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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: Y814

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00844

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245471**
2.STATE VENDOR OR MEDICAID NO.
(L2) **048540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ECUMEN SCENIC SHORES**
(L4) **402 - 13TH AVENUE**
(L5) **TWO HARBORS, MN** (L6) **55616**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2011**

6. DATE OF SURVEY **04/14/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (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
	45			
(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): On April 21, 2014 a Post Certificiation Revisit (PCR) by review of the plan of correction was completed by the Department of Health and on April 14, 2014 a PCR was completed by the Department of Public Safety. Based on the plan of correction, the facility has corrected the deficiencies issued pursuant to the standard survey completed on February 28, 2014, effective April 9, 2014.

Effective April 9, 2014 the facility is certified for 45 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Patricia Halverson, Unit Supervisor 05/06/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/06/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/05/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

May 6, 2014

Ms. Susan Johnson, Administrator
Ecumen Scenic Shores
402 - 13th Avenue
Two Harbors, Minnesota 55616

RE: Project Number S5471024

Dear Ms. Johnson:

On March 15, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 28, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 21, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 14, 2014 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 February 28, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 9, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 28, 2014, effective April 9, 2014 and therefore remedies outlined in our letter to you dated March 15, 2014, will not be imposed.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5471r14.rtf

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5471

June 6, 2014

Ms. Susan Johnson, Administrator
Ecumen Scenic Shores
402 - 13th Avenue
Two Harbors, MN 55616

Dear Ms. Johnson:

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 April 9, 2014 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245471	A. Building B. Wing	4/21/2014

Name of Facility	Street Address, City, State, Zip Code
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **04/09/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **04/09/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/09/2014**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/09/2014**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **04/09/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/09/2014**
ID Prefix **F0365** Reg. # **483.35(d)(3)** LSC	Correction Completed **04/09/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **04/09/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/09/2014**
ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **04/09/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	MM/PLH	05/06/2014	12835	04/21/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/28/2014			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245471	A. Building B. Wing 01 - MAIN BUILDING	4/14/2014

Name of Facility	Street Address, City, State, Zip Code
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	04/08/2014	ID Prefix Reg. # NFPA 101 LSC K0144	04/08/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By MM/PS	Date: 05/06/2014	Signature of Surveyor: 03005	Date: 04/14/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 2/26/2014		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: Y814

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00844

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245471**
2.STATE VENDOR OR MEDICAID NO.
(L2) **048540300**

3. NAME AND ADDRESS OF FACILITY
(L3) **ECUMEN SCENIC SHORES**
(L4) **402 - 13TH AVENUE**
(L5) **TWO HARBORS, MN** (L6) **55616**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **01/01/2011**

6. DATE OF SURVEY **02/28/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(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): On February 28, 2014 a standard survey was completed at this facility.

Deficiencies were found, whereby corrections are required. The facility has been given an opportunity to correct before remedies would be imposed. Post Certification Revisit to follow. Refer to the CMS 2567 for both health and life safety code along with the facility's plan of correction.

17. SURVEYOR SIGNATURE Date :
Kathy Killoran, HFE NEII 05/05/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
~~Mark Meath, Enforcement Specialist~~ 05/05/2014 (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
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 0860 0006 5192 3988

March 24, 2014

Mr. Blaine Gamst, Administrator
Ecumen Scenic Shores
402 - 13th Avenue
Two Harbors, Minnesota 55616

RE: Project Number S5471024

Dear Mr. Gamst:

On February 28, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. 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:

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

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

<u>Remedies</u> - 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:

Patricia Halverson, Unit Supervisor
Minnesota Department of Health
11 East Superior Street, Suite #290
Duluth, Minnesota 55802

Phone: (218) 302-6151
Fax: (218) 723-2359

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 April 9, 2014, 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 April 9, 2014 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 28, 2014 (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 August 28, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

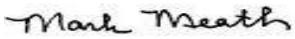
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5471s14.rtf

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

PRINTED: 03/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING _____ B. WING _____	02/28/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

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F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. Census: 39	F 000	OK 5-5-14 PLH F164 1. Corrective Action: A. Nurses educated on the need to provide privacy during blood glucose testing. B. DON spoke with Resident #5 and educated him on the need to allow the nurses to take him to a private area for blood glucose testing.	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the	F 164	2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice B. Residents will be taken to a private area for blood glucose testing. C. If the resident refuses to be moved to a private area, the residents in the surrounding area will be moved to provide privacy. 3. Date of Completion: April 9, 2014	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Blaine Hamerston — TITLE: Executive Director — (X6) DATE: 4/3/14

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 164	Continued From page 1 resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not provide privacy for 2 of 4 residents (R56, R5) observed during blood glucose monitoring. Findings include: R56's diagnoses included diabetes with long term insulin use. The 30 day Minimum Data Set (MDS) dated 12/31/13, indicate R56 was cognitively intact. The physician's orders signed on 2/6/14, indicated R56's blood glucose was checked four times a day. On 2/24/14, at 11:55 a.m. registered nurse (RN)-D was observed completing blood glucose testing for R56 in the main dining room before lunch. There was several other residents observed in the dining room waiting for lunch. R5's diagnoses included type 1 diabetes with long term insulin use. The quarterly MDS dated 11/26/13, indicated R5 had moderately impaired cognition. The physician's orders signed on 2/12/14, indicated R56's blood glucose was checked four times a day.	F 164	4. Reoccurrence will be Prevented by: A. All nursing staff members will be educated on the need to provide privacy during treatment at an all staff meeting to be held on Tuesday April 8, 2014. B. Random daily audits for two weeks followed by weekly audits for one month and then monthly for three months. C. Audits will be continued until QA committee determines the ability to discontinue monitoring. 5. The Correction will be Monitored by: A. DON or designee. B. DON will report summary of audits to QA committee for review and discussion. OK 5-5-14 PLH	

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F 164	Continued From page 2 On 2/24/14, at 4:39 p.m. licensed practical nurse (LPN)-A was observed to check R5's blood glucose in front of the west nursing station desk. The west nursing station desk is located near the unit kitchen/dining area and the hall to the main dining room. Another resident and a visitor were present in the area. The director of nursing (DON), interviewed on 2/27/14, at 8:20 a.m., stated blood glucose monitoring was usually completed in a private area unless the resident did not want to move.	F 164	F253 1. Corrective Action: A. The following actions will be taken to repair resident environments prior to date of 4/8/14: R15: Bathroom walls above floor boards across from the toilet will be repaired. R7: The lower portion of the wall in the bathroom will be repaired and the caulking replaced around the toilet. R14: The edging around the toilet will be caulked by. R60: Plunkett's Pest Control serviced facility for Silverfish insects on 3/12/14. The bathroom baseboard molding will be cleaned. It will be replaced with the flooring replacement project noted below. The baseboard heater in room will be painted.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure residents' rooms and/or bathrooms were maintained in clean, sanitary, and home-like conditions related to maintenance and structural repair and upkeep and/or pest control for 20 of 21 residents (R15, R7, R14, R60, R61, R17, R12, R35, R36, R11, R13, R41, R47, R16, R37, R65, R33, R21, R52, R38) whose rooms were observed. Findings include: An environmental tour was conducted with the environmental services director (ESD) on 2/26/14 at 1:15 p.m. The following was observed:	F 253		

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F 253	Continued From page 3 In R15's bathroom the walls above floor boards and across from the toilet were scraped with black marks. In R7's and R35's bathroom the lower portion of the wall was scraped, and caulking was missing from around the toilet on the floor. In R14's bathroom shared with R65 the edging around the toilet was discolored with dark orange and black staining. In the bathroom shared by R60, R41, and R13 the surveyor observed and stepped on a dark-colored silverfish bug crawling on the bathroom floor. The bathroom baseboard molding around the entire room was dingy and soiled. R60's bedroom base board heater had several scrape marks on the painted surface. In R61's bathroom shared with R38 the grout around the toilet on the floor was soiled. In R17's bathroom, shared with R52, the base board edging all around the floor was missing revealing a rough, uncleanable, unsightly surface. The ESD stated R17 had complained of seeing bugs in the bathroom and the ESD had removed the base board edging about 2 weeks ago. The ESD confirmed the facility did have a contract with a local pest control company but the company was not contacted for service. In R12's bedroom the bottom edge of the dresser was missing a wood covering, the bathroom molding was blackened and dirty, the wall between the 2 doors had black scrape marks, and the tile in the bathroom entrance was lifted	F 253	R61: The caulk around the toilet will be replaced. R17: The baseboard edging around the bathroom floor was replaced and cleaned on 3/28/14. New baseboard will be installed during the flooring replacement project noted below. Plunkett's Pest Control serviced the facility for Silverfish insects on 3/12/14. R12: The bottom edge of the dresser and the wall between the doors will be repaired. The chipped flooring will be replaced in accordance to the flooring replacement project noted below. The baseboard molding was cleaned and will also be replaced during the time of the flooring replacement project. R35: The scraped bathroom wall and the caulking around the toilet will be restored. R36: The flooring near the doorway will be replaced in	

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F 253	Continued From page 4 up with a piece of flooring chipped out. In R36's room the flooring at the door way was very worn and torn with a piece of flooring missing. In R11's bedroom the wall behind a blue recliner chair contained 6 gouged out areas; a wall was scraped near the bottom with long black marks; the walls above the floor boards in the bathroom were scraped; the floor beneath the toilet and sink were discolored, stained and dirty with orange, black and brown colored substances; the plaster board behind the wall-mounted soap dispenser was torn and peeled back; and a long, irregular shaped crack was noted in the wall under the bedroom window. In R47's bedroom the inside lower edge of the entry way wooden door had several large chipped areas; the right hand side of the floor near the toilet was stained and soiled; the wall behind the toilet had several nickel-size holes all the way through the plaster board; the bathroom sink faucet had a continual drip when turned all the way off; and the plaster under the bedroom window had a long crack to the wall-mounted floor heat unit. The ESD stated he was not aware of the dripping faucet was surprised he had not received a work order. In R16's bathroom the walls contained many scrapes and gouges and the floor in front of the shower stall was stained orange with a medium-sized rectangular shape. In R37's bedroom the window molding/weather stripping was pulled away from the bottom of the window; the strip molding on the wall opposite	F 253	accordance to the flooring replacement plan noted below. R11: The walls in the bedroom and bathroom will be repaired and painted. The bathroom floor will be cleaned and flooring will be replaced in accordance to the flooring replacement plan noted below. R13: The baseboard edging around the bathroom floor will be cleaned. New baseboard will be installed during the flooring replacement project noted below. Plunkett's Pest Control serviced the facility for Silverfish insects on 3/12/14. R41: The baseboard edging around the bathroom floor was r cleaned. New baseboard will be installed during the flooring replacement project noted below. Plunkett's Pest Control serviced the facility for Silverfish insects on 3/12/14.	

