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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YFI9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00557

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245554**
2.STATE VENDOR OR MEDICAID NO.
(L2) **792697900**

3. NAME AND ADDRESS OF FACILITY
(L3) **RENVILLA HEALTH CENTER**
(L4) **205 SOUTHEAST ELM AVENUE**
(L5) **RENVILLE, MN** (L6) **56284**

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) **07/01/2005**

6. DATE OF SURVEY **09/15/2014** (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)
09/30

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (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: * Code: **A*** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 10/07/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/07/2014 (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
04/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/16/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5554

Electronically Delivered: September 18, 2014

Ms. Cami Peterson-Devries, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

Dear Ms. Peterson-Devries:

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

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

Effective September 8, 2014, the above facility is certified for:

56 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 56 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 18, 2014

Ms. Cami Peterson-Devries, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

RE: Project Number S5554025

Dear Ms. Peterson-Devries:

On August 14, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 25, 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 September 15, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 18, 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 July 25, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 8, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 25, 2014, effective September 8, 2014 and therefore remedies outlined in our letter to you dated August 14, 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.

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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
245554	A. Building B. Wing	9/15/2014

Name of Facility	Street Address, City, State, Zip Code
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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 **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **09/08/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/08/2014**
ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/08/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/20/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **09/02/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/28/2014**
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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	10/07/2014	18623	09/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/25/2014

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245554	A. Building 01 - MAIN BUILDING 01 B. Wing	9/18/2014

Name of Facility	Street Address, City, State, Zip Code
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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 Reg. # **NFPA 101** LSC K0072	Correction Completed **07/25/2014**	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
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	10/07/2014	22373	09/18/2014
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
7/25/2014	

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245554	A. Building B. Wing	9/15/2014

Name of Facility	Street Address, City, State, Zip Code
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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 **F0309** Reg. # **483.25** LSC	**09/08/2014**	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		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** GD/AK	**Date:** 10/07/2014	**Signature of Surveyor:** 18623	**Date:** 09/15/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 7/25/2014		**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: YFI9

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00557

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245554**
2.STATE VENDOR OR MEDICAID NO.
(L2) **792697900**

3. NAME AND ADDRESS OF FACILITY
(L3) **RENVILLA HEALTH CENTER**
(L4) **205 SOUTHEAST ELM AVENUE**
(L5) **RENVILLE, MN** (L6) **56284**

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) **07/01/2005**

6. DATE OF SURVEY **07/25/2014** (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)
09/30

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

12.Total Facility Beds **56** (L18)

13.Total Certified Beds **56** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	56			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
See attached Fire Safety Evaluation System (FSES) dated 07/25/14 for Life Safety Code results.

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 09/08/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 09/11/2014 (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
04/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/16/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YFI9

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18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/07/2014 (L20)

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09/16/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5554

Electronically Delivered: September 18, 2014

Ms. Cami Peterson-Devries, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

Dear Ms. Peterson-Devries:

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If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 18, 2014

Ms. Cami Peterson-Devries, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

RE: Project Number S5554025

Dear Ms. Peterson-Devries:

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Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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
245554	A. Building B. Wing	9/15/2014

Name of Facility	Street Address, City, State, Zip Code
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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 **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **09/08/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/08/2014**
ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **09/08/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/08/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **08/20/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **09/02/2014**	ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **08/28/2014**
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	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	10/07/2014	18623	09/15/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/25/2014

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245554	01 - MAIN BUILDING 01	9/18/2014

Name of Facility	Street Address, City, State, Zip Code
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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 Reg. # NFPA 101 LSC K0072	Correction Completed 07/25/2014	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
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By PS/AK	Date: 10/07/2014	Signature of Surveyor: 22373	Date: 09/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/25/2014		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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245554	A. Building B. Wing	9/15/2014

Name of Facility	Street Address, City, State, Zip Code
RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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 **F0309** Reg. # **483.25** LSC	**09/08/2014**	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		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	GD/AK	10/07/2014	18623	09/15/2014
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
7/25/2014				

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
August 14, 2014

Ms. Cami Peterson-Devries, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5554025

Dear Ms. Peterson-Devries:

The above facility was surveyed on July 21, 2014 through July 25, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5554004 and H5554005. 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.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	C 07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

(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 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 interview and record review the facility failed to ensure appropriate care and monitoring was implemented for 1 of 3 residents reviewed who had skin breakdown (R71). The findings include: R71 had been admitted to the facility on 2/22/10, and had diagnosis including: Diabetes Mellitus (DM) Type I, bacterial infection, mood disorder, hypothyroidism, depression, and hypertension. The resident's record was reviewed and included documentation of arterial ulcers to the lower legs. The progress notes indicated that on 6/3/13, wound cultures of the left leg were positive for Methicillin Resistant Stapholoccos Aureus (MRSA). In addition, a progress note from 6/18/13, at 12:08 p.m. indicated a small sore had developed on the resident's right great toe. The progress note indicated R71 had been educated to keep his shoe off, and to wear only TED stockings and gripper socks. Additional documentation of the foot described erythema noted on top of left foot,	F 309	Specific Resident R71 : Resident record is closed. Identification All residents who are receiving wound care will be reviewed to ensure that the level of care is provided at its highest potential and that a root cause analysis is completed regarding cause of wound. Systemic Wound care policies were reviewed. All residents with wound care will be routinely reviewed with updates to ensure that the appropriate nursing care is provided and a root cause analysis is completed. The skin and wound protocols will be reviewed and education provided to all licensed nursing staff. Wound rounds will be completed weekly. Monitor	9/8/14

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

Electronically Signed | 08/25/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING _____ B. WING _____	C 07/25/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

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F 309	Continued From page 1 a small intact blister noted on top of left foot, white swollen areas noted around left great toe/toenail, and odor noted from left leg/foot. The record included progress notes regarding the resident's left foot wound to the great toe from 6/20/13-8/18/13. The notes reflected the progressive deterioration in the condition of the wound. A progress note dated 7/30/13, at 3:05 p.m. indicated the left great toe continued to show declining skin status with base on both nails yellow in color with moist appearance. "Color of tip of left great toe pale white/yellow. Poor circulation with no improvement noted or expected. Tip of right great toe had a small area which measured 0.4 cm diameter. Area was closed. No change since last week. Current Treatment: keep all pressure off areas." The note further indicated R71's family had purchased him open toed sandals. On 7/31/13, the resident's primary physician had documented a progress note indicating R71 had significant necrotic changes to his toes, particularly the left great toe. The physician's note indicated R71 had erythema extending from his toes up to just below the knee with some blistered, denuded areas on the left anterior to lateral mid (middle) tib-fib (tibia-fibula) area (lower leg bones that end at the knee joint). In addition, the notes included: "The culture results from 5/31/13, were MRSA in the left leg cellulitis and treated with Bactroban and Bactrim, however his infection worsened and [R71] was re-treated with Bactrim from 7/9-7/19/13. [R71] appears more confused and had a decline in mental status in the last two months. The family has chosen not to	F 309	The Director of Nursing or designee will review residents with wounds to ensure appropriate monitoring and care is completed based on wound care standards. Wound and clinical updates with interventions will be provided weekly to the IDT. Chart audits will be completed by the Directors of Nursing and/or designee to ensure appropriate interventions are in place. Performance Review Committee and Quality Assurance Committee will review results.	

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F 309	Continued From page 2 pursue angiography given his age and condition, the left leg does cause pain for which he receives Percocet. Below the knee amputation with spinal anesthesia was considered..." The physician's note also included: "ASSESSMENT/PLAN: MRSA cellulitis with peripheral vascular disease and what appears to be a dry gangrene type of process in his big toe on the left." A progress note dated 8/18/13, indicated an order had been received to modify the treatment to R71's gangrenous wound. The order was for Flagyl (an antibiotic) 500 mg (milligrams) to be crushed and sprinkled over the wound for odor control. "Use 1 (one) 500 mg Flagyl tab for each dressing change." The next progress note regarding the gangrenous foot was documented on 8/25/13, at 7:48 a.m. The note indicated the resident's dressing had been changed at 7:30 a.m. and when the dressing had been removed maggots were noted between the resident's toes on left foot. According to the note, the area had been cleaned but more maggots had appeared. The note indicated when the area had been cleaned multiple times, hospice had been informed of the maggots and the hospice nurse was going to talk with R71's doctor. Another progress note dated 8/25/13, at 2:46 p.m. indicated the hospice nurse had made a visit to the resident at 11:00 a.m. The hospice nurse had reportedly spoken to the resident's primary physician and it had been decided to soak the resident's foot then clean with hydrogen peroxide and coat with corn starch. The note indicated this had been done, and when the dressing was removed no more maggots had been noted.	F 309		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

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F 309	Continued From page 3 Although an entry was made in the resident's record 8/27/13, at 4:15 p.m., including: "...dressing change completed on 8/24/14 at approximately 11:00, lower legs and toes cleansed well before dressing applied, lower legs and toes were kept covered at all times and dressing was fully intact on the morning of 8/25/13 prior to dressing change. No skin was exposed, no drainage coming through dressing; minimal drainage, 2nd toe on left foot was fully gangrenous with tip of great toe gangrenous as well." The record did not indicate further investigation or root cause analysis had been conducted to evaluate the techniques used by staff when completing the dressing change in order to determine how the maggots might have gotten into the resident's wound. On 8/29/13, the resident's care plan was revised to include a diagnosis of bacterial infection with interventions to apply Ben Gay or icy hot around left heel wounds and left great toe to increase blood flow/circulation BID (twice a day). Keep all pressure off heels. Hospice to assess skin status and pressure points for signs of breakdown every visit, hospice will teach wound care protocol as ordered, hospice will assess for pain and medicate as needed prior to dressing change." During interview with director of nursing (DON)-B, at 12:30 p.m. on 7/25/14, she verified the resident had a long history of ischemic toes, and stasis ulcers on the lower extremities. No additional information regarding the wound care, or development of maggots was provided.	F 309		

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted from July 21st through July 25th 2014, and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5554004 was conducted. The complaint was unsubstantiated. An investigation of complaint H5554005, and was substantiated. A federal deficiency was issued as a result at F309.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.	F 167		9/8/14

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

Electronically Signed | 08/25/2014

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 167	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to make the State survey results readily accessible to residents, family and visitors. This had the potential to affect 1 of 1 resident (R65) observed and all 56 residents residing in the facility, visitors, and family. Findings include: On 7/21/14, at 3:00 p.m. documentation of the MDH [Minnesota Department of Health] Annual Survey results (survey book) dated 5/22/13, was observed in a three-ring binder on a counter at the South nurses' station partially hidden from the hallway by a wall. Additional obstacles to the accessibility of the survey results included a flower vase, a sign-in/sign-out log book, and a box of facial tissues. On 7/22/14, at 8:05 a.m. and on 7/23/14, at 7:00 a.m. the survey book was observed to still be located on the same counter at the South nurses' station behind a wall and hidden by a flower vase, a box of facial tissue and a sign-in/sign-out log book. On 7/23/13, at 1:30 p.m. when a family member (F)-J and R65 were at South nurses' station, F-J was asked if she knew where to find the MDH Annual Survey Results book, she stated she had "no idea." In addition, when R65 moved close to the counter, the top of R65's head was below the counter. The State survey results were not accessible to R65 or her family.	F 167	Survey book is located in a central place, marked as Survey, adhered to wall by chain and placed in a hanging file. Compliance will be monitored through weekly maintenance rounds completed by the maintenance director and/or designee. Staff will be educated on the importance of ensuring survey results are available to residents, families, and any person who comes to the facility.	

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F 167	Continued From page 2 R65's Minimum Data Set (MDS) dated 7/17/14, indicated R65 needed supervision to propel self on the unit. On 7/24/14, at 7:43 a.m. nursing assistant (NA)-H stated the facility always kept the survey book on top of the counter at the South nurses' station, and verified the State survey results book was partially hidden by a wall and close to the log book. - At 7:45 a.m. the administrator stated the survey book's proper place was on top of the counter, always close to the residents' mail box, and hooked by a chain but the chain "broke." The administrator stated she will have the broken chain replaced. The administrator verified the annual survey results should have been accessible to everybody at all times. - At 10:00 a.m. the facility's policy for posting the State survey results was requested from the administrator, who acknowledged there was no policy as it was "a regulation."	F 167		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		9/8/14

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F 225	Continued From page 3 The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediately report injuries of unknown origin for 1 of 1 resident (R29) to the administrator and the designated State agency (SA). In addition, the facility failed to immediately report alleged incidents of abuse for R58, R59 to the SA, and to timely submit investigated reports of alleged abuse for 4 of 5 residents (R23, R29, R58, R59) reviewed during abuse prohibition. Findings Include:	F 225	Specific Resident #29: Resident record is closed. Resident #58: Reviewed and reported incident, investigation completed, intervention put in place to address behavior. Care plan updated. Resident #59: Reviewed and reported incident, investigation completed, intervention put in place to address	

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	245554	A. BUILDING _____ B. WING _____	07/25/2014

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F 225	Continued From page 4 Injury of unknown origin: 29's incident report, dated 1/21/14, was reviewed and identified R29 had swelling of the left foot/ankle, discoloration in left inner ankle/heel area and complaint of (c/o) pain with movement and palpation. An order was received from nurse practitioner (NP)-D for the foot and ankle to be x-rayed to check for injury. The x-ray was completed on 1/21/14, and R29 was found to have a non-displaced fracture of the distal metaphysis of the left fibula. The results were sent to NP-D and NP-D advised there was no specific treatment for that type of fracture. An air cast splint was applied on R29's left foot on 1/23/14, for immobilization and comfort. The investigation report stated R29 had first noted to c/o pain on 1/16/14, located in the knee. Resident again reported pain on 1/18/14, of left foot and left foot was swollen at the time. The left foot was then periodically checked over the weekend and elevated with relief. Shoe was left off of left foot. The investigative report stated R29 was basically non-ambulatory most of the time except for restorative ambulation program. The report indicated R29 was transferred with stand-up lift and the injury could have occurred during a transfer or during ambulation if R29 stepped wrong and/or slightly twisted his ankle. The report also indicated the injury could have occurred while in standing lift if R29 moved foot or foot was displaced from standing plate during transfer procedure. Upon interview, R29 stated someone "bumped into my foot." No witnesses were noted for any incident. The report read dementia and memory impairment prevented R29 from being an accurate historian. The initial report was made to the SA one day later. The final investigative was submitted on 1/27/14, six days	F 225	behavior. Care plan updated. Resident #23: Vulnerable Adult log updated to track number of days from incident the investigation was filed and record auditing process. Identification All resident incidents within past 6 months were reviewed for injuries not observed by any person, or the source of the injury cannot be explained, or the injury is suspicious because of the extent of or location. No other injuries were identified. All residents identified through behavior documentation were reviewed to ensure appropriate reporting and assessments were completed as indicated. Care plans were updated to reflect behaviors with appropriate interventions. Systemic Policy was reviewed and appropriate. All staff will be trained on policy to ensure appropriate and timely reporting. Policy will be followed. Monitor The Social Service Director and the Administrator or designee will monitor compliance through monthly auditing. Audits will be reviewed at Performance Review and Quality Assurance committee.	

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F 225	Continued From page 5 after the incident occurred. The quarterly Minimum Data Set (MDS) dated 5/22/14, noted R29 had a score of 3 on the Brief Interview for Mental Status (BIMS) which indicated impaired cognition. Reporting and timely submission of reports: R58 was interviewed on 7/21/14, at 6:09 p.m. and when asked the question, "Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse?" R58 answered "Yes" to surveyor. R58 stated R24 had yelled at R58 to shut up two different times. R58 also stated nurse assistants (NAs) and nurses were aware of it as they were in the dining room at the time and R24 "has had a few talking's to." R58 was asked, "Have you seen any resident here being abused?" and R58 answered, "Yes", and stated R58 overheard R24 yell at other residents "to shut up." The quarterly MDS dated 6/4/14, indicated R58 scored a 15 of 15 on the BIMS which indicated intact cognition. On 7/21/14, at 6:32 p.m. registered nurse (RN)-D was asked whether staff were aware of R24's yelling, RN-D answered "yes" and stated the social worker (SS)-A had been notified about the yelling by different staff "more than once." RN-D also stated when that happens R24's behaviors were charted. At 6:37 p.m. SS-A stated she was aware of R24's yelling at R58, and stated one vulnerable adult (VA) report regarding R24 had been filed, but not one for R24 yelling at R58. SS-A stated she had talked to R58 and R24 individually about the	F 225		

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F 225	Continued From page 6	F 225		

yelling incident, but had not put notes into the computer about it. SS-A stated she only had her own paper notes, and said "Now I wish I would have documented it." SS-A stated she was also aware R24 has yelled at other residents. SS-A stated R24 had dementia, a "short fuse", and R24 apologized after the incidents. SS-A stated at the time she had not considered the yelling incidents from R24 as verbal abuse as R58 and R24 have a long history together. SS-A stated she had not submitted a report to the SA. SS-A stated the report was submitted to SA on 7/25/14, which was four days later.

On 7/23/14, at 1:51 p.m. SS-A stated the usual process was to talk to the staff or residents, investigate a little first, talk to the administrator, discuss, and then a decision was made whether to file a report to the SA. SS-A stated either SS-A or the administrator would make the report.
At 2:18 p.m. the administrator stated yes she was aware that reportable Incidents should be submitted immediately to the SA, and was also aware Investigative reports needed to be filed within five working days of the incident. Report of verbal abuse from R58 was not reported immediately to the SA regarding R24.

On 7/24/14, at 9:55 a.m. NA-H stated R24 yelled loudly "two times a day, every day" at residents and staff. We were told to try and calm R24 down and redirect her. NA-H stated after she yelled R24 then usually goes to her room and comes out later.

On 7/25/14, at 7:56 a.m. SS-A stated she had talked last night (on 7/24/14) to R58, R58 had expressed feeling uncomfortable around R24. SS-A stated R58 reported, "I would have gotten

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F 225	Continued From page 7 the strap" if I yelled like R24 did. SS-A stated "that is R24's nature; R24 has a gruff voice, and snaps at people." SS-A also stated, "I wished I would have put in the record [R58's] report of verbal abuse." SS-A stated, "I haven't really focused on the verbal between residents," but rather staff to resident abuse. At 8:37 a.m. SS-A said she had talked to staff about R24's behaviors, and stated, "but now when I talk to staff it is a different story." At 9:09 a.m. SS-A provided a copy of the e-mail from Office of Health Facility Complaints (OHFC) sent on 7/25/14, (confirmation of incident report to Minnesota Department of Health (MDH), saying she had filed an incident report last night regarding R24. When asked for the incident report, SS-A replied she could not provide a copy of the incident report as she had forgotten to push the print button when submitting the report. At 9:12 a.m. SS-A stated mental anguish was considered verbal abuse, however, she had not been focusing on verbal abuse. SS-A also stated she would now, indicating the facility should provide person centered care, focusing on how residents' felt. R59's quarterly MDS, dated 5/1/14, indicated R59 scored a six on the BIMS which indicated R59 had severely impaired cognition. A Progress note dated 2/14/14, by SS-A stated R59 was vulnerable due to impaired cognition and due to the cognition impairment, R59 had some difficulty completely expressing thoughts/words. The MDS indicated R59 was able comprehend most conversations if given time. R59 had diagnosis to include dementia. R59 on 6/23/14, reported R24 hit R59 on back of	F 225		

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F 225	Continued From page 8	F 225		

the head during bingo. Staff members overheard and witnessed R24 yell and slam R24's hand down on the table. The incident report identified a long standing history between R24 and R59 and it was not clear if anything physical happened between R24 and R59. Follow up plan was to have staff watch for agitation between R24 and R59 when together.

