the resident was observed coughing continuously, as another resident in the same table stated repeatedly "[R109] cover your mouth." At 6:15 p.m. NA-P and NA-K in the dining room stated R109 coughed like that everyday. At 6:17 p.m. when asked if the food had been thickened as noted in the meal ticket, NA-P stated the food had already been pre-thickened and added at times for example the soup staff would have to add the thickener however not for that particular meal. The pureed food on the plate was noted to be runny and thin. At 6:18 p.m.	2 565		

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2 565	Continued From page 16 R109 continued to cough with each bite. At 6:22 p.m. NA-P stood up and asked R109 if he was going to eat all his food. At 6:23 p.m. R109 coughed again. Staff still standing over resident. At 6:24 p.m. resident coughed again after a bite of the runny pureed food on the plate and was observed hold his head and NA-P asked R109 if he was having a headache and resident would nod. At 6:25 p.m. NA- asked NA-P "do you think I should give him juice." At 6:26 p.m. another NA came into the dinning room and NA-P requested her to wheel resident out of the dining room. -At 6:29 p.m. resident observed at the nursing station still coughing loud and holding his head. At 6:32 p.m. observed R109 had been moved into his room and was still cough. On 8/8/16, at 6:39 p.m. the nutritional service manager (NSM) stated the cook who had cooked that evening had left for the night and asked surveyor to come back and talk to cook the next day. When asked if she was familiar with what had been added to the pureed food for R109, NSM stated she would not exactly know what had been added to the food before it was brought to the floor for the pureed food. Surveyor requested if NSM would contact the cook and at this time NSM called the cook who indicated to all the pureed food cook stated he would add one to two scoops of thickener. -At 6:59 p.m. RN-B approached stated the nurse practitioner was working on resident diet order to determine if it was appropriate and at that time the food was pureed and liquids were supposed to be honey consistency. RN-B stated R109 had a history of aspiration pneumonia, and currently was on a patch to decrease secretions and was on Mucinex (used to relieve the symptoms of cough and loosen mucus in the chest). At 7:06 p.m. RN-B verified the 7/29/16, which directed	2 565		

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2 565	Continued From page 17 staff to add two teaspoons of thickener stated the nurse had signed off on it. RN-B stated on the meal ticket the three packets of thickener were for the coffee, juice and soup if he needed them and this was to alert staff of what the resident needed. -At 7:18 p.m. approached NA-P who had been assisting R109 with eating and she stated she had watched the tray from when it had been served and when she started to assist resident and she had not seen the LPN-C add thickener to the food as LPN-C had indicated. On 8/9/16, at 9:16 a.m. observed R109's food served into a divided plate covered and sat on top of the steam table. No thickener was added to plate at this time. At 9:18 a.m. the plate of food remained in the same spot. At 9:33 a.m. NA-F take the sippy cups of cranberry juice and water which were already honey thickened consistency and added a packet of thickener to each of the four ounce cups, then brought them back and set them on the tray on top of the steam table. As NA-F was mixing the thickener LPN-C came into the nourishment center and left never said a word. No thickener was added to the pureed food at this time. -At 9:39 a.m. when approached and asked about the thickened liquids dietary aide (DA)-A stated the liquids came already pre-thickened and showed surveyor bottles of honey and water and juice in the refrigerator that were opened. He indicated he poured the beverages and nursing took care of the rest if they needed to add more thickener to the beverages. -At 10:04 a.m. NA-F went to the dining room grabbed the tray surveyor went into the nourishment center NA-F stated she was going to assist resident and was warming the food. -At 10:07 a.m. NA-F went to R109's room door at	2 565		

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2 565	Continued From page 18 the door went in with the tray, applied the clothing protector, pulled a chair next to R109 and mixed the food. When approached and asked if she had added thickener to the food NA-F stated she had not. NA-F was then observed give resident one quick bite when surveyor intervened and stopped her before the second bite at 10:10 a.m. NA-F then came with surveyor out of the room stated she was not aware resident food was supposed to be added more thickener and thought was only the fluids which she had. As surveyor and NA walked out of the room resident was heard coughing. -At 10:13 a.m. NA-F went to room with the RN-B who looked at the meal ticket and looked at the food and stated the food consistency was good left the room. NA-F indicated to RN-B she had not seen the nurse add thickener to the food. -At 10:15 a.m. came back to room found LPN-C and NA-F in room. LPN-C verified she had not added the thickener to the food and was in another room doing a dressing change. LPN-C directed NA-F to add two teaspoons to the pureed food. -At 10:17 a.m. when asked if the NA-F had been informed about adding the thickener to the food LPN-C stated this had not been communicated to the NA-F. LPN verified the order was dated 7/29/16, and NA-F was a regular staff was not aware she was supposed to add the thickener to the food. -At 10:19 a.m. RN-B verified the team assignment sheet updated 8/8/16, did not have the two teaspoons order for thickener to be added to the food. RN-B stated he expected the nurses to implement the doctors orders and to make sure the orders were communicated to the nursing assistants. R109's nurse practitioner (NP) progress note	2 565		

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2 565	Continued From page 19 dated 7/12/16, indicated resident was at high risk aspiration and respiratory infectious due to the coughing. Resident physician order dated 7/22/16, indicated resident diet was pureed and honey thick liquids In addition another physician order dated 7/29/16, directed staff to "add 2 teaspoons of thickener to pureed diet three times a day [TID] during meals for coughing. Resident should be up in chair for meals at all times." The 2 North Group 9 Plan of Care dated 8/8/16, for nursing assistants indicated R109 was on a mechanical soft diet with nectar thick liquids. The plan of care did not indicated two teaspoons of thickener were supposed to be added to the food three times daily. R109's care plan dated 8/9/16, indicated resident had potential for nutrition related concerns diagnoses of intellectual disability, impulse control, and dysphagia. The care plan indicated resident continued to have coughing episodes with and without intake and was on pureed diet and honey thickened liquids. The care plan directed staff to "Add 2 teaspoons of thicken powder to puree diet TID during meals per orders..." On 8/11/16, at 3:23 p.m. registered dietician (RD) stated she had worked the kitchen the Friday when the order had been obtained 7/29/16, and had not been able to update the care plan and update the meal ticket. RD stated physician orders were part of the resident plan of care and acknowledged the order should have been implemented since nursing was aware of the order. RD further stated the new order was a trial to help with the coughing resident had with	2 565		

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2 565	Continued From page 20 eating. On 8/12/16, at 7:34 a.m. DON stated she would expect communication to the staff on the orders and staff was to follow all physician orders. R24's care plan dated 7/26/16, identified incontinence and directed staff to apply barrier cream to perineal area after each incontinence episode and observe condition of skin. The care plan further identified risk for alteration in skin integrity and directed staff to observe for changes in skin and report to licensed staff and a weekly skin assessment done by licensed staff. A facility document titled 2 North Plan of Care, undated indicated R24 had a history of skin breakdown in the sacral area and directed staff to lay R24 down in bed or reposition in wheel chair. During an initial interview on 8/8/16, at 3:50 p.m., RN-B stated R24 did not have a pressure ulcer. During an interview on 8/9/16, at 7:44 a.m., R24 stated he had pain. He stated the pain was in his Buttocks and stated it was because he had a sore on it. During an observation on 8/11/16, at 8:41 a.m. R24's right and left ischial tuberosity were noted to be reddened, excoriated and had five open areas approximately one centimeter x one centimeter each. The red areas were approximately four inches x two inches on the left side and approximately two inches x one inch on the right. A review of facility documents titled Weekly Skin Checklist indicated R24 had an open area on his	2 565		

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2 565	Continued From page 21	2 565		

right shin on 8/6/16, but did not identify an alteration to his buttocks. The Weekly Skin Checklist for July 2016 was not filled out for the entire month. The facility's failure to complete the weekly skin checks for R24 resulted in five new open areas to R24's buttocks.

A review of R24's Treatment Flowsheet dated 8/1/16 through 8/12/16, indicated the following:
- Reposition patient every two hours in order to displace weight on sacral/coccyx area. The area of the flowsheet designated for a nurses signature was left blank the entire months of July and August 2016.
- Skin assessment weekly on bath day. The area of the flowsheet designated for a nurses signature was left blank the entire months of July and August 2016.
- Apply barrier ointment to sacral coccyx area twice daily with cares. The facility did not follow the care plan forn monitoring the skin integrity.

During an interview on 8/11/16, at 8:18 a.m., NA-Q stated she updated the nurses when R24's bottom had sores and stated RN-B should have been aware of it.

During an interview on 8/11/16, at 2:42 p.m., R24 stated he had the sores on his bottom on and off for a year.

During an interview on 8/11/16, at 8:54 a.m., RN-B stated he was not aware R24 had an alteration to the skin on his bottom. He stated the nurses should be performing skin checks weekly for R24. He stated the nurses should be reporting anything that was not noted on a previous assessment. However, there was no evidence of skin assessments performed during the month of July even though R24 stated he has had the sore

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2 565	Continued From page 22 on his bottom for a year. During a subsequent interview on 8/11/16, at 2:57 p.m., RN-B described R24's bottom as "breakdown of left buttock, moving to the right." He stated it looked like it started as "chafing" and stated the skin had been "sheared" off. During an interview on 8/11/16, at 12:29 p.m. the DON stated weekly skin checks should have been completed for R24. The facility Care Plan policy reviewed 10/15, directed "6. The Resident Care Plan is constantly changing. It is to be updated routinely with changes in doctor's orders and resident condition change. The Resident Care Plan is reviewed for accuracy, updated with annual MDS..." SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least	2 570		9/21/16

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2 570	Continued From page 23 quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to reassess skin condition for 1 of 5 residents (R3) who developed a pressure ulcer in the facility. Findings include: During an observation on 8/11/16, at 7:23 a.m., licensed practical nurse (LPN)-A and RN-A completed a dressing change to R3's buttocks. R3's right and left ischial tuberosity ' s were red and excoriated with three separate open areas. RN-B described the area as having "lots of redness and three stage II pressure ulcers." LPN-A stated the wound had gotten bigger and now required a larger dressing than it had previously. The annual MDS dated 6/30/16, indicated he was cognitively intact, required extensive assistance for bed mobility, transfers and toileting and was frequently incontinent of bowel and bladder. A care area assessment dated 6/30/16, identified a "high risk for pressure ulcer due to a history of pressure ulcers." R3's care plan dated 8/5/16, identified impaired mobility and directed staff to assist with bed mobility, transfers and toileting. A review of R3's Sholom Home West Physician Order Report dated 7/22/16 through 8/22/16, indicated on 7/14/16, the nurse practitioner wrote the following order: Left buttock ulcer- cleanse with normal saline, apply skin prep to surrounding	2 570	See ePOC	

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2 570	Continued From page 24 skin, cover with Allevyn border (Allevyn Border is a wound covering dressing), change every other day. A Facility document titled weekly skin checklist dated 7/27/16, identified an open area on R3's left buttock. During an interview on 8/10/16, at 1:01 p.m., LPN-A stated she was aware of the open area to R3's buttocks. She stated the nurse practitioner saw him in July and found the area. During an interview on 8/11/16, at 7:02 a.m., two days after RN-A was made aware of the pressure ulcer on R3's buttock, RN-A stated she had not assessed the wound yet. She stated, "I think the nurses do the assessments daily" and stated she was responsible for the measuring of the wound. During an interview on 8/11/16, at 12:19 p.m., the DON stated when a skin concern was identified an incident report should be filled out and the care plan should be updated. She stated RN-A was responsible for implementing that process and stated she would have expected weekly skin assessments to be completed since the initial area was discovered by the nurse practitioner on 7/14/16. A facility policy titled Prevention and Treatment of Wounds, undated, directed staff to monitor pressure ulcers daily including the status of the surrounding skin, signs of infection and whether pain is present. The policy further directed staff to initiate weekly wound monitoring to include onset of skin condition, location of wound, stage of wound, length, width, depth and wound characteristics.	2 570		

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2 570	Continued From page 25 While the Physician Orders and Weekly Skin Checklist identified an open area to R3's buttock beginning on 7/14/16 and while nursing staff were completing a dressing change to R3's pressure ulcer every other day, there was no evidence an assessment of the wound was completed at any time between 7/14/16 and 8/11/16, to stage, describe, measure or track progress toward healing. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff related to the need to evaluate and update care plans and monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 570		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure adequate staffing for residents to receive the highest practicable well-being. This had the potential to affect all 145 residents in the facility.	2 800	See ePOC	9/21/16