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F 253	Continued From page 5 from the beds was soiled with a brown substance; the bed side stand was dingy and soiled on the bottom and around the edges; the dresser was missing a strip of wood finish along the bottom edge; and the bathroom entry way floor molding was soiled with a gray/black substance along with the entire bathroom floor edging/molding. In R21's bathroom, the floor around the toilet edging was stained dark orange and the wall and floor in the corner near the bathroom sink was discolored with a dark orange stain. In addition, the wall near the sink had several small open holes from a removed wall hanging or shelf. In R33's bedroom the cream-colored closets were missing several pieces on the lower edges and both closets were scraped. In addition, the painted bathroom walls were scraped and marred. The ESD stated he had been hired earlier this Fall and only had one part time assistant to help with all the building maintenance. The ESD stated the facility did not have a specific maintenance policy. The ESD further stated work order requests would be submitted directly and responded to as soon as possible. The ESD confirmed the ceiling in the main dining room had begun to leak in the middle of December and they were trying to deal with the roof leakage as an ongoing and recurring problem. The ESD stated he was aware of the bathroom floor molding's discolorations and reported it was probably caused from the moldings being waxed over time and then discoloring. The ESD verified he was not aware of the other observed environmental findings and the facility did not have a specific plan to replace or repair the observed resident	F 253	R47: The bedroom door will be repaired and painted. The plaster under the window will be repaired and painted. The floor near the toilet will be cleaned and replaced according to the flooring project noted below. The sink faucet will be repaired to proper working order. R16: The bathroom walls will be repaired and painted. The floor in the front of the shower stall will be cleaned and replaced in accordance to the flooring replacement project noted below. R37: Window molding at the bottom of the window will be repaired. New window will be installed in accordance to the window replacement project noted below. Strip molding on the wall opposite from the beds will be cleaned. Bed side stand will be cleaned. Dresser missing a strip of wood finish along bottom edge will be repaired and	

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F 253	Continued From page 6 room furnishings and surroundings. On 2/27/14, at approximately 10:30 a.m. the administrator stated a contractor and consultant had been contacted for the roof leak problem and would be visiting the facility in March. A Work History Report dated 1/7/14, indicated a facility inspection to 4 resident rooms was conducted. A Logbook Documentation dated 1/7/14, outlined several steps to be completed during the inspection which included checking all walls for paint scrapes, holes, or damaged areas; checking all doors and door frames for damage; checking window ledges for damage; checking bathroom walls for paint scrapes, holes, or damaged areas; checking bathroom fixtures for leaks or drips; and repairing all areas to like new condition as able. The facility Maintenance Work Orders policy effective 2/27/12, indicated if a problem was found with a piece of equipment or any part of the facility was in need of repair, an intranet work order or a written work order must be filled out and sent to the maintenance department. A written request could be also be put in the department's mailbox and would be picked up on daily rounds.	F 253	painted. The bathroom floor baseboard will be cleaned and replaced in accordance to the flooring replacement project. R65: The caulking around the toilet will be removed and replaced. R21: The bathroom walls will be repaired where the shelf was removed. The soap stain on the walls will be cleaned and restored. Leaking soap dispensers will be replaced in accordance to the resident bathroom soap dispenser replacement project. Bathroom flooring will be cleaned and replaced in accordance to the flooring replacement project. Toilet caulking will be removed and caulked. R33: The resident closet will be repaired to working order and scrapes will be repaired. The bathroom walls will be repaired.	
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.	F 282		

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F 282	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure the care plan was followed for 2 of 4 residents (R21, R61) reviewed for activities of daily living, 1 of 2 residents (R5) reviewed for pain and 1 of 2 residents (R65) reviewed for positioning . Findings include: R21 was observed to have several long facial hairs measuring approximately a half inch to an inch long on her cheeks and chin from 2/24/14 through 2/26/14. The quarterly Minimum Data Set (MDS) dated 1/14/14, indicated R21 needed the assistance of one staff for supervision, oversight or cueing with dressing and limited assistance of one staff with grooming. The activities of daily living (ADL) care plan dated 1/20/14, indicated R21 needed the assistance of one staff with all cares. The care plan directed staff to assist R21 with washing her face, combing her hair, applying deodorant and peri care in the morning, at night and as needed. The nursing assistant (NA) care guide indicated R21 required assistance of one staff with dressing, grooming and bathing. The director of nurses (DON), interviewed on 2/27/14, at 10:15 a.m., stated staff were expected to ask residents if they can remove visible facial hair. R61 did not receive assistance with shaving as directed by the plan of care. R61's diagnoses	F 282	R52: The bathroom wall will be restored. The caulking around the toilet will be replaced. R38: Grout around toilet will be removed, the area will be clean and caulk will be replaced. 2. Corrective Action as it applies to Other Residents: A. 100% audit of all resident rooms and bathrooms was completed on 4/2/14 to ensure clean and comfortable environments. Any actions resulting from the audit will be taken to restore environments by 4/8/14. B. Plunkett's Pest Control serviced the facility specifically for Silverfish insects on 3/12/14. Plunkett's notified ESD that Silverfish insects are very prevalent along the north shore but can be controlled with the right interventions. Plunkett's will continue to monitor and treat for Silverfish on their routine visits. Any report of insects in	

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F 282	Continued From page 8 included cerebral vascular accident and aspiration pneumonia. The plan of care dated 1/2/14, directed staff to encourage participation in grooming but failed to identify how much assistance was necessary. Review of the current nursing assistant care guide identified R61 required the assist of one staff member for grooming. R61 was observed to be up with morning cares completed on 2/25/14 at 9:02 a.m. R61 still had facial hair and he acknowledged not shaving yet today. On 2/25/14 at 4:00 p.m. R61 continued to have facial hair. When observed on 2/26/14 at 1:30 p.m. R61 continued to have facial hair. On 2/27/14 at 11:00 a.m. R61 had been shaved and no longer had any facial hair. On 2/26/14 at 1:30 p.m. a family member was observed to visit with R61. As R61 was wheeled from his room, the family member commented that he should have had his hair combed and been shaved. The family member was observed to attempt to comb R61's hair with her fingers. R61 was observed to have tousled hair on top of his head and the hair on the back of his head had been flattened from lying in bed. He continued to have facial hair. Interview with nursing assistant (NA)-E on 2/27/14 at 11:10 a.m. verified R61 was total assist with grooming. "We have to do everything for him." On 2/27/14 at 12:42 p.m. the DON stated grooming which included shaving, should be completed at the time of morning cares. "They (residents) should be offered a shave." R5 was not provided pain management as	F 282	the facility will result in immediate notification of pest the control company. C. Resident room and bathroom flooring replacement project: Ecumen Scenic Shores has developed a plan to replace the flooring in all resident rooms and bathrooms. Included in the flooring replacement is new baseboard. ESD has contacted flooring vendors to request bids to complete the necessary work. Once the bids are returned, facility will select competitive bid and set installation dates. It is the goal of Ecumen Scenic Shores to prioritize rooms most in need to be completed first. As part of the facility capital budget, facility planned for $25,000 for flooring replacement in 2014 and $25,000 in 2015. Facility feels this amount should adequately meet the flooring replacement needs.	