On 7/23/14, at 1:50 p.m. the social worker stated to surveyor she found out about the incident on the morning of 6/24/14. The social worker stated she had talked to the administrator about that incident and the administrator had told her she should have submitted a report. The report was submitted on 6/25/14, two days later.

R23's incident report indicated R23 fell on 3/12/14, while transferring with staff assistance from wheel chair (w/c) to exercise equipment without staff using gait belt. R23 lost balance and R23 fell hitting the head on arm rest of chair and door. R23 received a minor skin tear on left ear. The investigation found R23 lost balance during a transfer while receiving assistance from staff. It was found staff had not used a gait belt while assisting R23 which may have prevented R23's fall. Staff was disciplined and was given further training on facility procedure for assisting R23 to transfer. The report indicated R23 received minor injuries. The completed investigative report was dated as completed on 3/21/14, which was nine days later.

R23's Quarterly MDS dated 6/25/14, indicated R23 had scored a score of eight on the BIMS, indicating moderately impaired cognition.

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F 225	Continued From page 9 On 7/23/14, at 2:18 p.m. the administrator stated "yes" she was aware that reportable incidents should be submitted immediately to the SA, and was also aware investigative reports needed to be filed within five working days of the incident. The Abuse Prohibition Policy dated as revised/amended on 7/13, identified St. Francis Health Services had established safeguards to prohibit Maltreatment (Abuse or Neglect) of any VA (vulnerable adult) in the facility. The policy identified the safeguards would adhere to the Federal and State requirements, whichever was most stringent. "Components of the Abuse Prohibition Policy under A. states Definitions of Maltreatment/Abuse and Neglect: Definitions of potential maltreatment. (Physical Abuse, Sexual Abuse, Verbal Abuse, Mental Abuse, Neglect, Financial Exploitation, Resident to resident abuse)." The Reporting Mechanisms for Alleged Abuse Revised/Amended 7/13, identified St. Francis Health Services would follow procedures for reporting alleged maltreatment of a VA residing in our facility, to the appropriate authorities, as required by the most stringent federal regulations and state rules and statutes. "A. The person observing or suspecting abuse or a suspicious injury (this is a mandated reporter) to a resident in the facility must notify his/her supervisor immediately, who will report to the appropriate facility staff. C. Each facility must report any suspected abuse/neglect to MDH immediately ('immediately' means as soon as possible, but ought not exceed 24 hours after discovery of the incident). Save this notice of receipt of report from MDH. Keep it on file with the incident investigation.	F 225		

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F 225	Continued From page 10 D. The facility administrator must also be notified of alleged abuse/neglect situations immediately. E. Following completion of the investigation within five (5) working days, the facility must submit a copy of the investigation to MDH."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to operationalize the abuse prohibition policy, which had the potential to affect four of five residents (R29, R58, R59, R23). Findings Include: The Abuse Prohibition Policy Revised/Amended 7/13, identified St. Francis Health Services had established safeguards to prohibit Maltreatment (Abuse or Neglect) of any VA (vulnerable adult) in our facility. The safeguards would adhere to the Federal and State requirements, whichever was most stringent. The policy indicated: "Components of the Abuse Prohibition Policy under A. states Definitions of Maltreatment/Abuse and Neglect: Definitions of potential maltreatment. (Physical Abuse, Sexual Abuse, Verbal Abuse, Mental Abuse, Neglect, Financial	F 226	Specific Resident #29: Resident record is closed. Resident #58: Intervention put into place, location of activity altered, resident agreed not to sit next to other resident. Care plan updated. Resident #59: Staff training, activity altered, intervention put into place. Care plan updated. Resident #23: Vulnerable Adult log updated to track number of days from incident till the internal investigation needs to be entered and record auditing process. Identification	9/8/14

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F 226	Continued From page 11 Exploitation, Resident to resident abuse). The Reporting Mechanisms for Alleged Abuse Revised/Amended 7/13 states St. Francis Health Services will follow procedures for reporting alleged maltreatment of a VA residing in our facility, to the appropriate authorities, as required by the most stringent federal regulations and state rules and statutes. A. The person observing or suspecting abuse or a suspicious injury (this is a mandated reporter) to a resident in the facility must notify his/her supervisor immediately, who will report to the appropriate facility staff. C. Each facility must report any suspected abuse/neglect to MDH immediately ('immediately' means as soon as possible, but ought not exceed 24 hours after discovery of the incident). Save this notice of receipt of report from MDH. Keep it on file with the incident investigation. D. The facility administrator must also be notified of alleged abuse/neglect situations immediately. E. Following completion of the investigation within five (5) working days, the facility must submit a copy of the investigation to MDH." R29's the incident report dated 1/21/14, was reviewed and identified R29 to have swelling of left foot/ankle, discoloration in left inner ankle/heel area and complaint of (c/o) pain with movement and palpation. An x-ray was completed on 1/21/14, found R29 had a non-displaced fracture of the distal metaphysis of the left fibula. An air cast splint was applied on R29's left foot on 1/23/14, for immobilization and comfort. The investigation report indicated R29 was first noted to c/o pain located in the knee on 1/16/14.	F 226	System wide review of Abuse Prohibition Policy. Systemic Policy was reviewed and appropriate. All staff trained on Abuse Prohibition Policies to ensure appropriate and timely reporting. Policy will be followed. Monitor The Social Service Director and the Administrator or designee will monitor compliance through monthly auditing. Audits will be reviewed at Performance Review and Quality Assurance committee.	

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R29 again reported pain on 1/18/14, of left foot and left foot was swollen at the time. The left foot was then periodically checked over the weekend and elevated with relief. Shoe was left off of left foot. The investigative report identified R29 was non-ambulatory most of the time except for restorative ambulation program. The report indicated R29 was transferred with stand-up lift and the injury could have occurred during a transfer or during ambulation if R29 stepped wrong and/or slightly twisted his ankle. The report also indicated the injury could have occurred while in standing lift if R29 moved foot or foot was displaced from standing plate during transfer procedure. Upon interview, R29 stated someone "bumped into my foot." No witnesses were noted for any incident. The report read dementia and memory impairment prevented R29 from being an accurate historian. The initial report was made to the SA one day later. The final investigative report was submitted on 1/27/14, six days after the incident occurred.

On 7/23/14, at 2:18 p.m. the administrator stated yes she was aware that reportable incidents should be submitted immediately to the SA, and was also aware investigative reports needed to be filed within five working days of the incident.

R58 was interviewed on 7/21/14, at 6:09 p.m. and when asked the question "Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse?" R58 answered "Yes" to surveyor. R58 stated R24 had yelled at R58 to shut up two different times. R58 also stated nurse assistants (NAs) and nurses were aware of that as they were in the dining room at the time and R24 "has had a few talking's

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to." R58 was asked "Have you seen any resident here being abused" and R58 answered "Yes", and stated R58 overheard R24 yell at other residents "to shut up." The report was called to the SA on 7/25/14, four days later.

On 7/21/14, at 6:32 p.m. registered nurse (RN)-D when asked whether staff were aware of R24's yelling, RN-D answered "yes" and stated the social worker (SS)-A had been notified about that by different staff "more than once." RN-D also stated when that happens R24's behaviors are charted.
-At 6:37 p.m. SS-A stated she was aware of R24's yelling at R58, and stated one vulnerable adult (VA) report regarding R24 had been filed, but not one for R24 yelling at R58. SS-A stated she had talked to R58 and R24 individually about the yelling incident, but had not put notes into the computer about it. SS-A stated she only had her own paper notes, and said "now I wish I would have documented it." SS-A stated she was also aware R24 has yelled at other residents. SS-A stated R24 had dementia, a "short fuse", and R24 apologized after the incidents. SS-A stated at the time she had not considered the yelling incidents from R24 as verbal abuse as R58 and R24 have a long history together. SS-A stated she therefore at that time had not submitted a report to the SA.

On 7/23/14, at 1:51 p.m. SS-A stated the usual process was talking to the staff or residents, investigate a little first, talk to the administrator, discuss, and then the decision was made whether to file a report to the SA. SS-A stated either SS-A or the administrator would make the report.
-At 2:18 p.m. the administrator stated yes she was aware that reportable Incidents should be submitted immediately to the SA, and was also

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F 226	Continued From page 14 aware Investigative reports needed to be filed within five working days of the incident. The report of verbal abuse from R58 was not reported immediately to the SA regarding R24. R59's Quarterly MDS dated 5/1/14, indicated R59 scored a score 6 on the BIMS which depicted R59 as having impaired cognition. A Progress note dated 2/14/14, by SS-A stated R59 was vulnerable due to cognition and due to the cognition impairment R59 had some difficulty completely expressing thoughts/words, but was able to if given time, comprehend most conversations. R59 had a history of dementia. R59 on 6/23/14, reported R24 hit R59 on back of head during bingo. Staff members overheard and witnessed R24 yell and slam R24's hand down on table. The incident report stated there was a long standing history between R24 and R59 and it was not clear if anything physical happened between R24 and R59. Follow up plan was to have staff watch for agitation between R24 and R59 when together. On 7/23/14, at 1:50 p.m. the social worker stated to surveyor she found out about the incident on the morning of 6/24/14. The social worker stated she had talked to the administrator about that incident and the administrator had told her she should have submitted a report. The report was submitted on 6/25/14, two days later. - At 2:18 p.m. the administrator stated yes she was aware that reportable Incidents should be submitted immediately to the SA, and was also aware Investigative reports needed to be filed within five working days of the incident. The report was not followed in five days but rather	F 226		

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F 226	Continued From page 15 nine days later. R23's incident report stated R23 fell on 3/12/14, while transferring with staff assistance from wheel chair (w/c) to exercise equipment without staff using gait belt. R23 lost balance and R23 fell hitting the head on arm rest of chair and door. R23 received a minor skin tear on left ear. The investigation found R23 lost balance during a transfer while receiving assistance from staff. It was found staff had not used a gait belt while assisting R23 which may have prevented R23's fall. Staff was disciplined and was given further training on facility procedure for assisting R23 to transfer. The report stated R23 received minor injuries. The final investigative report was completed on 3/21/14, which was nine days later. On 7/23/14, at 1:51 p.m. the social worker (SS)-A stated she was hired in 2012 and the vulnerable adult (VA) policy was already in place. SS-A stated the usual process was talking to the staff or residents, investigate a little first, talk to the administrator, discuss, and then the decision is made whether to file a report. SS-A stated night staff will call administrator and they will talk about it, and the administrator will decide if a report was to be made, and either SS-A or the administrator will make the report. SS-A stated she would update the policy to read to report immediately to administrator/SA, then investigate. At 2:18 p.m. the administrator stated staff were trained to report immediately if a suspicion of abuse, were to call the administrator immediately, and if any suspicion talk to SS-A or administrator and one of them would report it. The administrator stated if reported late, staff should documented why. The administrator stated staff were told if the	F 226		

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	245554	A. BUILDING _____ B. WING _____	07/25/2014

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F 226	Continued From page 16 administrator was not available, they were to report it. The administrator stated staff were trained on the procedure yearly at a minimum. The administrator verified the facility's current Abuse Prohibition Policy used State terminology "maltreatment" instead of the Federal terminology "mistreatment" and said the policy was a corporate policy. The administrator also verified reportable incidents needed to be submitted immediately to the SA and investigation reports needed to be filed within five working dates of the incident.	F 226		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically-related social services for 1 of 1 resident (R24) identified as having behavioral outbursts which affected two residents (R58, R4). Findings include: On 7/23/14, at 9:40 a.m. R24 was observed to yell, "Don't sass at me!" at a volunteer (V)-A. R24 and V-A were at the Centennial Circle Garden, about 20 feet away from where surveyor was standing. V-A explained to R24 that empty spaces left at the activity table were for residents	F 250	Specific Resident #24: Assessment completed to identify and address needs, behavior monitoring in place, interventions including resident response to interventions in place, informed resident and family of choices and ramifications, staff trained on identifying and defusing escalating or potentially abusive situations. Care plan updated. Identification	9/8/14

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F 250	Continued From page 17 in wheelchairs who would be joining the activity. However, in a stern way R24 was observed to reply, "Ok, I'll keep quiet!" On 7/24/14, at 10:53 a.m. during interviews with R58 and R4, both residents identified R24 to be verbally abusive. R58 stated R24's yelling made her mad and also made R58 feel "about that high [measuring approximately an inch between thumb and pointer finger]." R58 added having to ask for a dose of Ativan (an anti-anxiety medication) because of anxiety caused by R24. R58 stated R24 yelled at everybody and had called other people names too. R58 stated, "I don't feel like a person with them letting her get by with all that crap." R4 stated it bothered her when R24 yelled "you old bitch" across the dining table at her. R58's quarterly MDS dated 6/4/14, indicated R58 was cognitively intact. R4's quarterly MDS dated 6/26/14, indicated R4 had moderate cognitive impairment. A review of R24's Progress Notes By Resident forms entered from 3/10/14 to 4/25/14, indicated R24 manifested behavioral symptoms: On 3/17/14, the notes indicated R24 had "elopement attempts and wandering" and a physical therapy note which depicted R24 as being "very upset with room change did hit out at nursing staff x2 occasions, did become verbally agitated with therapy," On 3/20/14, R24 was noted to be "hitting and yelling at staff at times." The progress notes thereafter lacked evidence to indicate R24's behavioral symptoms were being monitored. There were no comments in the physician's progress notes on 3/25/14, 4/29/14, 6/10/14 and	F 250	All resident behavior monitoring forms reviewed to identify behaviors and offer comprehensively assessed and resident specific interventions developed and care planned. Care plans and care guides will be updated as necessary. Systemic Policy was reviewed and appropriate. Assessments will be completed per MDS 3.0 Assessment Policy. A comprehensive, accurate and standardized assessment of each resident□s functional capacity, using the RAI manual and regulation will be completed per policy. Monitor The Social Service Director and the Administrator or designee will monitor compliance through monthly auditing. Audits will be reviewed at Performance Review and Quality Assurance committee.	

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F 250	Continued From page 18 7/8/14, regarding R24's behaviors. R24's admission MDS, dated 3/17/14, indicated R24 had severe cognitive impairment. The Behavioral Symptoms section, indicated R24 had physical behavioral symptoms directed towards others (such as hitting, kicking, pushing) and verbal behavioral symptoms directed towards others (such as threatening, screaming, cursing) occurring 4 to 6 days, but less than daily during the assessment period. The MDS identified R24 had other behavioral symptoms not directed towards others (such as hitting or scratching self) which occurred 1 to 3 days during the assessment period. R24's Care Area Assessment (CAA) summary, dated 3/17/14, indicated behavioral symptoms were triggered on the MDS. The Comments and Analysis of Findings sections of the Review of Indicators of Behavioral Symptoms (RIBS) form dated 3/21/14, were left blank. There was no documentation to explain causal or unique risk factors for the behavioral symptoms. A comment entered in the Care Plan Considerations section of the RIBS dated 3/21/14, read, "Care plan to allow for the best quality of life." Although the MDS had identified behaviors, the CAAs lacked a summary of R24's behavioral status, including but not limited to identification of resident specific behaviors, potential antecedents to the behaviors, and clinically related social service interventions and strategies to address the identified resident specific behaviors. R24's current care plan dated as initiated on 3/27/14, did not address behavioral symptoms. The diagnoses list section of R24's face sheet	F 250		

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F 250	Continued From page 19	F 250		

dated 4/28/14, indicated R24 had diagnoses to include cerebrovascular disease, generalized pain, and insomnia. R24's diagnoses list did not include dementia until it was added to the electronic medical records diagnoses list when updated on 7/24/14, after surveyor intervention.

R24's quarterly MDS dated 6/6/14, indicated R24 had severe cognitive impairment. The Behavioral Symptoms section indicated R24 did not manifest physical behavioral symptoms directed toward others; had verbal behavioral symptoms directed toward others and behavioral symptoms not directed toward others occurring 1 to 3 days during the assessment period. Although the quarterly MDS identified potential inprovement in R24's behaviors, the clinical record lacked evidence clinically related social services were developed to address the idenitifed behaviors.

There were two incident reports reviewed which involved R24, as follows:
1.) On 6/25/14, R59 accused R24 of hitting R59 on the back of the head. According to the investigation report, R24 denied hitting R59, the two staff members who were at the activity during the incident denied having observed any "hitting," but agreed they heard R24 yell, "Shut up!" and slammed her hand on the table making a loud noise.

2.) On 7/24/14, involving R24 and R4, where R24 allegedly yelled, "You old bitch!" across the dining table towards R4. Also staff reported R24 had a behavioral outburst, when R24 slammed hand on table and yelled "shut up" to a little girl who was sitting on R59's lap during a bingo activity.