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2 800	Continued From page 26 Findings include: The task of sufficient staffing was triggered by an OHFC (Office of Health Facility Complaints) complaints to survey, H5574085 and H5574083, as well as family complaints of lack of staffing on site. In addition, three OHFC surveyors entered the facility with the survey team to investigate three additional complaints. See F282 failure to follow the care plan. See F309 failure to provide cares for highest practicable wellbeing. See F312 activities of daily living. See F314 pressure ulcer development. Complaint number H5574083 noted, "Facility has been short staff and as a result there have been 22 falls in a month, In addition, medications were given late, wound care treatments were not being completed and residents were waiting up to 90 minutes for call lights to be answered." Complaint number H5574085 noted, "Facility short of staff and resident, R116 was not getting personal cares completed, and not being repositioned." R116 had recurrent stage 2 pressure ulcers (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater), which had opened 8/1/16, aide sheet was not updated to say reposition hourly, bottom red and non-blanchable, according to the nurse manager. R116 was not repositioned from 9:18 to 10:32 she sat, after the initial hour 36. Resident is nonverbal, unable to move, totally dependent on staff). " R136 was a Russian Speaking resident with mild cognitive impairment, moderate depression, and	2 800		

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2 800	Continued From page 27 required extensive assistance of one person for bed mobility, transfers, and toilet use. On 8/10/16, at 3:40 p.m. family member (F)-D (daughter of R136) Stated: "I know that people work hard, and weekends are short staffed. But there is also a lack of communication that impacts care. When I tell the staff I see a change in my father, or to watch for changes in his skin, (a bruise or scratch), I come back 3 days later and it's worse, and when I ask the nurse working, they know nothing about it, or they say it doesn't say where the scratch is; shouldn't they lift up his shirt and look? It seems like the staff are not even doing the skin checks. Changes don't get reported to the doctor when I point them out, and the next thing you know he is back on antibiotics, or back in the hospital. Just a lack of communication between staff and doctors, staff don't listen when given concerns. What about the people who don't have someone who can come every day. " A review of the residents chart revealed wound sites that worsened and required antibiotics and additional treatments, and documentation that R136's daughter notified staff of changes 24 hours before he was transferred to the hospital on 8/9/16. Grievances were reviewed and revealed: On 7/27/16, 2 South, medical doctor (MD)-A and consultant pharmacist (CP) approached voicing the following concerns related to resident service in the dining room during lunch today. Reported two of MD-A's residents had concerns with not eating. Requested aide to get a resident juice twice and nothing happened. MD-A then offered her patients applesauce and yogurt, which MD-A then served to the patients, MD-A also physically fed a resident soup. Call light audits indicated one call light was on greater than 15 minutes, two call lights were on greater than 20 minutes, two call	2 800		

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2 800	Continued From page 28 lights were on greater than 25 minutes, and one call light was on greater than 45 minutes. Staffing was not requested. On 7/25/16, spouse of R21 stated resident was not getting walked three times per day as ordered, "only 1 staff member ever walks him. " Call light audits indicated three call light was on greater than 15 minutes, one call light was on greater than 20 minutes, two call lights were on greater than 25 minutes, one call light was on greater than 30 minutes, one call light was on greater than 35 minutes. On 7/25/16, Day shift: 2 North had 2 LPN and 6 NA. 2 South had 1 manager working the unit, 1 LPN, 1 TMA and 3 NA. 3 North had 2 LPN and 6 NA. 3 South had 2 LPN and 6 NA. Evening shift: 2 North had 2 LPN and 6 NA, 2 South had 2 LPN (1 was agency), and 3 NA. 3 North 1 RN, 1 LPN, and 6 NA, 3 South had 1 LPN 2 TMP and 6 NA. Night shift: 2 North had 1 LPN, 2 NA. 2 South had 1 RN and 2 NA. 3 North had 1 LPN (agency nurse did double shift) and 2 NA. 3 South had 1 RN and 2 NA. The staff posting was incorrect for the number of LPN hours, as it was not updated with changes and the manger working the unit on day shift on 2 South was not counted in the direct staff hours. On 7/20/16, daughter stated mother, admitted 7/10/16, had not yet been showered. Call light audits indicated two call lights were on greater than 15 minutes, two call lights were on greater than 20 minutes, one call light was on greater than 25 minutes, one call light was on greater than 30 minutes and one call light was on greater than 40 minutes. On 7/11/16, Day shift: 2 North had 1 RN, 2 TMA and 6 NA. 2 South had 2 LPN, and 3 NA. 3 North had 2 LPN and 6 NA. 3 South had 1 RN, 1 LPN and 5 NA. Evening shift: 2 North had 2 LPN and 6 NA, 2 South had 2 LPN,	2 800		

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2 800	Continued From page 29 and 4 NA. 3 North 1 RN, 1 LPN, and 6 NA, 3 South had 2 LPN and 6 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN and 2 NA. 3 North had 1 RN and 2 NA. 3 South had 1 RN and 2 NA. The staff posting was incorrect for the number of RN, LPN and NA hours, as it was not updated with changes. On 7/11/16, spouse of R177 complained of staff not knowing how to properly read meal tickets, and residents were not getting their ordered diets. Call light audits indicated four call lights were on greater than 15 minutes, two call lights were on greater than 20 minutes. On 7/11/16, Day shift: 2 North had 2 LPN and 6 NA. 2 South had 1 LPN, 1 TMA and 2 NA. 3 North had 2 LPN and 6 NA. 3 South had 1 RN, 1 LPN and 6 NA. Evening shift: 2 North had 2 LPN and 6 NA, 2 South had 1 LPN, 1 TMA, and 2 NA. 3 North 1 RN, 2 TMA, and 5 NA, 3 South had 2 LPN and 6 NA. Night shift: 2 North 1 RN, 2 NA. 2 South had 1 RN and 2 NA. 3 North had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of RN, LPN and NA hours, as it was not updated with changes. Multiple complaints of lack of food from multiple residents in July. On 6/13/16, R126's, husband and daughter approached SW to request assistance to move to another facility due to NA's not following care plan, not meeting dietary needs, poor intake and gradual weight loss, an overall feeling that resident is not receiving quality of care she needs to be successful. Call light audits indicated four call lights were on greater than 15 minutes, three call lights were on greater than 20 minutes, two call light were on greater than 25 minutes and one call light was on greater than 45 minutes. On 6/13/16, Day shift: 2 North had 2 LPN and 4 NA.	2 800		

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2 800	Continued From page 30 2 South had 1 LPN, 1 TMA and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 4 NA. Evening shift: 2 North had 1 RN, 1 LPN and 4 NA, 2 South had 2 LPN, and 3 NA. 3 North 1 RN, 1 LPN and 5 NA, 3 South had 2 LPN and 4 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN and 1 NA. 3 North had 1 RN and 1 NA. 3 South had 1 RN and 2 NA. The staff posting was incorrect for the number of RN, LPN and NA hours, as it was not updated with changes. On 5/29/16, Call light audits indicated seven call lights were on greater than 15 minutes, five call lights were on greater than 20 minutes, and three call light were on greater than 25 minutes. On 5/29/16, Day shift: 2 North had 2 LPN and 4 NA. 2 South had 1 LPN, 1 TMA and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 4 NA. Evening shift: 2 North had 1 RN, 1 LPN and 4 NA, 2 South had 2 LPN, and 3 NA. 3 North 1 RN, 1 LPN and 5 NA, 3 South had 2 LPN and 4 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN and 1 NA. 3 North had 1 RN and 1 NA. 3 South had 1 RN and 2 NA. The staff posting was incorrect for the number of RN, LPN and NA hours, as it was not updated with changes. On 5/24/16, requested by surveyor investigating H H5574083, multiple falls in one day. Call light audits indicated six call lights were on greater than 15 minutes, two call lights were on greater than 20 minutes, two call lights were on greater than 25 minutes, one call light was on greater than 30 minutes and one call light was on greater than 35 minutes. On 5/24/16, Day shift: 2 North had 1 RN, 1 LPN and 6 NA. 2 South had 1 RN, 1 TMA and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. Evening shift: 2 North had 1 RN, 1 LPN (double from days) and 5	2 800		

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2 800	Continued From page 31 NA, 2 South had 1 RN, 1 TMA and 2 NA. 3 North 2 LPN and 5 NA, 3 South had 1 RN, 1 LPN and 3 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN and 1 NA. 3 North had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of RN, LPN and NA hours, as it was not updated with changes. On 5/19/16, staff did not take resident R135 to dining room for 30 minutes, and did not return from dining room for 30 minutes, was told inadequate staff on the floor. Call light audits indicated one call light was on greater than 15 minutes, and two call lights were on greater than 20 minutes. On 5/19/16, Day shift: 2 North had 1 RN, 1 LPN and 6 NA. 2 South had 2 LPN and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. Evening shift: 2 North had 2 LPN and 6 NA, 2 South had 1 LPN, 1 TMA and 2 NA. 3 North 2 RNS and 3 (SHORT 3 NA ON THIS SHIFT) NA. 3 South had 2 LPN and 5 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN, 1 LPN and 1 NA. 3 North had 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was not provided for that day. On 5/17/16, R140, letter from family verbal and physical threats against resident and visitor by resident adjacent, learned he was already hitting other people (no mention of OHFC report made). Unfounded allegation and response made, nurse manager meet with daughter that day.). Call light audits indicated two call lights were on greater than 15 minutes, one call light was on greater than 20 minutes, one call light was on greater than 25 minutes, three call lights were on greater than 30 minutes and one call light was on greater than 65 minutes (1 hour 5 minutes). On 5/17/16, Day shift: 2 North had 1 RN, 1 LPN and 6 NA. 2	2 800		

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2 800	Continued From page 32 South had 1 RN, 1 TMA and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. Evening shift: 2 North had 1 RN, 1 LPN (double from days) and 5 NA, 2 South had 1 RN, 1 TMA and 2 NA. 3 North 2 LPN and 5 NA, 3 South had 1 RN, 1 LPN and 3 NA, and a note to take no admit. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 RN and 1 NA. 3 North had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of LPN and NA hours, as it was not updated with changes. On 5/9/16, R500, complained nursing, was not bringing R500 to meals, he had untreated pain, not toileting/changing of incontinent pads (recorded weight loss in May and June). Call light audits indicated two call lights were on greater than 15 minutes, one call light was on greater than 30 minutes. On 5/9/16 staff was short 1 NA, Day shift: 2 North had 2 LPN and 5 NA. 2 South had 1 RN, 1 LPN and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. Evening shift: 2 North had 2 LPN and 6 NA, 2 South had 1 RN, 1 TMA and 2 NA. 3 North had 1 RN, 1 LPN and 5 NA, 3 South had 2 LPN (1 doubled from days) and 5 NA. Night shift: 2 North had1 LPN, 2 NA. 2 South had 1 RN and 1 NA. 3 North had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of LPN and NA hours, as it was not updated with changes. On 5/7/16, R146, waited 1 ½ hours for pain medication, was not dressed, staff argued over who was helping, daughter helped. (No mention of investigation or report to state agency (SA). Call light audits indicated one call light was on greater than 15 minutes, three call lights were on greater than 20 minutes, one call light was on greater than 25 minutes, one call light was on	2 800		

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2 800	Continued From page 33 greater than 30 minutes and one call light was on greater than 35 minutes. The staffing 5/7/16, on Day shift was short 1 NA for 2 North day shift, and had 2 LPN and 5 NA. 2 South had 1 LPN and 1 TMA and 2 NA. 3 N had 2 LPN and 5 NA. 3 South had 1 LPN, 2 TMA and 4 NA. Evening shift: 2 North had 2 LPN and 5 NA. 2 South had 1 LPN, 1 TMA, and 2 NA. 3 North had 1 RN, 1 LPN, and 5 NA. 3 South had 1 RN, 1 LPN, and 5 NA. Night shift: 1 LPN, 2 NA. 2 South had 1 LPN and 1 NA. 3 North had 1 LPN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of RN hours, as it was not updated with changes. On 8/8/16, at 5:30 p.m. MD-A arrived on 2 South and asked staff working their names and their positions. At 5:40 p.m. MD-A stated there had been a huge turnover this summer, and assumed these were some of the new nurses. Stated staffing had been a challenge and that was why one wing had been shut down, they didn't have enough staff (see Grievance on 7/27/16). On 8/11/16, 12:30 p.m. the director of nursing (DON) and the clinical services director for all of Sholom home (CSD) were interviewed for sufficient staffing. Stated basic staffing pattern is indicated on the staffing sheets. Day shift: 2 North had 1 RN, 1 LPN and 6 NA. 2 South had 1 RN, 1 TMA and 2 NA. 3 North had 2 LPN and 5 NA. 3 South had 2 LPN and 5 NA. Evening shift: 2 North had 1 RN, 1 LPN and 6 NA, 2 South had 1 RN, 1 TMA and 2 NA. 3 North 2 LPN and 5 NA, 3 South had 1 RN, 1 LPN and 3 NA. Night shift: 2 North 1 LPN, 2 NA. 2 South had 1 LPN and 1 NA. 3 North had 1 RN and 2 NA. 3 South had 1 LPN and 2 NA. The staff posting was incorrect for the number of LPN and NA hours, as it was not updated with changes.	2 800		