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F 282	Continued From page 9 directed by the plan of care. R5's diagnoses included polyneuropathy, diabetes, cardiovascular accident (CVA), and amputation of toes. R5's plan of care for October 2013, provided by the facility as current, directed staff to, "Ask me with cares and interactions if I am having pain, and watch for any non-verbal s/s pain, as I may not want to 'bother' anyone with complaints of pain." The care plan also indicated R5 was capable of rating pain, identifying the location and describing it to assist with identifying interventions. The care plan directed staff to use pain meds as needed, notify the physician if ineffective, and document the effectiveness of interventions used. The current nursing assistant care guide directed staff to observe for pain and report any signs/symptoms or complaints of pain to the nurse. When interviewed on 2/24/14, at 6:30 p.m. R5 stated he had pain, "All the time but there's nothing they can do about it." R5 described left arm pain, "Like an eight" (out of ten)" but was unsure what pain medications were administered or available. On 2/26/14, at 1:35 p.m. R5 reiterated there was pain every day in the left arm. R5 stated the pain in the left leg and foot had improved although he continued to have pain on a daily basis. Interview on 2/27/14, at 11:00 a.m. with nursing assistant (NA)-E indicated R5, "Never complains," but she does not ask him about pain. At 11:55 a.m. LPN-C indicated all R5 has ever talked about is the phantom pain in his toes.	F 282	D. Window Replacement Project: Ecumen Scenic Shores has a signed an agreement to replace all windows in the facility at a cost of $55,000. Windows have been ordered. Replacement will start in the spring. E. Dining Room Roofing Project To ensure the safety of residents, guests, and employees, the facility closed the dining room to resident use. On March 14th, a roof inspection company studied the roof to assess the current situation and to determine solutions to fix it. On March 24th, a construction company provided demolition of the sheet rock and insulation in the dining room. Facility is waiting to get the results of the inspection and will move forward with a plan to fix the room and restore the dining room at that time. F. HVAC Project	

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

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F 282	Continued From page 10 R65 did not receive positioning in the geri chair as directed by her plan of care. R65 was admitted on 2/19/14. She had multiple diagnoses including Alzheimer's, cerebral vascular accident (CVA), and atrial fibrillation. R65's initial plan of care was dated 2/19/14. The mobility section dated 2/24/14, directed elevation of the left upper extremity (LUE) on a bolster or pillow and heels/feet to be maintained at 90 degrees to prevent foot drop. The nursing assistant care guide dated 2/25/14, "Therapy is asking for Resident to have bilateral foot rests/boots on at all times to prevent foot drop. Her ankles need to be maintained at 90 degrees." The equipment list on the guide identified a left arm rest. On 2/24/14 at 11:55 a.m. R65 was observed sliding down in the geri chair and leaning to the left. She was sitting upright in the chair with her feet dangling unsupported. On 2/25/14 at 11:30 a.m. R65 was observed sliding down in the geri chair, leaning to the left. Although there was a padded foot rest on the chair, R65's feet dangled, unsupported by the foot rest. On 2/26/14 at 12:00 p.m. R65 was observed sliding down in the geri chair, leaning to the left. The lift sling remained under her and she wore a slippery housecoat. When offered lunch, she was not repositioned upright in the chair. On 2/26/14 at 4:30 p.m. R65 was observed sitting upright in the geri chair with a bolster pillow under her left arm and a pillow under her feet for support. On 2/27/14 at 6:25 a.m. R65 was observed up in her geri chair with the bolster pillow under her left arm and a pillow supporting her feet. However R65 was sliding down in the chair as the lift sheet remained under her and she wore a slippery housecoat.	F 282	Ecumen Scenic Shores has entered into an agreement to replace the main facility boiler, pumps, and controls and to install a new air conditioning unit. Estimated cost of the project will be $200,000. This work will be completed over the summer of 2014. 3. Date of Completion: 4/8/14 4. Reoccurrence will be Prevented by: A. ESD will develop a preventative maintenance reminder to regularly ensure environment is clean and comfortable. B. ESD will review the pest control policy and procedure and educate all staff by 4/9/14. C. All staff will be educated by April 9, 2014 on Facility Maintenance Work Order Policy and what to do if a problem is found with a piece of equipment or when any part of the facility is in need of repair. D. Meeting scheduled before 4/9/14 with all housekeeping staff to	

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	245471	A. BUILDING _____ B. WING _____	02/28/2014

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F 282	Continued From page 11 On 2/27/14 at 12:15 p.m. nursing assistant (NA)-E and NA-A stated R65 was repositioned every 2 hours but there's nothing special for her positioning. "We just make sure she's comfortable and safe." On 2/27/14 at 12:10 p.m. LPN-C stated they placed dycem in the chair to try and keep her more upright. "The hoyer sheet is a bigger problem than the nightgown." LPN-C acknowledged staff could remove the hoyer sheet but she hadn't identified a problem with it. On 2/27/14 at 1:00 p.m. the director of nursing (DON) stated they had been working with OT on positioning for R65.	F 282	review policies and procedures for cleaning resident rooms and bathrooms. Housekeeping department meetings will be held at least quarterly. E. ESD will implement a checklist to be used when cleaning resident rooms and bathrooms. 5. The Correction will be Monitored by: A. ESD or designee. B. The QA Committee will review the audit results on a quarterly basis and will provide further direction, as needed.	
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 did not provided effective pain management programs for 2 of 2 residents (R5, R65); provide appropriate positioning for 2 of 2 residents (R61, R65); and assess/monitor significant bruising 1 of 1 residents (R65). Findings include:	F 309	F282 1. Corrective Action: A. The care plans and group sheets of residents # 21, 61, 5 and 65 have been reviewed and revised. B. Resident #21 has had facial hair removed. C. Resident #61 has been shaven. D. Resident #5 has had his pain assessment revised to appropriately meet his needs for pain control. E. Resident #65 was re-assessed for w/c positioning needs and to	

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F 309	Continued From page 12 R5 was not provided routine pain management. R5 had multiple diagnoses including polyneuropathy, diabetes, cardiovascular accident (CVA), and amputation of toes. The Care Area Assessment (CAA) dated 2/26/14, indicated P5 was able to verbalize pain and had denied pain over the last 5 days prior to the assessment. R5, interviewed on 2/24/14, at 6:30 p.m., stated he had pain, "All the time but there's nothing they can do about it." R5 indicated the left arm pain gets to, "Like an eight" (out of ten) but he does not know what he gets for pain medication. At the conclusion of the interview, R5 stood to use the walker and lifted his left arm to the walker with his right hand. He grimaced when doing so and rubbed his left arm. When observed on 2/26/14, at 9:00 a.m. R5 ambulated slowly with his walker, grimacing at times when lifting his walker to take a step or leaning forward placing weight on his arms. On 2/26/14, at 1:35 p.m. R5 stated he had pain every day in his left arm. R5 indicated the left leg and foot pain had improved although he continued to have pain on a daily basis. He indicated, "Sometimes it's better, not as bad; sometimes it hurts a lot." R5 stated the left arm hurt both when active and at rest, but more so when he's up and active. R5 stated the nurses and doctors were aware of his ongoing pain. R5's plan of care dated October 2013, provided by the facility as current, directed staff to ask R5 about pain with each interaction and to watch for any non-verbal signs of pain as he may not be forthright about pain. The care plan indicated R5 was capable of rating pain, identifying the location and describing it to assist with identifying	F 309	determine if this resident will need to have her hoyer sheet left in positioning due to frequent transfers in and out of bed. The results of these assessments were added to her care plan and group sheet. 2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice. B. 100% audit of care plans and groups sheets related to facial hair, pain and positioning was completed and revisions were made as appropriate. C. All nursing staff will be educated on the need to remove facial hair of male and female residents on a routine basis. D. All nursing staff will be educated on the need to monitor for non-verbal and verbal signs of pain and treat pain according to care plans. E. All nursing staff will be educated on the need to position residents per plan of care and remove hoyer sheets from residents after	

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F 309	Continued From page 13 interventions. The care plan directed staff to use pain meds as needed, notify the physician if ineffective, and document the effectiveness of interventions used. R5 was described as independent with mobility, independent with set up for dressing and grooming and assist of one with bathing. R5 received no routine pain medications. Physician orders included Tylenol 325-650 mg as needed (PRN) for pain/fever, ibuprofen 400 to 800 mg maximum 3x/week PRN for foot pain and Tylenol ES 500 to 1000 mg PRN 3x/day for foot pain. Upper extremity pain was not addressed. There were no orders for upper extremity pain. The medication administration record (MAR) indicated R5 had only had Tylenol one time, on 2/5/14, for complaints of arm pain with documented results of, "Good relief". The nursing assistant (NA)-E was interviewed on 2/27/14, at 11:00 a.m. stated R5, "Never complains". NA-E does not ask R5 about pain. On 2/27/14, at 11:55 a.m. licensed practical nurse (LPN)-C stated R5 has only talked about phantom pain in his toes. LPN-C stated she asks him how he's doing and how he's feeling about mid-day. The director of nurses (DON), interviewed on 2/27/14, at 12:48 p.m., stated R5 didn't like to move his limbs. "It's inconsistent and based on his moods. He needs lots of encouragement." The DON further stated she had not heard of any pain issues for R5. R65 was not provided assessment and management of pain. R65 was admitted on 2/19/14, with diagnoses including Alzheimer's, cerebral vascular accident (CVA), left side	F 309	transfer if appropriate for the individual resident. F. This education will occur on Tuesday April 8, 2014. 3. Date of Completion: April 9, 2014 4. Reoccurrence will be Prevented by: A. Random daily audits for two weeks followed by weekly audits for one month and then monthly for three months. B. Audits will be continued until QA committee determines the ability to discontinue monitoring. 5. The Correction will be Monitored by: A. DON or designee B. DON will report summary of audits to QA Committee for review and discussion.	

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F 309	Continued From page 14 effected, osteoarthrosis, osteoporosis, and spinal stenosis. The admission record indicated R65 had numerous large, dark bruises throughout her body from a fall. The bruises included a 15 cm x 13 cm bruise on her left thigh and hip, a 6 cm x 13 cm dark purple bruise on her left rib cage, and a dark purple bruise on her left foot second toe running the width of her foot on the underside of her toes. The initial plan of care dated 2/19/14, did not address R65's ability to identify potential pain. The admission pain assessment dated 2/19/14 indicated, "Resident is agitated but not related to pain. Does not remember when staff has been in the room to help reposition, offer fluids or toilet her." The analysis indicated R5 denied pain; however, there was no assessment of R5's cognitive ability to identify or verbalize pain. There was no assessment recent injuries, of observed restlessness and agitation, or of potential pain due to recent CVA. P65's medical record included a physician fax on 2/24/14, requesting a scheduled dose of Tylenol 650 mg at bedtime. Physician's orders dated 2/25/14, directed Tylenol 650 mg at bedtime and instructed staff to update him if R65, "Seems uncomfortable". There was no update to the pain assessment or evidence of non-pharmacological interventions implemented. There was no documented evidence to indicate monitoring of R65's pain. R65's MAR for February 2014, included an order for Tylenol 325 mg 2 tabs orally every 4 hours as needed (PRN) for pain. R65 received 8 doses of PRN Tylenol in February for symptoms of needing help, general aches, saying "Owl Help me!",	F 309	F309 1. Corrective Action: A. Resident #5 and #65 have had their pain assessments revised to appropriately meet their needs for pain control. Care plans and group sheets were also revised. B. Resident #65 was re-assessed for w/c positioning needs and to determine if this resident will need to have her hoyer sheet left in positioning due to frequent transfers in and out of bed. The results of these assessments were added to her care plan and group sheet. C. Resident #61 has had his care plan and group sheet revised to include the need to elevate the HOB 45 degrees during tube feedings and medication administration. OT re-assessed resident #61 for upper extremity positioning needs and also bed positioning. This information was added to the care plan and group sheets.	