On 7/23/14, at 10:00 a.m., V-A was interviewed

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F 250	Continued From page 20 and stated she had volunteered in the facility for 14 years. V-A stated she felt embarrassed when R24 yelled at her within earshot of other people who were present in the area. V-A claimed R24 had yelled at some other people before, but had not done it "for a while." When V-A was asked if "other people" were residents of the facility, V-A stated R24 did yell at some residents and repeated R24 did not yell for some time until, "this morning." V-A stated she believed "all staff here [at the facility]" knew about R24's behaviors as they were reported to the staff when the behaviors had occurred "before." On 7/24/14, at 9:55 a.m. nursing assistant (NA)-H stated R24 yelled loudly "two times a day, every day" at other residents and staff. NA-H added, "We were told to try and calm [R24's name] down and re-direct her." At 10:30 a.m. housekeeping staff (HK)-B stated she witnessed R24 yell at somebody once "yesterday" when R24 yelled at V-A. HK-B stated aside from witnessing R24's yelling episode on 7/23/14, information about R24's verbally abusive behaviors were heard during meetings. HK-B did not remember what was said during the meetings or what to do about it. At 11:00 a.m. NA-B stated had not witnessed R24 yell or do anything to anybody, but had heard R24 was "very short" to people and did not like when children came to the facility. At 11:15 a.m. NA-C stated hearing from other staff R24 would be impatient during activities and would yell at others. NA-C was not aware if behaviors were being monitored and documented. At 11:30 a.m. NA-A stated R24 would yell at other residents during activities when R24 was upset. NA-A stated other residents would just keep quiet	F 250		

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F 250	Continued From page 21 and staff would intervene. NA-A stated they had reported R24's behaviors to the nurse manager or a registered nurse. NA-A was not aware if behaviors were being monitored and documented. At 11:40 a.m. registered nurse (RN)-A stated had observed R24 yell at other residents during activities, such as when residents were "playing ball." RN-A stated R24 yelled at other residents when frustrated. RN-A stated when staff report an incident regarding R24's verbally abusive behaviors, RN-A would approach and calm R24 down by talking. RN-A admitted there was neither monitoring, nor documentation for R24's behaviors. RN-A denied receiving a report about an incident involving R24 yelling at another resident on 7/23/14. On 7/25/14, at 7:56 a.m., director of nursing (DON)-B and the social worker reported that when R24, "first got to facility had some behavioral issues", however, the behaviors had not happened lately. The social worker and DON-B also stated R24's yelling behavior was not new and had happened, "way back when." DON-B confirmed dementia was not included in R24's admission diagnoses, and was added to diagnoses list on 7/24/14. DON-B stated adding dementia as a diagnosis for R24 was pulled from the doctor's progress notes on 3/25/14, 4/29/14, 6/10/14 and 7/8/14. DON-B confirmed dementia was not included in R24's latest quarterly Minimum Data Set (MDS), dated 6/6/14. DON-B stated R24 had dementia and had potential to have behavioral issues that may affect others. DON-B confirmed there was no care plan to address R24's risk for behavioral problems. The social worker confirmed a behavioral care plan was put in place on 7/24/14.	F 250		

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F 250	Continued From page 22 At 8:27 a.m. the social worker confirmed there was nothing in the progress notes about R24's behavior. The social worker stated there had been no report to her about R24's behavior, and added, "But now when I talk to staff, it is a different story." At 9:08 a.m. the social worker indicated there were no incident reports involving R24, except the ones that were provided to the surveyors, and said she had not been focusing on resident to resident abuse. During interview on 7/25/14, at 8:10 a.m. DON-B and SW stated they had interviewed all resident's who go to activities with R24, her roommate/bathroom share, and stated "all had no issues [with R24's behaviors]." SW said they interviewed people who go to the activities with R24 and R58 and received no complaints, the activities person was interviewed and said they had not seen anything. SW stated R24 was very hard of hearing and spoke very loudly, "That's just her. We provide her with person centered care." SW stated dementia was on the chart and in the medical records and there was a behavior plan at the desk to remove R24 when she was yelling. SW explained to take R24 to her room to calm down and then let her rejoin the group. When asked when the plan had been put into place, SW stated, "It's at the desk." When asked if the behavior plan was on the nursing assistant care sheets, DON-B indicated it had been done the night before. When asked if abuse was covered in orientation, the SW stated staff were told to provide "person centered care," and explained, with an example, that if residents were told the facility was short staffed, the residents would be fearful that there were not enough staff to care for them. SW	F 250		

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F 250	Continued From page 23	F 250		

stated, "I don't give an example of resident to resident abuse, and I probably should."
At 8:26 a.m., SW stated she had printed a "VA [vulnerable adult]" for R4 "last night" after R4 had verbally reported alleged verbal abuse from R24 to the surveyor on 7/24/14. SW stated she conducted an investigation and reported the allegation to the SA, but had hit "send", before printing the report and investigation, so did not have a copy of the VA report. SW stated, "I am finding out now that staff have not told us that [R24's name] had been yelling and pounding the table. There had been nothing in the progress notes about behavior, no reports made about R24, and now when I talk to staff it is a different story."

The facility's policy dated 11/2/10, directed facility staff to use the Resident Assessment Indicator (RAI) Process to "assess the resident's function." The policy directed to complete the MDS, CAA and utilizations guidelines by the Centers for Medicare and Medicaid Services (CMS) to "assess the resident to identify problems and formulate appropriate care plan goals and approaches for the resident." Under the facility's RAI Process' Procedure number 7, the "completion of the assessment process includes completing further assessments for the care areas triggered on the MDS," and that there must be a "summary statement of the causal factors, contributing factors or complicating factors as to why the resident has the problem." The facility's RAI process further directed to complete a Care Area Assessment summary and describe: the nature of the condition; complications and risk factors that affected the decision to proceed to care planning; factors that must be considered in making an individualized care plan interventions;

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F 250	Continued From page 24 and the need for referrals or further evaluation by appropriate health professionals.	F 250		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		9/8/14

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F 272	Continued From page 25 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess physical and verbally abusive behaviors for 1 of 3 residents (R24) reviewed for behaviors. Findings include: R24's record was reviewed. An admission MDS dated 3/17/14, indicated R24 had severe cognitive impairment. The Behavioral Symptoms section, identified R24 had physical behavioral symptoms directed towards others (such as hitting, kicking, pushing) and verbal behavioral symptoms directed towards others (such as threatening, screaming, cursing) occurring 4 to 6 days, but less than daily during the assessment period. The MDS identified R24 had other behavioral symptoms not directed towards others (hitting or scratching self) occurring 1 to 3 days in the assessment period. R24's Care Area Assessment (CAA) summary dated 3/17/14, indicated behavioral symptoms were triggered. The Comments and Analysis of Findings sections of the Review of Indicators of Behavioral Symptoms (RIBS) form dated 3/21/14, were left blank. The CAA lacked documentation to explain causal or unique risk factors for the behavioral symptoms. A comment entered in the Care Plan Considerations section of the RIBS dated 3/21/14, included: "Care plan to allow for the best quality of life." Although the admission	F 272	Specific Resident #24: Assessment completed to identify and address needs, behavior monitoring in place, interventions including resident response to interventions in place, informed resident and family of choices and ramifications, staff trained on identifying and defusing escalating or potentially abusive situations. Care plan updated. Identification All resident behavior monitoring forms reviewed to identify behaviors and offer comprehensively assessed and resident specific interventions developed and care planned. Care plans updated as necessary. Systemic The facility will do comprehensive assessments of resident□s behaviors and summary process. Monitor The Social Service Director and the Administrator or designee will monitor compliance through monthly auditing.	

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F 272	Continued From page 26 MDS identified the presence of behaviors during the assessment period, and the CAA for behaviors was triggered, the clinical record lacked evidence R24 was comprehensively assessed for the identified behaviors. On 7/25/14, at 7:56 a.m. the director of nursing (DON)-B and the social worker both verified R24 had not been comprehensively assessed for behaviors. The facility's policy 11/2/10, indicated staff were to use the Resident Assessment Indicator (RAI) Process to "assess the resident's function." The policy directed to complete the MDS, CAA and utilizations guidelines by the Centers for Medicare and Medicaid Services (CMS) to "assess the resident to identify problems and formulate appropriate care plan goals and approaches for the resident." In addition, under the facility RAI Process' Procedure number 7, direction included: "completion of the assessment process includes completing further assessments for the care areas triggered on the MDS," and a "summary statement of the causal factors, contributing factors or complicating factors as to why the resident has the problem." The facility's RAI process further directed that any care area assessment summary describe: nature of the condition; complications and risk factors that affect decision to proceed to care planning; factors that must be considered in making individualized care plan interventions; and the need for referral or further evaluation by appropriate health professionals.	F 272	Audits will be reviewed at Performance Review and Quality Assurance committee.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		9/8/14

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F 309	Continued From page 27 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 interview and record review the facility failed to ensure appropriate care and monitoring was implemented for 1 of 3 residents reviewed who had skin breakdown (R71). The findings include: R71 had been admitted to the facility on 2/22/10, and had diagnosis including: Diabetes Mellitus (DM) Type I, bacterial infection, mood disorder, hypothyroidism, depression, and hypertension. The resident's record was reviewed and included documentation of arterial ulcers to the lower legs. The progress notes indicated that on 6/3/13, wound cultures of the left leg were positive for Methicillin Resistant Stapholoccos Aureus (MRSA). In addition, a progress note from 6/18/13, at 12:08 p.m. indicated a small sore had developed on the resident's right great toe. The progress note indicated R71 had been educated to keep his shoe off, and to wear only TED stockings and gripper socks. Additional documentation of the foot described erythema noted on top of left foot, a small intact blister noted on top of left foot, white swollen areas noted around left great	F 309	Specific Resident R71 : Resident record is closed. Identification All residents who are receiving wound care will be reviewed to ensure that the level of care is provided at its highest potential and that a root cause analysis is completed regarding cause of wound. Systemic Wound care policies were reviewed. All residents with wound care will be routinely reviewed with updates to ensure that the appropriate nursing care is provided and a root cause analysis is completed. The skin and wound protocols will be reviewed and education provided to all licensed nursing staff. Wound rounds will be completed weekly. Monitor The Director of Nursing or designee will	

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	245554	A. BUILDING _____ B. WING _____	07/25/2014

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F 309	Continued From page 28 toe/toenail, and odor noted from left leg/foot. The record included progress notes regarding the resident's left foot wound to the great toe from 6/20/13-8/18/13. The notes reflected the progressive deterioration in the condition of the wound. A progress note dated 7/30/13, at 3:05 p.m. indicated the left great toe continued to show declining skin status with base on both nails yellow in color with moist appearance. "Color of tip of left great toe pale white/yellow. Poor circulation with no improvement noted or expected. Tip of right great toe had a small area which measured 0.4 cm diameter. Area was closed. No change since last week. Current Treatment: keep all pressure off areas." The note further indicated R71's family had purchased him open toed sandals. On 7/31/13, the resident's primary physician had documented a progress note indicating R71 had significant necrotic changes to his toes, particularly the left great toe. The physician's note indicated R71 had erythema extending from his toes up to just below the knee with some blistered, denuded areas on the left anterior to lateral mid (middle) tib-fib (tibia-fibula) area (lower leg bones that end at the knee joint). In addition, the notes included: "The culture results from 5/31/13, were MRSA in the left leg cellulitis and treated with Bactroban and Bactrim, however his infection worsened and [R71] was re-treated with Bactrim from 7/9-7/19/13. [R71] appears more confused and had a decline in mental status in the last two months. The family has chosen not to pursue angiography given his age and condition, the left leg does cause pain for which he receives	F 309	review residents with wounds to ensure appropriate monitoring and care is completed based on wound care standards. Wound and clinical updates with interventions will be provided weekly to the IDT. Chart audits will be completed by the Directors of Nursing and/or designee to ensure appropriate interventions are in place. Performance Review Committee and Quality Assurance Committee will review results.	

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F 309	Continued From page 29	F 309		

Percocet. Below the knee amputation with spinal anesthesia was considered..." The physician's note also included: "ASSESSMENT/PLAN: MRSA cellulitis with peripheral vascular disease and what appears to be a dry gangrene type of process in his big toe on the left."

A progress note dated 8/18/13, indicated an order had been received to modify the treatment to R71's gangrenous wound. The order was for Flagyl (an antibiotic) 500 mg (milligrams) to be crushed and sprinkled over the wound for odor control. "Use 1 (one) 500 mg Flagyl tab for each dressing change."

The next progress note regarding the gangrenous foot was documented on 8/25/13, at 7:48 a.m. The note indicated the resident's dressing had been changed at 7:30 a.m. and when the dressing had been removed maggots were noted between the resident's toes on left foot. According to the note, the area had been cleaned but more maggots had appeared. The note indicated when the area had been cleaned multiple times, hospice had been informed of the maggots and the hospice nurse was going to talk with R71's doctor.

Another progress note dated 8/25/13, at 2:46 p.m. indicated the hospice nurse had made a visit to the resident at 11:00 a.m. The hospice nurse had reportedly spoken to the resident's primary physician and it had been decided to soak the resident's foot then clean with hydrogen peroxide and coat with corn starch. The note indicated this had been done, and when the dressing was removed no more maggots had been noted.

Although an entry was made in the resident's

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F 309	Continued From page 30 record 8/27/13, at 4:15 p.m., including: "...dressing change completed on 8/24/14 at approximately 11:00, lower legs and toes cleansed well before dressing applied, lower legs and toes were kept covered at all times and dressing was fully intact on the morning of 8/25/13 prior to dressing change. No skin was exposed, no drainage coming through dressing; minimal drainage, 2nd toe on left foot was fully gangrenous with tip of great toe gangrenous as well." The record did not indicate further investigation or root cause analysis had been conducted to evaluate the techniques used by staff when completing the dressing change in order to determine how the maggots might have gotten into the resident's wound. On 8/29/13, the resident's care plan was revised to include a diagnosis of bacterial infection with interventions to apply Ben Gay or icy hot around left heel wounds and left great toe to increase blood flow/circulation BID (twice a day). Keep all pressure off heels. Hospice to assess skin status and pressure points for signs of breakdown every visit, hospice will teach wound care protocol as ordered, hospice will assess for pain and medicate as needed prior to dressing change." During interview with director of nursing (DON)-B, at 12:30 p.m. on 7/25/14, she verified the resident had a long history of ischemic toes, and stasis ulcers on the lower extremities. No additional information regarding the wound care, or development of maggots was provided.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		8/20/14

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F 323	Continued From page 31 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 ensure equipment was maintained in a safe working order, including bathroom assist bars, for 7 of 7 residents (R7, R65, R23, R43, R70, R58, R63). Findings include: The facility failed to maintain safe bathroom assist bars for 7 of 7 residents (R7, R65, R23, R43, R70, R58, and R63). During an environmental tour on 7/24/14, at 2:15 p.m. with the director of maintenance (DM) loose bathroom assist bars were identified and verified by the DM. Loose bathroom assist bars which moved approximately one to three inches back and forth were identified in a shared bathroom for R7 and R65. R7 had an OT (occupational therapist) - Therapist Progress & Discharge Summary dated 7/26/13, which indicated R7 was able to perform toileting tasks utilizing grab bars requiring standby assist. Care plan dated 2/25/14, revealed R7 was at risk for falls. R7's annual minimum data set (MDS) dated 4/23/14, indicated R7 required extensive assist of one for toilet use and had moderately	F 323	Specific Resident # 7 : Resident assessed to determine need for assist bars. Resident grab bars in BR were evaluated and tightened according to manufacture recommendations. Resident # 65: Resident assessed to determine need for assist bars. Resident grab bars in BR were evaluated and tightened according to manufacture recommendations. Resident # 23: Resident assessed to determine need for assist bars. Resident grab bars in BR were evaluated and tightened according to manufacture recommendations. Resident # 43: Resident assessed to determine need for assist bars. Resident grab bars in BR were evaluated and tightened according to manufacture recommendations. Resident # 70: Resident assessed to determine need for assist bars. Resident grab bars in BR were evaluated and tightened according to manufacture	

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F 323	Continued From page 32 impaired cognition. The corresponding care area assessment (CAA) dated 4/23/14, indicated falls had triggered for R7. The quarterly MDS dated 7/16/14, noted R7 had fallen in the last 90 days or since admit with no injury noted. R65's admission MDS dated 5/29/14, indicated R65 required extensive assist of one for toilet use and had severely impaired cognition. The MDS also revealed R65 had a history of falls with a fracture prior to admission. The CAA dated 5/29/14, indicated falls had triggered for R7. Care plan dated 6/9/14, indicated R65 had potential for falls. Loose bathroom assist bars moving approximately one to three inches back and forth were identified in the bathroom for R23. R23's care plan dated 11/26/12, indicated R23 was at risk for falls. The CAAs dated 10/16/13, indicated falls had triggered for R23. The quarterly MDS dated 6/25/14, indicated R23 required extensive assist of one for toilet use and had moderately impaired cognition. The MDS also depicted R23 as having one fall in the facility without an injury in the last 90 days. Loose bathroom assist bars moving approximately one to three inches back and forth were identified in the shared bathroom for R43 and R70. The assist bar on the right side was leaning forward to fit under a toilet paper holder which was pulled out of the wall approximately 1/2 inch. The right assist bar was not at the same height as the left side assist bar. DM verified the bar was set down a notch to be able to fit under the toilet paper holder.	F 323	recommendations. Resident # 58: Resident assessed to determine need for assist bars. Resident grab bars in BR were evaluated and tightened according to manufacture recommendations. Resident # 63: Resident assessed to determine need for assist bars. Resident grab bars in BR were evaluated and tightened according to manufacture recommendations. Identification All bathroom grabs used in the facility were evaluated and any bars found loose were tightened according to manufacture recommendations. Systemic Resident bathroom assist bars will be assessed to ensure appropriate. They will be applied according to manufacture recommendations. Monitor Monthly audits of all assist bars will be completed by Maintenance Director or designee. Performance Review Committee and Quality Assurance Committee will review results.	

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R43's had an OT - Therapist Progress & Discharge Summary dated 10/17/13, which indicated R43 was able to perform toileting tasks utilizing grab bars requiring supervision. Care plan dated 2/25/14, indicated R43 was at risk for injury. The annual MDS dated 5/9/14, indicated R43 required extensive assist of one for toileting and had intact cognition. The MDS also noted R43 had a fall in the facility in the last 90 days without an injury. The CAAs dated 5/9/14, indicated falls had triggered for R43.

R70's nursing assistant team sheet (undated) indicated R70 required extensive assist of two for transfers, had short term memory loss, needing cueing and reminders and was at risk for falls.

Loose bathroom assist bars moving approximately one to three inches back and forth were identified in a shared bathroom for R58 and R63.

R58's CAAs dated 12/18/13, indicated falls had triggered for R58. The quarterly MDS dated 6/4/14, indicated R58 required extensive assist of one for toileting and had intact cognition. The MDS also noted R58 had a fall in the facility in the last 90 days without an injury. Care plan dated 7/7/14, indicated R58 was at risk for falls.

R63's CAAs dated 4/24/14, indicated falls had triggered for R63. R63's admission MDS dated 4/24/14, indicated R63 required assist of one for toilet use, had no falls in the 90 days, and had intact cognition. The care plan dated 5/6/14, indicated R63 had potential for falls.

During an interview on 7/24/14, at 3:20 p.m. DM stated he did rounds one time per month to check

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for housekeeping issues and call lights and he did not check the bathroom assist bars. DM stated he had Maintenance Repair Request Forms on a clipboard kept behind the South nursing station front counter. DM stated the forms were for anyone to report a maintenance requests or concerns. DM stated he looked at the clipboard every day and tried to resolve any issues as soon as possible. DM verified the loose bathroom assist bars were not on the maintenance repair request forms. DM stated he had no written policy, but reviewed the maintenance request process at new employee orientation and annually to all staff.

During an interview on 7/25/14, at 8:41 a.m. registered nurse (RN)-B stated staff were trained and should write down maintenance issues and that any staff can report issues, "even housekeeping." RN-B stated the process was brought up at safety meetings, orientation for new hires and yearly inservice. RN-B verified R7, R65, R23, R43, R58 and R63 all used their bathrooms for toileting. RN-B stated she "was not sure" if R70 used the bathroom.

During an interview on 7/25/14, at 11:28 a.m. DM stated he was not sure how many bathroom assist bars were in the facility and, "I don't know if the assist bars are supposed to be like that or not, I installed new ones and they are just about the same."