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2 800	Continued From page 34 Supervisors did the staff changes and took call in's on the off shifts. Supplemental Nursing Service Agencies (SNSA) were currently in use, but expected the hiring and training to be completed and SNSA nurses to be phased out by September 1st. The last training class was starting on 8/15/16. Staffing was flexed for census, also look at acuity on TCU and have recently been increasing staffing for 2 North, because they had a couple of IV's (intravenous infusions). We expect the nurse manage (NM) to ask for more help, we look at behaviors, IV's, wounds, and admits to adjust staffing. Staffing was also flexed down when census decreased. The DCS verified staff had brought forward concerns about the workload and how groups were divided, but not in the last couple of months. DCS stated there are days that we have three call in's and cannot replace them, but we shuffle around as much as we can too even the work load. New nurses get one year of training and then leave to go to hospital jobs. The annual turnover rate which was reported at the Quality Assurance (QA) meeting, for the nursing (RN-LPN) was 82.52%, the monthly nursing department turnover rate ranged between 5.45%-11.67%. The annual turnover rate for NA was 65.14%. The monthly nursing department turnover rate ranged 1.92% to 10.71%. A review of the Termination Reason report indicated: 18% SNSA staff use, 13% terminated for misconduct, 4% no call/no show, 3% Job Abandonment, 2% terminated for performance, 2% Excessive Tardiness.	2 800		

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2 800	Continued From page 35 When asked about the call light waits (recorded above) DCS stated the facility expectation for answering call lights was five minutes or less, "would really like less than 10, maybe not communicated here very well." The DCS stated tracking and trending of falls and incidents for patterns was probably not done as it should have been by the prior nursing leadership group, and would be a focus of the new nursing leadership. The DCS stated there was no staffing policy, but provided the Call Light System policy, reviewed 10/15. Stated "Residents will have a means of contacting staff to obtain assistance at all times. Call lights will be answered promptly. Residents needs will be met in a timely manner. Staffing interviews On 8/8/16, at 11:55 a.m. when approached and asked about staffing nursing assistant (NA)-C stated " Woo you are asking me this has been a problem for a while here. We have 43 residents here and sometimes with being a long-term unit a lot of residents needed total help. We are just not able to get the work done like putting residents to the toilet and walking them sometimes the resident I have to walk I will tell them I just don't have time to do it because it's just too much. This new management has been doing something but it's still bad. I can go on and on about this and will not be done. The residents are not getting what they are supposed to get." On 8/8/16, at 12:04 p.m. NA-B stated staffing had gotten a lot better for the last two months but still was a problem. NA-B stated she had noticed a lot of new staff working in the facility as a lot of staff was coming and going right away. When asked about how she was able to provide cares NA-B stated she was able to do cares however felt she	2 800		

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2 800	Continued From page 36 rushed the residents through to get all the stuff done. On 8/9/16, at 7:21 a.m. NA-E approached surveyor called surveyor into a resident room and shut the door staff then stated the facility was very short staffed and thought the residents were not getting their needs met. "We sometimes have 16-20 residents and are told someone is coming but never comes. Do you want to tell me the residents are getting total cares? They continue to give particular staff raises but not some of us. It is so bad and we are not able to ambulate, toilet and do all the cares to the residents. We have to get the residents up by routine." On 8/10/16, at 6:37 a.m. NA-T stated "I don't think I am allowed to say anything. We have two aides at night as the census is low and when the census goes up we will get more help." On 8/10/16, at 6:43 a.m. NA-C approached surveyor in the hallway of 3 South unit and stated "we are working short today again." When asked if the facility was working on replacing the staff NA-C who appeared upset stated "we are iron people" when asked how short the unit was NA-C stated one NA. -At 6:50 a.m. licensed practical nurse (LPN)-A and NA-U were overheard in the hallway state they did not understand why they were always working short in the unit. When approached and asked about staffing NA-U stated "we are always working short staffed in this unit and this is almost daily thing." On 8/11/16, at 8:12 a.m. when approached and asked who was assigned to Group 1, 3 South LPN-B stated the group was split right now because there was not enough staff on the floor	2 800		

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2 800	Continued From page 37 and current five staff had been assigned according to room numbers to ensure the resident got the care they required. LPN-B stated "there was a miscommunication and we had to split the groups. This is not how we like it to be but it is what it is." Family members On 8/10/16, at 4:06 p.m. family member (FM)-A when asked is there enough staff to help family member replied, "No, are you kidding, there are not enough and the ones they have are very inefficient." FM-A further stated " The care they provide is very poor, I am sorry to say. "I am thinking of finding him a new place even though it would be more difficult for me to see them." On 8/12/16, at 12:00 pm family member (FM)-C stated, "I am concerned about the amount of staff at the nursing home, and their training. You know there is a problem with staffing when you see the activities people helping with the breakfast." FM-C said, "When a resident needs more help and does not speak up for themselves the care is not there." Staff interviews On 8/08/16, at 2:45 p.m. NA-M raised eyebrows when asked do you have enough staff to get your work done and stated "it all depends, today since you are here, we have enough. We have six [aides] today. Normally it is a good day if we have five. NA-M said, "Is that enough, no. We have a lot of two people assists for turning and EZ stands [mechanical lift that helps a resident stand up]. We might have to break up a group and rearrange it. I do not normally work this floor, so I do not know the residents which makes it harder to plan my work.	2 800		

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2 800	Continued From page 38 On 8/08/16, at 7:04 p.m. LPN-H stated, "No we do not have enough staff. We should have six aides but normally we have only five and have to split a team. Our patients have Alzheimer's and they sundown, so when the aide is busy the nurse has to stand with the resident to ensure they do not fall. The dining room can be crazy depending on the mood." On 8/09/16, at 8:15 a.m. anonymous licensed practical nurse (LPN) stated "the staffing here is so short. Administration has the right model but not enough staff to fill it. They did have a very big hiring fair recently but not everyone is staying. This morning 3 North had two people not show up so I had to rearrange staff. Most of the time we would have had to tell them to work short and only replace one staff member but not during survey. Sometimes the nurses cannot get everything done because they are trying to help the aides. The aides are rushing from one thing to the next which can cause problems. The aides care and try really hard. I observe staff as they are working to be sure they are following the care plan, I make sure to tell them if they are showing signs of burn out, to take a break. When we are short staffed, that is hard and a lot of the aides are tired." On 8/11/16, at 2:34 p.m. NA's were heard arguing at the nursing desk about assignments NA-R stated "I have group 4 otherwise I am going home." NA-S stated, "Not if I am here it is my regular group if I cannot have my group I am going home." SUGGESTED METHOD OF CORRECTION: The administrator or director of nursing could evaluate current resident care needs and determine staffing needs based on these needs.	2 800		

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2 800	Continued From page 39 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide appropriate textured food/fluids in order to prevent choking/aspiration for 1 of 1 resident (R109) who had been identified as at risk reviewed during a dining observations. In addition, the facility failed to follow physician orders for daily weights, for 1 of 1 resident (R180) reviewed for dialysis. Findings include: R109's meal service was observed on 8/8/16, at 6:13 p.m. R109 was heard coughing continuously when standing at the desk. At 6:14 p.m. the resident was observed coughing continuously, as	2 830	See ePOC	9/21/16

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2 830	Continued From page 40 another resident in the same table stated repeatedly, "[R109] cover your mouth." At 6:15 p.m. nursing assistants (NA)-P and NA-K in the dining room stated to R109 coughed like that every day. At 6:17 p.m. when asked if the food had been thickened as noted in the meal ticket, NA-P stated the food had already been pre-thickened and added at times for example the soup staff would have to add the thickener however, not for that particular meal. The pureed food on the plate was noted to be runny and thin. At 6:18 p.m. R109 continued to cough with each bite. At 6:22 p.m. NA-P stood up and asked R109 if he was going to eat all his food. At 6:23 p.m. R109 coughed again. Staff were still standing over the resident. At 6:24 p.m. the resident coughed again after a bite of the runny pureed food on the plate and was observed hold his head and NA-P asked R109 if he was having a headache and resident would nod. At 6:25 p.m. NA- asked NA-P "Do you think I should give him juice." At 6:26 p.m. another NA came into the dining room and NA-P requested her to wheel resident out of the dining room. -At 6:29 p.m. resident observed at the nursing station still coughing loud and holding his head. At 6:32 p.m. observed R109 had been moved into his room and was still cough. On 8/8/16, at 6:39 p.m. the nutritional service manager (NSM) stated the cook who had cooked that evening had left for the night. When asked if she was familiar with what had been added to the pureed food for R109, NSM stated she would not exactly know what had been added to the food before it was brought to the floor for the pureed food. A request of NSM to see if they would contact the cook at that time. NSM called the cook who indicated all the cook added one to two scoops of thickener to all pureed food.	2 830		

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2 830	Continued From page 41 -At 6:59 p.m. registered nurse (RN)-B approached stated the nurse practitioner was working on resident diet order to determine if it was appropriate and at that time the food was pureed and liquids were supposed to be honey consistency. RN-B stated R109 had a history of aspiration pneumonia, and currently was on a patch to decrease secretions and was on Mucinex (used to relieve the symptoms of cough and loosen mucus in the chest). At 7:06 p.m. RN-B verified the 7/29/16, which directed staff to add two teaspoons of thickener stated the nurse had signed off on it. RN-B stated on the meal ticket the three packets of thickener were for the coffee, juice and soup if he needed them and that was to alert staff of what the resident needed. -At 7:18 p.m. approached NA-P who had been assisting R109 with eating and she stated she had watched the tray from when it had been served and when she started to assist resident and she had not seen the licensed practical nurse (LPN)-C add thickener to the food as LPN-C had indicated. On 8/9/16, at 9:16 a.m. observed R109's food served into a divided plate covered and sat on top of the steam table. No thickener was added to plate at that time. At 9:18 a.m. the plate of food remained in the same spot. At 9:33 a.m. NA-F took the sippy cups of cranberry juice and water (which were already honey thickened consistency) and added a packet of thickener to each of the 4 ounce cups, then brought them back and set them on the tray on top of the steam table. As NA-F was mixing the thickener LPN-C came into the nourishment center and left never said a word. No thickener was added to the pureed food at that time. -At 9:39 a.m. when approached and asked about the thickened liquids dietary aide (DA)-A stated	2 830		

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2 830	Continued From page 42 the liquids came already pre-thickened. He indicated he poured the beverages and nursing took care of the rest if they needed to add more thickener to the beverages. -At 10:04 a.m. NA-F went to the dining room grabbed the tray and went into the nourishment center. NA-F stated she was going to assist resident and was warming the food. -At 10:07 a.m. NA-F went to R109's room door at the door went in with the tray, applied the clothing protector, pulled a chair next to R109 and mixed the food. When approached and asked if she had added thickener to the food NA-F stated she had not. NA-F was then observed give resident one quick bite when surveyor intervened and stopped her before the second bite at 10:10 a.m. NA-F stated she was not aware resident food was supposed to be added more thickener and thought that was only the fluids which she had. As NA-F walked out of the room, the resident was heard coughing. -At 10:13 a.m. NA-F went to room with the RN-B who looked at the meal ticket and looked at the food and stated the food consistency was good left the room. NA-F indicated to RN-B she had not seen the nurse add thickener to the food. -At 10:15 a.m. came back to room found LPN-C and NA-F in room. LPN-C verified she had not added the thickener to the food and was in another room doing a dressing change. LPN-C directed NA-F to add two teaspoons to the pureed food. -At 10:17 a.m. when asked if the NA-F had been informed about adding the thickener to the food LPN-C stated that had not been communicated to the NA-F. LPN verified the order was dated 7/29/16, and NA-F was a regular staff was not aware she was supposed to add the thickener to the food. -At 10:19 a.m. RN-B verified the team	2 830		