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F 309	Continued From page 15 complaint of hand pain or headache. Response to Tylenol was documented as Fair, Little help, Better and Asleep. On 2/24/14, at 5:20 p.m. R65 was seated in the geri-chair, restless and calling out, "Help me! Help me!" On 2/25/14, at 11:30 a.m. R65 was observed calling out to go to bed, stating she wanted to lay down. R65 appeared very restless in the geri chair and was asking to be covered up as she was cold. On 2/25/14, at 2:30 p.m. R65 was in bed with a family member at bedside. R65 was very restless, rolling back and forth, repeatedly asking for back rubs, foot rubs, scalp massage and frequently stated she wanted to cry. On 2/26/14, at 12:00 p.m. R65 was observed again calling out from her geri chair, requesting assistance in toileting and to return to bed. On 2/27/14, at 6:25 a.m. R65 was observed up in her geri chair calling out for something to drink and asking to be returned to bed. During these observations staff responded to R65's immediate request, but no one asked about pain or discomfort. When interviewed on 2/27/14 at 1:15 p.m. LPN-C stated staff was trying non pharmacological things with R65 first but acknowledged the use had been inconsistent. "We're trying to see if it works or not." When the director of nursing (DON) was interviewed on 2/27/14 at 12:20 p.m. about R65's pain she stated "I'm not sure where she's at with that. We're still very new with that with her." The DON further stated staff was still working on R65's pain management program. The facility policy dated 5/11 indicated residents would be provided, "Effective pain management that results in an optimal level of comfort". The	F 309	D. Resident #65 has had a new skin assessment completed and any new skin issues were documented on the assessment. The care plan of Resident #65 was reviewed and revised as appropriate. 2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice. B. 100 % audit of skin, pain management and positioning was completed. C. All nursing staff will be educated on the need to measure all bruises at admit and document the size and location of each one on the skin assessment. D. All nursing staff will be educated on the need to monitor non-verbal and verbal complaints of pain and to treat according to care plan. E. All nursing staff will be educated on the need to position residents per their plan of care. F. This education will occur on Tuesday, April 8, 2014.	

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F 309	Continued From page 16 policy indicated that a pain assessment would include, "Presence of pain, onset, location, quality, duration and intensity." As needed pain medications were to be monitored and documented for effectiveness. "Residents with daily pain have interventions and monitoring documented at least once a shift or more often, if needed on a pain monitoring form." R65 did not receive appropriate positioning in the geri chair. The initial plan of care dated 2/19/14, included a note dated 2/24/14, directing elevation of the left upper extremity (LUE) on a bolster or pillow and heels/feet to be maintained at 90 degrees to prevent foot drop. The nursing assistant care guide dated 2/25/14, directed, "Therapy is asking for Resident to have bilateral foot rests/boots on at all times to prevent foot drop. Her ankles need to be maintained at 90 degrees." The list of equipment included a left arm rest. On 2/24/14 at 11:55 a.m. R65 was observed sliding down in the geri chair, leaning to the left, with the feet unsupported. On 2/25/14, at 11:30 a.m. R65 was observed sliding down in the geri chair and leaning to the left. There was a padded foot rest on the chair, but R65's feet dangled unsupported. On 2/26/14, at 12:00 p.m. R65 was observed sliding down in the geri chair and leaning to the left with the lift sling under her. When offered lunch, R65 was not not repositioned upright in the chair. On 2/27/14, at 6:25 a.m. R65 was observed up in her geri chair with the bolster pillow under her left arm and a pillow supporting her feet; however, R65 was sliding down in the chair due to the lift sheet under her along with a slippery housecoat.	F 309	3. Date of Completion: April 9, 2014 4. Reoccurrence will be Prevented by: A. Random daily audits for two weeks followed by weekly audits for one month and then monthly for three months. B. Audits will be continued until QA committee determines the ability to discontinue monitoring. 5. The Correction will be Monitored by: A. DON or designee B. DON will report summary of audits to QA Committee for review and discussion.	

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F 309	Continued From page 17 On 2/27/14 at 12:15 p.m. NA-E and NA-A stated R65 was repositioned every 2 hours but there was nothing special for her positioning. "We just make sure she's comfortable and safe." On 2/27/14 at 12:10 p.m. LPN-C stated they placed dycem in the chair to try and keep R65 more upright. "The hoyer sheet is a bigger problem than the nightgown." On 2/27/14 at 1:00 p.m. the director of nursing (DON) stated they had been working with OT on positioning for R65. She indicated at 2:30 p.m. that RN-F placed the positioning sheet in the restorative book on 2/24/14 and revised it again on 2/25/14. The DON also stated that to ensure staff saw the positioning diagram it was placed on the care guide to check restorative and a message was sent through the documentation system on the computer. Review of the updated care guide for 2/25/14 revealed the positioning diagram was not addressed. R65 had numerous bruises on admission that were not accurately assessed. The initial care plan dated 2/19/14, identified the potential for bleeding due to the use of Plavix (anticoagulant). Upon admission on 2/19/14, the following bruises were documented: 27 cm x 18 cm bruise to left lateral thigh/hip 0.3 cm x 0.3 cm dark purple bruise to the posterior right great toe 4.5 cm x 13.5 cm dark purple bruise left lower ribs 2 cm x 7.5 cm yellow/green bruise below left arm pit 2.5 cm x 2.5 cm dark purple bruise to the superior	F 309		

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F 309	Continued From page 18 left elbow 7 cm x 4 cm dark purple bruise to the inferior left elbow 4 cm x 4 cm purple/green marbled bruise to side of left eye 4.5 cm x 4.5 cm red bruise on right upper inner arm' 4 cm x 2.5 cm dark purple bruise to the top side of the left shoulder 7 cm x 4 cm dark purple bruise to the right upper lateral arm 7 cm x 2 cm light red bruise to the right inner lower arm multiple pale red bruises from chest up to neck, upper torso in general 12 cm x 6 cm dark purple bruise top right hand 5 cm x 4 cm dark purple bruise top left hand On 2/26/14 at 7:30 a.m. R65's bruises were re-evaluated during her weekly skin check with the following differences identified: 21 cm x 15 cm area to top side left shoulder - several bruises/discolored patches An additional 1 cm x 2 cm bruise below the left armpit 15 cm x 13 cm bruise to left thigh/hip with an additional 1 cm x 3 cm bruise behind left knee No bruising to right great toe but left foot 3 cm x 3 cm area faint to second and third toes upper and lower aspects Many small yellow "blotches" to the upper torso in general Bruise to top of left hand was not addressed Interview with a family member (FM)-A on 2/25/14 at 2:30 p.m. revealed R65 had fallen at home when she had her stroke. "She's on blood	F 309		

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F 309	Continued From page 19 thinners so she bruises so easily." When interviewed about the differences in bruises identified from admission to the review on 2/26/14, LPN-C stated, on 2/27/14, at 12:22 p.m. "Mine are a little more detailed." She acknowledged the skin sheets should be filled out at the time of admission. "Measurements and shapes should be done - I draw pictures." LPN-C indicated bruises are monitored for healing and differences get passed on to the managers. LPN-C stated she had passed the differences on to managers. On 2/27/14 at 1:30 p.m. the director of nursing (DON) stated she needed to look into that a little more and see what the differences are. The DON further stated that to measure a, "Bunch of little bruises individually would be difficult." At 2:30 p.m. she stated, "It looks to me like [RN-D] misdocumented the right toe when it should have been left toe. [LPN-C] has more detailed documentation - [RN-D] didn't have that same detail but it looks like it would match up." When asked about identifying differences and changes when the data isn't accurate, the DON was unsure how that would be accomplished. When asked how new bruises or injuries of unknown origin could be identified the DON stated "I see what you're saying." R61 was not provided correct positioning in the bed and wheelchair. R61 had multiple diagnoses including right sided cerebral vascular accident with left sided hemiparesis, aspiration pneumonia, and atrial fibrillation.	F 309		

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F 309	Continued From page 20 The plan of care dated February 2014, indicated R61 required nutrition and medication via feeding tube; however, the care plan did not address positioning. The current nursing assistant care guide directed the head of bed (HOB) elevated at 45 degrees during feeding and 30-45 minutes after a feeding. The care plan was silent on the need for HOB elevation during medication administration. Occupational Therapy (OT) notes indicated the wheelchair began being adjusted with the help of maintenance on 1/9/14. On 1/13/14 the occupational therapist documented "Will need forearm strap on left trough for positioning. Pt. (patient) did not demonstrate ability to self-release however. Without strap LUE (left upper extremity) hangs dominant and at risk for injury." The February care plan indicated R61 had a left arm rest on his wheelchair. On 2/25/2014 at 11:27 a.m. R61 was observed in bed with HOB fully raised and the foot of bed raised. R61 was slumped over in the bed leaning to the left. His legs were folded unable to straighten them in bed. When asked at that time if he was comfortable in bed, R61 stated he was not, It's not the most comfortable bed I've been in." At that time NA-E entered the room and put the foot of the bed down so R61 was better able to straighten his legs. The HOB remained elevated and R61's torso was misaligned leaning to the left. R61 was observed in bed on 2/26/14, at 7:05 a.m.. The HOB was elevated approximately 20 degrees. R61's head was midway down the bed	F 309		

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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 309	Continued From page 21	F 309		

and his legs were bent with the feet flat against the bed. R61 was was unable to straighten his legs due to being low in the bed with a foot board at the end. On 2/26/14 at 8:05 a.m. R61 was observed during medication administration via feeding tube. LPN-C elevated the HOB to 45 degrees for administration of the medications and returned the HOB to approximately 20 degrees immediately after administration. R61 was not assisted up in the bed to allow room for the legs and feet until he stated he was uncomfortable. LPN-C then straightened his torso so he was more upright and centered in bed and able to straighten out his legs.