During an interview on 7/25/14, at 11:36 a.m. OT stated she would assess and recommend bathroom assist bars if they were needed. "They do get loose after time." OT stated they would look at them again if the resident came back on their caseload and/or, "Housekeeping or nursing

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F 323	Continued From page 35 will tell us or maintenance if they are loose, they tighten them or we find something else for them." OT further stated, "Maybe we should be checking them, we probably need to be doing that."	F 323		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet the needs of 9 of 9 residents (R43, R13, R30, R42, R39, R58, R55, R23, R50) who self-identified insufficient staff to meet their needs.	F 353	Specific The facility designee will review staffing daily to ensure that there is sufficient nursing staff to provide appropriate resident care and services, adjusting with	9/2/14

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F 353	Continued From page 36 Findings include: A review of the staffing schedules from 4/30/14 to 7/21/14, indicated a pattern of short staffing, for which the facility used mandated overtime (4 hours), or shifts remained unfilled. The facility administrator, who was in charge of scheduling and staffing, was unable to state what positions were needed, what percentage of mandated overtime was used, what percentage of shifts ran short, what the turnover percentage was, or how many open FTE's (full time equivalents - a measure of how many jobs were needed to fill the planned schedules). Although this was discussed at monthly quality meetings, the administrator stated "check with human resources." The facility had 44 falls from 3/1/14-7/21/14, 9 falls on day shift, 22 falls on evening shift, and 13 falls on night shift; the administrator stated the facility monitored fall times of day and did not find a correlation between staffing and falls. The administrator stated the facility paid time and a half for weekend shifts, even when staff were not into overtime hours. Staffing schedules reviewed for mandated over time included: From 6/2/14-6/15/14, the schedule indicated eleven day shift workers were mandated four hours overtime (OT). Seven evening shift workers were mandated four hours OT, nine night shift workers were mandated four hours OT. From 6/16/14-6/29/14, the schedule indicated twelve day shift, ten evening shift and thirteen night shift workers were mandated four hours OT. From 6/30/14-7/13/14, the schedule indicated fourteen days shift, nine evening shift were mandated four hours OT, and two night shift workers were sent home before the end of the	F 353	census, acuity and reallocating staff where appropriate. Identification The facility will review staffing daily on each area to ensure that there is sufficient nursing staff to provide appropriate resident care and services, adjusting with census, acuity and reallocating staff where appropriate. Systemic Staffing policies were reviewed. Minimum staffing requirement was defined. Staffing patterns will routinely be reviewed by Nursing Management team and the Directors of Nursing and/or Administrator to ensure that there is sufficient staffing for each area and that staff is appropriately reallocated to meet care needs when call-ins require it. Directors of Nursing and/or designee will evaluate cares and call light response to ensure that appropriate care is being provided. Staff will be instructed to go the nurse supervisor for assistance as necessary. Monitor Staffing patterns will be monitored by the Administrator/ Directors of Nursing or designee, adjusting with census, acuity and reallocating staff where appropriate. Random monthly resident interviews will be conducted to ensure resident needs are met. Performance Review Committee and Quality Assurance Committee will	

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F 353	Continued From page 37 eight hour shift. A review of the daily staffing sheets (some examples) noted below indicated: 4/2/14, DON-A (director of nursing) and DON-B split the evening charge nurse shift. 4/3/14 DON-B worked four hours of evening charge nurse shift. 4/20/14, the facility worked short 1/2 NA on the evening shift, and a resident was found on the floor at 8:50 p.m. 4/21/14, the facility worked short on day shift, because TMA was pulled to NA shift. 4/24/14, the facility worked short on evening shift 1 1/2 nursing assistants 4/26/14, the facility worked short 1 NA on the day shift, the day shift charge nurse stayed until 7 p.m. (4 hours OT), because the evening supervisor was pulled to an open nurse shift. 5/7/14, the facility worked short a TMA. 5/12/14, day shift short 2 NA, (but had one float scheduled so only short 1), there were six changes on the evening shift, a TMA was pulled to NA position and shifts were split, and on night shift, 2 NA's split a shift. 5/15/14 the facility worked short a trained medication aide (TMA) who was split between units on day shift and evening shift, and a resident fell from a chair or bed at 7:45 p.m. 5/17/14, a nurse came in at 5:00 a.m. and worked a 10 hour shift. a TMA worked a 12 hour shift (and then left an empty NA 1/2 shift on evenings, and a night shift charge nurse shift was split. 5/26/14, the facility worked short on the day shift, short on the evening shift, and one NA from the night shift worked until 10:00 a.m. on the 27th. The daily staffing sheet for 5/28/14, was not provided. 5/29/14, the facility worked short on the evening	F 353	review results.	

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F 353	Continued From page 38 shift. on 6/3/14 two NA called in sick and were replaced by one NA who worked the night shift and stayed until 10:00 a.m. 6/6/14, a day shift NA, went home early, a evening NA came late and left early, the census was 56 (full). 6/11/14 a day shift TMA was ill and replaced by a evening shift TMA, who was replaced by an LPN for 6 hours. , a nursing assistant shift was split, a resident fell from a chair or bed at 6:00 a.m.. 6/14/14, a evening TMA went home 1 hour early, an evening NA worked 7 hours (planned 8), and a evening NA worked only 4 hours (planned 8), and 2 night shift NA worked reduced hours. (a total reduction of 19 hours with a census of 55/56. 6/16/14 a TMA was short on the day shift, the evening charge nurse shift was split, an NA shift was split on evenings and nights. 6/17/14, an LPN was used as a TMA, leaving 1 nurse short on North unit until 12:30, and an NA was ill and not replaced. An LPN from the evening shift was changed to 12:30 to 9:00 hours on North unit and was not replaced after 9:00 6/18/14 A NA from North was pulled to South, a TMA from South was pulled to North, an NA was assigned on Mission and North. (usually two separate assignments). 6/20/14, one day shift TMA was reduced to 6.5 hours, the restorative aide was reduced to 4.5 hours and then pulled to evening NA duties. The evening charge nurse shift was spilt, the evening TMA was reduced 6 hours. the night shift charge nurse worked an extra hour. a night shift NA was reduced by 5 hours. 7/4/14, a day shift NA worked until 7 p.m. (12 hour shift) a evening TMA worked 6.25 hours, an evening NA worked 4.25 hours, a evening NA worked 7 hours, a night shift NA worked 4 hours	F 353		

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F 353	Continued From page 39	F 353		

and an NA came in at 4:00 a.m. (split shift).

Residents interviewed in stage 1 impacted by insufficient staffing included:

R43 had a quarterly Minimum Data Set (MDS) dated 5/21/14, and indicated a Brief Interview for Mental Status (BIMS) score of 13/15, which indicated no cognitive impairment, and required extensive assist of one staff with bed mobility, transfers, toilet use and personal hygiene. R43 was supposed to be on a toileting program trial, was occasionally incontinent of urine and frequently incontinent of bowel. R43 stated she had to wait 20-30 minutes for assistance in the daytime.

R13 had a significant change MDS dated 5/28/14, and indicated a BIMS score of 3/15, which indicated severe cognitive impairment, and required extensive assist of two staff with bed mobility, transfers and toilet use; and extensive assist of one staff for personal hygiene. R13 was frequently incontinent and was supposed to be on a toilet training program. R13 stated, "I think there should be more help... I sometimes wait a long time."

R30 had a quarterly MDS dated 7/2/14, and indicated a BIMS score of 14/15, which indicated no cognitive impairment, and required extensive assist of two staff with transfers and toilet use; and extensive assist of one staff for bed mobility and personal hygiene. R30 had an indwelling Foley catheter for obstruction and was always continent of bowel. R30 stated at night and in the morning, there was not enough help, and "they can't keep staff here."

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F 353	Continued From page 40 R42 had a quarterly MDS dated 6/30/14, and indicated a BIMS score of 7/15, which indicated severe cognitive impairment. R42 required extensive assist of two staff for bed mobility, transfers, toilet use, and extensive assist of one staff for personal hygiene, and was always incontinent of urine and occasionally incontinent of stool. R42 stated she was having bladder problems and should have more help, "By the time they get to me, I am wet... should be given medicine for it, some think I am a nuisance because I like to help and they are busy." R39 had a quarterly MDS dated 7/11/14, and indicated a BIMS score of 13/15, which indicated no cognitive impairment. R39 required extensive assist of two staff with bed mobility, transfers and toilet use, and extensive assist of one staff for personal hygiene. R39 was on a toileting program and had decreased incontinence when taken to the toilet in a timely fashion. R39 stated the facility could have more help, "I have messed myself and diaper, [I'm] supposed to use commode everyday between 3:30 p.m. and 3:45 p.m., but they are sometimes late." R58 had a quarterly MDS dated 6/13/14, and indicated a BIMS score of 15/15, which indicated no cognitive impairment, and required extensive assist of one staff toilet use and personal hygiene. R58 stated she sometimes had to wait 30 minutes or longer while waiting on the toilet for aides to come from the other side to assist. R58 was on a toileting program and was usually incontinent. R58 had a discussion with the administrator about changing her incontinence pad more than twice a day, because her bedside lounge chair was wet and needed to be cleaned, "The administrator stated this was embarrassing"	F 353		

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F 353	Continued From page 41 for R58. R55 had a quarterly MDS dated 6/13/14, and indicated a BIMS score of 11/15, which indicated moderate cognitive impairment, and required extensive assist of one staff with bed mobility, transfers and toilet use and personal hygiene. R55 was occasionally incontinent of bowel and bladder. R55 stated, "Sometimes I wait too long to get to the bathroom, [I] don't think there is enough staff. I don't want to wait for help, I had to go really bad, usually get up in the night. In the evening it takes quite a while to get a pill." R23 had a quarterly MDS dated 7/2/14, and indicated a BIMS score of 9/15, which indicated moderate cognitive impairment, and required limited assist of one staff with bed mobility, transfers and toilet use and personal hygiene. R23 was frequently incontinent of urine. R23 stated, "Sometimes I wait 30 minutes for assist in the evenings." R50 had a 14 day MDS dated 7/7/14, a BIMS score of 13/15, which indicated no cognitive impairment, and required extensive assist of 2 with bed mobility, transfers, toilet use, and personal hygiene. R50 was frequently incontinent of urine and rarely incontinent of bowel. R50 stated, "I think they need more people at night, basically it takes them a long time, depends on who was working. I have not had an accident , I am not scared, but I am concerned." On 7/23/14, at 9:33 a.m. NA-F stated they were normally able to get things done, but sometimes really busy answering call lights. NA-F stated sometimes the facility was short staffed and the staff "really have to work as a team." NA-F stated,	F 353		

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F 353	Continued From page 42	F 353		

"If your name was circled on the time sheet [schedule] it means you have to stay 4 hours past your 8 hour shift [mandatory overtime]. They have been staffing better in the last month, knowing you [the State agency] were coming."

On 7/25/14, at 9:00 a.m. the facility temporary staffer (TS) was interviewed and explained the different codes used on the staffing sheets. TS stated a circled shift meant a four hour mandated over-time shift. TS further stated staff also sometimes went home early (as indicated on the schedule sheets 3 hour, 5 hour, 6 hour, or 7 hour shifts). TS stated the basic staffing pattern for nursing assistants (NA) was six on days, six on evening shift, and three on the night shift plus one person came in early to make it four staff for two hours in the early morning. TS stated the facility had worked short, but had gotten better in the last two to three months. Weekend one (on the schedule) remained two staff short on day shift, two staff short short on evening shift, and two staff short on night shift. TS stated it was a fair statement working short happened fairly frequently, although it had gotten better in the last few months.

On 7/25/14, at 9:22 a.m. DON-B stated the facility could provide call light logs because the facility deleted them after the monthly quality review. DON-B stated each morning the staff reviewed the length of call light response times on the units and DON-B then interviewed residents to see if their needs were met. DON-B stated the only call light logs she had now were in the last week, when asked what the longest time of call light was on, she stated the longest call light time was 25 minutes. Although DON-B stated she interviewed the staff to see what happened,

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F 353	Continued From page 43 DON-B stated she did not interview the resident whose call light was on for 25 minutes (this week), but had interviewed this resident in the past when her call light was on. On 7/25/14, at 11:00 a.m. A family member (FM)-B of R65 requested to speak to a surveyor and stated her mother was not cared for as she would expect. (FM)-B stated a swollen hand was noted on admission from the hospital to the nursing home. (FM)-B stated, "[I] had to tell facility how to care for mother's swollen hand, keeping it elevated, etc." In addition, (FM)-B stated R65 did not have a bath for a week, because she had not been put on the bath schedule. R65's hearing aides were not placed in the resident's ears consistently. (FM)-B also stated, "There were times the staff was pretty busy. One time at 11:00 a.m., [R65's name] was still waiting for staff to give her a shower, she had not had breakfast yet, and had not been dressed that morning." On 7/25/14, at 11:15 a.m. The administrator verified mandated overtime was used in the facility and she did not know how much mandated overtime, the percentage of short shifts worked, the percent of turnover, or what positions were open in the facility. On 7/25/14, at 12:35 the administrator stated corporate did two week statistics for us and track for us, the staffing was determined by looking at the case mix index which for us was .99, generally staff a 1-8 ratio on days and evening, and never above 1-10. Falls were reviewed every morning in IDT (interdisciplinary team), "I have them do a root cause analysis (RCA), and want to hear back within a couple of days." The facility	F 353		

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F 353	Continued From page 44 looked at the QA (quality assurance) process, at that time could not correlate staffing with falls/ injuries, accidents, or resident to resident incidents. Staffing was talked about at board meetings and monthly performance reviews, "Because they talk about job openings, turnover, and retention in QA monthly." The administrator stated the facility had done some things to try and balance staffing, have changed the TMA's, and ensure charge coverage all over the building on every shift. "We have changed activity schedules, extended until 8:00 p.m. to help with the boredom problem, we are using the team approach. For one to ones use family, activities in the evenings to try to help keep resident's busy. We started an 0500 [5:00 a.m.] person started coming in for the early risers, we are always adjusting to the needs as they occur." The administrator verified the first weekend of the schedule was short, but shifts were posted and weekend, and mandate OT as needed. "We offer time and 1/2 for all weekend shifts [even if not overtime], add nurses or any discipline needed." On 7/25/14, at 1:00 p.m. the human resources director (HR) stated the facility had the following open shifts: .9 (considered full time) NA on the night shift. .9 NA on the night shift. .5 NA on the evening shift. .2 NA on the evening shift (was ready to offer the position, but had not put the offer out yet). .9 RN supervisor on the evening shift (was ready to offer the position, but had not put the offer out yet). The HR was unable to state the percentage of open shifts and stated you will need to ask the administrator.	F 353		

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F 371	Continued From page 45	F 371		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to store food under sanitary conditions, follow equipment sanitation procedures to promote sanitation and food safety in the main kitchen and kitchenette refrigerator and consistently monitor dishwasher temperatures. This had the potential to affect 56 of 56 residents who resided in the facility and ate out of the main kitchen and/or kitchenette refrigerator. Findings include: During the kitchen tour on 7/21/14, at 4:00 p.m. the following was observed and confirmed by the dietary director (DD): Food storage: - Flour and sugar plastic bins approximately two feet in length by 1 1/2 feet wide with a slide back clear plastic top were not labeled with an opened or used by date to prevent the possibility of food borne illness. The clear top cover for the flour had	F 371	Specific Food Storage: All food storage items dry, refrigerated and frozen will be labeled and dated when opened and/or put into proper storage containers. All food storage areas were reviewed to ensure all food is labeled appropriated. Policy was reviewed and is appropriate. Unclean Equipment: All equipment will be properly wiped down and sanitized at the end of each shift. Policy and guidelines were reviewed and deemed appropriate. Equipment unable to be cleaned was replaced. Dishwasher temperature: Temperatures will be taken twice daily. Policy was reviewed and is appropriate. Thermometer changes to the dishwasher were made according to manufacture guidelines.	8/28/14

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F 371	Continued From page 46 brown food buildup around the edges and front handle of the cover. The DD verified the cover was unclean and the bins should be dated when the contents were put in the bins. - In the dry storage area three plastic containers containing dry cereals were not dated with an opened or used by date to prevent the possibility of food borne illness. - In the dry storage area, a six pound bag of cake mix had been opened, not dated with an opened or used by date nor stored in a sealed food-grade plastic bag to prevent the possibility of food borne illness. The Centennial Circle refrigerator contained the following: - three orange juice containers were not labeled not dated. - two prune juice containers (one labeled, not dated; one not labeled not dated). - two grape juice containers (one labeled, not dated; one not labeled, not dated). - one tomato juice container (not labeled, not dated). - one cranberry juice container (labeled, not dated). The DD verified all juice containers should have been identified and dated. Unclean equipment: During tour on 7/23/14, at 1:45 p.m. the following observed and confirmed by the DD: - below the stainless steel center food preparation table there was a heavy flaky rust buildup on the entire length of the base where two doors slide back and forth. There was also a heavy food particle buildup in a crevice that is inside the length of the two doors where pots and pans were stored. The front of the doors had hardened food particle splatter. The left side of the table	F 371	Identification All staff will be trained on cleaning, food labeling, and importance of dishwasher temperatures. All equipment and containers were inspected to ensure proper cleaning can occur. Systemic Any new equipment will have a cleaning procedure established prior to being put into use. Staff will be educated on the importance of cleaning and sanitizing and reporting any poor equipment or food preparation issues to the Food Services Director. Monitor Observational and written audits will be done by the Food Service Director or designee. Compliance will be monitored by the Food Service Director, the Administrator and reviewed by the Performance Management Committee.	

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F 371	Continued From page 47 had food splatter and there was heavy dust buildup on and around the electric receptacle. Dishwashing temperatures: During the kitchen tour on 7/21/14, at 4:00 p.m. the final rinse dishwasher temperature was recorded two times per day (AM and PM). Review of the dishwasher temperature logs for June and July, 2014 indicated the following: July 2014: 30 of 62 (48%) final rinse temperatures were recorded; there were two final rinse temperatures below 180 degrees Fahrenheit (F). In addition the 7/4/14 recorded temperature for final rinse was 200/140, on 7/5/14 was 193/148, on 7/6/14 was 148/182, indicating wash temperatures below 150 degrees F. June 2014: 11 of 60 (18%) final rinse temperatures were recorded; there were three final rinse temperatures below 180 degrees F. In addition the 6/18/14 recorded temperature for final rinse was 195/145/145, indicating a wash temperature below 150 degrees F. No other temperature logs were provided. There were a total of five final rinse temperatures below 180 degrees F and 81 of 122 possible opportunities in the past 2 months for which temperatures were not recorded at all. No other temperature logs were provided and the DD and DA verified they had not been recording the temperatures at all. During interview on 7/21/14 at 4:00 p.m. the DD stated that she started at the facility in mid-June and noticed staff was not recording any temperatures, so she implemented a temperature log. DD stated, "They sometimes miss doing it	F 371		

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though, I believe the lower temperatures are the wash cycle temperatures, not the rinse and they recorded the wrong one. They were not recording any temps for quite a while. "

During interview on 7/23/14, at 1:45 p.m. dietary aide (DA) stated she recorded the wash temperatures on July 5 and 6th because, "That is what we were doing before, but the last supervisor stopped giving us sheets and then we didn't record the temps for a long time after that."

Review of the facility Food Labeling Policy & Procedure dated 7/1/2011 indicated "all foods need to have a label & date on the package, container, box that is to be stored in the cooler, freezer, store room, ect [sic].. " The policy further stated, "When food is removed from original container and put in storage container it needs to be labeled to what it is and date opened and any open container without a opened date on it will be thrown immediately."

Review of the facility Shelves and Other Surfaces - Sanitation (undated) indicated, "Wash surface with a warm sanitizing solution. Use a brush when necessary. "

Review of the facility Cabinets and Drawers - Sanitation of Equipment (undated) indicated, "Use a mild detergent and water, removable drawers should be removed and washed. Rinse shelves and drawers with a clean sponge and dry."