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2 830	Continued From page 43 assignment sheet updated 8/8/16, did not have the two teaspoons order for thickener to be added to the food. RN-B stated he expected the nurses to implement the doctors' orders and to make sure the orders were communicated to the nursing assistants. R109's nutrition Care Area Assessment (CAA) dated 11/5/15, indicated the resident was on a mechanically altered diet, had dysphagia, was edentulous and did not have dentures. CAA indicated R109's diet had been downgraded to pureed and honey thickened liquids but continued to have as needed cough which may or may not be related to intake. The resident quarterly Minimum Data Set (MDS) dated 5/3/16, indicated resident required extensive physical assistance of one staff with eating, had coughing or choking during meals or when swallowing medications and was on a mechanically altered diet. In addition the MDS indicated resident had a diagnoses of dysphagia. R109's nurse practitioner (NP) progress note dated 7/12/16, indicated resident was at high risk aspiration and respiratory infectious due to the coughing. Resident physician order dated 7/22/16, indicated resident diet was pureed and honey thick liquids. In addition, another physician order dated 7/29/16, directed staff to "add 2 teaspoons of thickener to pureed diet three times a day [TID] during meals for coughing. Resident should be up in chair for meals at all times." The 2 North Group 9 Plan of Care dated 8/8/16, for nursing assistants indicated R109 was on a mechanical soft diet with nectar thick liquids. The	2 830		

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2 830	Continued From page 44 plan of care did not indicated two teaspoons of thickener were supposed to be added to the food three times daily. R109's care plan dated 8/9/16, indicated resident had potential for nutrition related concerns diagnoses of intellectual disability, impulse control, and dysphagia. The care plan indicated resident continued to have coughing episodes with and without intake and was on pureed diet and honey thickened liquids. The care plan directed staff to "Add 2 teaspoons of thicken powder to puree diet TID during meals per orders..." On 8/11/16, at 3:23 p.m. registered dietician (RD) stated she had worked the kitchen the Friday when the order had been obtained 7/29/16, and had not been able to update the care plan and update the meal ticket. RD stated physician orders were part of the resident plan of care and acknowledged the order should have been implemented since nursing was aware of the order. RD further stated the new order was a trial to help with the coughing resident had with eating. On 8/12/16, at 7:34 a.m. the director of nursing (DON) stated she would expect communication to the staff on the orders and staff was to follow all physician orders. R180's diagnoses included heart failure, hypertension and end stage renal disease (ESRD) obtained from the 14 day MDS dated 6/6/16. In addition the MDS indicated R180 received dialysis. On 8/9/16, at 12:30 p.m. when approached and	2 830		

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2 830	Continued From page 45 asked how dialysis was going R180 stated everything was going well. R180 stated he had increased weight which was good as he was not eating well at the time he had been admitted to the facility. When asked about the diet and fluid restriction resident stated he was on a regular diet and did not have a fluid restrictions as surveyor noted two glasses of water on top of the night stand next to bed. On 8/11/16, at 9:10 a.m. went to resident room observed resident seated at edge of bed. R180 stated he had eaten breakfast in his room. R180 was observed to have slight edema on the face and lower extremities and appeared tired. When asked how he had slept resident stated well "I know am a little puffy." R180's Hospital Discharge Summaries dated 5/18/16, directed "Daily weights: Call provider for weight gain of more than 2 pounds per day or 5 pounds per week." In addition Physician Orders dated 6/30/16, directed the same. During review of the vital signs weight section the following weights were noted missing according to months: -May 5/19/16, 5/27/16, 5/28/16. -June 6/1/16, 6/11/16, 6/14/16, 6/16/16, 6/17/16, 6/21/16, 6/30/16 -July 7/1/16, 7/2/16, 7/3/16, 7/4/16, 7/5/16, 7/7/16, 7/8/16, 7/9/16, 7/12/16, 7/15/16, 7/16/16, 7/11/16 -August 8/2/16, 8/3/16, 8/4/16, 8/5/16, 8/6/16, 8/7/16, 8/8/16, 8/9/16, 8/10/16. During review of the Medication and Treatment Administration Records for May 2016, through August 2016, it was revealed weights had not been documented in the record. In addition review of the interdisciplinary team notes (IDT) it	2 830		

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	00380	A. BUILDING: _____ B. WING _____	08/12/2016

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2 830	Continued From page 46 was revealed the weights had not been documented there either. R180's nutrition CAA dated 5/26/16, indicated resident had a significant weight loss over the past 180 day period and the weight loss was attributed to fluid status changes that were planned with dialysis, however also with decreased intake prior to and during the hospitalization, which resulted in weight loss below dry weight. CAA indicated the possible complications of significant weight loss of both fluid and actual mass loss include skin breakdown, higher risk for infection, depression, edema, cardiac/kidney strain, altered labs and death. R180's undated care plan indicated resident was on dialysis and identified resident was at risk for shortness of breath (SOB), chest pain, edema and elevated blood pressure. The care plan directed staff to monitor and follow the physician orders. The 2 North Group 8 Plan of Care updated 8/11/16, directed staff to do a daily weight. On 8/11/16, at 3:31 p.m. RN-B verified resident had an order for daily weights in the physician orders. RN-B then reviewed the vital signs tab and verified there were a lot of missing weights in the computer. RN-B stated he was going to check in the both the medication and treatment administration records on the nurses carts to see if the staff was recording the weights in there. -At 3:33 p.m. RN-B approached stated he had checked and found "they are not recording them." RN-B stated he would expect the nursing assistant to get the weights daily in the morning and record the weight to Point of Care which	2 830		

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2 830	Continued From page 47 would populate to Matrix. RN-B further stated he would expect the nurses to check daily to make sure the weights were done. On 8/12/16, at 7:45 a.m. the DON stated she would expect the staff to follow the physician orders. On 8/12/16, at 10:1 a.m. via telephone the RN to the primary doctor's clinic stated she would expect the care center to follow the physician orders but thought the resident sometimes may have not been weighed due to other medical appointments or dialysis days which was not documented why the weights had not been obtained in the resident medical record. SUGGESTED METHOD OF CORRECTION: The DON or her designee could develop polices and procedures regarding assessing and monitoring the use of tickener for foods/fluids. The DON or her designee could educate staff on the policies and procedures. The DON or her designee could develop a monitoring system to ensue residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty One (21) Days.	2 830		
2 850	MN Rule 4658.0520 Subp. 2 D Adequate and Proper Nursing Care; Shaving Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: D. Assistance with or supervision of shaving of all residents as necessary to keep them clean and well-groomed.	2 850		9/21/16

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2 850	Continued From page 48 This MN Requirement is not met as evidenced by: Based on observations, interview and document review, the facility failed to provide grooming for 1 of 3 residents (R116) who was dependent for activities of daily living (ADL) reviewed for ADL. Findings include: On 8/8/16, at 6:00 p.m. resident was observed seated on the Broda wheelchair in the DR. Observed resident with multiple white facial hairs approximately half inch long on the lower chin area. On 8/9/16, at 10:30 a.m. during another random visit to the unit resident was observed on her wheelchair outside the dining room across from the nursing station with eyes closed and still noted to have the facial hairs. On 8/10/16, at 6:53 a.m. resident was observed a sleep eyes closed lying on her right side pillow behind back. Resident remained to have the facial hairs. -At 8:36 a.m. nursing assistant (NA)- A was observed reposition resident stated she was going to get another resident up and would come back in later to get resident ready for the day. -At 8:52 a.m. to 9:29 a.m. both NA-A and NA-U were observed provide morning care, which included oral cares and washing resident up however never acknowledged or offered to remove the visible long white facial hairs. -At 10:32 a.m. licensed practical nurse (LPN)-B was observed wheel resident to room, tilted Broda chair to the back then turned resident to the right side and tucked a pillow under. During the observation, LPN-B looked at resident face	2 850	See ePOC	

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2 850	Continued From page 49 but never acknowledged to remove the facial hairs. On 8/10/16, at 10:51 a.m. the RN-E stated resident had late on set progression of Alzheimer's disease, was dependent on staff for all cares and was non-verbal. On 8/11/16, at 7:30 a.m. was observed on the Broda chair at the dining table dressed for the day. When approached the white facial hairs were still not remove and visible from standing 20 feet away. At 9:16 a.m. resident still in the dining room facial hair visible from standing 20 feet several staff by the steam table close to the table resident was seated none offered to remove the facial hairs. -At 10:27 a.m. NA-U stated she had completed providing resident cares for that morning. -At 10:30 a.m. LPN-A stated "[R116] was scheduled to get a shower today." LPN-A indicated because the unit had been working short resident had not received her shower yet. LPN-A further stated due to insufficient staff, many residents did not get there scheduled showers/baths however thought it was getting better now as the unit had been added a sixth aide to assist with cares. On 8/11/16, at 3:09 p.m. LPN-A verified the long white facial hair on resident lower chin area. LPN-A actually touched resident chin and stated the staff was supposed to have removed it for resident with cares. LPN-A stated she was going to have one of the staff remove it and thought there were two residents in the unit who needed assistance to remove the facial hairs. LPN-A further stated resident had received shower after lunch as evening staff had come in early to assist since the unit was short of one NA.	2 850		

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2 850	Continued From page 50 R116's diagnoses included dementia, contracture, muscle weakness, anxiety, failure to thrive and osteoporosis obtained from the annual Minimum Data Set dated 5/31/16. The MDS indicated resident had severely impaired cognition and required extensive to total dependence of one to two staff on all activities of daily living which included bed mobility, toilet use and transfers. R116's pressure ulcer Care Area Assessment dated 5/31/16, indicated resident was at risk for pressure ulcer related to impaired mobility, dementia and bowel incontinence. CAA directed staff to assist with cares. R116's activities of daily living care plan dated 6/11/16, indicated resident had potential alteration in self-care ability, needed assist with dressing/grooming/bathing and oral care related to advanced dementia with behavioral disturbance. The care plan directed staff for grooming to provide assist of one with combing hair, oral care, nail care and shaving. The 3 South Weekly Bath List dated 8/8/16, indicated resident was scheduled to get a bath on Thursdays AM. On 8/11/16, at 3:16 p.m. registered nurse (RN)-A unit manager stated staff should have automatically removed the facial hairs "You think. Am totally with you." RN further stated staff was supposed to follow the plan of care. On 8/12/16, at 7:36 a.m. the director of nursing stated she would expect staff to follow the plan of care, to reposition timely and assist a resident to remove the facial hairs with cares "it's a dignity	2 850		

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2 850	Continued From page 51 thing." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service all staff on performing activities of daily living (such as shaving) for residents. Also the director of nursing or designee could monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 850		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to prevent skin breakdown for 4 of 5 residents (R24, R3, R28, R116) reviewed for	2 900	See ePOC	9/21/16

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2 900	Continued From page 52 pressure ulcers. This resulted in actual harm for R3 and R24 who developed multiple stage II pressure ulcers (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Findings include: R24 did not have a pressure ulcer according to the registered nurse (RN)-B interview on 8/8/16, at 3:50 p.m. During an interview on 8/9/16, at 7:44 a.m., R24 stated he had pain. He stated the pain was in his buttocks and stated it was because he had a sore on it. During an observation on 8/11/16, at 8:41 a.m. R24's right and left ischial tuberosity ' s (the ischial tuberosity is a bony swelling on the buttocks that bears the weight of the body in sitting) were noted to be reddened, excoriated and had five open areas approximately one centimeter (cm) x one cm each. The red areas were approximately four inches x two inches on the left side and approximately two inches x one inch on the right. R24's Care Area Assessment (CAA) dated 4/6/16, indicated risk for pressure ulcers due to need for extensive assist with bed mobility and incontinence. The quarterly Minimum Data Set (MDS) dated 6/30/16, indicated he was cognitively intact, occasionally incontinent of bladder, frequently incontinent of bowel and required extensive assistance for bed mobility, toileting and transfers. R24's care plan dated 7/26/16, identified incontinence and directed staff to apply barrier cream to perineal area after each	2 900		

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2 900	Continued From page 53 incontinence episode and observe condition of skin. The care plan further identified risk for alteration in skin integrity and directed staff to observe for changes in skin and report to licensed staff and a weekly skin assessment done by licensed staff. A review of R24's Treatment Flowsheet dated 8/1/16 through 8/31/16, indicated the following: - Reposition patient every two hours in order to displace weight on sacral/coccyx area. - Skin assessment weekly on bath day. - Apply barrier ointment to sacral coccyx area twice daily with cares. A review of facility document titled Weekly Skin Checklist indicated R24 had an open area on his right shin on 8/6/16, but did not identify an alteration to his buttocks. The Weekly Skin Checklist for July 2016 was not filled out for the entire month. A review of a Sholom Home West Resident Progress Note dated as a late entry on 8/12/16, indicated R3 "has stage 2 ulcers [multiple open areas on right and left buttocks]." Family notified of pressure ulcers. A facility document titled 2 North Plan of Care, undated indicated R24 had a history of skin breakdown in the sacral area and directed staff to lay R24 down in bed or reposition in wheel chair. During an interview on 8/11/16, at 8:18 a.m., nursing assistant (NA)-Q stated R24 complained of pain in his bottom and stated he gets "rashes" on it. She stated it gets better and then worse. NA-Q stated she updated the nurses when R24's bottom had sores and stated RN-B should have been aware of it.	2 900		