On 2/26/14 at 1:00 p.m. R61 was observed in bed asleep. The HOB was elevated approximately 20 degrees. R61 was side lying with his torso bent, his head at the edge of the bed and his legs folded up nearly knee to chest. R61 was low in the bed with no room to straighten his legs.

R61 was observed on 2/2714 at 6:00 a.m. awake in bed. The HOB was up approximately 20 degrees and he had slid down in bed placing his feet flat against the footboard. At 9:00 a.m. R61 was observed lying flat in bed with his feet hanging off the edge of the bed past the footboard. R61 admitted it wasn't very comfortable and stated he hoped to get out of bed soon.

R61 was observed in his wheelchair around the nursing station on 2/26/14 at 11:10 a.m.. R61 was wheeling independently with the left arm dangling along side w/c. Although there was staff in the area at the time, no one intervened to assist R61's arm back into the positioning arm rest on the wheelchair. At 11:16 a.m. NA-E assisted R61

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	245471	A. BUILDING _____ B. WING _____	02/28/2014

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F 309	Continued From page 22 to place his arm in the positioning arm rest. NA-E, interviewed on 2/2714 at 11:10 a.m., stated staff attempted to keep R61's knees up and something under his feet when in bed. NA-E acknowledged the need to assist R61 with keeping his left arm in the positioning rest on the wheelchair. NA-E stated R61 was very tall and it was difficult to keep him well positioned. On 2/27/14 at 12:43 a.m. the DON stated she expected R61 to be positioned appropriately in the wheelchair, "Where he's comfortable without leaning." The DON further acknowledged that OT had reviewed his wheelchair positioning and had recommended an arm trough. For bed positioning the DON indicated R61 needed to have pillows in place to ensure comfort and positioning. The DON verified the HOB should remain upright for medications as well as feeding. During interview with the Occupational Therapist on 2/17/14, at 2:45 p.m. she verified working with R61 on wheelchair positioning but denied knowledge of any difficulties with bed positioning. The OT acknowledged a challenge with positioning R61's left arm and it was not good for R61's arm/shoulder to dangle without support when in the wheelchair.	F 309	F311 1. Corrective Action: A. Resident #21 and Resident #61 have had their facial hair removed. Resident #61 has been assisted with grooming. B. Resident #21 will have assistance with changing clothing and her clothing will be washed as she will allow. Staff will encourage her to change clothes and offer alternate choices of clothing to replace her soiled clothing while they are in the laundry. This information is noted on her care plan and group sheet.	
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced	F 311		

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F 311	Continued From page 23 by: Based on observation, interview and document review, the facility did not provide grooming and dressing assistance for 2 of 4 residents (R21, R61) reviewed for activities of daily living. Findings include: R21 was observed wearing the same clothing and with several long facial hairs measuring approximately a half inch to an inch long on her cheeks and chin from 2/24/14 through 2/26/14. The Care Area Assessment (CAA) dated 10/10/13, indicated R21 needed assistance with dressing, bathing and personal hygiene mainly due to balance issues and a decline in cognition. The Behavior Assessment dated 1/7/14, indicated R21 had no behavioral symptoms during the review period. The quarterly Minimum Data Set (MDS) dated 1/14/14, indicated R21 needed the assistance of one staff for supervision, oversight or cueing with dressing and limited assistance of one staff with grooming. R21 had severe cognitive impairment, but no care rejection identified. The activities of daily living (ADL) care plan dated 1/20/14, indicated R21 needed the assistance of one staff with all cares. The care plan directed staff to assist R21 with washing her face, combing her hair, applying deodorant and peri care in the morning, at night and as needed. The care plan directed R21's soiled clothing to be taken the laundry, but lacked direction for what to do if R21 refused to allow her clothing to be washed. The nursing assistant (NA) care guide	F 311	2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice. B. 100% audit of facial hair and grooming needs was completed. C. Nursing staff will be educated the need to groom and shave residents routinely. D. Nursing staff will be educated on the need to provide choices and alternative options related to refusals. E. Education will be provided at the all staff meeting on Tuesday April 9, 2014. 3. Date of Completion: April 9, 2014 4. Reoccurrence will be Prevented by: A. Random daily audits for two weeks followed by weekly audits for one month and then monthly for three months.	

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F 311	Continued From page 24 indicated R21 needed the assistance of one staff with dressing, grooming and bathing. On 2/24/14, at 4:24 p.m. R21 stated she does not like long facial hair but, "Nobody here cares!" On 2/27/14, at 10:00 a.m. R21 stated she always pulled it out with her fingers or a tweezers. Although the facial hairs had been removed, R21 started picking at the areas where the facial hair had been. The nursing assistant (NA)-E, interviewed on 2/27/14, at 10:10 a.m., stated she was assigned care for R21 all week. NA-E stated she did not remove the facial hair so it must have been done the previous afternoon. NA-E stated R21 was adamant about wearing the same clothing and refused to let it be sent to the laundry. NA-A stated R21 was mostly independent with cares, gets herself dressed, and, "We just check on her." The director of nurses, interviewed on 2/27/14, at 10:15 a.m., stated staff were expected to ask residents if they can remove visible facial hair. The DON expected staff to assist R21 with clothing change and to notify licensed staff if R21 refused. The DON verified the care plan did not address refusal to change or launder clothing. R61 did not receive assistance with shaving. R61 had multiple diagnoses including cerebral vascular accident, aspiration pneumonia, and atrial fibrillation. The plan of care dated 1/2/14, directed staff to encourage participation in grooming. Review of the current nursing assistant care guide identified R61 required the assist of one for grooming. Review of Occupational Therapy (OT) progress	F 311	B. Audits will be continued until QA committee determines the ability to discontinue monitoring. 5. The Correction will be Monitored by: C. DON or designee D. DON will report summary of audits to QA Committee for review and discussion.	

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F 311	Continued From page 25 notes from 12/23/13, through 2/20/14, revealed R61 received assistance with grooming from OT until discharge from OT on 2/20/14, when the goals were met. When interviewed on 2/27/14 at 2:45 p.m. the OT indicated R61 had become as independent as possible. She indicated that although R61 made progress, he still needed assistance with grooming tasks. R61 was observed to be up with morning cares completed on 2/25/14, at 9:02 a.m. R61 still had facial hair and acknowledged not shaving yet today. On 2/25/14 at 4:00 p.m. R61 continued to have facial hair. When observed on 2/26/14 at 1:30 p.m. R61 continued to have facial hair. On 2/27/14 at 11:00 a.m. R61 had been shaved and no longer had any facial hair. On 2/26/14 at 1:30 p.m. a family member was observed to visit with R61. As R61 was wheeled from his room, the family member commented that he should have been shaved and had his hair combed. The family member was observed to attempt to comb R61's hair with her fingers. R61 was observed to have tousled hair on top of his head and the hair on the back of his head had been flattened from lying in bed. He continued to have facial hair. Interview with nursing assistant (NA)-E on 2/27/14 at 11:10 a.m. verified R61 required total assist with grooming. "We have to do everything for him." On 2/27/14 at 12:42 p.m. the DON stated grooming which included shaving, should be completed at the time of morning cares. Facility policy reviewed/revised 5/2011 titled "Nursing Care Standards" directed "Assistance with or supervision of shaving of residents as	F 311		

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F 311	Continued From page 26 necessary to keep them clean and well groomed."	F 311		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor call light use for 1 of 1 residents (R65) at risk of injury from the call light cord. Findings include: R65's call light was removed for safety; however staff were not informed to ensure compliance. R65 was admitted on 2/19/14, with diagnoses including Alzheimer's, cerebral vascular accident (CVA), left side effected, osteoarthrosis, osteoporosis, and spinal stenosis. Review of admission assessments revealed no indication of a safety issue related to call light use at that time. The initial care plan dated 2/19/14, had a note dated 2/20/14, that indicate the call light was removed by R65's husband and indicated every 2 hour safety checks. On 2/2514, at 12:00 p.m. the nursing assistant care guide was reviewed and did not address R65's call light or safety checks.	F 323	F323 1. Corrective Action: A. Resident #65 was re-assessed to determine safety needs related to call light use. The call light was removed and she was placed on planned safety checks at least every 30 minutes. This information was added to her care plan and group sheet. 2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice. B. 100% audit was completed to determine the resident safety needs related to call lights. The care plans and group sheets were revised as appropriate. C. All staff will be educated on safety checks and call light	