Review of the facility Recording of Dishmachine Temperatures (undated) indicated, "Record temperatures daily on 'Dishmachine Temperature Log,' any inaccurate temperatures must be

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F 371	Continued From page 49 brought to the attention of the Dietary Manager immediately....to ensure that the wash and rinse temperatures are properly monitored and controlled, a log must be completed by those who are directly involved in the dish washing process. Entries must be made for each day."	F 371		

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	245554	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 25, 2014. At the time of this survey, Building 01 of Renvilla Health Center 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2014

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
	245554	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE** **RENVILLE, MN 56284**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 By eMail 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. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Renvilla Health Center was built in 1963, with building additions constructed in 1970 and 1993. This one-story with partial basement facility is fully fire sprinkler protected. The original building and both additions were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a licensed capacity of 56 beds and had a census of 56 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct	K 072		7/25/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2014**

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RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE** **RENVILLE, MN 56284**

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K 072	Continued From page 2 exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and a staff interview, the facility has corridor obstructions. In an emergency evacuation situation, these obstructions could interfere with the convenient and effective removal of residents, staff and visitors from the affected smoke compartment. FINDINGS INCLUDE: On 07/25/2014 between 11:30 AM and 3:00 PM, it was observed that: A). Interior finish materials mounted on corridor walls in the 100 Wing and 200 Wing have diminished the width of these existing corridors. The original corridor width of 82 1/4-inches has been reduced at various points along the entire length of the corridors by as little as one-inch [between the aluminum siding on one side to the lap siding on the opposite side) to as much as 5 1/4-inches [between the faux tree trunk on one side to the frame of the faux window on the other side].; B). Grab rails mounted on corridor walls of the 100 Wing and 200 Wing project between 5-inches and 5 1/2-inches into the corridors, as measured from the original gypsum wall board to the outside edges of the wooden rails. **NOTE** This K-Tag will not need to be corrected if an FSES can establish that the facility has an overall level of fire safety equivalent to that required by the Life Safety Code, 2000	K 072	Corrected by successful passing of FSES Survey conducted July 25th, 2014.	

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	245554	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/25/2014**

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RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE** **RENVILLE, MN 56284**

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K 072	Continued From page 3 edition.	K 072		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245554	A. BUILDING **02 - 2008 RESIDENT WING ADDITION** B. WING _____	**07/25/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 25, 2014. At the time of this survey, Building 02 of Renvilla Health Center was found 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) 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. Building 02 of Renvilla Health Center consists of the 2008 resident wing addition. It is one-story, has a partial basement, is fully fire sprinkler protected and was determined to be of Type II(000) construction. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. All resident rooms are equipped with automatic, interconnected smoke detection. The facility has a capacity of 56 beds and had a census of 56 at time of the survey.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/25/2014

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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	245554	A. BUILDING _____ B. WING _____	C 07/25/2014

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RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted from July 21st through July 25th 2014, and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5554004 was conducted. The complaint was unsubstantiated. An investigation of complaint H5554005, and was substantiated. A federal deficiency was issued as a result at F309.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at	F 272		

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

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F 272	Continued From page 1 least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess physical and verbally abusive behaviors for 1 of 3 residents (R24) reviewed for behaviors. Findings include: R24's record was reviewed. An admission MDS	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 272	Continued From page 2 dated 3/17/14, indicated R24 had severe cognitive impairment. The Behavioral Symptoms section, identified R24 had physical behavioral symptoms directed towards others (such as hitting, kicking, pushing) and verbal behavioral symptoms directed towards others (such as threatening, screaming, cursing) occurring 4 to 6 days, but less than daily during the assessment period. The MDS identified R24 had other behavioral symptoms not directed towards others (hitting or scratching self) occurring 1 to 3 days in the assessment period. R24's Care Area Assessment (CAA) summary dated 3/17/14, indicated behavioral symptoms were triggered. The Comments and Analysis of Findings sections of the Review of Indicators of Behavioral Symptoms (RIBS) form dated 3/21/14, were left blank. The CAA lacked documentation to explain causal or unique risk factors for the behavioral symptoms. A comment entered in the Care Plan Considerations section of the RIBS dated 3/21/14, included: "Care plan to allow for the best quality of life." Although the admission MDS identified the presence of behaviors during the assessment period, and the CAA for behaviors was triggered, the clinical record lacked evidence R24 was comprehensively assessed for the identified behaviors. On 7/25/14, at 7:56 a.m. the director of nursing (DON)-B and the social worker both verified R24 had not been comprehensively assessed for behaviors. The facility's policy 11/2/10, indicated staff were to use the Resident Assessment Indicator (RAI) Process to "assess the resident's function." The policy directed to complete the MDS, CAA and	F 272		

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F 272	Continued From page 3 utilizations guidelines by the Centers for Medicare and Medicaid Services (CMS) to "assess the resident to identify problems and formulate appropriate care plan goals and approaches for the resident." In addition, under the facility RAI Process' Procedure number 7, direction included: "completion of the assessment process includes completing further assessments for the care areas triggered on the MDS," and a "summary statement of the causal factors, contributing factors or complicating factors as to why the resident has the problem." The facility's RAI process further directed that any care area assessment summary describe: nature of the condition; complications and risk factors that affect decision to proceed to care planning; factors that must be considered in making individualized care plan interventions; and the need for referral or further evaluation by appropriate health professionals.	F 272		
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 interview and record review the facility failed to ensure appropriate care and monitoring was implemented for 1 of 3 residents reviewed who had skin breakdown (R71).	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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RENVILLA HEALTH CENTER	**205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284**

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F 309	Continued From page 4 The findings include: R71 had been admitted to the facility on 2/22/10, and had diagnosis including: Diabetes Mellitus (DM) Type I, bacterial infection, mood disorder, hypothyroidism, depression, and hypertension. The resident's record was reviewed and included documentation of arterial ulcers to the lower legs. The progress notes indicated that on 6/3/13, wound cultures of the left leg were positive for Methicillin Resistant Stapholoccos Aureus (MRSA). In addition, a progress note from 6/18/13, at 12:08 p.m. indicated a small sore had developed on the resident's right great toe. The progress note indicated R71 had been educated to keep his shoe off, and to wear only TED stockings and gripper socks. Additional documentation of the foot described erythema noted on top of left foot, a small intact blister noted on top of left foot, white swollen areas noted around left great toe/toenail, and odor noted from left leg/foot. The record included progress notes regarding the resident's left foot wound to the great toe from 6/20/13-8/18/13. The notes reflected the progressive deterioration in the condition of the wound. A progress note dated 7/30/13, at 3:05 p.m. indicated the left great toe continued to show declining skin status with base on both nails yellow in color with moist appearance. "Color of tip of left great toe pale white/yellow. Poor circulation with no improvement noted or expected. Tip of right great toe had a small area	F 309		

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F 309	Continued From page 5 which measured 0.4 cm diameter. Area was closed. No change since last week. Current Treatment: keep all pressure off areas." The note further indicated R71's family had purchased him open toed sandals. On 7/31/13, the resident's primary physician had documented a progress note indicating R71 had significant necrotic changes to his toes, particularly the left great toe. The physician's note indicated R71 had erythema extending from his toes up to just below the knee with some blistered, denuded areas on the left anterior to lateral mid (middle) tib-fib (tibia-fibula) area (lower leg bones that end at the knee joint). In addition, the notes included: "The culture results from 5/31/13, were MRSA in the left leg cellulitis and treated with Bactroban and Bactrim, however his infection worsened and [R71] was re-treated with Bactrim from 7/9-7/19/13. [R71] appears more confused and had a decline in mental status in the last two months. The family has chosen not to pursue angiography given his age and condition, the left leg does cause pain for which he receives Percocet. Below the knee amputation with spinal anesthesia was considered..." The physician's note also included: "ASSESSMENT/PLAN: MRSA cellulitis with peripheral vascular disease and what appears to be a dry gangrene type of process in his big toe on the left." A progress note dated 8/18/13, indicated an order had been received to modify the treatment to R71's gangrenous wound. The order was for Flagyl (an antibiotic) 500 mg (milligrams) to be crushed and sprinkled over the wound for odor control. "Use 1 (one) 500 mg Flagyl tab for each dressing change."	F 309		

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F 309	Continued From page 6 The next progress note regarding the gangrenous foot was documented on 8/25/13, at 7:48 a.m. The note indicated the resident's dressing had been changed at 7:30 a.m. and when the dressing had been removed maggots were noted between the resident's toes on left foot. According to the note, the area had been cleaned but more maggots had appeared. The note indicated when the area had been cleaned multiple times, hospice had been informed of the maggots and the hospice nurse was going to talk with R71's doctor. Another progress note dated 8/25/13, at 2:46 p.m. indicated the hospice nurse had made a visit to the resident at 11:00 a.m. The hospice nurse had reportedly spoken to the resident's primary physician and it had been decided to soak the resident's foot then clean with hydrogen peroxide and coat with corn starch. The note indicated this had been done, and when the dressing was removed no more maggots had been noted. Although an entry was made in the resident's record 8/27/13, at 4:15 p.m., including: "...dressing change completed on 8/24/14 at approximately 11:00, lower legs and toes cleansed well before dressing applied, lower legs and toes were kept covered at all times and dressing was fully intact on the morning of 8/25/13 prior to dressing change. No skin was exposed, no drainage coming through dressing; minimal drainage, 2nd toe on left foot was fully gangrenous with tip of great toe gangrenous as well." The record did not indicate further investigation or root cause analysis had been conducted to evaluate the techniques used by staff when completing the dressing change in order to determine how the maggots might have	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 309	Continued From page 7 gotten into the resident's wound. On 8/29/13, the resident's care plan was revised to include a diagnosis of bacterial infection with interventions to apply Ben Gay or icy hot around left heel wounds and left great toe to increase blood flow/circulation BID (twice a day). Keep all pressure off heels. Hospice to assess skin status and pressure points for signs of breakdown every visit, hospice will teach wound care protocol as ordered, hospice will assess for pain and medicate as needed prior to dressing change." During interview with director of nursing (DON)-B, at 12:30 p.m. on 7/25/14, she verified the resident had a long history of ischemic toes, and stasis ulcers on the lower extremities. No additional information regarding the wound care, or development of maggots was provided.	F 309		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
August 14, 2014

Ms. Cami Peterson-Devries, Administrator
Renvilla Health Center
205 Southeast Elm Avenue
Renville, Minnesota 56284

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5554025

Dear Ms. Peterson-Devries:

The above facility was surveyed on July 21, 2014 through July 25, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint numbers H5554004 and H5554005. 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.

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00557	A. BUILDING: _____ B. WING _____	C 07/25/2014

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RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

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2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure appropriate care and monitoring was implemented for 1 of 3 residents reviewed who had skin breakdown (R71). The findings include: R71 had been admitted to the facility on 2/22/10, and had diagnosis including: Diabetes Mellitus (DM) Type I, bacterial infection, mood disorder, hypothyroidism, depression, and hypertension. The resident's record was reviewed and included documentation of arterial ulcers to the lower legs. The progress notes indicated that on 6/3/13, wound cultures of the left leg were positive for Methicillin Resistant Stapholoccos Aureus (MRSA). In addition, a progress note from 6/18/13, at 12:08 p.m. indicated a small sore had developed	2 830	Corrected by August 28th, 2014	8/28/14

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	00557	A. BUILDING: _____ B. WING _____	C 07/25/2014

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2 830	Continued From page 1 on the resident's right great toe. The progress note indicated R71 had been educated to keep his shoe off, and to wear only TED stockings and gripper socks. Additional documentation of the foot described erythema noted on top of left foot, a small intact blister noted on top of left foot, white swollen areas noted around left great toe/toenail, and odor noted from left leg/foot. The record included progress notes regarding the resident's left foot wound to the great toe from 6/20/13-8/18/13. The notes reflected the progressive deterioration in the condition of the wound. A progress note dated 7/30/13, at 3:05 p.m. indicated the left great toe continued to show declining skin status with base on both nails yellow in color with moist appearance. "Color of tip of left great toe pale white/yellow. Poor circulation with no improvement noted or expected. Tip of right great toe had a small area which measured 0.4 cm diameter. Area was closed. No change since last week. Current Treatment: keep all pressure off areas." The note further indicated R71's family had purchased him open toed sandals. On 7/31/13, the resident's primary physician had documented a progress note indicating R71 had significant necrotic changes to his toes, particularly the left great toe. The physician's note indicated R71 had erythema extending from his toes up to just below the knee with some blistered, denuded areas on the left anterior to lateral mid (middle) tib-fib (tibia-fibula) area (lower leg bones that end at the knee joint). In addition, the notes included: "The culture results from 5/31/13, were MRSA in the left leg cellulitis and treated with Bactroban and Bactrim, however his	2 830		

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2 830	Continued From page 2 infection worsened and [R71] was re-treated with Bactrim from 7/9-7/19/13. [R71] appears more confused and had a decline in mental status in the last two months. The family has chosen not to pursue angiography given his age and condition, the left leg does cause pain for which he receives Percocet. Below the knee amputation with spinal anesthesia was considered..." The physician's note also included: "ASSESSMENT/PLAN: MRSA cellulitis with peripheral vascular disease and what appears to be a dry gangrene type of process in his big toe on the left." A progress note dated 8/18/13, indicated an order had been received to modify the treatment to R71's gangrenous wound. The order was for Flagyl (an antibiotic) 500 mg (milligrams) to be crushed and sprinkled over the wound for odor control. "Use 1 (one) 500 mg Flagyl tab for each dressing change." The next progress note regarding the gangrenous foot was documented on 8/25/13, at 7:48 a.m. The note indicated the resident's dressing had been changed at 7:30 a.m. and when the dressing had been removed maggots were noted between the resident's toes on left foot. According to the note, the area had been cleaned but more maggots had appeared. The note indicated when the area had been cleaned multiple times, hospice had been informed of the maggots and the hospice nurse was going to talk with R71's doctor. Another progress note dated 8/25/13, at 2:46 p.m. indicated the hospice nurse had made a visit to the resident at 11:00 a.m. The hospice nurse had reportedly spoken to the resident's primary physician and it had been decided to soak the resident's foot then clean with hydrogen peroxide	2 830		

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2 830	Continued From page 3 and coat with corn starch. The note indicated this had been done, and when the dressing was removed no more maggots had been noted. Although an entry was made in the resident's record 8/27/13, at 4:15 p.m., including: "...dressing change completed on 8/24/14 at approximately 11:00, lower legs and toes cleansed well before dressing applied, lower legs and toes were kept covered at all times and dressing was fully intact on the morning of 8/25/13 prior to dressing change. No skin was exposed, no drainage coming through dressing; minimal drainage, 2nd toe on left foot was fully gangrenous with tip of great toe gangrenous as well." The record did not indicate further investigation or root cause analysis had been conducted to evaluate the techniques used by staff when completing the dressing change in order to determine how the maggots might have gotten into the resident's wound. On 8/29/13, the resident's care plan was revised to include a diagnosis of bacterial infection with interventions to apply Ben Gay or icy hot around left heel wounds and left great toe to increase blood flow/circulation BID (twice a day). Keep all pressure off heels. Hospice to assess skin status and pressure points for signs of breakdown every visit, hospice will teach wound care protocol as ordered, hospice will assess for pain and medicate as needed prior to dressing change." During interview with director of nursing (DON)-B, at 12:30 p.m. on 7/25/14, she verified the resident had a long history of ischemic toes, and stasis ulcers on the lower extremities. No additional information regarding the wound care, or development of maggots was provided.	2 830		

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2 830	Continued From page 4 SUGGESTED METHOD OF CORRECTION: The administrator, director of nurses or designee could develop a policy and procedure for skin integrity maintenance, wound care and pressure ulcers. The administrator, director of nurses or designee could provide education to licensed nurses regarding documentation of wounds, physician notification and treatment. The administrative staff or designee could audit for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		

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

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

Electronically Signed | 08/25/14

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 21st - July 25th 2014, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, complaint investigation(s) were also completed at the time of the recertification survey. An investigation of complaint H5554004 was conducted, and was unsubstantiated. An investigation of complaint H5554005, and was substantiate.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 540	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's	2 540		9/8/14

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2 540	Continued From page 2 comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess physical and verbally abusive behaviors for 1 of 3 residents (R24) reviewed for behaviors. Findings include: R24's record was reviewed. An admission MDS dated 3/17/14, indicated R24 had severe cognitive impairment. The Behavioral Symptoms section, identified R24 had physical behavioral symptoms directed towards others (such as hitting, kicking, pushing) and verbal behavioral symptoms directed towards others (such as threatening, screaming, cursing) occurring 4 to 6 days, but less than daily during the assessment period. The MDS identified R24 had other	2 540	Corrected by September 8th, 2014	

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2 540	Continued From page 3 behavioral symptoms not directed towards others (hitting or scratching self) occurring 1 to 3 days in the assessment period. R24's Care Area Assessment (CAA) summary dated 3/17/14, indicated behavioral symptoms were triggered. The Comments and Analysis of Findings sections of the Review of Indicators of Behavioral Symptoms (RIBS) form dated 3/21/14, were left blank. The CAA lacked documentation to explain causal or unique risk factors for the behavioral symptoms. A comment entered in the Care Plan Considerations section of the RIBS dated 3/21/14, included: "Care plan to allow for the best quality of life." Although the admission MDS identified the presence of behaviors during the assessment period, and the CAA for behaviors was triggered, the clinical record lacked evidence R24 was comprehensively assessed for the identified behaviors. On 7/25/14, at 7:56 a.m. the director of nursing (DON)-B and the social worker both verified R24 had not been comprehensively assessed for behaviors. The facility's policy 11/2/10, indicated staff were to use the Resident Assessment Indicator (RAI) Process to "assess the resident's function." The policy directed to complete the MDS, CAA and utilizations guidelines by the Centers for Medicare and Medicaid Services (CMS) to "assess the resident to identify problems and formulate appropriate care plan goals and approaches for the resident." In addition, under the facility RAI Process' Procedure number 7, direction included: "completion of the assessment process includes completing further assessments for the care areas triggered on the MDS," and a "summary statement of the causal factors, contributing	2 540		

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2 540	Continued From page 4 factors or complicating factors as to why the resident has the problem." The facility's RAI process further directed that any care area assessment summary describe: nature of the condition; complications and risk factors that affect decision to proceed to care planning; factors that must be considered in making individualized care plan interventions; and the need for referral or further evaluation by appropriate health professionals. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could assure that upon admission, a comprehensive assessment is conducted each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. The director of nursing or designee could monitor to assure that residents are appropriately assessed to determine placement in the dementia/memory care unit at the time of admission. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 540		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.	2 800		8/21/14

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2 800	Continued From page 5 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to meet the needs of 9 of 9 residents (R43, R13, R30, R42, R39, R58, R55, R23, R50) who self-identified insufficient staff to meet their needs. Findings include: A review of the staffing schedules from 4/30/14 to 7/21/14, indicated a pattern of short staffing, for which the facility used mandated overtime (4 hours), or shifts remained unfilled. The facility administrator, who was in charge of scheduling and staffing, was unable to state what positions were needed, what percentage of mandated overtime was used, what percentage of shifts ran short, what the turnover percentage was, or how many open FTE's (full time equivalents - a measure of how many jobs were needed to fill the planned schedules). Although this was discussed at monthly quality meetings, the administrator stated "check with human resources." The facility had 44 falls from 3/1/14-7/21/14, 9 falls on day shift, 22 falls on evening shift, and 13 falls on night shift; the administrator stated the facility monitored fall times of day and did not find a correlation between staffing and falls. The administrator stated the facility paid time and a half for weekend shifts, even when staff were not into overtime hours. Staffing schedules reviewed for mandated over time included: From 6/2/14-6/15/14, the schedule indicated eleven day shift workers were mandated four hours overtime (OT). Seven evening shift workers were mandated four hours OT, nine night shift	2 800	Corrected August 21, 2014	