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2 900	Continued From page 54 During an interview on 8/11/16, at 2:42 p.m., R24 stated he had the sore on his bottom on and off for a year. During an interview on 8/11/16, at 8:54 a.m., RN-B stated he was not aware R24 had an alteration to the skin on his bottom. He stated the nurses should be performing skin checks weekly for R24. He stated the nurses should be reporting anything that was not noted on a previous assessment. However, there was no evidence of skin assessments performed during the month of July even though R24 stated he had the sore on his bottom for a year. During a subsequent interview on 8/11/16, at 2:57 p.m., RN-B described R24's bottom as "breakdown of left buttock, moving to the right." He stated it looked like it started as "chafing" and stated the skin had been "sheared" off. During an interview on 8/11/16, at 12:29 p.m. the director of nursing (DON) stated weekly skin checks should have been completed for R24. She stated RN-B should have been aware of the pressure ulcers on R24's bottom. R24 was not comprehensively re-assessed for skin integrity as R24 developed five open areas on the buttocks and the facility did not ensure R24 received the necessary treatment and services to promote healing and prevent new sores from developing. R3's did not have any skin alterations on 8/9/16, at 7:12 a.m., per RN-A. RN-A stated she was unaware of any alterations to R3's skin. She stated she was going to look at it. At 7:28 a.m., RN-A stated she had looked at buttocks had an open area present on his right buttock and was described the area as a stage I pressure ulcer	2 900		

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2 900	Continued From page 55 (non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators). During an observation on 8/11/16, at 7:23 a.m., licensed practical nurse (LPN)-A and RN-A completed a dressing change to R3's buttocks. R3's right and left ischial tuberosity ' s were red and excoriated with three separate open areas. RN-B described the area as having "lots of redness and three stage II pressure ulcers." LPN-A stated the wound had gotten bigger and now required a larger dressing than it had previously. A review of Sholom Home West Resident Progress Notes dated 2/12/16 through 8/11/16, identified a history of open areas to R3's buttocks beginning on 2/16/16. (Identified as a stage II pressure ulcer on 2/23/16.) The annual MDS dated 6/30/16, indicated he was cognitively intact, required extensive assistance for bed mobility, transfers and toileting and was frequently incontinent of bowel and bladder. A care area assessment dated 6/30/16, identified a "high risk for pressure ulcer due to a history of pressure ulcers." R3's care plan dated 8/5/16, identified impaired mobility and directed staff to assist with bed mobility, transfers and toileting. R3's care plan was updated on 8/11/16, to include an open area on his left buttock measuring 1.5 cm (centimeters) x 1.5 cm. However, a review of Sholom Home West Resident Progress Notes dated 8/11/16, indicated: message left for nurse practitioner regarding the "two open areas (1.2	2 900		

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2 900	Continued From page 56 cm x 1.2 cm) on resident's (R3's) left buttock. Further, during observation on 8/11/16, at 7:23 a.m., R3 had three open areas on his buttocks. A review of R3's Sholom Home West Physician Order Report dated 7/22/16 through 8/22/16, indicated on 7/14/16, the nurse practitioner wrote the following order: Left buttock ulcer- cleanse with normal saline, apply skin prep to surrounding skin, cover with Allevyn border (Allevyn Border is a wound covering dressing), change every other day. A Facility document titled weekly skin checklist dated 7/27/16, identified an open area on R3's left buttock. While the Physician Orders and Weekly Skin Checklist identified an open area to R3's buttock beginning on 7/14/16, there was no evidence an assessment of the wound was completed at any time between 7/14/16 and 8/11/16, to stage, describe, measure or track progress toward healing. During an interview on 8/10/16, at 1:01 p.m., LPN-A stated she was aware of the open area to R3's buttocks. She stated the nurse practitioner saw him in July and found the area. LPN-A further stated R3 had problems with his bottom in the past. During an interview on 8/11/16, at 7:02 a.m., two days after RN-A was made aware of the pressure ulcer on R3's buttock, RN-A stated she had not assessed the wound yet. She stated, "I think the nurses do the assessments daily" and stated she was responsible for the measuring of the wound. During an interview on 8/11/16, at 12:19 p.m., the	2 900		

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2 900	Continued From page 57 DON stated when a skin concern was identified an incident report should be filled out and the care plan should be updated. She stated RN-A was responsible for implementing that process and stated she would have expected weekly skin assessments to be completed since the initial area was discovered by the nurse practitioner on 7/14/16. R28's quarterly MDS dated 6/23/16, indicated she was moderately cognitively impaired, frequently incontinent of bowel and bladder and required extensive assistance of two staff for bed mobility, toileting and transfers. R28's care plan dated 7/31/16, indicated she required assistance using a mechanical stand to transfer related to osteoarthritis and neuropathy. The care plan further identified a pressure ulcer to R28's right buttocks and directed staff to monitor weekly, reposition with pillows and provide a pressure relieving cushion in wheel chair. A facility document titled 2 North-Plan of Care, undated directed staff to "be diligent with turning and repositioning" but did not identify a frequency. Prior to inquiry by surveyor, the care plan reflected every hour repositioning based on tissue tolerance tests. A Sholom Home West Resident Progress Noted dated 7/29/16, indicated R28 had a stage II pressure ulcer present on her right buttock. During continuous observation on 8/10/16, at 8:06 a.m. R28 was seated in a standard wheel chair with a cushion on the seat. At 8:58 a.m., R28 remained seated in the wheel chair in the dining room. At 9:26 a.m., Staff escorted R28 to her room where she remained seated in her chair without repositioning until 10:07 a.m. At that time	2 900		

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2 900	Continued From page 58 R28 had been seated in her wheel chair for two hours and one minute. During an interview on 8/10/16, at 10:15 a.m., NA-Q stated she knows to reposition R28 every two hours and stated it was last done around 8:30 a.m. However, R28 was seated in the dining room at 8:30 a.m. and had not been repositioned. At 10:24 a.m., NA-Q stated R28 had left for the beauty shop and had still not been repositioned. At that time, R28 had been in her wheel chair for two hours and 18 minutes without repositioning. During an interview on 8/10/16, at 10:11 a.m., registered nurse (RN)-B stated another staff completed the assessments and the care plans and he updated the care sheets (the 2 North -Plan of Care). RN-B stated if the care plan directed staff to reposition R28 every hour it should be reflected on the care sheet and staff should be repositioning her every hour. During an interview on 8/11/6, at 12:26 p.m., the DON stated R28 should have been repositioned every hour as directed by the care plan. She further indicated the care sheets should indicate a frequency to guide the nursing assistants. R116 was observed on 8/10/16, at 6:53 a.m. R116 was lying in bed with their eyes closed and lying on her right side pillow behind back. On top of the night stand were two Posey sleeves (provide comfortable protection for fragile or sensitive skin that may bruise or tear easily). -At 6:56 a.m. observed NA-U go to room stated she was going to get resident dressed but was going to leave R116 and would be back in 45 minutes. -At 7:14 a.m. observed NA-U reviewing the	2 900		

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2 900	Continued From page 59 assignment sheet with NA-A outside resident room never heard discuss the last time R116 had been repositioned. When approached and asked about resident NA-A stated she was not a regular staff in the unit however was going to get resident up shortly. NA-A further stated because she did not know residents in the unit she would follow the care plan. -At 7:19 a.m. NA-A was observed go to room with linen stated she was not getting resident up but was just getting what she would need ready. NA-A never repositioned resident and left the room shortly. -At 7:27 a.m. resident asleep still observed wearing the arm sleeves on both arms still lying on her back to the right side. No activity to room until 8:28 a.m. -At 8:29 a.m. LPN-A stated she had informed NA-A that R116 was supposed to be repositioned every hour. When asked when resident had been last repositioned LPN-A stated she had got to the unit since 6:30 a.m. and did not know when resident had last been repositioned. LPN-A stated resident had an open area which was improving however, the area was a recurring one in the same area. -At 8:32 a.m. both NA-A and LPN-A were observed provide pericare and repositioned R116. During the observation R116's bottom appeared red and non-blanchable. The area on the tail of the coccyx was observed covered with a thick layer of cream. LPN-A wiped the area and a scabbed area was observed. LPN-A stated the bottom was red and non-blanchable because resident skin was so fragile. LPN-A verified the left heel boot was not on. At 8:36 a.m. NA-A stated LPN-A had informed her resident was supposed to be repositioned hourly however when she looked at the NA assignment sheet it directed resident to be repositioned one to two	2 900		

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2 900	Continued From page 60 hours and because she had been pulled from another unit later into the shift she had not been told when resident had been repositioned last. R116 went one hour and 39 minutes without being repositioned. -At 8:45 a.m. LPN-A verified resident Derma-savers (protect fragile skin from sustaining damage caused by friction, rubbing, abrasion and pressure that could lead to skin breakdowns, tears and splits) and Posey sleeves were supposed to be on at all times. LPN-A stated it was not on in the treatment sheet and was going to add it "I didn't know. I thought they were supposed to be off at night when staff put lotion." -At 8:50 a.m. RN-A nurse manager reviewed the care plan in the computer and verified R116's skin care plan directed staff to turn resident side to side hourly when in bed and also verified the care plan was contradicting as it directed staff to reposition resident one to two hours and then hourly. RN-A verified the Derma and Posey sleeves were supposed to be on at all times. RN-A stated she would expect the staff to follow any resident plan of care and she was going to have a word with the staff as that was important. On 8/10/16, at 8:52 a.m. to 9:18 a.m. R116's cares were observed provided by NA-A and NA-U who during the observed turned resident to the left and right never placed a pillow, three times never put a pillow to protect the boney prominences when repositioning. On 8/10/16, at 10:36 a.m. LPN-A approached stated she had reviewed the NA group Plan of Care sheet and had noticed both the one to two hours and every hour for repositioning. LPN-A stated she was going to make sure it was update to reflect the hourly repositioning schedule only	2 900		

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2 900	Continued From page 61 as this was confusing and misleading for the staff. At 10:42 a.m. LPN-A stated R116 had an open area that was pressure related as it was the same area where it had healed before. LPN-A further stated she thought it was healing well and was a stage II. On 8/10/16, at 10:51 a.m. the RN-E stated resident had late on set progression of Alzheimer's disease, was dependent on staff for all cares and was non-verbal. On 8/12/16, at 7:20 a.m. observed resident seated on Broda chair in front of the dining room door noted to have blue boots to both feet however did not have the pillow placed on foot rest when in Broda to protect skin as directed by the care plan. -At 7:30 a.m. RN-A verified the pillow was not on the foot rest as directed by the care plan to protect skin breakdown. R116's diagnoses included dementia, contracture, muscle weakness, anxiety, failure to thrive and osteoporosis obtained from the annual MDS dated 5/31/16. The MDS indicated resident had severe impaired cognition and required extensive to total dependence of one to two staff on all activities of daily living which included bed mobility, toilet use and transfers. In addition the MDS indicated R116 was at risk for pressure ulcers and did not have unhealed pressure area at the time of the assessment. R116's pressure ulcer CAA dated 5/31/16, indicated resident was at risk for pressure ulcer related to impaired mobility, dementia, bowel incontinence. CAA directed staff to assist with turning and repositioning and observed skin daily with cares.	2 900		

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2 900	Continued From page 62 R116's care plan dated 7/8/16, indicated resident was at risk for alteration in skin integrity related to dementia, incontinence of bowel and bladder, dependency with ADLs, poor nutritional intake, and had a chair fast status. R116 had a history of bruising easy and had fragile skin. The care plan directed staff "Place pillow on foot rest when resident is in BRODA chair, elevate lower extremities when in bed above level of heart. Turn side to side hourly while in bed, use pillows to protect bony prominences when repositioning, Repositioning hourly while in BRODA chair (specialized wheelchair), Posey sleeves upper extremities (Full arm) and derma-savers to lower extremities at all times, remove at bedtime [HS] to apply lotion, then reapply. Heel blue boots on to both feet when lying in bed and sitting up daily on all three shifts..." During review of the Event Reports assessments and the Interdisciplinary team notes (IDT) the following were revealed: -A Weekly Summary dated 7/7/16, indicated resident required physical extensive assistance of staff with bed mobility and repositioning. -Skin Integrity Events -- Pressure Sore/Stasis Ulcer/Arterial dated 8/1/16, indicated R116 had a stage II- partial thickness loss of skin layers that presents clinically as an abrasion blister, or shallow crater. The open area was on the left buttocks and measured 1.5 centimeters (cm) by 1.0 cm. The assessment indicated resident had history of pressure ulcer and directed interventions included but not limited to turning and repositioning and use of pressure relieving devices in chair and bed. -Interdisciplinary note (IDT) note dated 8/4/16, indicated resident pressure open area on right bottom measured "1/4 cm x 1/8 cm, washed with	2 900		