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F 323	Continued From page 27 On 2/24/14, at 5:25 p.m. R65's call light box was observed in place on the wall. When the call light was checked for function on 2/25/14, at 11:30 a.m. R65's call light box was not on the wall and nursing assistant (NA)-E stated, "I'm not sure why she (R65) doesn't have one - the box is gone. Maybe it wasn't working and they took it out to replace it." Interdisciplinary notes dated 2/25/14, at 2:28 p.m., identified as a late entry for 2/20/14, at 4:00 p.m. indicated R65's family member removed the call light box as, "She doesn't use this anyway, she just gets wrapped up in it." The note also indicated R65 pulled the call light box off the wall when restless in bed. The note indicated R65 would be checked every 2 hours for safety and the direction would be verbally passed on to staff. On 2/25/14, at 11:40 a.m. NA-E and NA- F stated they didn't know when the call light was removed, "Sometime yesterday I think. They took it away I think because she was taking it apart." The environmental services director (ESD) stated he knew nothing about it but needed to find the box as they are individually programmed to the room and bed. The call light box was found on R65's dresser. The ESD then asked NA-E and NA-F what they wanted to do about the call light. NA-F responded, "I'm not sure, I asked about a bed alarm and was told we couldn't have one because we're trying to go alarm free." The ESD stated he would talk to nursing management for direction. At 11:55 a.m. the ESD stated the call light had been removed because R65 was found wrapped up in the cord. "I guess she's really restless and she got tangled up in the cord or something." The	F 323	use related to individual resident needs. D. All staff meeting will be held on Tuesday, April 8, 2014. 3. Date of Completion: April 9, 2014 4. Reoccurrence will be Prevented by: A. Random daily audits for two weeks followed by weekly audits for one month and then monthly for three months. B. Audits will be continued until QA committee determines the ability to discontinue monitoring. 5. The Correction will be Monitored by: A. DON or designee B. DON will report summary of audits to QA Committee for review and discussion.	

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

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F 323	Continued From page 28 ESD stated the call light was removed for R65's safety. On 2/27/14 at 12:50 p.m. Social Worker (SW)-A stated R65's husband requested the call light be removed from the wall because R65 was agitated by it and kept pulling it off the wall. The care plan was updated to check on R65 every couple of hours after the call light was removed Thursday night (2/20/14)." On 2/27/14, at 1:00 p.m. the director of nursing (DON) stated staff was informed of the removal of the call light. She was unaware staff wasn't consistently informed of that change in intervention.	F 323	F365 1. Corrective Action: A. Resident #65 has been re-assessed for food and fluid consistency needs. The physician was updated with the ST recommendations and orders were obtained. B. The care plan and group sheet of Resident #65 was updated to reflect current food and fluid consistency needs. 2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice B. The policy for diet consistency and standing orders were reviewed and revised as appropriate. C. 100% audit will be completed related to food and fluid consistency orders and care plans and group sheets will be revised as appropriate.	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility did not provide nectar thickened liquids as ordered by the physician for 1 of 1 residents (R65). Findings include: R65 did not consistently receive nectar thickened fluids. R65 was admitted on 2/19/14, with diagnoses including Alzheimer's and a cerebral vascular accident (CVA), with her left side effected. The original physician's order on 2/19/14, identified honey thickened liquids.	F 365		

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F 365	Continued From page 29 The initial plan of care dated 2/19/14, directed a pureed diet. The speech therapist (ST) received a physician's order for nectar thickened fluids on 2/20/14. The nursing assistant care guide dated 2/25/14, directed a pureed diet with honey thickened liquids. On 2/26/14, at 7:30 a.m. nursing assistant (NA)-G was observed to give R65 unthickened liquids at the bedside with licensed practical nurse (LPN)-C present. R65 coughed with swallowing the first two sips of water. The next two sips were smaller and there was no coughing. At 12:00 p.m. during lunch LPN-C told NA-G he could not give R65 unthickened water. Unthickened water could, "Only be done by a nurse." NA-G then asked about family members and LPN-C stated "Yes [family member] can give it to her but [family member] needs to be observed by a nurse." On 2/26/14, at 3:55 p.m. LPN-A stated R65 was on a pureed diet with nectar thickened liquids but, "She can have any thin fluids in between meals" as long as the unthickened fluids were provided by licensed staff. When asked for clarification on the fluids LPN-A stated, "Not just water any fluids." On 2/26/14, at 4:05 p.m. the director of nursing (DON) was asked for clarification regarding R65's fluids. The DON stated R65 could have unthickened water from the licensed nurses, not all nursing staff and only water. Reviewed a ST note dated 2/24/14, that read, "Will allow nursing staff to trial thin liquids during snack or between meal times." The DON then stated she was going to have to clarify the instructions with ST. Regarding the physician order for nectar thickened liquids dated 2/20/14, the DON stated	F 365	D. All staff will be educated on the need to follow food and fluid consistency orders. E. The all staff meeting will be held on Tuesday April 8, 2014. 3. Date of Completion: April 9, 2014 4. Reoccurrence will be Prevented by: A. Random daily audits for two weeks followed by weekly audits for one month and then monthly for three months. B. Audits will be continued until QA committee determines the ability to discontinue monitoring. 5. The Correction will be Monitored by: A. DON or designee B. DON will report summary of audits to QA Committee for review and discussion.	

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F 365	Continued From page 30 she would clarify the orders. Progress notes by the DON dated 2/26/14, at 5:15 p.m. indicated, "Received clarification of diet - ST stated thin liquid trial is with water between meals only, with no food or snacks, no straws OK for sippy cup water to be given by nurse or with nurse supervision and enc small sips. Monitor for s/s aspiration." Another noted dated 2/26/14 at 6:11 p.m. stated "Writer just spoke with [primary physician] who clarified and okay's residents diet order for pureed textures with nectar thick liquids." On 2/27/14 at 6:30 a.m. LPN-G was observed to give R65 sips of unthickened water via a sippy cup. At 6:45 a.m. LPN-G informed staff that the water was now thickened, "So anybody can give her sips of water." On 2/27/14 at 8:30 a.m. regarding the physician on 2/26/14, for nectar thickened liquids, the DON stated, "The standing orders do allow for changing diet consistency at the discretion of the RN/RD (registered dietician)." When asked if that included upgrading the resident's diet to a less restrictive option without the physician's knowledge the DON replied, "Yes". At 1:00 p.m. when asked how long the standing order could be used before contacting the physician, the DON replied, "30 days, "No, wait - I'll have to check our policy." The ST was interviewed on 2/27/14, at 3:40 p.m. and stated, "When I do a trial they don't want a physicians order until it's a permanent thing." The ST stated, "Someone in nursing" did not want to obtain a physician's order until the change was permanent.	F 365		

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F 365	Continued From page 31 The DON was asked for the standing order policy on 2/27/14 at 4:10 p.m. and stated she would look for it. No further information was provided.	F 365		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431	F431 1. Corrective Action: A. Resident #35 had a "Order change sticker" added to the insulin vial and new label sent from pharmacy to be placed by pharmacist to reflect current order. B. Resident #29 had her insulin pens individually labeled with her name and date opened will be added as pens get put into use. C. Resident #16 had her inhaler labeled with her name and date opened. D. The medication rooms were audited and all expired medications were removed from the room and med room refrigerator. E. Medication Room Refrigerator temperatures continue to be monitored on a daily basis with	

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F 431	Continued From page 32 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure insulin pens and inhaled medications were properly labeled with the resident's name and date opened for 2 of residents (R16, R29) in 1 of 2 medication carts; insulin vials were not properly labeled for dose changes for 1 of residents (R35) observed during the medication administration task; . Findings include: R35's insulin vial label was not labeled to indicate a dosing schedule change. During the medication administration task, on 2/24/14, at 4:45 p.m. licensed practical nurse (LPN)-B was observed to draw up and administer Novolog insulin for R35. Both the Novolog insulin vial and box labels were labeled with directions to administer 6 units SQ [subcutaneous] three times daily with meals. The Medication Administration Record (MAR) dated 2/1/14, to 2/28/14, revealed R35 was to receive Novolog insulin 6 units sq at 0700, 9 units at 1200, and 10 units at 1700. LPN-B stated usually a sticker would be placed on the medication bottle or box indicating a dose change. LPN-B further stated the nurse receiving the order change would be responsible for placing the dose change sticker on the bottle or box. LPN-B verified R35's MAR for the Novolog insulin and the insulin vial and box did not match. A Client Diagnosis Report dated 2/6/14, indication R35's diagnoses included diabetes. R35's	F 431	adjustments made to keep temperature within guidelines. F. The water basin has been removed from the counter and discarded. G. The ESD has been educated that he cannot be in the medication room without nurse supervision. H. New Medication Fridge has been ordered on 3/28/2014 for the West nursing medication room. 2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice. B. 100% audit of medication carts and medication rooms were completed to assure that medications are labeled with resident names and date opened as appropriate. C. 100% audit of medication carts and medication rooms was completed to assure that there are no expired medications present.	