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2 800	Continued From page 6 workers were mandated four hours OT. From 6/16/14-6/29/14, the schedule indicated twelve day shift, ten evening shift and thirteen night shift workers were mandated four hours OT. From 6/30/14-7/13/14, the schedule indicated fourteen days shift, nine evening shift were mandated four hours OT, and two night shift workers were sent home before the end of the eight hour shift. A review of the daily staffing sheets (some examples) noted below indicated: 4/2/14, DON-A (director of nursing) and DON-B split the evening charge nurse shift. 4/3/14 DON-B worked four hours of evening charge nurse shift. 4/20/14, the facility worked short 1/2 NA on the evening shift, and a resident was found on the floor at 8:50 p.m. 4/21/14, the facility worked short on day shift, because TMA was pulled to NA shift. 4/24/14, the facility worked short on evening shift 1 1/2 nursing assistants 4/26/14, the facility worked short 1 NA on the day shift, the day shift charge nurse stayed until 7 p.m. (4 hours OT), because the evening supervisor was pulled to an open nurse shift. 5/7/14, the facility worked short a TMA. 5/12/14, day shift short 2 NA, (but had one float scheduled so only short 1), there were six changes on the evening shift, a TMA was pulled to NA position and shifts were split, and on night shift, 2 NA's split a shift. 5/15/14 the facility worked short a trained medication aide (TMA) who was split between units on day shift and evening shift, and a resident fell from a chair or bed at 7:45 p.m. 5/17/14, a nurse came in at 5:00 a.m. and worked a 10 hour shift. a TMA worked a 12 hour shift (and then left an empty NA 1/2 shift on evenings,	2 800		

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2 800	Continued From page 7 and a night shift charge nurse shift was split. 5/26/14, the facility worked short on the day shift, short on the evening shift, and one NA from the night shift worked until 10:00 a.m. on the 27th. The daily staffing sheet for 5/28/14, was not provided. 5/29/14, the facility worked short on the evening shift. on 6/3/14 two NA called in sick and were replaced by one NA who worked the night shift and stayed until 10:00 a.m. 6/6/14, a day shift NA, went home early, a evening NA came late and left early, the census was 56 (full). 6/11/14 a day shift TMA was ill and replaced by a evening shift TMA, who was replaced by an LPN for 6 hours. , a nursing assistant shift was split, a resident fell from a chair or bed at 6:00 a.m.. 6/14/14, a evening TMA went home 1 hour early, an evening NA worked 7 hours (planned 8), and a evening NA worked only 4 hours (planned 8), and 2 night shift NA worked reduced hours. (a total reduction of 19 hours with a census of 55/56. 6/16/14 a TMA was short on the day shift, the evening charge nurse shift was split, an NA shift was split on evenings and nights. 6/17/14, an LPN was used as a TMA, leaving 1 nurse short on North unit until 12:30, and an NA was ill and not replaced. An LPN from the evening shift was changed to 12:30 to 9:00 hours on North unit and was not replaced after 9:00 6/18/14 A NA from North was pulled to South, a TMA from South was pulled to North, an NA was assigned on Mission and North. (usually two separate assignments). 6/20/14, one day shift TMA was reduced to 6.5 hours, the restorative aide was reduced to 4.5 hours and then pulled to evening NA duties. The evening charge nurse shift was spilt, the evening TMA was reduced 6 hours. the night shift charge	2 800		

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2 800	Continued From page 8 nurse worked an extra hour. a night shift NA was reduced by 5 hours. 7/4/14, a day shift NA worked until 7 p.m. (12 hour shift) a evening TMA worked 6.25 hours, an evening NA worked 4.25 hours, a evening NA worked 7 hours, a night shift NA worked 4 hours and an NA came in at 4:00 a.m. (split shift). Residents interviewed in stage 1 impacted by insufficient staffing included: R43 had a quarterly Minimum Data Set (MDS) dated 5/21/14, and indicated a Brief Interview for Mental Status (BIMS) score of 13/15, which indicated no cognitive impairment, and required extensive assist of one staff with bed mobility, transfers, toilet use and personal hygiene. R43 was supposed to be on a toileting program trial, was occasionally incontinent of urine and frequently incontinent of bowel. R43 stated she had to wait 20-30 minutes for assistance in the daytime. R13 had a significant change MDS dated 5/28/14, and indicated a BIMS score of 3/15, which indicated severe cognitive impairment, and required extensive assist of two staff with bed mobility, transfers and toilet use; and extensive assist of one staff for personal hygiene. R13 was frequently incontinent and was supposed to be on a toilet training program. R13 stated, "I think there should be more help... I sometimes wait a long time." R30 had a quarterly MDS dated 7/2/14, and indicated a BIMS score of 14/15, which indicated no cognitive impairment, and required extensive assist of two staff with transfers and toilet use; and extensive assist of one staff for bed mobility and personal hygiene. R30 had an indwelling	2 800		

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2 800	Continued From page 9 Foley catheter for obstruction and was always continent of bowel. R30 stated at night and in the morning, there was not enough help, and "they can't keep staff here." R42 had a quarterly MDS dated 6/30/14, and indicated a BIMS score of 7/15, which indicated severe cognitive impairment. R42 required extensive assist of two staff for bed mobility, transfers, toilet use, and extensive assist of one staff for personal hygiene, and was always incontinent of urine and occasionally incontinent of stool. R42 stated she was having bladder problems and should have more help, "By the time they get to me, I am wet... should be given medicine for it, some think I am a nuisance because I like to help and they are busy." R39 had a quarterly MDS dated 7/11/14, and indicated a BIMS score of 13/15, which indicated no cognitive impairment. R39 required extensive assist of two staff with bed mobility, transfers and toilet use, and extensive assist of one staff for personal hygiene. R39 was on a toileting program and had decreased incontinence when taken to the toilet in a timely fashion. R39 stated the facility could have more help, "I have messed myself and diaper, [I'm] supposed to use commode everyday between 3:30 p.m. and 3:45 p.m., but they are sometimes late." R58 had a quarterly MDS dated 6/13/14, and indicated a BIMS score of 15/15, which indicated no cognitive impairment, and required extensive assist of one staff toilet use and personal hygiene. R58 stated she sometimes had to wait 30 minutes or longer while waiting on the toilet for aides to come from the other side to assist. R58 was on a toileting program and was usually incontinent. R58 had a discussion with the	2 800		

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2 800	Continued From page 10 administrator about changing her incontinence pad more than twice a day, because her bedside lounge chair was wet and needed to be cleaned, "The administrator stated this was embarrassing" for R58. R55 had a quarterly MDS dated 6/13/14, and indicated a BIMS score of 11/15, which indicated moderate cognitive impairment, and required extensive assist of one staff with bed mobility, transfers and toilet use and personal hygiene. R55 was occasionally incontinent of bowel and bladder. R55 stated, "Sometimes I wait too long to get to the bathroom, [I] don't think there is enough staff. I don't want to wait for help, I had to go really bad, usually get up in the night. In the evening it takes quite a while to get a pill." R23 had a quarterly MDS dated 7/2/14, and indicated a BIMS score of 9/15, which indicated moderate cognitive impairment, and required limited assist of one staff with bed mobility, transfers and toilet use and personal hygiene. R23 was frequently incontinent of urine. R23 stated, "Sometimes I wait 30 minutes for assist in the evenings." R50 had a 14 day MDS dated 7/7/14, a BIMS score of 13/15, which indicated no cognitive impairment, and required extensive assist of 2 with bed mobility, transfers, toilet use, and personal hygiene. R50 was frequently incontinent of urine and rarely incontinent of bowel. R50 stated, "I think they need more people at night, basically it takes them a long time, depends on who was working. I have not had an accident , I am not scared, but I am concerned." On 7/23/14, at 9:33 a.m. NA-F stated they were normally able to get things done, but sometimes	2 800		

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2 800	Continued From page 11 really busy answering call lights. NA-F stated sometimes the facility was short staffed and the staff "really have to work as a team." NA-F stated, "If your name was circled on the time sheet [schedule] it means you have to stay 4 hours past your 8 hour shift [mandatory overtime]. They have been staffing better in the last month, knowing you [the State agency] were coming." On 7/25/14, at 9:00 a.m. the facility temporary staffer (TS) was interviewed and explained the different codes used on the staffing sheets. TS stated a circled shift meant a four hour mandated over-time shift. TS further stated staff also sometimes went home early (as indicated on the schedule sheets 3 hour, 5 hour, 6 hour, or 7 hour shifts). TS stated the basic staffing pattern for nursing assistants (NA) was six on days, six on evening shift, and three on the night shift plus one person came in early to make it four staff for two hours in the early morning. TS stated the facility had worked short, but had gotten better in the last two to three months. Weekend one (on the schedule) remained two staff short on day shift, two staff short short on evening shift, and two staff short on night shift. TS stated it was a fair statement working short happened fairly frequently, although it had gotten better in the last few months. On 7/25/14, at 9:22 a.m. DON-B stated the facility could provide call light logs because the facility deleted them after the monthly quality review. DON-B stated each morning the staff reviewed the length of call light response times on the units and DON-B then interviewed residents to see if their needs were met. DON-B stated the only call light logs she had now were in the last week, when asked what the longest time of call light was on, she stated the longest call light time was	2 800		

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2 800	Continued From page 12 25 minutes. Although DON-B stated she interviewed the staff to see what happened, DON-B stated she did not interview the resident whose call light was on for 25 minutes (this week), but had interviewed this resident in the past when her call light was on. On 7/25/14, at 11:00 a.m. A family member (FM)-B of R65 requested to speak to a surveyor and stated her mother was not cared for as she would expect. (FM)-B stated a swollen hand was noted on admission from the hospital to the nursing home. (FM)-B stated, "[I] had to tell facility how to care for mother's swollen hand, keeping it elevated, etc." In addition, (FM)-B stated R65 did not have a bath for a week, because she had not been put on the bath schedule. R65's hearing aides were not placed in the resident's ears consistently. (FM)-B also stated, "There were times the staff was pretty busy. One time at 11:00 a.m., [R65's name] was still waiting for staff to give her a shower, she had not had breakfast yet, and had not been dressed that morning." On 7/25/14, at 11:15 a.m. The administrator verified mandated overtime was used in the facility and she did not know how much mandated overtime, the percentage of short shifts worked, the percent of turnover, or what positions were open in the facility. On 7/25/14, at 12:35 the administrator stated corporate did two week statistics for us and track for us, the staffing was determined by looking at the case mix index which for us was .99, generally staff a 1-8 ratio on days and evening, and never above 1-10. Falls were reviewed every morning in IDT (interdisciplinary team), "I have them do a root cause analysis (RCA), and want to	2 800		

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2 800	Continued From page 13 hear back within a couple of days." The facility looked at the QA (quality assurance) process, at that time could not correlate staffing with falls/ injuries, accidents, or resident to resident incidents. Staffing was talked about at board meetings and monthly performance reviews, "Because they talk about job openings, turnover, and retention in QA monthly." The administrator stated the facility had done some things to try and balance staffing, have changed the TMA's, and ensure charge coverage all over the building on every shift. "We have changed activity schedules, extended until 8:00 p.m. to help with the boredom problem, we are using the team approach. For one to ones use family, activities in the evenings to try to help keep resident's busy. We started an 0500 [5:00 a.m.] person started coming in for the early risers, we are always adjusting to the needs as they occur." The administrator verified the first weekend of the schedule was short, but shifts were posted and weekend, and mandate OT as needed. "We offer time and 1/2 for all weekend shifts [even if not overtime], add nurses or any discipline needed." On 7/25/14, at 1:00 p.m. the human resources director (HR) stated the facility had the following open shifts: .9 (considered full time) NA on the night shift. .9 NA on the night shift. .5 NA on the evening shift. .2 NA on the evening shift (was ready to offer the position, but had not put the offer out yet). .9 RN supervisor on the evening shift (was ready to offer the position, but had not put the offer out yet). The HR was unable to state the percentage of open shifts and stated you will need to ask the administrator.	2 800		

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2 800	Continued From page 14 SUGGESTED METHOD OF CORRECTION: The facility administrator or director of nursing could review and revise policies and staffing schedules to assure adequate staff are available to assist residents in a timely manner and to meet all resident needs. A designated staff could monitor the system to assure cares are being delivered and residents are supported to achieve and maintain their highest practicable physical, mental, and psychosocial well-being. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure appropriate care and monitoring was implemented for 1 of 3 residents reviewed who had skin breakdown (R71).	2 830	Corrected by August 28th, 2014	8/28/14

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2 830	Continued From page 15 The findings include: R71 had been admitted to the facility on 2/22/10, and had diagnosis including: Diabetes Mellitus (DM) Type I, bacterial infection, mood disorder, hypothyroidism, depression, and hypertension. The resident's record was reviewed and included documentation of arterial ulcers to the lower legs. The progress notes indicated that on 6/3/13, wound cultures of the left leg were positive for Methicillin Resistant Stapholoccos Aureus (MRSA). In addition, a progress note from 6/18/13, at 12:08 p.m. indicated a small sore had developed on the resident's right great toe. The progress note indicated R71 had been educated to keep his shoe off, and to wear only TED stockings and gripper socks. Additional documentation of the foot described erythema noted on top of left foot, a small intact blister noted on top of left foot, white swollen areas noted around left great toe/toenail, and odor noted from left leg/foot. The record included progress notes regarding the resident's left foot wound to the great toe from 6/20/13-8/18/13. The notes reflected the progressive deterioration in the condition of the wound. A progress note dated 7/30/13, at 3:05 p.m. indicated the left great toe continued to show declining skin status with base on both nails yellow in color with moist appearance. "Color of tip of left great toe pale white/yellow. Poor circulation with no improvement noted or expected. Tip of right great toe had a small area which measured 0.4 cm diameter. Area was closed. No change since last week. Current	2 830		

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2 830	Continued From page 16 Treatment: keep all pressure off areas." The note further indicated R71's family had purchased him open toed sandals. On 7/31/13, the resident's primary physician had documented a progress note indicating R71 had significant necrotic changes to his toes, particularly the left great toe. The physician's note indicated R71 had erythema extending from his toes up to just below the knee with some blistered, denuded areas on the left anterior to lateral mid (middle) tib-fib (tibia-fibula) area (lower leg bones that end at the knee joint). In addition, the notes included: "The culture results from 5/31/13, were MRSA in the left leg cellulitis and treated with Bactroban and Bactrim, however his infection worsened and [R71] was re-treated with Bactrim from 7/9-7/19/13. [R71] appears more confused and had a decline in mental status in the last two months. The family has chosen not to pursue angiography given his age and condition, the left leg does cause pain for which he receives Percocet. Below the knee amputation with spinal anesthesia was considered..." The physician's note also included: "ASSESSMENT/PLAN: MRSA cellulitis with peripheral vascular disease and what appears to be a dry gangrene type of process in his big toe on the left." A progress note dated 8/18/13, indicated an order had been received to modify the treatment to R71's gangrenous wound. The order was for Flagyl (an antibiotic) 500 mg (milligrams) to be crushed and sprinkled over the wound for odor control. "Use 1 (one) 500 mg Flagyl tab for each dressing change." The next progress note regarding the gangrenous foot was documented on 8/25/13, at 7:48 a.m. The note indicated the resident's dressing had	2 830		

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2 830	Continued From page 17 been changed at 7:30 a.m. and when the dressing had been removed maggots were noted between the resident's toes on left foot. According to the note, the area had been cleaned but more maggots had appeared. The note indicated when the area had been cleaned multiple times, hospice had been informed of the maggots and the hospice nurse was going to talk with R71's doctor. Another progress note dated 8/25/13, at 2:46 p.m. indicated the hospice nurse had made a visit to the resident at 11:00 a.m. The hospice nurse had reportedly spoken to the resident's primary physician and it had been decided to soak the resident's foot then clean with hydrogen peroxide and coat with corn starch. The note indicated this had been done, and when the dressing was removed no more maggots had been noted. Although an entry was made in the resident's record 8/27/13, at 4:15 p.m., including: "...dressing change completed on 8/24/14 at approximately 11:00, lower legs and toes cleansed well before dressing applied, lower legs and toes were kept covered at all times and dressing was fully intact on the morning of 8/25/13 prior to dressing change. No skin was exposed, no drainage coming through dressing; minimal drainage, 2nd toe on left foot was fully gangrenous with tip of great toe gangrenous as well." The record did not indicate further investigation or root cause analysis had been conducted to evaluate the techniques used by staff when completing the dressing change in order to determine how the maggots might have gotten into the resident's wound. On 8/29/13, the resident's care plan was revised to include a diagnosis of bacterial infection with	2 830		

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2 830	Continued From page 18 interventions to apply Ben Gay or icy hot around left heel wounds and left great toe to increase blood flow/circulation BID (twice a day). Keep all pressure off heels. Hospice to assess skin status and pressure points for signs of breakdown every visit, hospice will teach wound care protocol as ordered, hospice will assess for pain and medicate as needed prior to dressing change." During interview with director of nursing (DON)-B, at 12:30 p.m. on 7/25/14, she verified the resident had a long history of ischemic toes, and stasis ulcers on the lower extremities. No additional information regarding the wound care, or development of maggots was provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nurses or designee could develop a policy and procedure for skin integrity maintenance, wound care and pressure ulcers. The administrator, director of nurses or designee could provide education to licensed nurses regarding documentation of wounds, physician notification and treatment. The administrative staff or designee could audit for compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 830		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.	21015		8/28/14

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21015	Continued From page 19 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to store food under sanitary conditions, follow equipment sanitation procedures to promote sanitation and food safety in the main kitchen and kitchenette refrigerator and consistently monitor dishwasher temperatures. This had the potential to affect 56 of 56 residents who resided in the facility and ate out of the main kitchen and/or kitchenette refrigerator. Findings include: During the kitchen tour on 7/21/14, at 4:00 p.m. the following was observed and confirmed by the dietary director (DD): Food storage: - Flour and sugar plastic bins approximately two feet in length by 1 1/2 feet wide with a slide back clear plastic top were not labeled with an opened or used by date to prevent the possibility of food borne illness. The clear top cover for the flour had brown food buildup around the edges and front handle of the cover. The DD verified the cover was unclean and the bins should be dated when the contents were put in the bins. - In the dry storage area three plastic containers containing dry cereals were not dated with an opened or used by date to prevent the possibility of food borne illness. - In the dry storage area, a six pound bag of cake mix had been opened, not dated with an opened or used by date nor stored in a sealed food-grade plastic bag to prevent the possibility of food borne illness. The Centennial Circle refrigerator contained the	21015	Corrected by August 28st , 2014	

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21015	Continued From page 20 following: - three orange juice containers were not labeled not dated. - two prune juice containers (one labeled, not dated; one not labeled not dated). - two grape juice containers (one labeled, not dated; one not labeled, not dated). - one tomato juice container (not labeled, not dated). - one cranberry juice container (labeled, not dated). The DD verified all juice containers should have been identified and dated. Unclean equipment: During tour on 7/23/14, at 1:45 p.m. the following observed and confirmed by the DD: - below the stainless steel center food preparation table there was a heavy flaky rust buildup on the entire length of the base where two doors slide back and forth. There was also a heavy food particle buildup in a crevice that is inside the length of the two doors where pots and pans were stored. The front of the doors had hardened food particle splatter. The left side of the table had food splatter and there was heavy dust buildup on and around the electric receptacle. Dishwashing temperatures: During the kitchen tour on 7/21/14, at 4:00 p.m. the final rinse dishwasher temperature was recorded two times per day (AM and PM). Review of the dishwasher temperature logs for June and July, 2014 indicated the following: July 2014: 30 of 62 (48%) final rinse temperatures were recorded; there were two final rinse temperatures below 180 degrees Fahrenheit (F). In addition the 7/4/14 recorded temperature for final rinse was 200/140, on 7/5/14 was 193/148, on 7/6/14 was 148/182, indicating	21015		