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2 900	Continued From page 63 normal saline [NS], patted dry, barrier cream applied to area." On 8/12/16, at 7:36 a.m. DON stated she would expect staff to have repositioned resident timely, removed the facial hairs and followed the plan of care. A facility policy titled Prevention and Treatment of Wounds, undated, directed staff to monitor pressure ulcers daily including the status of the surrounding skin, signs of infection and whether pain is present. The policy further directed staff to initiate weekly wound monitoring to include onset of skin condition, location of wound, stage of wound, length, width, depth and wound characteristics. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing, and to promote healing of pressure ulcers. The director of nursing or designee could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food.	2 960		9/21/16

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2 960	Continued From page 64 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide food in an attractive and proper appearance for 1 of 1 resident (R162) observed for dining. Findings include: During dining room observation on 8/9/16, at 8:55 a.m. an unidentified nursing assistant (NA) placed hot cereal in front of R162 out of R162's reach. R162 was awake and stared at the cereal. -At 9:10 a.m. a nursing assistant woke R162 up when they placed a divided plate with scrambled eggs and pureed bread in front of R162. -At 9:12 a.m. nursing assistant (NA)-E was observed to sit down next to R162. NA-E put the contents of an individual jelly packet on R162 scrambled eggs. NA-E then mixed the scrambled eggs with jelly and pureed bread together. NA-E put the plate with eggs and bread in front of R162 and placed the cream of rice on the table on the opposite side of the placemat, out of R162's reach. NA-E then left the table. R162 tasted the mixture of scrambled eggs pureed bread and then attempted to reach the cereal. R162 sat in wheelchair looking at other residents and then closed her eyes. -At 9:21 a.m. NA-E sat down at the table and moved the plate with the mixture of scrambled eggs and pureed bread away from R162, and started feeding R162 cream of rice. R162 ate 100% (percent) of the cream of rice and 0% of the egg and bread mixture. R162's quarterly Minimum Data Set (MDS) dated 6/8/16, indicated R162 was severely cognitively	2 960	See ePOC	

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2 960	Continued From page 65 impaired and was rarely able to communicate needs. R162's MDS indicated R162's diagnoses included Alzheimer's disease, and dysphagia (difficulty swallowing). R162's nutritional care plan dated 6/8/16, indicated R162 had dysphagia and had a weight decline from January 2016, to April 2016. The goal listed on the care plan was to maintain weight at 125 pounds or greater. The care plan instructed staff to "provide feeding assistance at meals if res [resident] accepts. May feed self some items w/[with] fingers (does not like to use utensils). Divided plate at meals for pureed diet." R162's vision care plan revised 7/1/16, indicated R162 had impaired vision and was unable to read or identify colors. The care plan instructed staff to observe for inability to find food on plate at meals and assist as needed. R162's nursing assistant assignment sheet dated 6/22/16, instructed staff that R162 required assist with feeding and was to be seated at a table with staff. R162 ' s Physician Order Report signed 7/5/16, instructed staff R162 was to be given a pureed diet, ok for regular soft breads, gefilte fish, and scrambled eggs. It also instructed staff to offer pudding, ice cream or yogurt three times a day between meals because of weight loss. " Give R162 four ounces of Mighty shake (a high calorie, high protein liquid supplement) three times a day for weight loss. " R162's weights reviewed from 2/19/16 through 8/5/16. Highest weight recorded was 130 pounds on 5/25/16. Current weight on 8/5/16, was 121.4 pounds.	2 960		

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2 960	Continued From page 66 On 8/10/16, at 1:12 p.m. NA-I stated, "You do not put the food in front of a resident who needs help before you are ready for them to eat. A resident's tray is served the way it is meant to be eaten. You can mix the gravy with the potatoes or meat but not mix them all together." On 8/10/16, at 1:22 p.m. NA-H stated "you do not mix all of a resident's food together before feeding them. They will refuse to eat it." On 8/10/16, at 1:24 p.m. NA-J stated "I would never mix a residents food together. We are taught that is a dignity issue and I want to treat all my residents with dignity." On 8/10/16, at 1:58 p.m. LPN-G stated "[R162] does not like people to feed her. She will put her finger into the food and lick it off. She likes her tray to have each item separate and will eat all of one and then all of the next. If you leave her food within reach she can eat most of it by herself. If her food is at the far edge of the placemat she cannot reach it to feed herself. Sometimes we have to wake her up or sit with her and talk to her." On 8/11/16, at 3:05 p.m. LPN-F stated, "It is not okay to mix a resident's food together, even if they are on a puree diet. It would most likely not appeal to the resident and they would refuse to eat it. You can add appropriate seasoning, if it is ok with their diet." On 8/12/16 at 11:06 a.m. the director of nurses (DON) stated that she expected staff to ask the resident if they wanted salt or pepper or anything else when they brought the food to the table. DON said she would not expect staff to place jelly on scrambled eggs unless the resident requested	2 960		

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2 960	Continued From page 67 it. DON said it would not be appropriate to mix scrambled eggs and pureed bread together unless the resident requests it. SUGGESTED METHOD OF CORRECTION: The dietitian and food service director could ensure policies and procedures are accurateand address food palatability. Appropriate staff could be trained. Audits of food temperatures could be conducted and residents randomly interviewed for satisfaction. The results of the audits could be brought to the quality committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 960		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed ensure disinfecting of the glucometer machine for 2 of 2 residents (R5, R253) was performed during a random observation. Findings include: R5's annual Minimum Data Set (MDS) dated 7/17/16, indicated R5 was severely cognitively impaired and was rarely able to communicate. R5's MDS indicated R5's diagnoses included	21375	See ePOC	9/21/16

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21375	Continued From page 68 diabetes and dementia. Physicians Order Report signed by physician on 5/18/16, indicated R5 was to have blood sugar checks done three times a day before meals. During random observation on 8/09/16 at 7:20 a.m. R5's blood sugar (BS) was checked by licensed practical nurse (LPN)-F with a glucometer (a machine for checking blood sugars) while R5 was sitting in a wheelchair in the hallway across from the nurses desk. R5's BS was 86. LPN-F removed gloves and put the glucometer on top of the lancets (a small sharp pointed object for drawing blood) without cleaning the glucometer. R253 Resident Face Sheet printed 8/5/16, indicated R253's diagnoses included diabetes, dementia, and history of methicillin resistant staphylococcus aureus infection (a bacterial infection that is very resistive to antibiotic treatment.) Diabetic flow sheet dated 8/5/16, indicated R253 was to have BS checks done twice a day on Monday, Wednesday, and Friday. During a continuous observation on 8/09/16, at 7:26 a.m. R253was approached by LPN-F in the hallway in front of the nurses desk. LPN-F wiped R253's finger with an alcohol wipe and stuck it with a lancet and then checked R253's BS using the same glucometer that had been used to check R5's BS and had not been cleaned. R253's blood sugar was 117. LPN-F then removed gloves, threw the soiled lancet away and put the glucometer on top of loose lancets that were in a plastic caddy without cleaning the glucometer. Surveyor was unable to stop LPN-F before checking R253's blood sugar. On 8/09/16, at 8:00 a.m. LPN-F said, "We clean	21375		

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21375	Continued From page 69	21375		

the glucometer twice a shift. They are getting individual glucometers soon." LPN-F verified she should have offered to take both residents to their rooms but did not and she acknowledge she did not clean glucometer between residents.

On 8/09/2016, at 8:01 a.m. LPN-E stated, "We clean the glucometers after each use with sanitizing wipes. We wipe the glucometers down well and wrap them in a clean wipe for at least two minutes and then let them air dry."

On 8/09/16, at 8:15 a.m. LPN-D nurse manager stated "It was expected glucometers to be cleaned after every time they were used. A glucometer was to be cleaned in accordance with specific product used some have a two minute wet time and some products have a three minute wet time. Staff should do blood sugars in resident's rooms unless the resident refused."

On 8/12/16, at 11:06 a.m. the director of nurses (DON) stated, "I expect them [staff] to do blood sugar checks privately not out in the main stream. I would expect to them [staff] to ask the resident to go to their room. They [staff] have become a task oriented group. We need to go back to the basics." DON further stated, "The staff are supposed to clean the glucometer between each resident. We have ordered glucometers for each resident. The staff were just all trained on when to clean the glucometers."

Cleaning Glucose Machine policy revised 07/16, instructed staff, "To prevent the transmission of blood-borne pathogens glucometers will be cleaned after each use."

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate

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21375	Continued From page 70 staff on the appropriate cleaning of multiple patient use equipment to prevent cross contamination and then monitor for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21375		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		9/21/16

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21390	Continued From page 71 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to perform tracking, trending and analysis of infections. In addition, the facility failed to implement a policy and procedure related to pneumococcal conjugate vaccine (PCV13) for 4 of 5 residents (R50, R84, R153, R176) whose vaccination histories were reviewed. This had the potential to affect all 145 residents residing in the facility. Findings include: The Monthly Infection Control Logs for the 2N (2 north) unit were reviewed from December 2015 through June 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved but did not identify any organisms. No logs were available prior to December 2015 or for the months of July and August of 2016. Monthly Infection Control Logs for the 3N (3 North) unit were reviewed From July 2015 through April 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available for the months of June, July and August of 2016. Monthly Infection Control Logs were reviewed for the 2 south unit from July 2015 through March 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available from April 2016 through August 2016. Monthly Infection Control Logs were reviewed for the 3 South unit from July 2015 through June	21390	See ePOC	

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21390	Continued From page 72 2016. The logs identified the resident name, type of infection, the antibiotic prescribed, and the dated the infection was resolved. No logs were available for the months of July and August 2016. During an interview on 8/12/16, at 10:31 a.m., the DON stated there was a plan in place to keep infection control logs and review the logs ongoing to determine if patterns exist. She stated the facility is currently doing spot checks and observing staff's infection control practiced across different shifts. While the facility had been keeping logs to identify resident infection and illness, there was no evidence of ongoing tracking and trending past June 2016. A policy for tracking and trending of resident infections was requested, but none was received. The Center for Disease Control and Prevention Identified "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine 23) should receive a dose of PCV13. The dose of PCV13 should be administered at least 1 year after the most recent PPSV23 dose. R50's Immunization record, undated indicated the 102 year old resident received the Pneumovax PPSV23 on 1/1/05. There was no evidence she had been offered the PCV13 vaccine since her admission to the facility on 10/10/2011. R94's immunization record, undated, indicated the 84 year old received the Pneumovax PPSV23	21390		

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21390	Continued From page 73 but did not specify a date. The undated record was signed by R94 on 2/3/2012. There was no evidence she had been offered the PCV13 vaccine since her re-admission to the facility on 2/1/2016. R153's immunization record dated 7/5/2016 indicated the 82 year old resident received the Pneumovax PPSV23 6/26/2008. There was no evidence she had been offered the PCV13 vaccine since her admission to the facility on 7/11/2016. R176's immunization record, undated, indicated the 70 year old resident received the Pneumovax PPSV23 on 8/4/2011. There was no evidence she had been offered the PCV13 vaccine since his admission to the facility on 3/12/2014. During an interview on 8/12/16, at 10:57 a.m., the registered nurse clinical specialist (RNCS)-A stated the facility had not started implementing the pneumococcal PCV13 at this time. A policy for the pneumococcal PCV13 was requested but not received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise Infection Control program and ensure that resident and staff infections are monitored and analyzed. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control	21426		9/21/16

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21426	Continued From page 74 (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure employee evaluations for tuberculosis (TB) were complete for 2 of 5 employees (E1, E2) reviewed. Findings include: E1 started in the facility on 8/3/16. She received the First step TST on 8/3/16 and had it read on 8/5/16. However, E1's symptom screen was incomplete. E2 received the first step TST on 4/22/16 and had it read on 4/25/16. She had a second step TST result read on 5/9/16, however there no evidence	21426	See ePOC	

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21426	Continued From page 75 of the second step TST being given. The documentation lacked the name of person administering the test, date and time administered, location, tuberculin manufacturer, expiration date and lot number. During an interview on 8/12/16, at 10:11 a.m., registered nurse (RN)-F stated she was responsible for the employee infection control program. She stated E2's documentation was her error and stated E1 started her employment on the east campus and her symptom screen should have been completed there. RN-F stated she usually reviews the documentation and it got missed. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing and/or designee could monitor to assure tuberculin screening procedures were developed and implemented to ensure staff was free of tuberculosis prior to working with residents. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan	21530		9/21/16

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21530	Continued From page 76 system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to act on recommendations made by the consultant pharmacist for 1 of 5 residents (R147) reviewed for unnecessary medications. Findings include: A review of a Physician Recommendation From Pharmacist for R147 dated 11/25/15, indicated	21530	See ePOC	