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	245471	A. BUILDING _____ B. WING _____	02/28/2014

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F 431	Continued From page 33 Physician's Orders dated and signed 2/6/14, directed Novolog insulin 100 units per ml solution sq 6 units daily at breakfast time, 9 units at lunch time, and 10 units with supper at 1700. R29's Levemir flex pen lacked proper labeling of resident name and opened date. On 2/26/14, at 9:15 a.m. during the medication storage task, the medication cart on the east unit was inspected with LPN-B. In the top drawer of the medication cart, a divided section was observed to contain several insulin flex pens with several different resident names either written on the pens or labeled with the residents' name in black magic marker. One opened Levimir flex pen with an expiration date of 1/2016, was observed in the cart drawer with no resident's name written or affixed on a label and no opened date written on the pen. LPN-B stated the only resident on the East unit receiving the Levimir insulin pen was R29. LPN-B further stated the flex pen should have been labeled with R29's name and an opened date should have been marked on the flex pen as well. A Client Diagnosis Report dated 1/7/14, indicated R29's diagnoses included diabetes. R29's Physician Orders dated and signed 1/7/14, directed Levemir 100 units per ml solution pen sq [subcutaneous] 4 units at 2000. On 2/26/14, at 9:34 a.m. during a medication administration observation, LPN-B was observed to remove a small box containing Symbicort [inhaled medication] from the second drawer of the East unit's medication cart for administration to R16. The box and the inhaler inside the box	F 431	D. The nursing staff will be educated on the need to monitor for labeling and dating of medications, monitor and discard expired medications. E. A sign will be placed on the medication room door to inform staff that only nurses and those authorized to administer medications may be in the Medication Room unsupervised. Staff will receive this education at the all staff meeting. F. All staff will be educated on the need to discard water after defrosting refrigerator at the all staff meeting. G. The all staff meeting will be held on Tuesday April 8, 2014. 3. Date of Completion: April 9, 2014. 4. Reoccurrence will be Prevented by: A. Random daily audits for two weeks followed by weekly audits for one month and then monthly for three months.	

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F 431	Continued From page 34 lacked a label containing the resident's name or an opened date. LPN-B verified the inhaler had been opened with more than several doses already missing from the dose counter on top of the inhaler. LPN-B stated the Symbicort inhaler was ordered for R16 and confirmed both the Symicort box and inhaler lacked a resident label and opened date. LPN-B further stated the inhaler should have been labeled when it was received from the pharmacy and should have been labeled with an opened date when the Symbicort was first used. A Client Diagnosis Report dated 1/8/14, indicated R16's diagnoses included chronic bronchitis. R16's Physician's Orders dated and signed 1/8/14, directed Symbicort aeresol 80 - 4.5 mcg inhalation 1 puff BID [twice daily] at 0800 and 2000. On 2/27/14, at 3:30 p.m. the director of nursing (DON) stated all resident's prescription medications should contain a resident label and when opened, an opened date. The DON further stated a change of dose label should be affixed to resident medication labels when a change in physician orders is received. The facility's Medication Pass policy reviewed and revised 5/2011, directed all medication should be kept in their original container bearing the original label with legible information stating the prescription number, name of the drug, strength, and quality of drug, expiration dates of all time-dated drugs, directions for use, patient's name, physician's name, date of original issue or in the case of refill, the most recent date thereof, and name and address of the licensed pharmacy which issued the medications.	F 431	B. Audits will be continued until QA committee determines the ability to discontinue monitoring. 5. The Correction will be monitored by: A. DON or designee B. DON will report summary of audits to QA Committee for review and discussion.	

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F 431	Continued From page 35 On 2/26/14 at 10:30 a.m. during on a tour of the West medication room the following refrigerated medications were found to be expired: Stock Tylenol suppositories expired 9/11/13. Aplisol (for mantoux tests) serum vial was illegible for date opened and the manufacturers recommendation was to discard 30 days after opening. Tubersol (for mantoux tests) serum vial was not dated when opened and the manufacturers recommendation was to discard 30 days after opening. The expiration dates of the medications were verified by LPN-C at the time of the tour. At the time of the tour the gasket to the refrigerator was folded away in the upper right corner of the door making the door difficult to close and seal. The edging on the door was also broken away. The refrigerator temperature at the time was 50 degrees; however, the door was not tightly sealed during the tour. Review of the refrigerator log revealed temperatures were maintained between 38 and 40 degrees Fahrenheit. Interview with the DON on 2/26/14, at 12:20 p.m. revealed she was unaware the refrigerator door wasn't sealing. The DON stated the Environmental Services Director (ESD) had worked on the gasket. On 2/26/14, at 12:25 p.m. the ESD indicated the refrigerator needed to be replaced, the gasket had been repaired once. On 2/26/14 at 10:30 a.m. there was a basin of stagnant water on the counter in the medication room. The water was very discolored and there	F 431		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 431	Continued From page 36 was a washcloth in the basin. The basin was labeled directing staff not to remove it as it was used for defrosting the refrigerator. The basin of dirty water was stored on the counter right next to the warming blanket containing fluids for peritoneal dialysis. LPN-C was unsure why the water was stored on the counter. On 2/26/14 at 12:20 p.m. the dirty water remained on the medication room counter. The DON stated she did not know why the water was stored on the counter and verified it should not have been left there. On 2/26/14, at 12:18 p.m. the ESD was observed the use a key on his key ring to open the med room door, let himself in, and close the door. Although the DON, LPN-B and LPN-C were at the nursing station at the time, no one intervened or followed the ESD into the medication room. At 12:20 p.m. the ESD came out of the medication room. Although the same nursing staff were present, no nursing staff intervened with the ESD. When interviewed at the time the ESD stated he wasn't informed the medication room was a secured area with limited access. He stated he just went in to check the light fixture and he was responsible for checking the oxygen storage. At 12:30 p.m. the DON stated she was unaware the ESD couldn't enter the medication room unsupervised. The DON further stated she thought the medication security was related to only the schedule II narcotics, not all medications. At the time of this observation, there were numerous prescription medications located on the open shelving of the medication room as verified by the DON.	F 431	F441 1. Corrective Action: A. The LPN was educated on the need to sanitize hands prior to and between medication pass	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 37 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	and to wear gloves if touching medications during administration. B. The LPN was educated to wear gloves during the peritoneal dialysis process per the Stay Safe exchange procedure. C. The LPN was educated to wear gloves during blood glucose testing per policy. 2. Corrective Action as it applies to Other Residents: 3. A. All residents have the potential to be effected by these deficient practices. B. The nursing staff will be educated on infection control practices including hand washing/ hand sanitizing and glove use during procedures and medication administration. C. The education will occur during the all staff meeting which will be held on Tuesday, April 8, 2014. D. As audits are conducted, additional education will be	

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F 441	Continued From page 38 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain proper infection control practices with medication handling for 1 of 4 residents (R16) observed during medication administration task; for 3 of 3 observed for blood glucose monitoring (R10, R39, R5); and for 1 of 1 residents (R56) with dialysis exchange. Findings include: R16's oral medications were handled with bare hands during observed medication administration. During observation of medication administration for R16 on 2/26/14, at 9:34 a.m., licensed practical nurse (LPN)-B removed 5 oral medications from a white, paper medication cup with bare hands. LPN-B prepare R16's morning medications and placed them into a white paper medication cup. LPN-B entered R16's room and got water from the bathroom sink. LPN-B placed a small white paper towel on R16's over-bed table and removed, 1 by 1, the oral medications from the small white paper medication cup, setting the tablets in a row on the paper towel. R16 turned around in the wheelchair to face the over-bed table. LPN-B handed R16 the water glass and commented the medications were set up the way R16 liked to take them. R16 was observed to take each medication, one at a time with a sip of water from the drinking cup. LPN-B assisted R16 with the inhaler, holding the inhaler to R16's mouth, counting to 3 and then depressing the cylinder while R16 inhaled. A Client Diagnosis Report dated 1/8/14, indicated	F 441	provided to address any infection control need. 4. Date of Completion: April 9, 2014 5. Reoccurrence will be Prevented by: A. Random daily audits for two weeks followed by weekly audits for one month and then monthly for three months. B. Audits will be continued until QA committee determines the ability to discontinue monitoring. 6. The Correction will be Monitored by: A. DON or designee B. DON will report summary of audits to QA Committee for review and discussion.	

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F 441	Continued From page 39 R16's diagnoses included acute myocardial infarction, essential hypertension, and chronic obstructive pulmonary disease. On 2/26/14, at 10:00 a.m. LPN-B stated she usually sets out R16's medications on the paper towel, but she should have worn gloves to handle the medications. LPN-B stated she also touched other items and did not sanitize her hands before touching the medications. LPN-B stated R16 might have wondered why she was wearing gloves. On 2/2/7/14, at 3:30 p.m. the director of nursing (DON) stated oral medications should not be handled with bare hands. The DON further stated she would expect nurses to wear gloves if they needed to touch medications and to sanitize or wash their hands after removal of the gloves. A Medication Pass policy reviewed and revised 5/2011, did not to address bare hand contact of oral medications during administration. On 2/24/14, LPN-A was observed to not wear gloves during blood glucose checks and a dialysis exchange. R10 was observed during blood glucose monitoring on 2/24/14, at 3:50 p.m. LPN-A washed her hands in R10's bathroom but did not don gloves. LPN-A cleansed R10's finger with an alcohol wipe, set up the blood glucose monitoring machine, poked R10's finger with the lancet, obtained the blood sample on the strip in the machine, wiped the R10's finger with a cotton ball and told R10 the results. LPN-A exited R10's room, returned to the nursing station and washed her hands in the nursing station bathroom. R39 was observed during blood glucose	F 441		