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21015	Continued From page 21 wash temperatures below 150 degrees F. June 2014: 11 of 60 (18%) final rinse temperatures were recorded; there were three final rinse temperatures below 180 degrees F. In addition the 6/18/14 recorded temperature for final rinse was 195/145/145, indicating a wash temperature below 150 degrees F. No other temperature logs were provided. There were a total of five final rinse temperatures below 180 degrees F and 81 of 122 possible opportunities in the past 2 months for which temperatures were not recorded at all. No other temperature logs were provided and the DD and DA verified they had not been recording the temperatures at all. During interview on 7/21/14 at 4:00 p.m. the DD stated that she started at the facility in mid-June and noticed staff was not recording any temperatures, so she implemented a temperature log. DD stated, "They sometimes miss doing it though, I believe the lower temperatures are the wash cycle temperatures, not the rinse and they recorded the wrong one. They were not recording any temps for quite a while. " During interview on 7/23/14, at 1:45 p.m. dietary aide (DA) stated she recorded the wash temperatures on July 5 and 6th because, "That is what we were doing before, but the last supervisor stopped giving us sheets and then we didn't record the temps for a long time after that." Review of the facility Food Labeling Policy & Procedure dated 7/1/2011 indicated "all foods need to have a label & date on the package, container, box that is to be stored in the cooler, freezer, store room, ect [sic].. " The policy further	21015		

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21015	Continued From page 22 stated, "When food is removed from original container and put in storage container it needs to be labeled to what it is and date opened and any open container without a opened date on it will be thrown immediately." Review of the facility Shelves and Other Surfaces - Sanitation (undated) indicated, "Wash surface with a warm sanitizing solution. Use a brush when necessary. " Review of the facility Cabinets and Drawers - Sanitation of Equipment (undated) indicated, "Use a mild detergent and water, removable drawers should be removed and washed. Rinse shelves and drawers with a clean sponge and dry." Review of the facility Recording of Dishmachine Temperatures (undated) indicated, "Record temperatures daily on 'Dishmachine Temperature Log,' any inaccurate temperatures must be brought to the attention of the Dietary Manager immediately....to ensure that the wash and rinse temperatures are properly monitored and controlled, a log must be completed by those who are directly involved in the dish washing process. Entries must be made for each day." SUGGESTED METHOD FOR CORRECTION: The Administrator and the Dietician could review and revise food service policies and procedures to assure that food is served in a sanitary manner. Staff could be trained as necessary. The Certified Dietary Manager could monitor the service of food on a periodic basis. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		

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21426	Continued From page 23	21426		
21426	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and comment review, the facility failed to ensure tuberculosis (TB) screening was completed within 72 hours from admission for 2 of 5 residents (R24, R65) from the census sample reviewed for TB screening. Findings include: R24 was admitted to facility on 3/10/14, the medical record lacked evidence of screening for TB completed for R24. The first step TB test was administered to R24 on 4/5/14, or 26 days after	21426	Corrected August 28th, 2014	8/28/14

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21426	Continued From page 24 admission. R65 was admitted to facility on 5/22/14, the medical record lacked evidence of screening for TB completed for R65. The first step TB test was administered to R65 on 5/30/14, eight (8) days after admission. On 7/24/14, at 8:02 a.m. the director of nursing (DON)-B, stated there was no questionnaire for TB screening in the facility's new computer software (Optimus), so staff had to do TB screening by the use of the paper form, however, DON-B verified the medical record lacked documentation to indicate TB screening was completed for R24. On 7/25/14, at 3:00 p.m. DON-A verified there was no evidence in R65's medical records to indicate TB screening was completed for R65. The facility's policy on Tuberculosis dated 12/09, did not provide directions for screening residents for TB. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review, revise policies and procedures to ensure residents are screened for TB. Facility staff could be educated on these policies and procedures. The DON or designee could develop a monitoring system to ensure ongoing compliance. Time Period for Correction: Twenty-one (21) days.	21426		
21485	MN Rule 4658.1005 Subp. 3 Social Services;AdmissionHistory &Assessment	21485		9/8/14

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21485	Continued From page 25 Subp. 3. Admission history and assessment. A psychosocial history and assessment must be completed for each new resident within 14 days after admission. The psychosocial history and assessment must contain sufficient information related to the resident's condition to develop care planning goals based on that resident's needs and strengths and may be used as a part of the comprehensive resident assessment required by part 4658.0400. The psychosocial history and assessment must be included in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide medically-related social services for 1 of 1 resident (R24) identified as having behavioral outbursts which affected two residents (R58, R4). Findings include: On 7/23/14, at 9:40 a.m. R24 was observed to yell, "Don't sass at me!" at a volunteer (V)-A. R24 and V-A were at the Centennial Circle Garden, about 20 feet away from where surveyor was standing. V-A explained to R24 that empty spaces left at the activity table were for residents in wheelchairs who would be joining the activity. However, in a stern way R24 was observed to reply, "Ok, I'll keep quiet!" On 7/24/14, at 10:53 a.m. during interviews with R58 and R4, both residents identified R24 to be verbally abusive. R58 stated R24's yelling made her mad and also made R58 feel "about that high [measuring approximately an inch between thumb and pointer finger]." R58 added having to ask for	21485	Corrected by September 8th, 2014	

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21485	Continued From page 26 a dose of Ativan (an anti-anxiety medication) because of anxiety caused by R24. R58 stated R24 yelled at everybody and had called other people names too. R58 stated, "I don't feel like a person with them letting her get by with all that crap." R4 stated it bothered her when R24 yelled "you old bitch" across the dining table at her. R58's quarterly MDS dated 6/4/14, indicated R58 was cognitively intact. R4's quarterly MDS dated 6/26/14, indicated R4 had moderate cognitive impairment. A review of R24's Progress Notes By Resident forms entered from 3/10/14 to 4/25/14, indicated R24 manifested behavioral symptoms: On 3/17/14, the notes indicated R24 had "elopement attempts and wandering" and a physical therapy note which depicted R24 as being "very upset with room change did hit out at nursing staff x2 occasions, did become verbally agitated with therapy," On 3/20/14, R24 was noted to be "hitting and yelling at staff at times." The progress notes thereafter lacked evidence to indicate R24's behavioral symptoms were being monitored. There were no comments in the physician's progress notes on 3/25/14, 4/29/14, 6/10/14 and 7/8/14, regarding R24's behaviors. R24's admission MDS, dated 3/17/14, indicated R24 had severe cognitive impairment. The Behavioral Symptoms section, indicated R24 had physical behavioral symptoms directed towards others (such as hitting, kicking, pushing) and verbal behavioral symptoms directed towards others (such as threatening, screaming, cursing) occurring 4 to 6 days, but less than daily during the assessment period. The MDS identified R24	21485		

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21485	Continued From page 27 had other behavioral symptoms not directed towards others (such as hitting or scratching self) which occurred 1 to 3 days during the assessment period. R24's Care Area Assessment (CAA) summary, dated 3/17/14, indicated behavioral symptoms were triggered on the MDS. The Comments and Analysis of Findings sections of the Review of Indicators of Behavioral Symptoms (RIBS) form dated 3/21/14, were left blank. There was no documentation to explain causal or unique risk factors for the behavioral symptoms. A comment entered in the Care Plan Considerations section of the RIBS dated 3/21/14, read, "Care plan to allow for the best quality of life." Although the MDS had identified behaviors, the CAAs lacked a summary of R24's behavioral status, including but not limited to identification of resident specific behaviors, potential antecedents to the behaviors, and clinically related social service interventions and strategies to address the identified resident specific behaviors. R24's current care plan dated as initiated on 3/27/14, did not address behavioral symptoms. The diagnoses list section of R24's face sheet dated 4/28/14, indicated R24 had diagnoses to include cerebrovascular disease, generalized pain, and insomnia. R24's diagnoses list did not include dementia until it was added to the electronic medical records diagnoses list when updated on 7/24/14, after surveyor intervention. R24's quarterly MDS dated 6/6/14, indicated R24 had severe cognitive impairment. The Behavioral Symptoms section indicated R24 did not manifest physical behavioral symptoms directed toward others; had verbal behavioral symptoms directed	21485		

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21485	Continued From page 28 toward others and behavioral symptoms not directed toward others occurring 1 to 3 days during the assessment period. Although the quarterly MDS identified potential inprovement in R24's behaviors, the clinical record lacked evidence clinically related social services were developed to address the idenitifed behaviors. There were two incident reports reviewed which involved R24, as follows: 1.) On 6/25/14, R59 accused R24 of hitting R59 on the back of the head. According to the investigation report, R24 denied hitting R59, the two staff members who were at the activity during the incident denied having observed any "hitting," but agreed they heard R24 yell, "Shut up!" and slammed her hand on the table making a loud noise. 2.) On 7/24/14, involving R24 and R4, where R24 allegedly yelled, "You old bitch!" across the dining table towards R4. Also staff reported R24 had a behavioral outburst, when R24 slammed hand on table and yelled "shut up" to a little girl who was sitting on R59's lap during a bingo activity. On 7/23/14, at 10:00 a.m., V-A was interviewed and stated she had volunteered in the facility for 14 years. V-A stated she felt embarrassed when R24 yelled at her within earshot of other people who were present in the area. V-A claimed R24 had yelled at some other people before, but had not done it "for a while." When V-A was asked if "other people" were residents of the facility, V-A stated R24 did yell at some residents and repeated R24 did not yell for some time until, "this morning." V-A stated she believed "all staff here [at the facility]" knew about R24's behaviors as they were reported to the staff when the behaviors had occurred "before."	21485		

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21485	Continued From page 29 On 7/24/14, at 9:55 a.m. nursing assistant (NA)-H stated R24 yelled loudly "two times a day, every day" at other residents and staff. NA-H added, "We were told to try and calm [R24's name] down and re-direct her." At 10:30 a.m. housekeeping staff (HK)-B stated she witnessed R24 yell at somebody once "yesterday" when R24 yelled at V-A. HK-B stated aside from witnessing R24's yelling episode on 7/23/14, information about R24's verbally abusive behaviors were heard during meetings. HK-B did not remember what was said during the meetings or what to do about it. At 11:00 a.m. NA-B stated had not witnessed R24 yell or do anything to anybody, but had heard R24 was "very short" to people and did not like when children came to the facility. At 11:15 a.m. NA-C stated hearing from other staff R24 would be impatient during activities and would yell at others. NA-C was not aware if behaviors were being monitored and documented. At 11:30 a.m. NA-A stated R24 would yell at other residents during activities when R24 was upset. NA-A stated other residents would just keep quiet and staff would intervene. NA-A stated they had reported R24's behaviors to the nurse manager or a registered nurse. NA-A was not aware if behaviors were being monitored and documented. At 11:40 a.m. registered nurse (RN)-A stated had observed R24 yell at other residents during activities, such as when residents were "playing ball." RN-A stated R24 yelled at other residents when frustrated. RN-A stated when staff report an incident regarding R24's verbally abusive behaviors, RN-A would approach and calm R24 down by talking. RN-A admitted there was neither monitoring, nor documentation for R24's	21485		

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21485	Continued From page 30	21485		

behaviors. RN-A denied receiving a report about an incident involving R24 yelling at another resident on 7/23/14.

On 7/25/14, at 7:56 a.m., director of nursing (DON)-B and the social worker reported that when R24, "first got to facility had some behavioral issues", however, the behaviors had not happened lately. The social worker and DON-B also stated R24's yelling behavior was not new and had happened, "way back when."
DON-B confirmed dementia was not included in R24's admission diagnoses, and was added to diagnoses list on 7/24/14. DON-B stated adding dementia as a diagnosis for R24 was pulled from the doctor's progress notes on 3/25/14, 4/29/14, 6/10/14 and 7/8/14. DON-B confirmed dementia was not included in R24's latest quarterly Minimum Data Set (MDS), dated 6/6/14. DON-B stated R24 had dementia and had potential to have behavioral issues that may affect others. DON-B confirmed there was no care plan to address R24's risk for behavioral problems. The social worker confirmed a behavioral care plan was put in place on 7/24/14.
At 8:27 a.m. the social worker confirmed there was nothing in the progress notes about R24's behavior. The social worker stated there had been no report to her about R24's behavior, and added, "But now when I talk to staff, it is a different story."
At 9:08 a.m. the social worker indicated there were no incident reports involving R24, except the ones that were provided to the surveyors, and said she had not been focusing on resident to resident abuse.
Wong, Becky
During interview on 7/25/14, at 8:10 a.m. DON-B and SW stated they had interviewed all resident's who go to activities with R24, her

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roommate/bathroom share, and stated "all had no issues [with R24's behaviors]." SW said they interviewed people who go to the activities with R24 and R58 and received no complaints, the activities person was interviewed and said they had not seen anything. SW stated R24 was very hard of hearing and spoke very loudly, "That's just her. We provide her with person centered care." SW stated dementia was on the chart and in the medical records and there was a behavior plan at the desk to remove R24 when she was yelling. SW explained to take R24 to her room to calm down and then let her rejoin the group. When asked when the plan had been put into place, SW stated, "It's at the desk." When asked if the behavior plan was on the nursing assistant care sheets, DON-B indicated it had been done the night before.

When asked if abuse was covered in orientation, the SW stated staff were told to provide "person centered care," and explained, with an example, that if residents were told the facility was short staffed, the residents would be fearful that there were not enough staff to care for them. SW stated, "I don't give an example of resident to resident abuse, and I probably should."
At 8:26 a.m., SW stated she had printed a "VA [vulnerable adult]" for R4 "last night" after R4 had verbally reported alleged verbal abuse from R24 to the surveyor on 7/24/14. SW stated she conducted an investigation and reported the allegation to the SA, but had hit "send", before printing the report and investigation, so did not have a copy of the VA report. SW stated, "I am finding out now that staff have not told us that [R24's name] had been yelling and pounding the table. There had been nothing in the progress notes about behavior, no reports made about R24, and now when I talk to staff it is a different

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21485	Continued From page 32 story." The facility's policy dated 11/2/10, directed facility staff to use the Resident Assessment Indicator (RAI) Process to "assess the resident's function." The policy directed to complete the MDS, CAA and utilizations guidelines by the Centers for Medicare and Medicaid Services (CMS) to "assess the resident to identify problems and formulate appropriate care plan goals and approaches for the resident." Under the facility's RAI Process' Procedure number 7, the "completion of the assessment process includes completing further assessments for the care areas triggered on the MDS," and that there must be a "summary statement of the causal factors, contributing factors or complicating factors as to why the resident has the problem." The facility's RAI process further directed to complete a Care Area Assessment summary and describe: the nature of the condition; complications and risk factors that affected the decision to proceed to care planning; factors that must be considered in making an individualized care plan interventions; and the need for referrals or further evaluation by appropriate health professionals. SUGGESTED METHOD OF CORRECTION: The administrator, social worker or designee could review, revise or develop policies and procedures to ensure resident behaviors are identified, comprehensively assessed and resident specific interventions are developed and care planned. All facility staff could be educated on these policies and procedures. The administrator, social worker or designee could develop a monitoring system to ensure ongoing compliance. Time Period for Correction: Twenty-one (21) days.	21485		

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21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure equipment was maintained in a safe working order, including bathroom assist bars, for 7 of 7 residents (R7, R65, R23, R43, R70, R58, R63). Findings include: The facility failed to maintain safe bathroom assist bars for 7 of 7 residents (R7, R65, R23, R43, R70, R58, and R63). During an environmental tour on 7/24/14, at 2:15 p.m. with the director of maintenance (DM) loose bathroom assist bars were identified and verified by the DM. Loose bathroom assist bars which moved approximately one to three inches back and forth were identified in a shared bathroom for R7 and R65. R7 had an OT (occupational therapist) - Therapist Progress & Discharge Summary dated 7/26/13, which indicated R7 was able to perform toileting tasks utilizing grab bars requiring standby assist.	21685	Plant Housekeeping, Operation, & Maintenance: Corrected August 20th, 2014	8/20/14

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21685	Continued From page 34 Care plan dated 2/25/14, revealed R7 was at risk for falls. R7's annual minimum data set (MDS) dated 4/23/14, indicated R7 required extensive assist of one for toilet use and had moderately impaired cognition. The corresponding care area assessment (CAA) dated 4/23/14, indicated falls had triggered for R7. The quarterly MDS dated 7/16/14, noted R7 had fallen in the last 90 days or since admit with no injury noted. R65's admission MDS dated 5/29/14, indicated R65 required extensive assist of one for toilet use and had severely impaired cognition. The MDS also revealed R65 had a history of falls with a fracture prior to admission. The CAA dated 5/29/14, indicated falls had triggered for R7. Care plan dated 6/9/14, indicated R65 had potential for falls. Loose bathroom assist bars moving approximately one to three inches back and forth were identified in the bathroom for R23. R23's care plan dated 11/26/12, indicated R23 was at risk for falls. The CAAs dated 10/16/13, indicated falls had triggered for R23. The quarterly MDS dated 6/25/14, indicated R23 required extensive assist of one for toilet use and had moderately impaired cognition. The MDS also depicted R23 as having one fall in the facility without an injury in the last 90 days. Loose bathroom assist bars moving approximately one to three inches back and forth were identified in the shared bathroom for R43 and R70. The assist bar on the right side was leaning forward to fit under a toilet paper holder which was pulled out of the wall approximately 1/2 inch. The right assist bar was not at the same height as the left side assist bar. DM verified the	21685		

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21685	Continued From page 35 bar was set down a notch to be able to fit under the toilet paper holder. R43's had an OT - Therapist Progress & Discharge Summary dated 10/17/13, which indicated R43 was able to perform toileting tasks utilizing grab bars requiring supervision. Care plan dated 2/25/14, indicated R43 was at risk for injury. The annual MDS dated 5/9/14, indicated R43 required extensive assist of one for toileting and had intact cognition. The MDS also noted R43 had a fall in the facility in the last 90 days without an injury. The CAAs dated 5/9/14, indicated falls had triggered for R43. R70's nursing assistant team sheet (undated) indicated R70 required extensive assist of two for transfers, had short term memory loss, needing cueing and reminders and was at risk for falls. Loose bathroom assist bars moving approximately one to three inches back and forth were identified in a shared bathroom for R58 and R63. R58's CAAs dated 12/18/13, indicated falls had triggered for R58. The quarterly MDS dated 6/4/14, indicated R58 required extensive assist of one for toileting and had intact cognition. The MDS also noted R58 had a fall in the facility in the last 90 days without an injury. Care plan dated 7/7/14, indicated R58 was at risk for falls. R63's CAAs dated 4/24/14, indicated falls had triggered for R63. R63's admission MDS dated 4/24/14, indicated R63 required assist of one for toilet use, had no falls in the 90 days, and had intact cognition. The care plan dated 5/6/14, indicated R63 had potential for falls.	21685		