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21530	Continued From page 77 R147 was currently taking Quetiapine (Quetiapine is an anti-psychotic medication used to treat certain mental/mood conditions associated with Bipolar Disorder) 100 milligrams (mg) at bed time and Divalproex (Divalproex is used to treat the manic phase of bipolar disorder) 2 tablets at bedtime for mixed Bipolar Disorder. The recommendation indicated progress notes and nursing notes have been reporting no changes in behavior, reports of hallucinations or delusions and recommended a tapering of R147's Seroquel to 75mg. There was no evidence the recommendation was followed up on by the facility. R147's significant change Minimum Data Set dated 5/25/16, indicated she was moderately cognitively impaired, displayed no behaviors and no symptoms of depression. R147's care plan dated 8/12/16, identified a potential for alteration in psychosocial well-being related to diagnosis of Parkinson's disease and bipolar disorder. The care plan further identified the use of psychotropic medications, potential for behavioral symptoms and identified a sleep pattern of "8 hour intervals." On 8/2/16, a Physician Recommendation from Pharmacist again recommended a taper of Quetiapine from 100mg to 75mg and indicated the progress and nursing noted reported no changes in behavior, no hallucinations and no delusion. During an interview on 8/11/16, at 12:51 p.m., social worker (SW)-B stated the pharmacist reviews medications monthly. She stated she documents on each resident every quarter and reviews why they are taking certain medications.	21530		

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21530	Continued From page 78 SW-B stated R147 has not shown any signs of manic behaviors. During an interview on 8/11/16, at 3:11 p.m., registered nurse (RN)-B stated the pharmacy recommendations are given to the physician or the nurse practitioner for follow-up. He stated if there are new orders based on the recommendations they will show up in the medication administration record. RN-B stated there was no process in place for following up on the pharmacists recommendations. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Staff could be educated as necessary. The director of nursing or designee could monitor medications on a regular basis to ensure compliance with state and federal regulations. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure grab bars on toilets were secured for 6 of 10 residents (R29,	21665	See ePOC	9/21/16

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21665	Continued From page 79 R58, R186, R101, R96, R176). This has the potential to affect 118 residents who have grab bars on their toilets. Findings include: R29's left grab bars affixed to the bed was observed on 8/8/16, at 2:51 p.m. during resident room observations to be loose moved three inches back and forth when touched. Resident stated she used it and noted the grab bar had been loose for a while now. On 8/10/16, at 11:47 a.m. when asked about the grab bar resident again stated she had thought about letting the staff know to fix it but she always forgot something's. R29's activities of daily living (ADL)/Functional Status Care Area Assessment (CAA) dated 4/16/16, indicated resident required extensive assist with bed mobility, transfers, ambulation, locomotion, dressing, toilet use and personal hygiene. R29's quarterly Minimum Data Set (MDS) dated 7/9/16, indicated resident had intact cognition. Resident diagnoses included Parkinson's tremors, osteoporosis and osteoarthritis obtained from the face sheet dated 8/8/16. R29's care plan dated 8/8/16, indicated resident had an alteration in mobility related to weakness, depression, arthritis, history of falls and history of fractures. Care plan directed staff to provide extensive assist with bed mobility. Staff was to lift feet into/out of bed and extensive assistance with ambulation using a walker and transfer belt. The care plan did not indicated resident used grab bars in the bed for mobility.	21665		

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21665	Continued From page 80 2 North Group 8 assignment sheet updated 8/9/16, indicated resident had safety grab bars. The plan of care did not indicate who was responsible for checking the grab bars to ensure they were properly affixed to the bed frame. On 8/10/16, at 11:52 a.m. registered nurse (RN)-B stated maintenance fixed the grab bars. RN- B stated he would expect the staff to put in a work order either in paper if they did not have access to the computer. At 11:53 a.m. RN-B went to room and verified the left grab bar was loose. He indicated he thought it was a loose from bolts not fitting properly. -At 12:10 p.m. nursing assistant (NA)-O stated she had not noticed the loose grab bar. When asked if resident used the grab bars to turn side to side when in bed or when she got in and out of the bed and during cares NA-O stated "yes she does." -At 12:18 p.m. RN-B stated about two weeks ago the interim director of nursing (DON) had requested the staff to do an assessment and check if residents needed to have the grab bars in the beds. At the time resident had indicated she wanted to keep the grab bars in her bed and had been given the risks and benefits of the grab bars. RN-B stated he had not at the time checked the grab bars to make sure they were properly affixed to the bed frame and had not since completed an assessment and was getting to it. RN-B further stated maintenance had also gone through the entire unit he thought and switched out the beds if a resident had asked to have only one grab bar and was not sure if maintenance had check the grab bars to make sure they were properly affixed to the bed and directed the surveyor to the maintenance staff.	21665		

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21665	Continued From page 81 On 8/10/16, at 12:47 p.m. environmental supervisor (EVS) stated he had been in his position for the last one week. He indicated his department did not have grab bars on a routine preventative routine plan to be checked and his department depended on house-keeping and nursing to report any concerns for his staff to come and fix the grab bars. -At 12:51 maintenance staff verified the grab bar was loose. He indicated it was the bolts that needed to be tightened up. He further stated the grab bar on the left was supposed to be affixed firmly to the bed frame as the right side and that was caused due to the residents using the grab bars repeatedly. R58's grab bars on toilet seat were observed to move the toilet seat 15 degrees to the right and left during the initial tour on 8/9/16, at 10:17 a.m. R58's admission MDS dated 5/31/16, indicated R58 was cognitively intact, walked in room using a walker with supervision and required assistance with toileting. R58's MDS indicated R58's diagnoses included congestive heart failure, hypertension, and Alzheimer's disease. R58's care plan revised 6/17/16, indicated R58 required assistance with toileting related to dementia and impaired mobility and was at risk for falls. The care plan instructed staff to anticipate needs for toileting, follow safety precautions, and assist of one to transfer on and off the toilet. The Nursing Assistant Assignment sheet dated 6/23/16, instructed staff that R58 required minimal assist with ambulation and toileting.	21665		

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21665	Continued From page 82 Progress Note dated 6/29/16, indicated R58 was independent with toileting. During interview on 8/9/16, at 10:22 a.m. NA-L verified R58 used the toilet and the seat/grab bar combination are supposed to be tight and the seat should not wiggle. During interview on 8/11/16, at 12:13 p.m. EVS said, "This [toilet grab bar] needs to be replaced. We need to develop a preventative program for checking this [toilet grab bar]." R186's room was observed on 8/8/16, at 2:41 p.m. The grab bars on toilet seat were observed to be loose, allowing the toilet seat to move side to side. On 8/9/16, at 10:50 a.m. toilet grab bars were still loose. R186's quarterly MDS dated 6/23/16, indicated R186 was severely cognitively impaired, did not walk in room, required assistance with toileting. R186's MDS indicated R186's diagnoses included osteoarthritis, and Alzheimer's disease. R186's care plan revised 8/3/16, indicated R186 required assistance to transfer on and off the toilet and was at risk for falls. The care plan instructed staff to anticipate needs for toileting, follow safety precautions, and provide assist of one to transfer on and off the toilet. The Nursing Assistant Assignment Sheet dated 8/4/16, instructed staff that R186 required assist with transfers and toileting. During interview on 8/8/16, at 2:45 p.m. NA-K verified R186 used the toilet with staff assistance and that the toilet seat moving might cause a fall.	21665		

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21665	Continued From page 83 NA-K was observed telling the health unit coordinator about the loose toilet grab bars. During interview on 8/11/16, at 12:17 p.m. the administrator verified the toilet grab bar was loose. R101's room was observed on 8/8/16, at 5:19 p.m. and the grab bars on the toilet seat were observed to be loose, allowing the toilet seat to twist. R101's MDS dated 6/1/16, indicated R101 was severely cognitively impaired, required assistance with toileting. R101's MDS indicated R101's diagnoses included hypertension, and dementia. The Nursing Assistant Assignment Sheet dated 6/23/16, indicated R101 was a fall risk and instructed staff that R101 required assist with ambulation using a front wheel walker and with toileting. R101's care plan revised 7/1/16, indicated R101 required assistance with toileting related to dementia and impaired mobility and was at risk for falls related to unsteady gait and history of falls. The care plan instructed staff to anticipate needs for toileting, follow safety precautions, and assist of one to transfer on and off the toilet. During interview on 8/8/16, at 5:25 p.m. NA-N verified R101 used the toilet and stated, "The seat should not wiggle this much." During interview on 8/11/16, at 12:13 p.m. EVS said all but one nut that secured the toilet grab bar were loose.	21665		

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21665	Continued From page 84 R96's room was observed on 8/8/16, at 6:13 p.m. The bilateral grab bars on the toilet when grabbed caused the toilet seat to twist. R96's quarterly MDS dated 6/16/16, indicated R96 was moderately cognitively impaired, and required assistance with toileting. R96's MDS indicated R58's diagnoses included seizure disorder, and dementia. The Nursing Assistant Assignment sheet dated 6/23/16, instructed staff that R96 required assist with of EZ Stand (a mechanical lift that assists a resident to come to a standing position) for transfers with toileting. R96's care plan revised 7/1/16, indicated R96 had impaired range of motion due to contractures in both hips and knees. R96 required assistance with toileting related to and cognitive changes, impaired sitting balance and was at risk for falls. The care plan instructed staff to provide assist of two staff member to transfer R96 on and off the toilet. During interview on 8/8/16, at 6:25 p.m. NA-N verified R96 used the bathroom and stated the seat should not wiggle this much. During interview on 8/11/16, at 12:07 p.m. EVS verified toilet grab bar and seat were loose. EVS stated he depended on nursing and housekeeping staff to notify maintenance that a repair is needed. R176's room was observed on 8/8/16, at 3:31 p.m. The grab bars on toilet seat were observed to be loose, allowing the toilet seat to twist side to	21665		

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21665	Continued From page 85 side. R176's quarterly MDS dated 5/28/16, indicated R176 was severely cognitively impaired, walked in room using a walker with assistance and required assistance with toileting. R176's MDS indicated R176's diagnoses included Parkinson ' s (involuntary movement disorder), and Dementia. R176's care plan revised 6/17/16, indicated R176 required assistance with toileting related to muscle weakness and Parkinson ' s and was at risk for falls. The care plan instructed staff to anticipate needs for safety, toilet safety frame (toilet grab bars), and assist of one staff for toilet use and incontinence care. The Nursing Assistant Assignment sheet dated 6/23/16, instructed staff that R176 required assist of two staff to transfer and reposition. Staff were to assist R176 to the bathroom upon rising, after meals, at bed time, during rounds at night and as needed. During interview on 8/8/16, at 3:35 p.m. NA-N verified R176 used the bathroom and stated the seat should not wiggle this much. During interview on 8/11/16, at 12:09 p.m. EVS verified the toilet seat turned 15 to 20 degrees to the left and right. EVS said this was a fall risk. During interview at end of environmental tour on 8/11/16, at 12:21 p.m. the EVS said, "I would expect the nursing assistants and housekeeping to notify maintenance immediately if they saw a loose grab bar." EVS verified that the grab bars on the toilets were not to be loose and that all but one of the grab bars observed could be fixed with	21665		

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21665	Continued From page 86 a wrench. The EVS stated one grab bar on the toilet was broken and needed to be replaced. EVS stated, "If a resident grabbed the bar with one hand it could move, causing them to slip." EVS stated they did not have a preventative maintenance program for checking the toilet grab bars. During interview on 8/11/16, at 4:41 p.m. the administrator stated, "We do not have a policy for reporting issues to maintenance but we do have a process, both paper and computer for staff to report things that need to be fixed. All staff can use at least one of the systems." During interview on 8/12/16, at 11:06 a.m. the DON said, "I would expect the nursing assistants and nurses to report loose grab bars to maintenance." SUGGESTED METHOD FOR CORRECTION: The administrator and environmental services director could monitor the status of physical plant conditions periodically to insure that a routine maintenance plan in place is being effectively instituted. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility.	21805		9/21/16

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21805	Continued From page 87 This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a dignified dining experience for 5 of 24 residents (R59, R152, R162, R167, R176) who required assistance to eat. Findings include: During an observationon 8/8/16, at 5:46 p.m., nusring assistant (NA)-K was heard calling out "she is a feeder" three separate times and stated "both of these are feeders." NA-K was referring to R59 and R162. During an observation on 8/10/16, at 12:32 p.m., LPN-F was passing out clothing protectors and was referring to them as "bibs." At 12:40 p.m., while staff was passing out soup a dietary staff member called out, "make sure you give the whole table except (patients name), his soup is different. R59's quarterly Mminimum Data Set (MDS) dated 5/17/16, indicated she was severely cognitively impaired and required extensive assistance to eat. The MDS further indicated R59 was only able to communicate her needs "sometimes." During an observation on 8/9/16, at 8:55 a.m., an unidentified nursing assistant (NA) place a bowl of hot cereal in front of R59 but left it out of R59's reach. During an observation on 8/10/16, at 1:00 p.m., R59's table mates sat eating their soup while R59 was left with no food in front of her.	21805	See ePOC	