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F 441	Continued From page 40 monitoring on 2/24/14, at 3:58 p.m. LPN-A washed her hands in R39's bathroom but did not don gloves. LPN-A set up the supplies and the blood glucose monitoring machine, cleansed R39's finger with an alcohol wipe, poked R39's finger with the lancet, obtained the blood sample and wiped R39's finger with a cotton ball, threw away the trash, picked up the blood glucose machine and returned to the medication room. The LPN wrapped machine in the Super Sani wipe and then washed her hands in the nursing station bathroom. R5 was observed during blood glucose monitoring on 2/24/14, at 4:39 p.m. LPN-A was observed to check R5's blood glucose in front of the west nursing station desk. The LPN did not wash her hands or apply gloves. LPN-A cleaned R5's finger with an alcohol wipe, poked R5's finger with the lancet, obtained the blood sample, wiped R5's finger with a cotton ball, threw away the supplies, put the machine in the medication room and washed her hands in the nursing station bathroom. R56 was observed during a manual peritoneal dialysis fluid exchange on 2/24/14, at 4:06 p.m. LPN-A washed her hands in R56's bathroom and cleaned the tray table and the intravenous (IV) pole and the organizer with Alcavis (a disinfectant). LPN-A obtained the supplies from the closet, applied a mask, washed her hands, opened bag containing the dialysis solution, checked the solution for proper dosage, set up the organizer and IV pole, cleaned the catheter tip, pushed the new dialysis catheter cap into the organizer, connected the drain to the organizer and turned the dial to drain. All of this was done with bare hands. LPN-A put the supplies away,	F 441		

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F 441	Continued From page 41 washed her hands in the resident's room and exited the room. LPN-A returned to R56's room at 4:32 p.m., washed her hands in R56's bathroom but did not apply gloves. LPN-A turned the organizer dial from flush to fill and exited the room. The LPN did not wash her hands and returned to the medication cart. LPN-A returned to R56's room at 4:47 p.m. turned the organizer dial to turn off the flow and clamped the dialysis tubing. LPN-A washed her hands in R56's bathroom but did not apply gloves before disconnecting the tubing from the old dialysis tubing cap in the organizer and inserting it into the new dialysis tubing cap. LPN-A weighed the bag containing the dialysis exchange returns, exited the room with the bag containing the dialysis exchange returns and entered the soiled utility room. LPN-A donned gloves and hung the bag to drain into the hopper. The LPN stated it did not take long to drain, flushed the hopper twice and threw the empty bag into the garbage. LPN-A exited the soiled utility room and washed her hands in the nursing station bathroom. LPN-A was interviewed on 2/26/14, at 4:10 p.m. and stated she should have worn gloves when doing blood glucose checks and when using the Alcavis because it had bleach in it. The Stay Safe Exchange Procedure was reviewed with LPN-A and verified the procedure directed the use of gloves. LPN-A verified that was the procedure she was taught and she did not wear gloves as directed by the procedure. LPN-A was trained for the procedure of manual dialysis exchange during an insevice from the dialysis agency on 1/18/14. On 2/27/14, at 8:20 a.m. during an interview, the DON stated staff should be wearing gloves when doing blood glucose checks and as directed in	F 441		

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F 441	Continued From page 42 the Stay Safe Exchange Procedure for dialysis exchanges. On 2/27/14 at 1:45 p.m. two registered nurses (RN) from the dialysis agency were interviewed. RN-B verified staff should be wearing gloves prior to cleaning the extension set, when separating the tubing or opening the dialysis system and when doing exit site care. RN-C stated she did the teaching for R56's dialysis exchanges and staff were instructed to use gloves when they connect and disconnect the dialysis tubing and when dumping the return solution. Staff should be following the procedure. The (not dated) Obtaining Blood Specimen for Glucose Testing (Capillary Puncture) policy directed staff perform hand hygiene and don gloves. The (not dated) Stay Safe Exchange Procedure for doing the manual peritoneal dialysis exchange directed staff to do a one minute hand wash after setting up supplies and putting on the mask. To clean hands with sanitizer and put on gloves before connecting the tubing to drain and when disconnecting the tubing from draining.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by; Based upon observation, interview and	F 463	F463 1. Corrective Action: A. Resident #15 had her call light system audited and it is functioning properly. 2. Corrective Action as it applies to Other Residents: A. All residents have the potential to be effected by this deficient practice. B. A 100% audit of resident call lights was completed and the findings showed that all were functioning appropriately. C. All staff were educated on the functioning of the new call light system. They are to notify the ESD/Nurse Supervisor immediately if a call light is not functioning.	

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F 463	Continued From page 43 document review the facility failed to provide a functioning call light for 1 of 39 (R15) residents reviewed for call light function. Findings include: R15's call light was not functional on 2/25/14, at 11:40 a.m. Nursing assistant (NA)-A stated the call light did not light outside R15's door nor on the call light pager. Further investigation indicated the call light box was not pushed all the way into the wall. The Annual Minimum Data Set (MDS) dated 10/13/13, identified R15 had no cognitive impairment and required extensive assistance of one for activities of daily living (ADL), bed mobility and transfers. The environmental services director (ESD), interviewed on 2/25/14, at 11:45 a.m., stated the system was only two weeks old and the routine was to check call light function weekly. On 2/27/14, at 9:00 a.m. ESD stated the new call light system is supposed to show an alert on the main computer; the director of nursing (DON) and the administrator's computers when there is an problem. If the call light cord is not connected the problem should show on the staff pager and main computer. Staff are unable to shut off a call light unless the cord is properly connected to the wall. ESD stated he did not know why the computer didn't indicate the call light wasn't pushed in all the way.	F 463	D. All staff will be re-educated on the call light system and reporting any malfunction at the all staff meeting which will be held on Tuesday April 8, 2014. 3. Date of Completion: April 9, 2014. 4. Reoccurrence will be Prevented by: A. Random daily audits for two weeks followed by weekly audits for one month and then monthly for three months. 6. Audits will be continued until QA committee determines the ability to discontinue monitoring. 7. The Correction will be Monitored by: E. ESD or designee F. ESD will report summary of audits to QA Committee for review and discussion.	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ECUMEN SCENIC SHORES	402 - 13TH AVENUE TWO HARBORS, MN 55616

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATION HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES K TAGS TO: Health Care Fire Inspections State Fire Marshal Division 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By E-Mail to: marian.whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date.	K 000	POC ok PS 4-8-14 RECEIVED APR - 4 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

EXIT: 4-28-14 DC: 4-9-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Blaine Samuelson — TITLE: Executive Director — (X6) DATE: 4/3/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245471	A. BUILDING 01 - MAIN BUILDING B. WING _____	02/26/2014

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K 000	Continued From page 1 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Ecumen Scenic Shores 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. Ecumen Scenic Shores is a 1-story building with a small partial basement. The building was constructed in 1979, with a kitchen addition, in 2001. An assisted living building is connected and properly fire separated. Therefore, the facility was inspected as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 45 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.	K 050	K 050 1. Corrective Action: a. Director of Maintenance was educated on the proper way to conduct and record fire drills. 4-8-14 b. A new form provided by State Fire Marshal was implemented to record fire drills. The form will verify the quality of the drill, actions taken by the staff and the shift the drills were conducted on. 2. Corrective Action as it applies to Other Residents: a. Fire drill education will be provided to all staff before April 8, 2014.	

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K 050	Continued From page 2 The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of available documentation and interview, it was determined that fire drills were not conducted at as required by LSC(00) Section 19.7.1.2. This deficient practice could affect all occupants including residents, visitors and staff in the event of a fire emergency. Findings include: On 2-26-14 at the conclusion of the inspection, at approximately 10:30AM, based on a review of available fire drill documentation it was determined that fire drills were not conducted and documented (in the past 12 months) as required. A computerized record of drills was available. However, drills were not documented on a form that would allow to verify the quality of the drill, actions taken by the staff, and the shift the drills were conducted on. This deficient practice was confirmed by the facility Director of Maintenance (MJ) and (BG) Administrator at the time of exit	K 050	3. Date of Completion: April 8, 2014 4. Reoccurrence ~~will be~~ Prevented by: a. Monthly audits to ensure fire drills are being conducted as required. 5. The Correction will be Monitored by: a. ESD or designee b. ESD will report summary of audits to QA Committee for review and discussion.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised	K 144	K 144 1. Corrective Action: a. Environmental Services Director was educated on the proper way to conduct emergency generator inspections and testing on a weekly and monthly basis.	

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K 144	Continued From page 3 under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on a review of available documentation, it could not be verified that the emergency generator is being properly inspected and tested weekly and monthly as required by NFPA 110. This deficient practices could affect all residents staff and visitors. Findings include: At the conclusion of the facility tour on 2-26-14 at 10:30 AM, based on interview, and review of the documentation, with the Facility Maintenance Director, it could not be determined, if the emergency generator is being inspected weekly and or monthly in accordance with the requirements as outline in NFPA 110. A computerized record of the dates of inspection was available. However, it could not be determined if all the parameters of required inspection are being met. This would include the monthly 30% load testing. The generator is a 150 KW, fueled by diesel. Forms were provided to the facility at the time of exit. This deficient practice was confirmed by the Director of Facility Maintenance(MJ) and (BG) Administrator at the time of exit.	K 144	b. A new form provided by state fire marshal was implemented to document the weekly and monthly inspections/testing. c. Ziegler will service the generator by 4/9/14 and will determine our KW load as required on monthly test documentation. 2. Corrective Action as it applies to Other Residents: a. All staff education on emergency generators by 4/8/14. 3. Date of Completion: April 8, 2014 4. Reoccurrence will be Prevented by: a. Monthly and weekly audits to ensure tests and inspections are being conducted as required. 5. The Correction will be Monitored by: a. ESD or designee	

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			b. ESD will report summary of audits to QA Committee for review and discussion.	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7876

March 24, 2014

Mr. Blaine Gamst, Administrator Administrator
Ecumen Scenic Shores
402 - 13th Avenue
Two Harbors, Minnesota 55616

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5471024

Dear Mr. Gamst:

The above facility was surveyed on February 24, 2014 through February 28, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 11 East Superior St #290, Duluth, Minnesota 55802. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Patricia Halverson at (218) 302-6151.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File