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21685	Continued From page 36 During an interview on 7/24/14, at 3:20 p.m. DM stated he did rounds one time per month to check for housekeeping issues and call lights and he did not check the bathroom assist bars. DM stated he had Maintenance Repair Request Forms on a clipboard kept behind the South nursing station front counter. DM stated the forms were for anyone to report a maintenance requests or concerns. DM stated he looked at the clipboard every day and tried to resolve any issues as soon as possible. DM verified the loose bathroom assist bars were not on the maintenance repair request forms. DM stated he had no written policy, but reviewed the maintenance request process at new employee orientation and annually to all staff. During an interview on 7/25/14, at 8:41 a.m. registered nurse (RN)-B stated staff were trained and should write down maintenance issues and that any staff can report issues, "even housekeeping." RN-B stated the process was brought up at safety meetings, orientation for new hires and yearly inservice. RN-B verified R7, R65, R23, R43, R58 and R63 all used their bathrooms for toileting. RN-B stated she "was not sure" if R70 used the bathroom. During an interview on 7/25/14, at 11:28 a.m. DM stated he was not sure how many bathroom assist bars were in the facility and, "I don't know if the assist bars are supposed to be like that or not, I installed new ones and they are just about the same." During an interview on 7/25/14, at 11:36 a.m. OT stated she would assess and recommend bathroom assist bars if they were needed. "They do get loose after time." OT stated they would look at them again if the resident came back on	21685		

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21685	Continued From page 37 their caseload and/or, "Housekeeping or nursing will tell us or maintenance if they are loose, they tighten them or we find something else for them." OT further stated, "Maybe we should be checking them, we probably need to be doing that." SUGGESTED METHOD FOR CORRECTION: The administrator and/or designee could develop a maintenance program to maintain a safe environment for the residents. The maintenance director or designee could educate all appropriate staff on the policies/procedures, and monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21685		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision.	21990		9/8/14

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21990	Continued From page 38 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report injuries of unknown origin for 1 of 1 resident (R29) to the administrator and the designated State agency (SA). In addition, the facility failed to immediately report alleged incidents of abuse for R58 and R59 to the SA, and to timely submit investigated reports of alleged abuse for 4 of 5 residents (R23, R29, R58, R59) reviewed during abuse prohibition. Findings Include: Injury of unknown origin: 29's incident report, dated 1/21/14, was reviewed and identified R29 had swelling of the left foot/ankle, discoloration in left inner ankle/heel area and complaint of (c/o) pain with movement and palpation. An order was received from nurse practitioner (NP)-D for the foot and ankle to be x-rayed to check for injury. The x-ray was completed on 1/21/14, and R29 was found to have a non-displaced fracture of the distal metaphysis of the left fibula. The results were sent to NP-D and NP-D advised there was no specific treatment for that type of fracture. An air cast splint was applied on R29's left foot on 1/23/14, for immobilization and comfort. The investigation report stated R29 had first noted to c/o pain on 1/16/14, located in the knee. Resident again reported pain on 1/18/14, of left foot and left foot was swollen at the time. The left foot was then periodically checked over the weekend and elevated with relief. Shoe was left off of left foot. The investigative report stated R29 was basically non-ambulatory most of the time	21990	Corrected by September 8th, 2014	

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21990	Continued From page 39 except for restorative ambulation program. The report indicated R29 was transferred with stand-up lift and the injury could have occurred during a transfer or during ambulation if R29 stepped wrong and/or slightly twisted his ankle. The report also indicated the injury could have occurred while in standing lift if R29 moved foot or foot was displaced from standing plate during transfer procedure. Upon interview, R29 stated someone "bumped into my foot." No witnesses were noted for any incident. The report read dementia and memory impairment prevented R29 from being an accurate historian. The initial report was made to the SA one day later. The final investigative was submitted on 1/27/14, six days after the incident occurred. The quarterly Minimum Data Set (MDS) dated 5/22/14, noted R29 had a score of 3 on the Brief Interview for Mental Status (BIMS) which indicated impaired cognition. Reporting and timely submission of reports: R58 was interviewed on 7/21/14, at 6:09 p.m. and when asked the question, "Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse?" R58 answered "Yes" to surveyor. R58 stated R24 had yelled at R58 to shut up two different times. R58 also stated nurse assistants (NAs) and nurses were aware of it as they were in the dining room at the time and R24 "has had a few talking's to." R58 was asked, "Have you seen any resident here being abused?" and R58 answered, "Yes", and stated R58 overheard R24 yell at other residents "to shut up." The quarterly MDS dated 6/4/14, indicated R58 scored a 15 of 15 on the BIMS which indicated	21990		

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21990	Continued From page 40 intact cognition. On 7/21/14, at 6:32 p.m. registered nurse (RN)-D was asked whether staff were aware of R24's yelling, RN-D answered "yes" and stated the social worker (SS)-A had been notified about the yelling by different staff "more than once." RN-D also stated when that happens R24's behaviors were charted. At 6:37 p.m. SS-A stated she was aware of R24's yelling at R58, and stated one vulnerable adult (VA) report regarding R24 had been filed, but not one for R24 yelling at R58. SS-A stated she had talked to R58 and R24 individually about the yelling incident, but had not put notes into the computer about it. SS-A stated she only had her own paper notes, and said "Now I wish I would have documented it." SS-A stated she was also aware R24 has yelled at other residents. SS-A stated R24 had dementia, a "short fuse", and R24 apologized after the incidents. SS-A stated at the time she had not considered the yelling incidents from R24 as verbal abuse as R58 and R24 have a long history together. SS-A stated she had not submitted a report to the SA. SS-A stated the report was submitted to SA on 7/25/14, which was four days later. On 7/23/14, at 1:51 p.m. SS-A stated the usual process was to talk to the staff or residents, investigate a little first, talk to the administrator, discuss, and then a decision was made whether to file a report to the SA. SS-A stated either SS-A or the administrator would make the report. At 2:18 p.m. the administrator stated yes she was aware that reportable Incidents should be submitted immediately to the SA, and was also aware Investigative reports needed to be filed within five working days of the incident. Report of verbal abuse from R58 was not reported	21990		

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21990	Continued From page 41 immediately to the SA regarding R24. On 7/24/14, at 9:55 a.m. NA-H stated R24 yelled loudly "two times a day, every day" at residents and staff. We were told to try and calm R24 down and redirect her. NA-H stated after she yelled R24 then usually goes to her room and comes out later. On 7/25/14, at 7:56 a.m. SS-A stated she had talked last night (on 7/24/14) to R58, R58 had expressed feeling uncomfortable around R24. SS-A stated R58 reported, "I would have gotten the strap" if I yelled like R24 did. SS-A stated "that is R24's nature; R24 has a gruff voice, and snaps at people." SS-A also stated, "I wished I would have put in the record [R58's] report of verbal abuse." SS-A stated, "I haven't really focused on the verbal between residents," but rather staff to resident abuse. At 8:37 a.m. SS-A said she had talked to staff about R24's behaviors, and stated, "but now when I talk to staff it is a different story." At 9:09 a.m. SS-A provided a copy of the e-mail from Office of Health Facility Complaints (OHFC) sent on 7/25/14, (confirmation of incident report to Minnesota Department of Health (MDH), saying she had filed an incident report last night regarding R24. When asked for the incident report, SS-A replied she could not provide a copy of the incident report as she had forgotten to push the print button when submitting the report. At 9:12 a.m. SS-A stated mental anguish was considered verbal abuse, however, she had not been focusing on verbal abuse. SS-A also stated she would now, indicating the facility should provide person centered care, focusing on how residents' felt.	21990		

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21990	Continued From page 42 R59's quarterly MDS, dated 5/1/14, indicated R59 scored a six on the BIMS which indicated R59 had severely impaired cognition. A Progress note dated 2/14/14, by SS-A stated R59 was vulnerable due to impaired cognition and due to the cognition impairment, R59 had some difficulty completely expressing thoughts/words. The MDS indicated R59 was able comprehend most conversations if given time. R59 had diagnosis to include dementia. R59 on 6/23/14, reported R24 hit R59 on back of the head during bingo. Staff members overheard and witnessed R24 yell and slam R24's hand down on the table. The incident report identified a long standing history between R24 and R59 and it was not clear if anything physical happened between R24 and R59. Follow up plan was to have staff watch for agitation between R24 and R59 when together. On 7/23/14, at 1:50 p.m. the social worker stated to surveyor she found out about the incident on the morning of 6/24/14. The social worker stated she had talked to the administrator about that incident and the administrator had told her she should have submitted a report. The report was submitted on 6/25/14, two days later. R23's incident report indicated R23 fell on 3/12/14, while transferring with staff assistance from wheel chair (w/c) to exercise equipment without staff using gait belt. R23 lost balance and R23 fell hitting the head on arm rest of chair and door. R23 received a minor skin tear on left ear. The investigation found R23 lost balance during a transfer while receiving assistance from staff. It was found staff had not used a gait belt while assisting R23 which may have prevented R23's	21990		

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21990	Continued From page 43	21990		

fall. Staff was disciplined and was given further training on facility procedure for assisting R23 to transfer. The report indicated R23 received minor injuries. The completed investigative report was dated as completed on 3/21/14, which was nine days later.

R23's Quarterly MDS dated 6/25/14, indicated R23 had scored a score of eight on the BIMS, indicating moderately impaired cognition.

On 7/23/14, at 2:18 p.m. the administrator stated "yes" she was aware that reportable incidents should be submitted immediately to the SA, and was also aware investigative reports needed to be filed within five working days of the incident.

The Abuse Prohibition Policy dated as revised/amended on 7/13, identified St. Francis Health Services had established safeguards to prohibit Maltreatment (Abuse or Neglect) of any VA (vulnerable adult) in the facility. The policy identified the safeguards would adhere to the Federal and State requirements, whichever was most stringent. "Components of the Abuse Prohibition Policy under A. states Definitions of Maltreatment/Abuse and Neglect: Definitions of potential maltreatment. (Physical Abuse, Sexual Abuse, Verbal Abuse, Mental Abuse, Neglect, Financial Exploitation, Resident to resident abuse)."

The Reporting Mechanisms for Alleged Abuse Revised/Amended 7/13, identified St. Francis Health Services would follow procedures for reporting alleged maltreatment of a VA residing in our facility, to the appropriate authorities, as required by the most stringent federal regulations and state rules and statutes.

"A. The person observing or suspecting abuse

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21990	Continued From page 44 or a suspicious injury (this is a mandated reporter) to a resident in the facility must notify his/her supervisor immediately, who will report to the appropriate facility staff. C. Each facility must report any suspected abuse/neglect to MDH immediately ('immediately' means as soon as possible, but ought not exceed 24 hours after discovery of the incident). Save this notice of receipt of report from MDH. Keep it on file with the incident investigation. D. The facility administrator must also be notified of alleged abuse/neglect situations immediately. E. Following completion of the investigation within five (5) working days, the facility must submit a copy of the investigation to MDH." SUGGESTED METHOD OF CORRECTION: The administrator, nursing and social service directors could ensure staff have received adequate training in immediate reporting of allegations of misappropriation of property to ensure investigations would take place in a timely manner at the time the allegation is learned. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21990		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken	22000		9/8/14

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22000	Continued From page 45 to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult.	22000		

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22000	Continued From page 46 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to operationalize the abuse prohibition policy, which had the potential to affect four of five residents (R29, R58, R59, R23). Findings Include: The Abuse Prohibition Policy Revised/Amended 7/13, identified St. Francis Health Services had established safeguards to prohibit Maltreatment (Abuse or Neglect) of any VA (vulnerable adult) in our facility. The safeguards would adhere to the Federal and State requirements, whichever was most stringent. The policy indicated: "Components of the Abuse Prohibition Policy under A. states Definitions of Maltreatment/Abuse and Neglect: Definitions of potential maltreatment. (Physical Abuse, Sexual Abuse, Verbal Abuse, Mental Abuse, Neglect, Financial Exploitation, Resident to resident abuse). The Reporting Mechanisms for Alleged Abuse Revised/Amended 7/13 states St. Francis Health Services will follow procedures for reporting alleged maltreatment of a VA residing in our facility, to the appropriate authorities, as required by the most stringent federal regulations and state rules and statutes. A. The person observing or suspecting abuse or a suspicious injury (this is a mandated reporter) to a resident in the facility must notify his/her supervisor immediately, who will report to the appropriate facility staff. C. Each facility must report any suspected abuse/neglect to MDH immediately ('immediately' means as soon as possible, but ought not exceed	22000	Corrected by September 8th, 2014	

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RENVILLA HEALTH CENTER	205 SOUTHEAST ELM AVENUE RENVILLE, MN 56284

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
22000	Continued From page 47 24 hours after discovery of the incident). Save this notice of receipt of report from MDH. Keep it on file with the incident investigation. D. The facility administrator must also be notified of alleged abuse/neglect situations immediately. E. Following completion of the investigation within five (5) working days, the facility must submit a copy of the investigation to MDH." R29's the incident report dated 1/21/14, was reviewed and identified R29 to have swelling of left foot/ankle, discoloration in left inner ankle/heel area and complaint of (c/o) pain with movement and palpation. An x-ray was completed on 1/21/14, found R29 had a non-displaced fracture of the distal metaphysis of the left fibula. An air cast splint was applied on R29's left foot on 1/23/14, for immobilization and comfort. The investigation report indicated R29 was first noted to c/o pain located in the knee on 1/16/14. R29 again reported pain on 1/18/14, of left foot and left foot was swollen at the time. The left foot was then periodically checked over the weekend and elevated with relief. Shoe was left off of left foot. The investigative report identified R29 was non-ambulatory most of the time except for restorative ambulation program. The report indicated R29 was transferred with stand-up lift and the injury could have occurred during a transfer or during ambulation if R29 stepped wrong and/or slightly twisted his ankle. The report also indicated the injury could have occurred while in standing lift if R29 moved foot or foot was displaced from standing plate during transfer procedure. Upon interview, R29 stated someone "bumped into my foot." No witnesses were noted for any incident. The report read dementia and memory impairment prevented R29 from being	22000		

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22000	Continued From page 48 an accurate historian. The initial report was made to the SA one day later. The final investigative report was submitted on 1/27/14, six days after the incident occurred. On 7/23/14, at 2:18 p.m. the administrator stated yes she was aware that reportable incidents should be submitted immediately to the SA, and was also aware investigative reports needed to be filed within five working days of the incident. R58 was interviewed on 7/21/14, at 6:09 p.m. and when asked the question "Has staff, a resident or anyone else here abused you-this includes verbal, physical or sexual abuse?" R58 answered "Yes" to surveyor. R58 stated R24 had yelled at R58 to shut up two different times. R58 also stated nurse assistants (NAs) and nurses were aware of that as they were in the dining room at the time and R24 "has had a few talking's to." R58 was asked "Have you seen any resident here being abused" and R58 answered "Yes", and stated R58 overheard R24 yell at other residents "to shut up." The report was called to the SA on 7/25/14, four days later. On 7/21/14, at 6:32 p.m. registered nurse (RN)-D when asked whether staff were aware of R24's yelling, RN-D answered "yes" and stated the social worker (SS)-A had been notified about that by different staff "more than once." RN-D also stated when that happens R24's behaviors are charted. -At 6:37 p.m. SS-A stated she was aware of R24's yelling at R58, and stated one vulnerable adult (VA) report regarding R24 had been filed, but not one for R24 yelling at R58. SS-A stated she had talked to R58 and R24 individually about the yelling incident, but had not put notes into the	22000		

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22000	Continued From page 49 computer about it. SS-A stated she only had her own paper notes, and said "now I wish I would have documented it." SS-A stated she was also aware R24 has yelled at other residents. SS-A stated R24 had dementia, a "short fuse", and R24 apologized after the incidents. SS-A stated at the time she had not considered the yelling incidents from R24 as verbal abuse as R58 and R24 have a long history together. SS-A stated she therefore at that time had not submitted a report to the SA. On 7/23/14, at 1:51 p.m. SS-A stated the usual process was talking to the staff or residents, investigate a little first, talk to the administrator, discuss, and then the decision was made whether to file a report to the SA. SS-A stated either SS-A or the administrator would make the report. -At 2:18 p.m. the administrator stated yes she was aware that reportable Incidents should be submitted immediately to the SA, and was also aware Investigative reports needed to be filed within five working days of the incident. The report of verbal abuse from R58 was not reported immediately to the SA regarding R24. R59's Quarterly MDS dated 5/1/14, indicated R59 scored a score 6 on the BIMS which depicted R59 as having impaired cognition. A Progress note dated 2/14/14, by SS-A stated R59 was vulnerable due to cognition and due to the cognition impairment R59 had some difficulty completely expressing thoughts/words, but was able to if given time, comprehend most conversations. R59 had a history of dementia. R59 on 6/23/14, reported R24 hit R59 on back of head during bingo. Staff members overheard and witnessed R24 yell and slam R24's hand down on table. The incident report stated there was a long	22000		

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22000	Continued From page 50 standing history between R24 and R59 and it was not clear if anything physical happened between R24 and R59. Follow up plan was to have staff watch for agitation between R24 and R59 when together. On 7/23/14, at 1:50 p.m. the social worker stated to surveyor she found out about the incident on the morning of 6/24/14. The social worker stated she had talked to the administrator about that incident and the administrator had told her she should have submitted a report. The report was submitted on 6/25/14, two days later. - At 2:18 p.m. the administrator stated yes she was aware that reportable Incidents should be submitted immediately to the SA, and was also aware Investigative reports needed to be filed within five working days of the incident. The report was not followed in five days but rather nine days later. R23's incident report stated R23 fell on 3/12/14, while transferring with staff assistance from wheel chair (w/c) to exercise equipment without staff using gait belt. R23 lost balance and R23 fell hitting the head on arm rest of chair and door. R23 received a minor skin tear on left ear. The investigation found R23 lost balance during a transfer while receiving assistance from staff. It was found staff had not used a gait belt while assisting R23 which may have prevented R23's fall. Staff was disciplined and was given further training on facility procedure for assisting R23 to transfer. The report stated R23 received minor injuries. The final investigative report was completed on 3/21/14, which was nine days later. On 7/23/14, at 1:51 p.m. the social worker (SS)-A stated she was hired in 2012 and the vulnerable	22000		

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22000	Continued From page 51 adult (VA) policy was already in place. SS-A stated the usual process was talking to the staff or residents, investigate a little first, talk to the administrator, discuss, and then the decision is made whether to file a report. SS-A stated night staff will call administrator and they will talk about it, and the administrator will decide if a report was to be made, and either SS-A or the administrator will make the report. SS-A stated she would update the policy to read to report immediately to administrator/SA, then investigate. At 2:18 p.m. the administrator stated staff were trained to report immediately if a suspicion of abuse, were to call the administrator immediately, and if any suspicion talk to SS-A or administrator and one of them would report it. The administrator stated if reported late, staff should documented why. The administrator stated staff were told if the administrator was not available, they were to report it. The administrator stated staff were trained on the procedure yearly at a minimum. The administrator verified the facility's current Abuse Prohibition Policy used State terminology "maltreatment" instead of the Federal terminology "mistreatment" and said the policy was a corporate policy. The administrator also verified reportable incidents needed to be submitted immediately to the SA and investigation reports needed to be filed within five working dates of the incident. SUGGESTED METHOD FOR CORRECTION: The administraor or designee could audit, and provide education and training to all staff regarding reporting responsibilities and implementing the procedures of the Abuse Prevention Policy and Vulnerable adult(s). TIME PERIOD FOR CORRECTION: Fourteen	22000		

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22000	Continued From page 52 (14) days.	22000		