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21805	Continued From page 88 R152's annual MDS dated 5/21/16 indicated she was severely cognitively impaired, rarely understood others, but could ususally be understood, but was able to eat independently after set-up. However, a Physicians Order Report dated 8/2/16, instructed staff to assist R152 with eating. The MDS further identified an impairment to R152's bilateral upper extremeties. During an observation on 8/10/16, at 12:41 p.m., a staff member placed a bowl of soup on the upper right hand corner of the table, out of R152's reach. At 12:51 p.m., R152's soup remained out of her reach. She sat at the table with her head down. At 12:55 p.m. staff served the main course to R152's table. At 12:58, 17 minutes after being served her soup, staff sat down and assisted R152 to eat her meal. On 8/10/16, at 5:55 p.m., R152 sat at the table in the dining room with no food in front of her. Her tablemates were eating their soup. On 8/11/16, at 8:55 a.m., R152 sat at the dining table from 8:55 a.m. to 9:08 a.m. waiting for staff to asisst her to eat. R162's quartely MDS dated 6/8/16, indicated she was severely cognitvely impaired, was rarely able to communicate her needs and required extensive assistance to eat. During an observation on 8/9/16, at 8:55 a.m., a staff member placed a bowl of hot cereal on the table, out of R162's reach and walked away. At 9:10 a.m., a staff member placed a plate containing scrambled eggs and pureed bread in front of R162. The staff member opened a jelly packet, placed it on R162's scrambled eggs and mixed it with the pureed bread and left the table. The bowl of cereal remined out of reach. R162	21805		

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21805	Continued From page 89	21805		

tasted the egg and bread mixture and attempted to reach for the creal. She looked at her tablemates and then closed her eyes. At 9:21 a.m, 26 minutes after receiving her food, NA-E sat with R162 and fed her. She ate 100% of her cereal but did not eat the mixture of eggs and bread.

During an observation on 8/10/16, at 12:38 p.m., a staff member placed a bowl of soup in front of R162. At 12:44 p.m., licensed practical nurse (LPN)-F stood behind and to the right of R162 and fed her five spoonfuls of soup and left. At 12:55 p.m., the main course was placed on the table out of R162's reach. At 1:00 p.m., NA-H lifted a chair over R162's head and sat down to feed another resident at the table. NA-H awoke R162 by speaking with her and moved the food within her reach. R162 ate 50% of her meal after it was placed within her reach.

R176's quarterly MDS dated 5/28/16 indicated he was severely cognitively impiared and required extensive assistance to eat.

During an observation on 8/11/16, at 8:55 a.m., R176 was seated at the dining room table with food in front of him. No staff members were assisting him to eat. R176's tablemates had food and were eating their meal. At 9:12 a.m., LPN-F sat down and assisted R176 to eat, 17 minutes after his table mates.

On 8/10/16, at 1:12 p.m., NA-I stated the resident's food should not be place in front of them unitl staff is ready to assist them to eat.

On 8/10/16, at 1:22 p.m., NA-H stated food should not be left in front of a resident who needs

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21805	Continued From page 90 help for more than "five minutes tops" or the food will get cold. On 8/10/16, at 1:58 p.m., LPN-G stated R162 did not like to be fed. She stated R162 likes to have her food separated and will eat one thing at a time. LPN-G stated if R162's food is placed in front of her she will eat most of it by herself. LPN-G further stated staff need to sit and assist the residents as needed after trays are passed. On 8/11/16, at 3:05 p.m., LPN-F stated she had fed R176. She stated she did no how long was too long for a resident to sit with food in front of them wihout being assisted. LPN-F referred to the resident's who need assistance as "Feeders" and stated "we have a lot of feeders." She stated 15 to 20 minutes would be a long time to sit with your food in front of you. On 8/12/16, at 11:06 a.m., the director of nursing (DON) stated "I don;t know if we have enough staff in the dining room at this time." She further stated she expected the food to be served within 15 minutes of the scheduled meal time and all residents at the same table should be served within 30 seconds to a minute of each other. She stated staff should sit down and assist the residents right away so their food does not get cold. An undated facility policy titled Feeding A Resident instructed staff on how to feed a resident but dis not address how long a residents meal should sit in front of them before assistance is provided. SUGGESTED METHOD OF CORRECTION: The DON or designee could educate staff on dignity and respect. The DON or designee could	21805		

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21805	Continued From page 91 then interview residents routinely to ensure residents feel their dignity and respect are being maintained. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21805		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers,	22000		9/21/16

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22000	Continued From page 92 knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to operationalization their Abuse Prohibition policy for 2 of 4 residents (R55, R108), who were reviewed for vulnerable adult (VA) reporting, and abuse Prohibition. Findings include: Sholom Policy and Procedure Abuse Prohibition-Vulnerable Adult Protection/Abuse Prevention Plan revised 6/1/16, noted: Policy: 2. Residents will receive competent and compassionate care and treatment at all times. There is zero tolerance for maltreatment of residents section VI. Reporting and Investigating/Responding section E.	22000	See ePOC	

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Notification: 1. Any known or suspected -abuse must be reported to the administrator immediately (Immediately means "as soon as possible") then contact the Director of Nursing. 2. The Administrator and/or designee will review events with the reporter and determine the need for immediate reporting to external agencies. b: The regulations require that facilities report incidents to the Minnesota Department of Health immediately (immediately means "as soon as possible").

R55 was admitted 11/27/15, with admission diagnoses of dementia without behavioral disturbance, major depressive disorder, hypertension, lung disease, weakness and spinal stenosis (internal narrowing of spinal column which may cause radiating pain, weakness, and/or numbness) per R55's admission Face Sheet.

On 2/28/16, a visitor reported she had overheard a nursing assistant (NA)-F state to R55, "Now I've got you here, you are going to sit for 30 minutes [on the toilet]." The visitor further reported that NA-F then turned saw a nurse staff member and allegedly said, " You didn't hear that. " The incident was reported to the State agency (SA) on 2/28/16. NA-F during an interview on 2/29/16, denied the allegation stating, "I didn't say that." During the investigation NA-F was not suspended to protect R55, as directed by the policy.

The allegation of abuse occurred on a Sunday 2/28/16, the investigative report was due on Friday 3/4/16, and was not submitted until 3/7/16.

Progress notes of the time of the event were requested, but not provided. An Incident tracking log dated February 26th was provided, the

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22000	Continued From page 94 incident was not listed, although a VA report was made to the SA on 2/28/16. On 8/12/16, AT 8:33 a.m. an interview with the director of social work services (DSW)-A, social worker (SW)-B, administrator, and registered nurse (RN)-B regarding abuse and timely reporting. DSW-A stated she was the person who completed the initial report for R55 on 2/28/16, and when asked why the alleged perpetrator had not been suspended, stated "good question." The director of nursing (DON) who was no longer with the company was the person who submitted the report to the AS late, and DSW-A was not aware it had been submitted late. DSW-A verified the facility policy for Abuse Prohibition was not followed, R55 should have been protected by suspending NA-F (the alleged perpetrator), during the investigation. In addition, the five day investigative report should have been submitted in a timely fashion. R108 was observed on first floor of facility by the courtyard on 8/10/16, at 1:33 p.m. R108 asked if he could speak with writer. R108 stated that there was a dietary aide (DA)-A who he had a verbal altercation with a couple months ago and now DA-A would not serve him." The only way I get to eat is to get one of the other aides to help bring me my food in the 2 north dining room." R108 stated he had told the kitchen manager and nurse manager three months ago and wrote a letter to the facility's executive committee director and was told by all three they would take care of it but no one had followed up yet. R108 stated he met with Ombudsman and other staff after the incident and was told they would look into the issue but the staff member still was not bringing food to him. R108 stated he did not appreciate	22000		

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22000	Continued From page 95 being ignored and felt singled out. Progress notes created by RD dated 12/30/15, indicated they were late entry notes from care conference held on 12/23/15. R108's nutritional status was stable and discussed concern that nutrition staff was not serving him-which appeared to have been related to a miscommunication between nursing and the dietary aid and would now be resolved. The administrator was informed of R108's concerns on 8/10/16, at 2:32 p.m. and a request of the reporting documentation, incident tracking log and operational policy regarding abuse prohibition regarding incident was made. The administrator stated he had not been employed at facility at the time when the incident occurred but he would expect staff to follow up with resident and follow format, report incident to supervisor and from there it moved up to administration. On 8/11/16, at 8:45 a.m. R108 was observed in dining room eating breakfast. R108 stated NA-G brought him his breakfast tray and identified DA-A as the staff member he had words with and who would not bring him his meals. Also stated DA-A had not brought him any meals since having words with him and he continued to serve the other residents. On 8/11/16, at 9:03 a.m. DA-A stated the facility had rules that dietary aides are not supposed to serve residents and the food can only be served when NAs or nurses are present. The incident occurred when R108 came in to dining room and wanted DA-A to serve him and DA-A told him he could not serve him. DA-A sated R108 called him a "jerk" and "a*****e." DA-A stated R108 stated nobody would serve him and everyone else had	22000		

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their food which was not true as there was not a NA, licensed practical nurse or RN in the dining room at that time. Only one resident had food because her NA had brought her to the dining room and gave her cereal. Stated he explained to R108 the rule was a nurse or NA needs to be present in the dining room before food can be delivered to residents because that is the facility rule. DA-A stated his duties are to stand by the steam table, read meal tickets and put food on plates and then the NA's or nursing staff served it to the residents. DA-A stated he told his supervisor right away about R108 being upset, which was the facility policy.

On 8/11/16, at 9:20 a.m. SW-B stated that the registered dietician (RD) at the time of the incident was no longer employed at the facility but had met with R108 on 12/10/15, regarding his concern with DA-A who would not serve him. The RD at the time of the incident sent an email to the nutrition director and food service supervisors regarding R108's concern. At the 12/23/15, care conference RD documented resident's concern which was related to miscommunication and would be resolved.

On 8/11/16, at 11:27 a.m. SS-B stated that during the care conference on 12/22/15, she was unaware of a verbal altercation but just that an aide did not serve R108 so she did not report it. The facility would have suspended staff person, investigated the incident, reported, interviewed and provided re-education. The procedure was there but staff was unaware of altercation.

On 8/11/16, at 4:23 p.m. administrator stated when he was told yesterday about R108's concerns (which was 8/10/16) that he did not think it was a reportable incident. He would have

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	00380	A. BUILDING: _____ B. WING _____	08/12/2016

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SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(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
22000	Continued From page 97 liked to talk with the resident himself and he was intending to talk with him. The administrator went to his staff and thought their research and reports were credible. He was uncertain of the timeframe but the documentation did not substantiate the complaint but he would have liked to have met with the resident for a preliminary investigation. The next step was to talk with resident and determine if he should report it. On 8/11/16, at 4:34 p.m. the administrator said he was going to complete the investigation now. On 8/12/16, at 8:33 a.m. interview with administrator, SS-A, and SS-B. SS-A stated they met with R108 on 8/11/16, in the afternoon. It was determined that DA-A did serve food to residents and R108 felt that he was not being served by DA-A. DA-A was suspended pending investigation. The administrator stated that he made the call to DA-A and that he responded with some choice words. The administrator further stated that an incident report had been filed with the Minnesota Department of Health. SS-A stated the facility was supposed to report immediately with immediate facts. In that incident, they wanted to speak with R108 first to know what happened. "We should have gathered the preliminary information sooner and then reported it." The facility did not prevent potential further alleged retaliation from DA-A to R108, as DA-A continued to serve other residents in the dining room and did not serve R108 their meals from the date of the incident according to the care conference note which was dated 12/23/15, to current. In addition, the facility did not report the continued non-serving of meals to R108 by DA-A to the SA in a timely manner once the facility was made aware of it on 8/10/16. SUGGESTED METHOD OF CORRECTION:	22000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00380	A. BUILDING: _____ B. WING _____	08/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHOLOM HOME WEST	3620 PHILLIPS PARKWAY SOUTH SAINT LOUIS PARK, MN 55426

(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
22000	Continued From page 98 The administrator could in-service all staff on the need to immediately reporting suspected abuse/neglect to the designated state agency/common entry point according to the facility's policy. The director of nurses' could monitor incident reports for implementation of this requirement. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	22000		